Virginia Long-Term Care Clinician Network Monthly Forum

December 18, 2024

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care.

Please use the chat box:

- **Your name, practice and areas of practice**
- **Best wishes for some restful days over the next month!**

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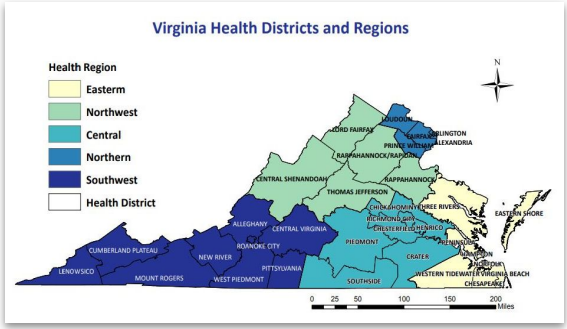
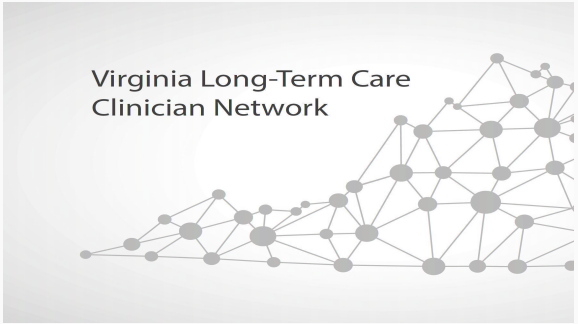
Welcome New Members!

Samantha Halterman - Northwest/Central Region
Alyssa Jessup - Eastern Region
Hyacinth Johnson - Central Region
Jennifer Johan - Northern Region
Utam Lekhraj - Eastern Region
Laura Manner - Eastern Region
Shirley Dodson McAdoo - Eastern Region
Ashley Singleton - Central Region

Invite your work colleagues to join so they can get Education, Support and CME!



285 Members Strong!



For great resources: look for previous slide sets and newsletters under *Forums & Events* and *Resources* on our website.

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Chat Waterfall

In Chat, respond to the question below, but don't hit the send button yet! Wait for the countdown…

How does your team, if you have one, do workday scheduling? Do you self schedule, a non clinical person make a schedule, texts to colleagues seeking coverage, etc.?

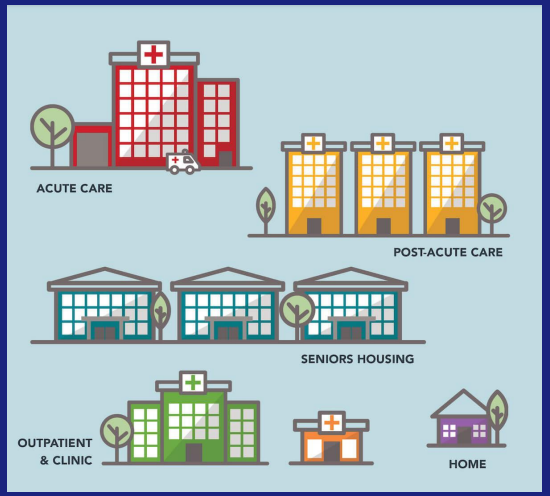
Jones Run Falls about an hour from Waynesboro VA

Diabetes Update in PALTC

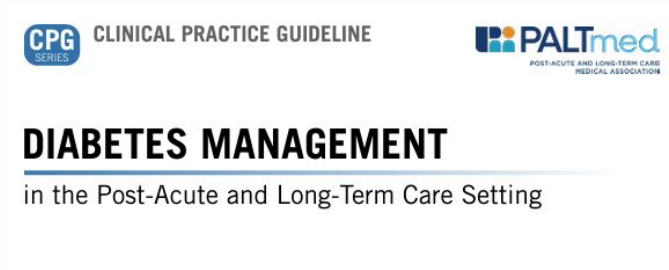
GLP-1 Agonists and Continuous Glucose Monitoring

Carl J. “Christian” Bergman, MD, CMD, FACP, AGSF
Associate Professor, Division of Geriatric Medicine, VCU

I have no relevant conflicts of interest.

