

Not Taking "No" For An Answer

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An Interview with a CGM Reimbursement Guru

Jean Corrigan RN, MA, CDE, is program director for Winthrop University Hospital's pediatric diabetes program. This ADA nationally recognized pediatric program serves over 1000 diabetes patients, 40 percent of whom are on insulin pumps. A highly regarded diabetes educator, she has extensive experience using continuous glucose monitoring (CGM). We were privileged to see her speak at the American Association of Diabetes Educators conference last year and were grateful for all the reimbursement tips in particular—in fact, in our opinion, she's quite the reimbursement guru and she shares her expertise in this interview.

KELLY: Thanks for taking the time to talk to us. Could you tell us a bit about your history with the use of continuous glucose monitoring (CGM)? We were impressed that over 75 people in your practice wear a CGM!

J. CORRIGAN: We used the hospital CGM for many years and saw the potential of what it could do for patients in adding an important and valuable piece to the diabetes puzzle. So when home sensing devices were FDA approved (home CGM model), we certainly wanted to try the systems and assess the potential advantages for our patients and their families. We started with placing some reliable patients on the system, enlisting their feedback. Then we studied the graphs the system provided to see if we should expand this to a broader population. What we've seen is that for the right patients, this technology has the potential to open a new horizon for diabetes management. Being able to look at trends over a period of time, assess the patterns and make adjustments to the diabetes regimen can assist the practitioner in improving diabetes control. Improvement may mean a reduction in HgbA1c or perhaps reducing the variability of blood glucose readings, reducing hypoglycemic events, or even reducing the actual blood glucose readings performed in a day. Any of these advantages has an impact on the daily life of the patient and their family. Using sensing devices can give the patient the ability to see where they are at that moment, where their readings might be going, and how different foods, exercise and stress could be affecting their blood glucose readings.

KAKU: Which patients benefit the most from using CGM?

J. CORRIGAN: Well, the trick is to assess whether the person can and will use it properly. CGM is not FDA approved to dose off of—meaning it will not totally replace fingersticks. The patient has to be willing/able to do the calibrations, confirm any unusual readings with fingersticks, perform blood glucose readings for insulin dosing, change insertion sites regularly, etc. For some patients, the data is overwhelming and they find it difficult to understand trends and

patterns. Some find the concept of lag time between interstitial readings and blood and the potential for a wider variation in readings during times of unsteady states of glucose disconcerting. I have some teenagers who say, "I see what it can do for me but I am not going to wear another set or device." As we are all well aware, there are many challenges in the teenage population. However, if they are ready for the potential advantages this device could bring them, many have great success in improving their glucose control.

KELLY: What are some of the major barriers to CGM use? What improvements could be made?

J. CORRIGAN: I don't think the actual functioning of the device for most people is a big barrier as long as people have the right education. I think you have to have the ability in your practice to take adequate time to educate people and when you do that with any type of diabetes management, of course you get much better results. So, education is the key to success. Adequate time is required to properly educate the family to the use of the device. Additional support is necessary over the first few weeks to further educate the family to the potential advantages of the system. The concept of trend management information provided by sensor downloads and how to utilize that data to make diabetes regimen changes is essential information for successful use. One change we would like to see—perhaps because of our pediatric population—is user-settable alarms so that at night the parents can hear the alarms even when the child is under the blankets or in another room. Our parents have also stated that they would benefit from having the transmitter and receiver be capable of communicating with each other at an even greater distance. Obviously, less frequent calibrations and more accurate sensors would also be advantageous. Everybody would love to see all these improvements as time goes on. I believe the advantages of sensoring to a patient are tremendous—what we have right now is really terrific.

KELLY: Thank you for that wish list! What was it exactly that made you say in your inspiring talk at AADE that you should be able to get reimbursement for anyone? We would love readers to have advice for their healthcare professionals.

