Question & Answer

Recorded December 16, 2020 from the live webinar:

Break Through Inertia: Strategies to Make Your Practice the Intervention

Question:
In my experience pharmacists we are not included well in reimbursement and with 2021 CMS PFS update we are limited more. Do you have any ideas for enhancing the ability to practice better team-based care and get reimbursement especially with regional MCA’s having inconsistent approval of using pharmacists?

Answer:
While I have no ability to assist with CMS reimbursement for PharmD – I do encourage you and your pharmacy colleagues to send letters of petition to CMS alerting them of the services you are able to provide and wanting a “seat at the table.” You all provide VALUABLE counseling to patients when they are picking up meds and your expertise is CRITICAL.

I have found that my pharmacy colleagues that work in institutions (i.e. hospitals) are certainly able to participate to their fullest capabilities and licensure and are important members of the team. In the meantime, one area where your participation is badly needed is in notifying the prescriber when a patient has NOT picked up a medication – either they refused because of cost or some other reason. Often times we are missing this important piece of the equation.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

I would love to see more billing initiation and interpretation to be open for all. For now one thing that can help the current flow is to assist in obtaining the CGM for the patient. I think the biggest barrier is when I send an RX to a pharmacy for refill or starting the pre-approval process and I will get back response that it is not covered. Often times a pre-approval or a redirect to DME is all that is needed. Sharing with patients some of the assistance or free trials that are available is also helpful. That process, although time consuming, will overcome so many of the current barriers that are encountered at the pharmacy level.

-Eden Miller, DO
Question:
If a patient is not on multiple daily injections (MDI) of insulin, are most insurances now willing to cover a CGM? Historically we were told it would be covered only if MDI.

Answer:
My experience is YES, most commercial payers WILL cover CGM – and not all even require a patient to be on any insulin – or even medication in some cases. My recommendation is to just send a prescription for a reader and sensor (Libre) or a reader, sensor and transmitter (Dexcom). And see what happens. If too expensive, the patient can refuse to pick up – but at least you tried.

As for CMS (Medicare), YES, those patients MUST be on at LEAST 3 injections of insulin/daily AND performing blood glucose testing AT LEAST 4x daily AND this must be DOCUMENTED in your note with mention that the frequent blood glucose tests are required by both you and the patient to make therapeutic adjustments to insulin dosing and decisions. Some DME will require proof (copy of a BG log) however, the documentation requirements have been relaxed during the pandemic, once this emergency has cleared you can expect those requirements to be required – so make sure your notes reflect what is needed.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

Lucia said it perfectly. Most commercial insurances cover some form of CGM for all patients. Medicaid is similar to Medicare, but often times they will only cover one brand. Also when a denial is provided, make sure a pre-approval is done and often times all that needs to be done is redirecting from pharmacy benefit to a DME insurance benefit. The denial reason isn’t always obvious.

-Eden Miller, DO

Question:
Do you have any suggestions for GLP1 coverage for Medicare/Medicaid patients? I find it difficult to intensify with cost coverage issues.

Answer:
My experience has found that all commercial payers, Medicare and Medicaid WILL COVER at least one GLP-1RA and SGLT2i. I provide a list of available medications (trade name) to the patient and instruct them to find out which is covered, and what the expected out of pocket cost will be for them. Also to find out if mail-order is cheaper and how many days’ supply, they are allowed. Just because it is covered does not mean it is affordable. I have not had any patient refuse to take ownership. I explain why I need for them to check and that my goal is make sure
they have access to the most affordable and appropriate treatment. This is a great example of patient-centered care and SHARED-DECISION making. A win-win.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

Yes, all insurances cover something in each class…and yes some require failure. I use what I call the 60 second prior authorization approach. In summary, I dictate in the note what is needed for the patient, what they have done in the past, other secondary things like weight, adherence, BP and cardiovascular risk, and in the plan say please let this note serve as a prior authorization for XYZ med for whatever reason, a1c, weight, CV risk…..then cap it off with the ADA, AHA, AACE, ACC, guidelines that all endorse this medical treatment and I will inform the patient if the insurance company denies my professional opinion that the insurance company is not currently following the standards of care set aside by the ADA, AHA, etc.

-Eden Miller, DO

Question:
You suggested that a practitioner can place the CGM in office with patient. Can this be done by Registered Dietitian who is also Certified Diabetes Care and Education Specialist? Or does it need to be MD/DO/NP, etc.?

Answer:
CGM sensors can be PLACED and the data later UPLOADED by ANYONE in the office. The USE must be prescribed or ordered by a QHCP (MD/DO/NP/PA). 95250 is billed once the patient RETURNS the sensor and at least 3 days of data is retrievable. This code includes the placing of the sensor, the patient education AND the upload – which is why it is billed when the patient returns and ONKLY if 3 or more days reordered. The code 95250 is SPECIFIC to PROFESSIONAL CGM.