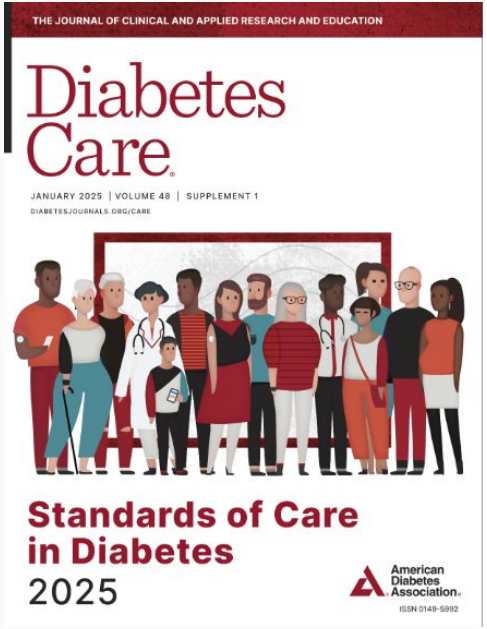


Key Resources

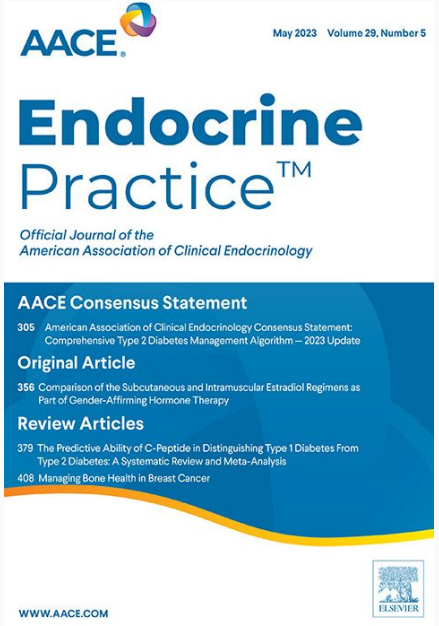


August 2024

https://paltmed.org/sites/default/files/2024-08/Diabetes_Text-August22-2024.pdf



https://diabetesjournals.org/care/issue/48/Supplement_1



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Diabetes in PALTC Background

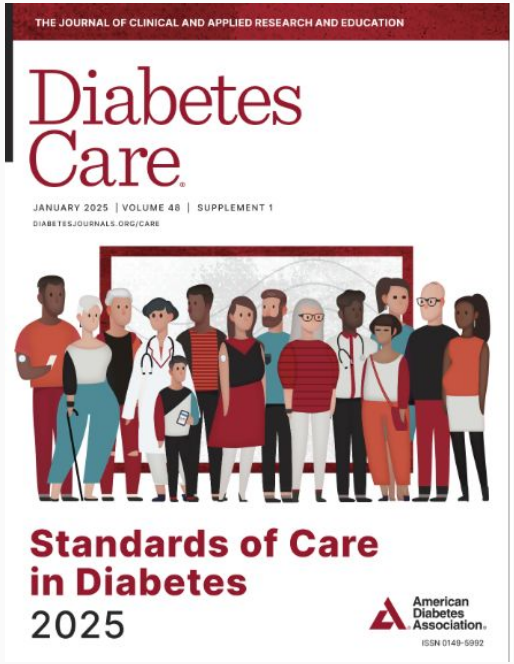
- Annual cost of diagnosed diabetes in US (2022) was $413 billion (direct and indirect)
  - Has increased by 35% between 2012 and 2022.
- Prevalence of diabetes in PALTC 25-34%
- Independent predictor of placement in nursing home or assisted living
- Unclear treatment goals in this patient population
- High rate of co-morbid conditions

Key Recommendations

- Avoid prescribing restrictive diets
- Avoid strict adherence to low A1C numbers
- Avoid sliding scale insulin
- Consider newer oral agents (DPP4, SGLT2)
- Consider newer injectable GLP1 analogs

DPP-4, dipeptidyl peptidase 4; GLP1-RA, glucagon-like 1 receptor agonist; SGLT2, sodium glucose transporter 2 Sources: Evans et al, 2022; Karagiannis et al, 2022; Le et al, 2022; Lipska, et al, 2015; Miller et al, 2022; Pandya et al, 2023; Remelli et al, 2022; Thomas et al, 2021; Umpierrez & Klonoff, 2018 (References from PALTmed Diabtes CPG)

Highlights from ADA – Standards of Care 2025



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Decision Cycle for Person-Centered Glycemic Management in Type 2 Diabetes