J. CORRIGAN: We realized 90% of our patients were not going to be able to afford this on an ongoing basis and we would like insurance to cover it to improve diabetes management. We wrote letters of medical necessity to our patient's insurance company and if they were denied coverage for that particular item we filed an appeal. If denied again, then we wrote a more extensive letter. We eventually found out, after a few cycles that once the insurance company's denials had been exhausted we had the opportunity to request an external review by the New York State External Appeal application process, which we did. We wrote another extensive letter to the New York State External Appeals, filled out their external review application, attached all the denial letters from the insurance companies and provided chart notes, as well as letters and documentation that we had previously sent to the insurance companies. In this package we also sent all the scientific articles that we thought were pertinent showing continuous glucose monitoring systems, their accuracy and the potential advantages to diabetes management. The documentation included 60 to 70 pages of relevant material. We then sent it as required in the time frame indicated to New York State External Board of Appeals—and generally after their extensive review, denial was overturned.

KELLY: That's a lot of paperwork but what a great result! And, we hear you have received no rejections after dozens of applications?

J. CORRIGAN: I had one rejection by the State personally in all the appeals I have sent. The last time I counted, we had at least 75 children or adolescents on sensing devices. We would tell the parents,

“You’re probably going to get denied at first, but we will appeal the denial.” We tell them right upfront about time limits to file appeals after a denial so that they have all the knowledge about how the system works. We walk them through what the process will be and how we must work together through this process. They needed to follow up with their insurance company by phone almost weekly to ensure our letters of medical necessity were received and that we received prompt notification of denial so that we could submit the next appeal. And then, upon the final denial by the insurance company, we’d send everything to the State. We decided early on that we would not take no for an answer.

KAKU: Wow, that’s inspiring for your patients to learn the steps about how to possibly get a CGM and improve their management.

J. CORRIGAN: Our priority is always quality patient care. If we didn’t attempt to assist our patients in achieving insurance reimbursement for this device, I feel we would be remiss. Over the first year of doing this, we fine-tuned our letters to insurance companies and coordinated the process with the families so that it became easier as time went on. It took a great deal of time that first year to fine-tune the documentation so we could use it and then relate it to the individual patient but after the first year it became a much easier process. We felt our time was well spent because it would directly impact our patients’ care.

KELLY: Well we know TCOYD Founder Dr. Steve Edelman would agree—he has over 100 patients in his practice on CGM as well. But he hasn’t had quite your success in reimbursement. What was the magic of what’s in the letter?

J. CORRIGAN: I think being very specific about the wide variability of blood sugars, the range of lows and highs, any severe hypoglycemia, as well as the impact on a person’s lifestyle. I have some children who have excellent A1cs but they’re testing blood sugars 10 to 14 times a

day, and they're 5, 6 years old. That certainly greatly impacts the family's lifestyle. CGM isn't going to eliminate the need for fingerstick testing but it may safely reduce the number of those blood glucose readings down to a more manageable number per day. What kind of impact does that have on a child's life as well as their families? Tremendous!

KAKU: Thank you so much. One last question—we have read that reimbursement is improving. Can you tell us, are you finding it easier to get approvals these days?

J. CORRIGAN: Over the past 6 months to a year there are certain insurance companies that do not even require extensive letters of medical necessity anymore. At present, Empire Blue Cross and Blue Shield, AETNA and United HealthCare all have a simple process to approve sensoring devices. It appears they all understand the importance and advantages of these devices. Oxford still requires numerous submissions. But there has been tremendous progress. Within the last six months, we have seen several insurance companies processing reimbursement requests without numerous letters and rejections. It's great to see this improvement.

KELLY: Well clearly you have been a pioneer for patients—we thank you and we know many patients and families will be excited to take your insights to their own doctors and educators! Thank you for your inspiration.

Kaku Armah and Kelly Close are editors of diaTribe (www.diatribes.com), a free online newsletter for intensively managed patients with diabetes. Dr. Steve Edelman, is on diaTribe's advisory board—and introduced Kelly to CGM in 2002.

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