OUTPATIENT INTRAVENOUS INSULIN TREATMENT (NCD 40.7)

Guideline Number: MPG230.05

Approval Date: April 8, 2020

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OVERVIEW

The term outpatient intravenous (IV) insulin therapy (OIVIT) refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin via any means, guided by the results of measurement of:

- Respiratory quotient; and/or
- Urine urea nitrogen (uun); and/or
- Arterial, venous, or capillary glucose; and/or
- Potassium concentration; and performed in scheduled recurring periodic intermittent episodes.

This regimen is also sometimes termed Cellular Activation Therapy (CAT), Chronic Intermittent Intravenous Insulin Therapy (CIIT), Hepatic Activation Therapy (HAT), Intercellular Activation Therapy (iCAT), Metabolic Activation Therapy (MAT), Pulsatile Intravenous Insulin Treatment (PIVIT), Pulse Insulin Therapy (PIT), and Pulsatile Therapy (PT).

In OIVIT, insulin is intravenously administered in the outpatient setting for a variety of indications. Most commonly, it is delivered in pulses, but it may be delivered as a more conventional drip solution. The insulin administration is adjunctive to the patient's routine diabetic management regimen (oral agent or insulin-based) or other disease management regimen, typically performed on an intermittent basis (often weekly), and frequently performed chronically without duration limits. Glucose or other carbohydrate is available ad libitum (in accordance with patient desire).

GUIDELINES

The Centers for Medicare and Medicaid Services (CMS) determines that the evidence is adequate to conclude that OIVIT does not improve health outcomes in the Medicare population. Therefore, CMS determines that OIVIT is not reasonable and necessary for any indication under section 1862(a) (1) (A) of the Social Security Act. Services comprising an Outpatient Intravenous Insulin Therapy regimen are nationally non-covered under Medicare when furnished pursuant to an OIVIT regimen. HCPCS code G9147 is to be used for billing non-covered OIVIT and any services comprising of an OIVIT regimen. CPT codes 99199 or 94681 (with or without diabetes related conditions) are not to be used on claims billing for non-covered OIVIT and any services comprising an OIVIT regimen when furnished pursuant to an OIVIT regimen.

Individual components of OIVIT may have medical uses in conventional treatment regimens for diabetes and other conditions. Coverage for such other uses may be determined by other local or national Medicare determinations, and do not pertain to OIVIT. For example, see Pub. 100-03, NCD Manual, Section 40.2, Home Blood Glucose Monitors, Section 40.3, Closed-loop Blood Glucose Control Devices (CBGCD), Section 190.20, Blood Glucose Testing, and Section 280.14, Infusion Pumps, as well as Pub. 100-04, Claims Processing Manual, Chapter 18, Section 90, Diabetics Screening.
APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>94681</td>
<td>Oxygen uptake, expired gas analysis; including CO₂ output, percentage oxygen extracted</td>
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<tr>
<td>99199</td>
<td>Unlisted special service, procedure or report</td>
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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<td>G9147</td>
<td>Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration (Noncovered)</td>
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PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

REFERENCES

**CMS National Coverage Determination (NCD)**

NCD 40.7 Outpatient Intravenous Insulin Treatment

**CMS Claims Processing Manual**

Chapter 4; § 320 Outpatient Intravenous Insulin Treatment (OIVIT)

**CMS Transmittal**

Transmittal 1854, Change Request 10086, Dated 05/26/2017 (ICD-10 Coding Revisions to National Coverage Determination (NCDs))

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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| 04/08/2020 | **Policy Summary Guidelines**  
  • Added language to indicate HCPCS code G9147 is to be used for billing non-covered outpatient intravenous insulin therapy (OIVIT) and any services comprising of an OIVIT regimen  
  • Removed language pertaining to claims billing for HCPCS codes 99199 and 94681 for non-covered OIVIT  
  **Applicable Codes**  
  • Added notation to clarify HCPCS code G9147 is “not covered” |
Outpatient Intravenous Insulin Treatment (NCD 40.7)

UnitedHealthcare Medicare Advantage Policy Guideline

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Approved 04/08/2020