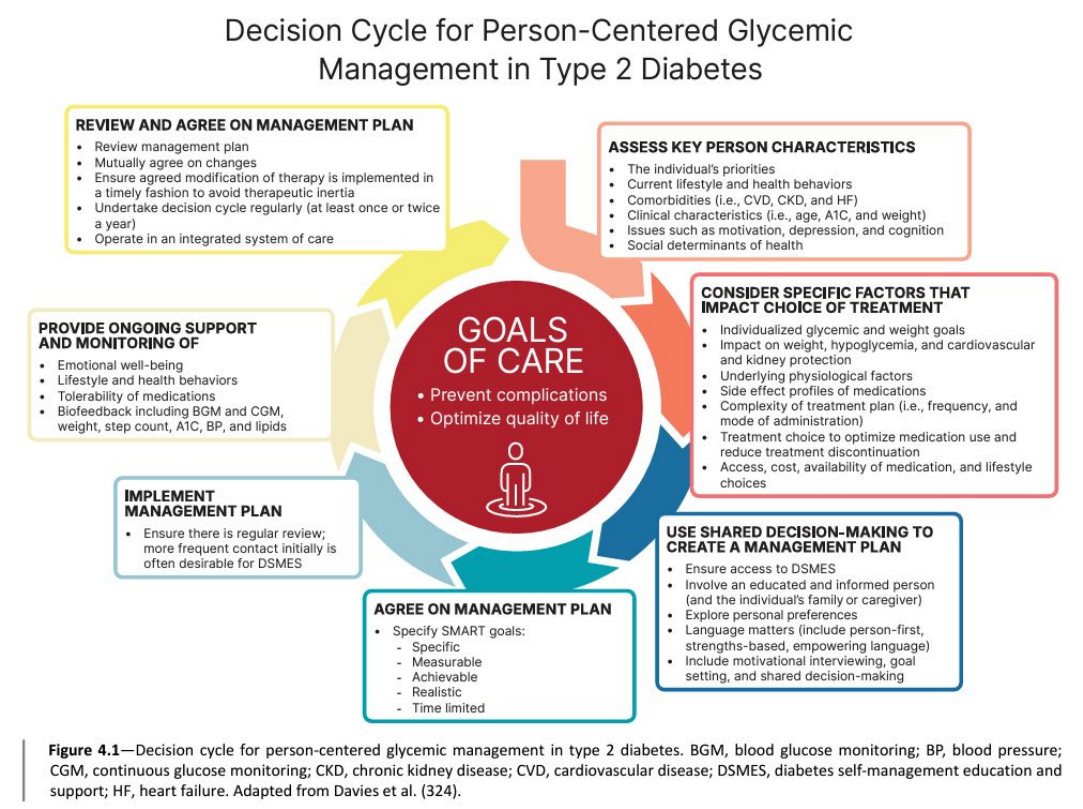

Figure 4.1—Decision cycle for person-centered glycemic management in type 2 diabetes. BGM, blood glucose monitoring; BP, blood pressure; CGM, continuous glucose monitoring; CKD, chronic kidney disease; CVD, cardiovascular disease; DSMES, diabetes self-management education and support; HF, heart failure. Adapted from Davies et al. (324).

https://diabetesjournals.org/care/issue/48/Supplement_1

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Fasting – Religious vs. Intermittent

Table 5.5—Changes in medications during fasting

Medication name	Risk of hypoglycemia	Timing	Total daily dose
Metformin, SGLT2 inhibitor, DPP-4 inhibitor, GLP-1 receptor agonist, acarbose, or pioglitazone	Low	• If once daily, then take at main mealtime. • If twice daily, then split dose between the two meals. • If once weekly, no change of time.	• No change
New generation sulfonylurea (glimepiride and gliclazide)	Low to moderate	• If once daily, then take at main mealtime. • If twice daily, then split dose between the two meals.	• Reduce dose if glucose levels are within individualized goal range and if no hypoglycemia or hyperglycemia is present at baseline.
Older generation of sulfonylurea (glyburide)	Moderate to high	• Take at time of main meal	• Replace with newer-generation sulfonylurea or reduce dose by 50%.
Basal insulin	Moderate to high	• For longer-acting basal analogs (glargine 300 or degludec), no need to change timing. • For other basal insulins, take at beginning of breaking fast meal.	• Choose the insulin with lower risk of hypoglycemia among the class. • Reduce dose by 25–35% if not well managed.
Prandial insulin	High	• At mealtime	• Reduce dose of insulin for the meal followed by fasting (35–50%). • For other meals, insulin dose should match carbohydrate intake.
Mixed insulin and insulin coformulations	High	• If once daily, then take at main mealtime. • If twice daily, then split dose between the two meals	• Reduce dose of insulin for the meal followed by fasting (35–50%). • For other meals, no change of dose.

DPP-4, dipeptidyl peptidase 4; GLP-1, glucagon-like peptide 1; SGLT2, sodium–glucose cotransporter 2.

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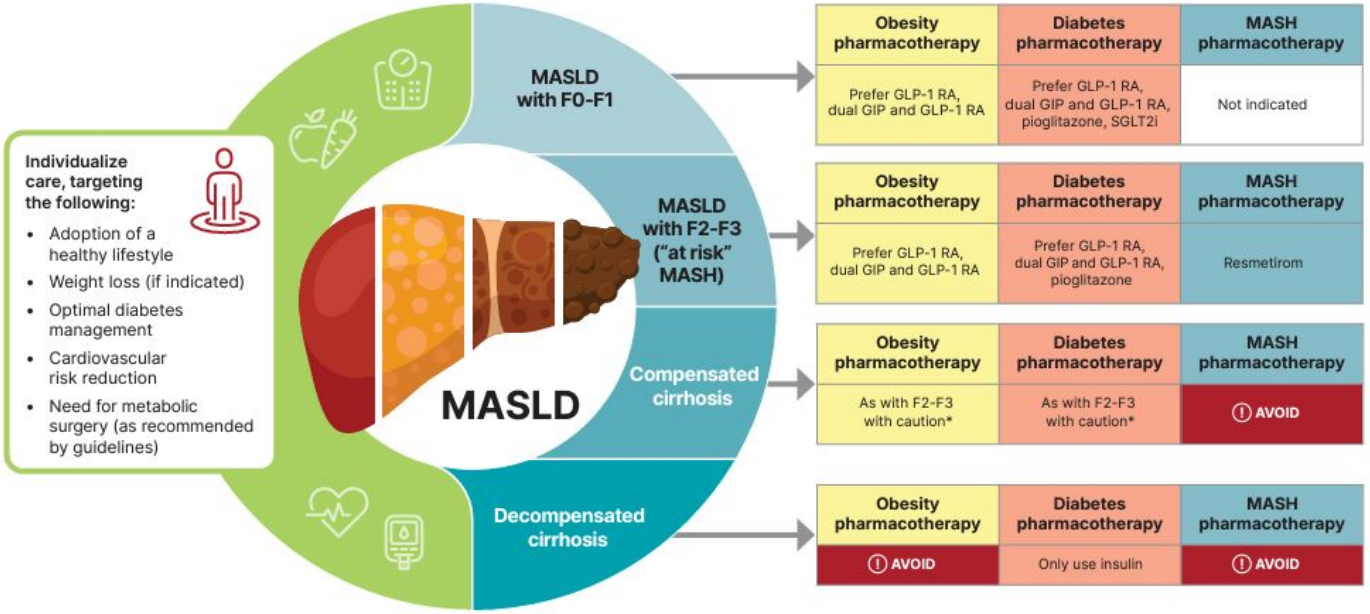
Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD) Treatment Algorithm