The interpretation can ONLY be billed by QHCP. 95251 – this applies to interpretation of either pro or personal data and ca be billed on the same day as 95250 or 95249. The patient does not need to be present.

Code 95249 is the placement and training of a patient-owned device who chooses to have the initial training in done in your office by your staff. The caveat is that you cannot bill for this UNTIL the patient has returned (or in the case or remote monitoring) has uploaded at least 3 days of data.

This can only be billed ONCE per the lifetime of a specific device. You can bill again if you have a patient switch from one CGM to another (i.e. Libre 14-day to a Libre 2 or to a Dexcom or etc.)

-Lucia M. Novak, MSN, ANP-BC, BC-ADM
Question:
I work in a clinic that serves mostly uninsured and underserved patients. Some of my patients really need CGM but are not able to afford it. What other resources or suggestions do you have for patients that are not able to afford CGM?

Answer:
Unfortunately, there is no good answer here – even though CGM is more affordable, it does not necessarily make them more accessible or affordable for all. If you have access to pharma reps in your work place, then you can request complimentary readers (at least for the Libre and Libre 2). They will also provide complimentary (not “samples” per se) sensors and you can use these to see how patients are doing – especially if they have no BG data. The Professional sensors are NOT complimentary – your office will need to purchase these at about $65/each. If you do use a complimentary reader and sensor – just keep in mind that those are single patient only and you cannot use the reader for another patient.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

Also several cell phones will load the free app and then there are free trials from Dexcom and Libre 14-day system and probably the Libre 2 in the near future. Now that is just one time but can illuminate at least one time which is better than nothing.

-Eden Miller, DO

Question:
Regardless of insurance coverage, can MD/DO write a script for a CGM at any point in patient's diabetes journey? For example, will practitioners be able to write a script for CGM for a patient newly diagnosed with diabetes and only on Metformin?

Answer:
Yes – write the prescription. If it gets covered, FANTASTIC! If not, well at least you tried. The real issue is – HOW does your patient want to monitor their glucose and take ownership of their diabetes management. Not everyone wants to use a sensor – but many folks do. They require a prescription – and for commercial insured – they simply take that prescription to ANY pharmacy and then see what happens.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

You can write for anything and support why you are doing it, and back it up with the ADA recommendations.

-Eden Miller, DO
Question:
Is it okay to not go through the step by step guideline and to skip Metformin and go directly to GLP1 or SGLT2?

Answer:
This is a GREAT question! The answer to this is “Yes, but it depends.” On what?

- 1) FDA indication. If the drug has the coveted FDA indication to REDUCE THE RISK OF MACE or hospitalization for heart failure OR progression of renal disease – then YES, if your patient has these things then you can use these meds WITHOUT needing to start with metformin.

- 2) The insurance – they do not always seem to follow science and will usually choose meds based on whatever $$ deal they make with the manufacturer – and then change what they cover every year – sometimes every 6 months!

-Lucia M. Novak, MSN, ANP-BC, BC-ADM

You can do anything you think is best for the patient.

-Eden Miller, DO

Question:
Could you discuss the use of NPH and U500 in more detail in terms of timing, and dose adjustment when transitioning from multiple daily injections (MDI)?

Answer:
This is a day’s worth of information! – here is a quick take

NPH: typically dosed as a basal insulin and if so – in the morning and again at bedtime. Used quite a bit during gestational diabetes because of how impactful it is on glucose intolerance of pregnancy.

- NPH has a peak at about 6 hours after dose (but is highly variable). So patients MUST have another meal or a snack around that time to prevent hypoglycemia.
- Breakfast dose – MUST eat lunch or will have early afternoon hypoglycemia
- Dinner dose -MUST have a bedtime snack or will experience nocturnal hypoglycemia
- Bedtime dose – does not typically require any bedtime snack because the peak will be occurring when the dawn phenomenon is expected to start.

U500- This is a beast in and of itself. It acts as both basal and bolus insulin and is typically used for patients that require > 200 units a day to help with volume.
This is now available in pens and if you must use a vial – please ensure you prescribe the u500 syringe – and educate your patient that they MUST have this type of syringe for safety. Both the pens and the u500 syringe do not need for you to calculate insulin dose. They do it for you. So 20 units of u100 = 20 units of u200 = 20 units of u500. The difference if the higher concentrations are less liquid (volume) not less or more insulin. This is all I can comfortably discuss in this forum. Go directly to the manufacture site (i.e. Lilly) and they offer lots of good, practical information.

-Lucia M. Novak, MSN, ANP-BC, BC-ADM