*Individualized care and close monitoring needed in compensated cirrhosis given limited safety data available.

Figure 4.3—Metabolic dysfunction–associated steatotic liver disease (MASLD) treatment algorithm. F0-F1, no to minimal fibrosis; F2-F3, moderate fibrosis; F4, cirrhosis; GIP, glucose-dependent insulinotropic polypeptide; GLP-1 RA, glucagon-like peptide 1 receptor agonist; MASH, metabolic dysfunction–associated steatohepatitis; SGLT2i, sodium–glucose cotransporter 2 inhibitor.

https://diabetesjournals.org/care/issue/48/Supplement_1

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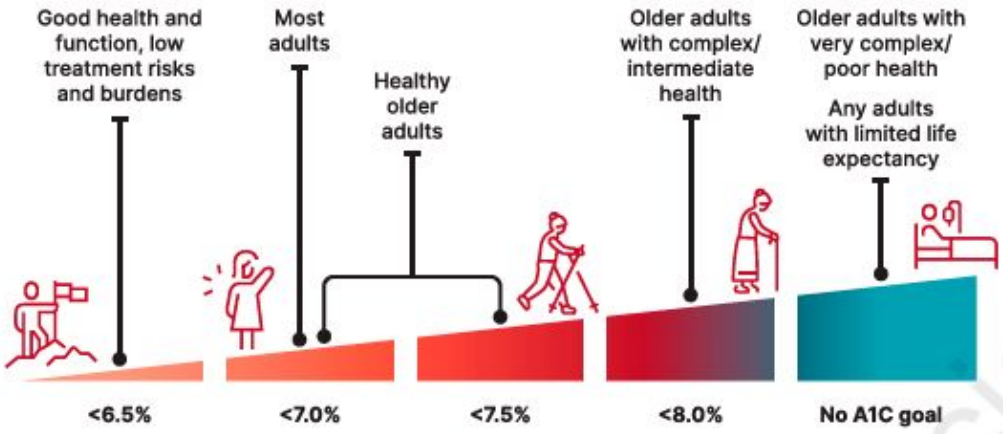
Individualized A1C Goals



Modifying Factors

Favor more stringent goal	Favor less stringent goal
Short diabetes duration	Long diabetes duration
Low hypoglycemia risk	High hypoglycemia risk
Low treatment risks and burdens	High treatment risks and burdens
Pharmacotherapy with cardiovascular, kidney, weight, or other benefits	Pharmacotherapy without nonglycemic benefits
No cardiovascular complications	Established cardiovascular complications
Few or minor comorbidities	Severe, life-limiting comorbidities

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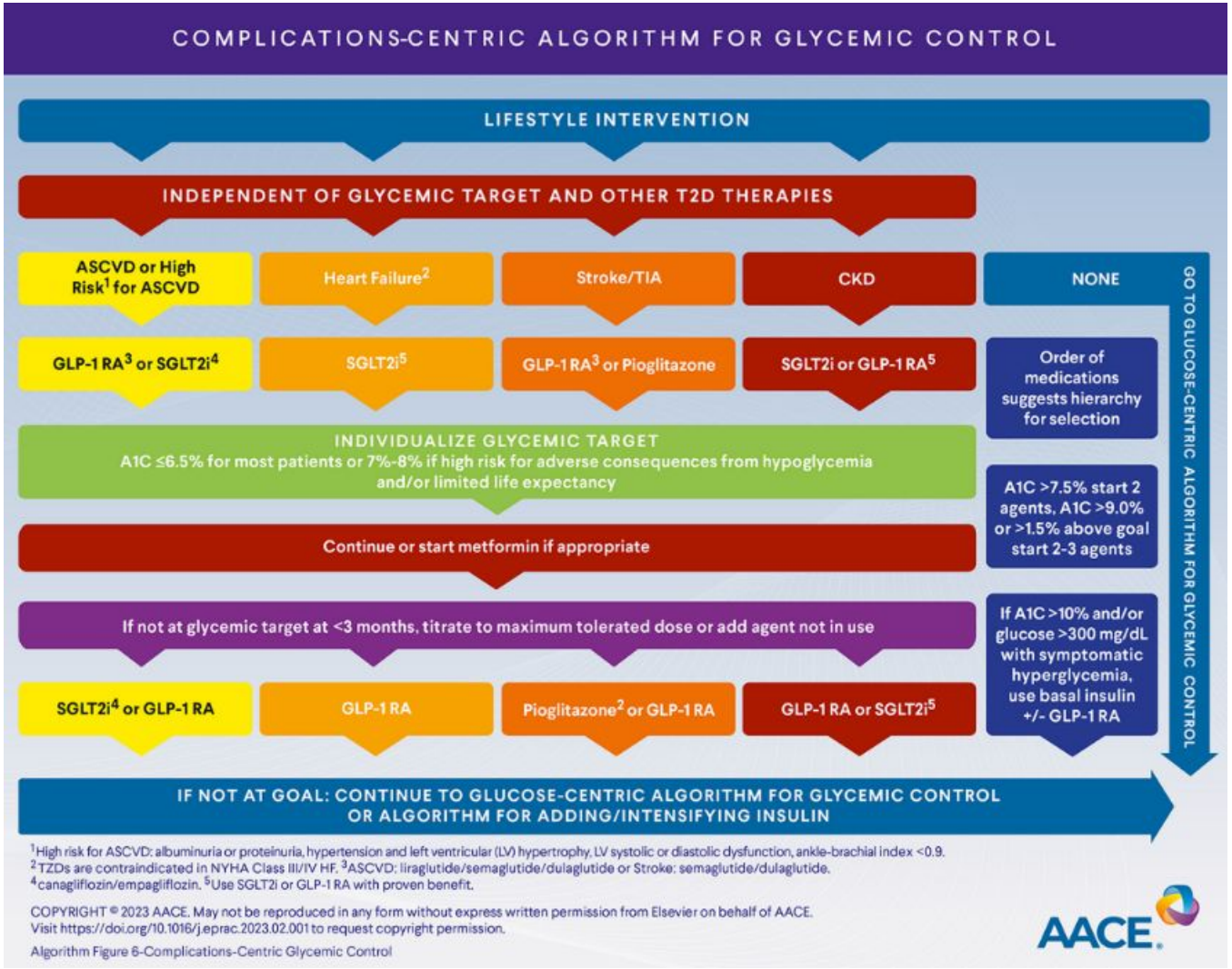

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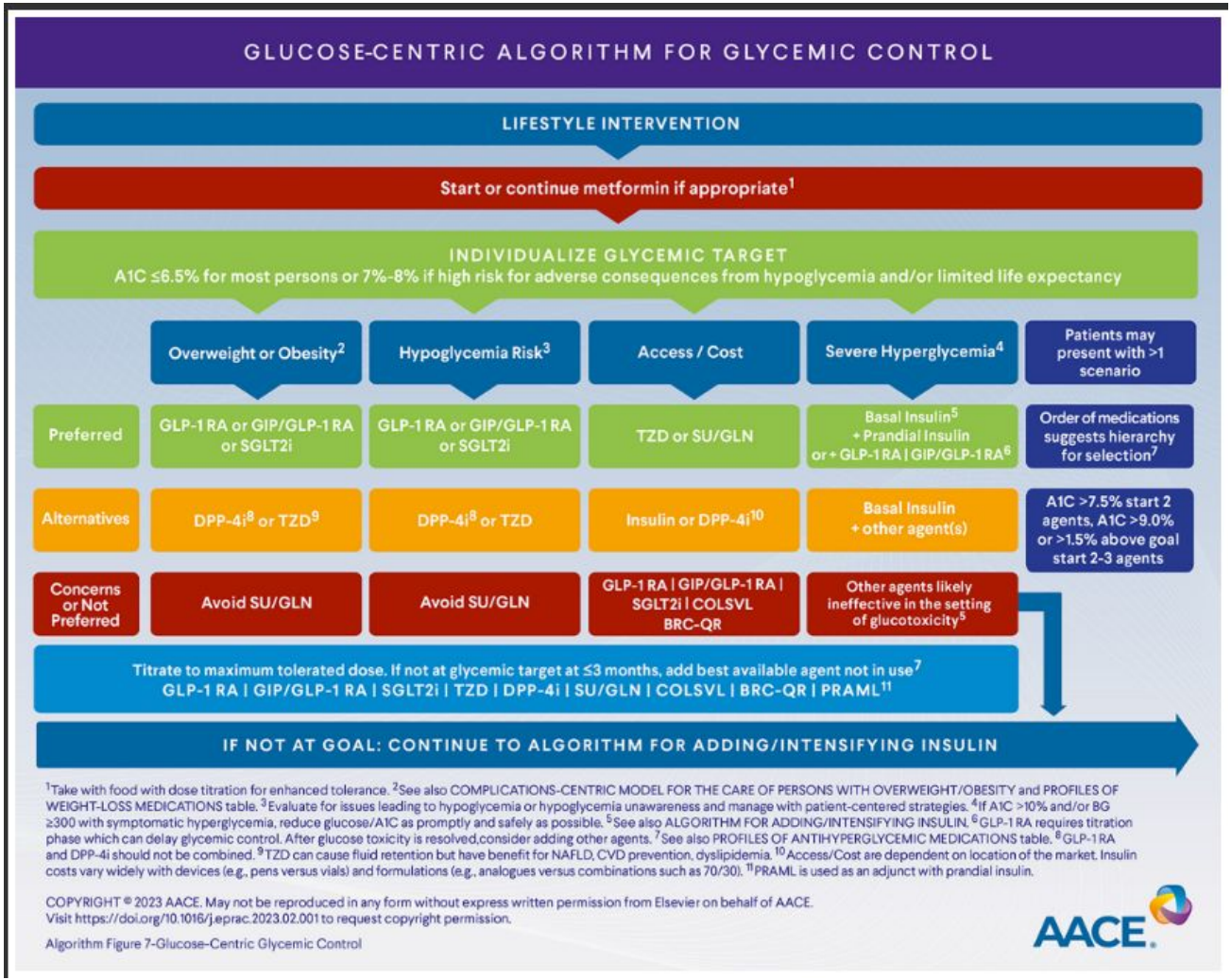

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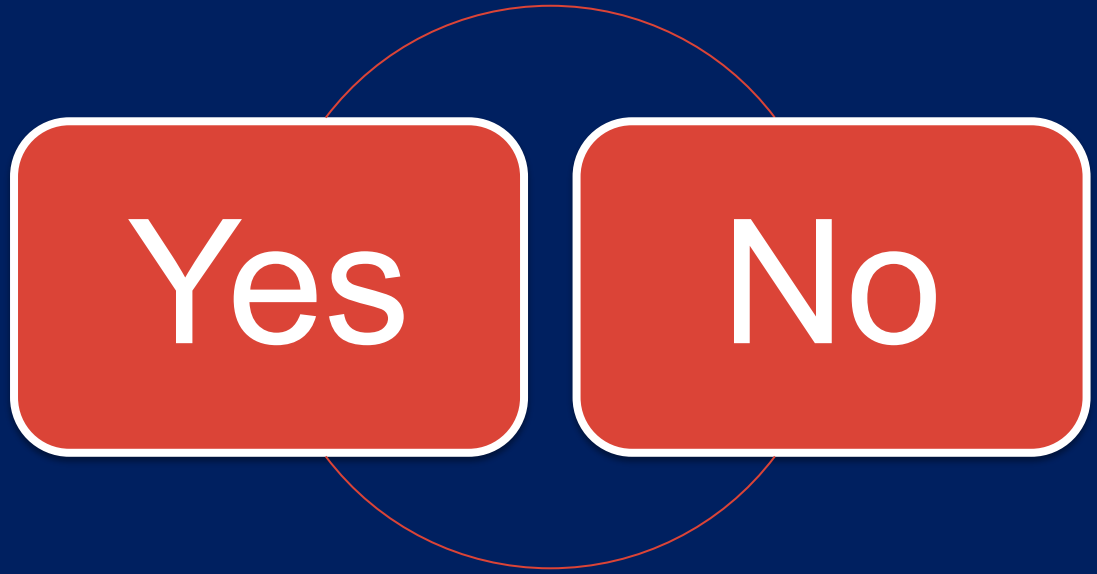
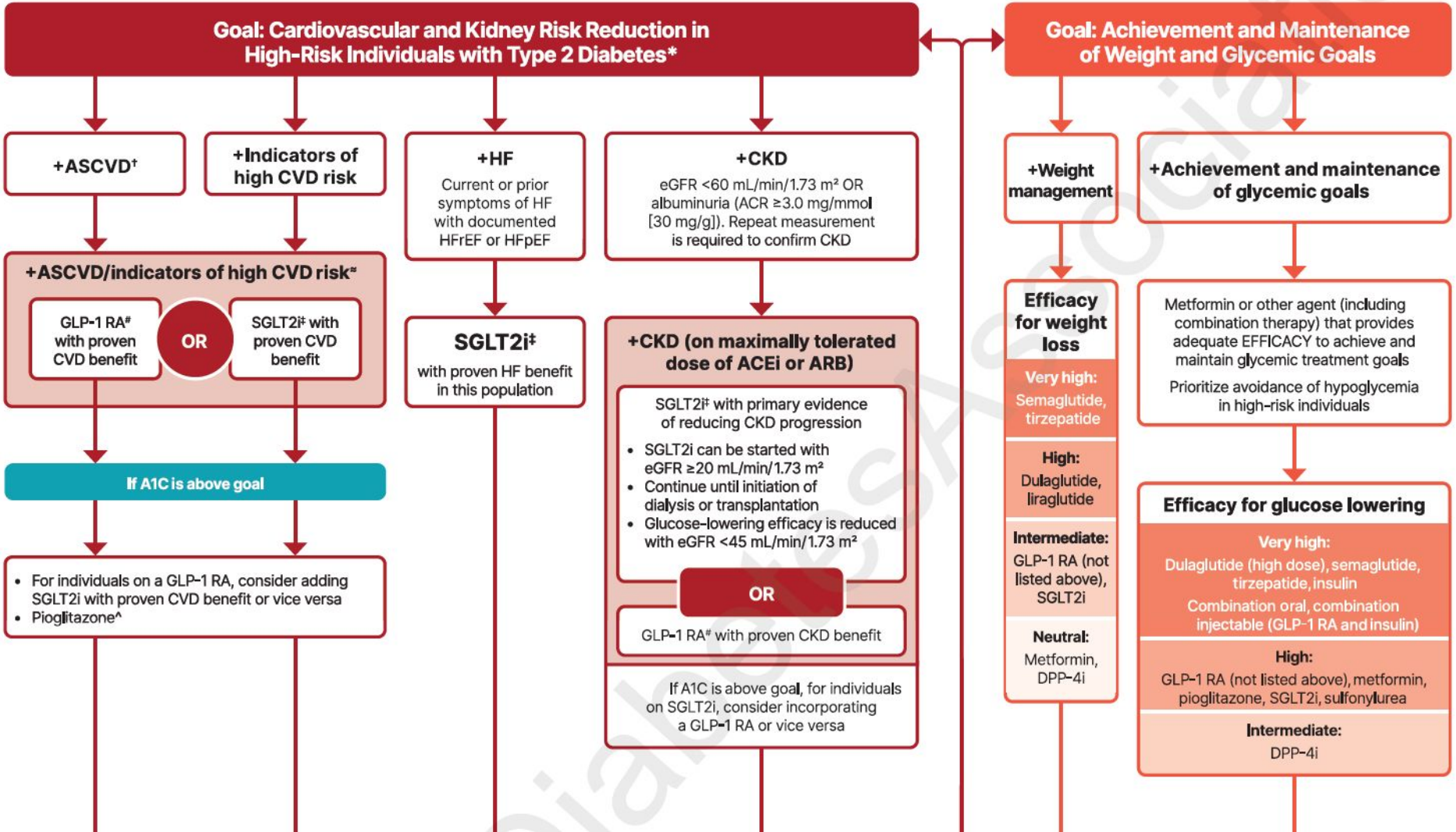
Poll Question:

Are you routinely using GLP-1RA in your PALTC practice?



Glucose Lowering Medications in T2DM

- SGLT-2 inhibitors
  - mechanism: SGLT2 inhibitors inhibit the coupled reabsorption of sodium and glucose from the proximal tubules, thereby increasing renal glucose and sodium excretion
  - intermediate/high efficacy, no risk of hypoglycemia, benefit for wt loss, MACE, HF, CKD
  - possible DKA risk, necrotizing fasciitis of perineum, higher UTI/urogenital infections, volume depletion/dehydration
  - **canagliflozin (Invokana) PO, dapagliflozin (Farxiga) PO, empagliflozin (Jardiance) PO**
- GLP-1RA
  - mechanism: GLP-1 receptor agonists work by mimicking the action of GLP-1, it regulates blood sugar levels by stimulating insulin secretion, inhibiting glucagon release, and slowing gastric emptying
  - high efficacy, no hypoglycemia risk, weight loss benefit high, benefit for MACE, neutral in HF, benefit in CKD
  - concerns: thyroid cancer, ileus, pancreatitis, gallbladder disease, diabetic retinopathy, decreased drug absorption, GI side effects (not for gastroparesis pts)
  - **exenatide (Byetta) BID IM, liraglutide (Victoza) qD IM, dulaglutide (Trulicity) qW IM, semaglutide (Ozempic) qW IM, tirzepatide (Mounjaro) qW IM**
- DPP-4i
  - mechanism: block DPP-4 from inactivating GLP-1 thus, increasing incretin levels (GLP-1 and GIP), which inhibit glucagon release, which in turn increases insulin secretion, decreases gastric emptying, and decreases blood glucose levels
  - intermediate efficacy, no risk of hypoglycemia, neutral benefit weight loss, MACE, HF, CKD
  - concerns: pancreatitis, joint pain, bullous pemphigoid
  - **linagliptin (Trajenta) PO, saxagliptin (Onglyza) PO, sitagliptin (Januvia) PO**


Goal: Cardiovascular and Kidney Risk Reduction in High-Risk Individuals with Type 2 Diabetes*
+ASCVD†
+Indicators of high CVD risk
+ASCVD/indicators of high CVD risk≈
GLP-1 RA# with proven CVD benefit
OR
SGLT2i‡ with proven CVD benefit
If A1C is above goal
For individuals on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit or vice versa
Pioglitazone^
+HF
Current or prior symptoms of HF with documented HFrEF or HFpEF
SGLT2i‡
with proven HF benefit in this population
+CKD
eGFR <60 mL/min/1.73 m² OR albuminuria (ACR ≥3.0 mg/mmol [30 mg/g]). Repeat measurement is required to confirm CKD
+CKD (on maximally tolerated dose of ACEi or ARB)
SGLT2i‡ with primary evidence of reducing CKD progression
SGLT2i can be started with eGFR ≥20 mL/min/1.73 m²
Continue until initiation of dialysis or transplantation
Glucose-lowering efficacy is reduced with eGFR <45 mL/min/1.73 m²
OR
GLP-1 RA# with proven CKD benefit
If A1C is above goal, for individuals on SGLT2i, consider incorporating a GLP-1 RA or vice versa
Goal: Achievement and Maintenance of Weight and Glycemic Goals
+Weight management
+Achievement and maintenance of glycemic goals
Efficacy for weight loss
Very high:
Semaglutide, tirzepatide
High:
Dulaglutide, liraglutide
Intermediate:
GLP-1 RA (not listed above), SGLT2i
Neutral:
Metformin, DPP-4i
Metformin or other agent (including combination therapy) that provides adequate EFFICACY to achieve and maintain glycemic treatment goals
Prioritize avoidance of hypoglycemia in high-risk individuals
Efficacy for glucose lowering
Very high:
Dulaglutide (high dose), semaglutide, tirzepatide, insulin
Combination oral, combination injectable (GLP-1 RA and insulin)
High:
GLP-1 RA (not listed above), metformin, pioglitazone, SGLT2i, sulfonylurea
Intermediate:
DPP-4i

Glucose Lowering Medications in T2DM

Table 9.3—Median monthly (30-day) AWP and NADAC of maximum approved daily dose of noninsulin glucose-lowering agents in the U.S.

Class	Compound	Dosage strength/ product (if applicable)	Maximum approved daily dose†	Median AWP (min, max)*	Median NADAC (min, max)*
SGLT2 inhibitors	• Bexagliflozin	20 mg	20 mg	$47	NA
	• Canagliflozin	300 mg	300 mg	$718	$574
	• Dapagliflozin	10 mg	10 mg	$664	$352
	• Empagliflozin	25 mg	25 mg	$733	$586
	• Ertugliflozin	15 mg	15 mg	$428	$343
GLP-1 RAs	• Dulaglutide	4.5 mg pen	4.5 mg‡	$1,173	$941
	• Exenatide	10 mg pen	20 mg	$1,020	$818
	• Exenatide (ER)	2 mg pen	2 mg‡	$993	$1,101
	• Liraglutide	18 mg/3 mL pen	1.8 mg	$929	$1,077
	• Semaglutide	2 mg pen	2 mg‡	$1,162	$933
		14 mg (tablet)	14 mg	$1,162	$933
DPP-4 inhibitors	• Alogliptin	25 mg	25 mg	$234	$145
	• Linagliptin	5 mg	5 mg	$630	$503
	• Saxagliptin	5 mg	5 mg	$524 ($523, $524)	$165
	• Sitagliptin	100 mg	100 mg	$588	$550

https://diabetesjournals.org/care/issue/48/Supplement_1

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Virginia Medicaid Formulary 2025

Diabetes: Injectable Hypoglycemics
Byetta®
Humalog Cartridge & Vial & Pen
Humalog Kwikpen 100 unit/ml
Humalog Junior Kwikpen
Humalog Mix 50/50 vial & Humalog Mix 75/25 vial
Humulin 500 U/M pen/vial
Humulin® 70/30 pen/vial (OTC)
Humulin® N pen/vial (OTC)
Humulin® R pen/vial
insulin aspart cartridge pen/vial
insulin aspart/insulin aspart protamine insulin pen
insulin aspart/insulin aspart protamine vial
insulin lispro vial
insulin lispro Jr. Kwikpen
insulin lispro Pen
Lantus® Solostar® and vial
Levemir®pen/vial
Toujeo Solostar® Pen
Trulicity™
Victoza®

Diabetes: Oral Hypoglycemics
acarbose
FaRxiga™
glimepiride
glipizide IR & ER
glyburide & micronized
glyburide/metformin
Janumet® & Janumet XR®
Januvia®
Jardiance®
Jentadueto™
Jentadueto XR™
Kombiglyze XR™
metformin & metformin ER
nateglinide
Onglyza™
pioglitazone
repaglinide
Synjardy®
Synjardy® XR
Tradjenta™
Xigduo™ XR

Reminders:

- exenatide (Byetta) is a twice-daily IM injectable GLP-1RA.
- dulaglutide (Trulicity) is a weekly IM injectable GLP-1RA
- liraglutide (Victoza) is a daily IM injectable GLP-1RA

https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/

Diabetes Standards – Older Adults

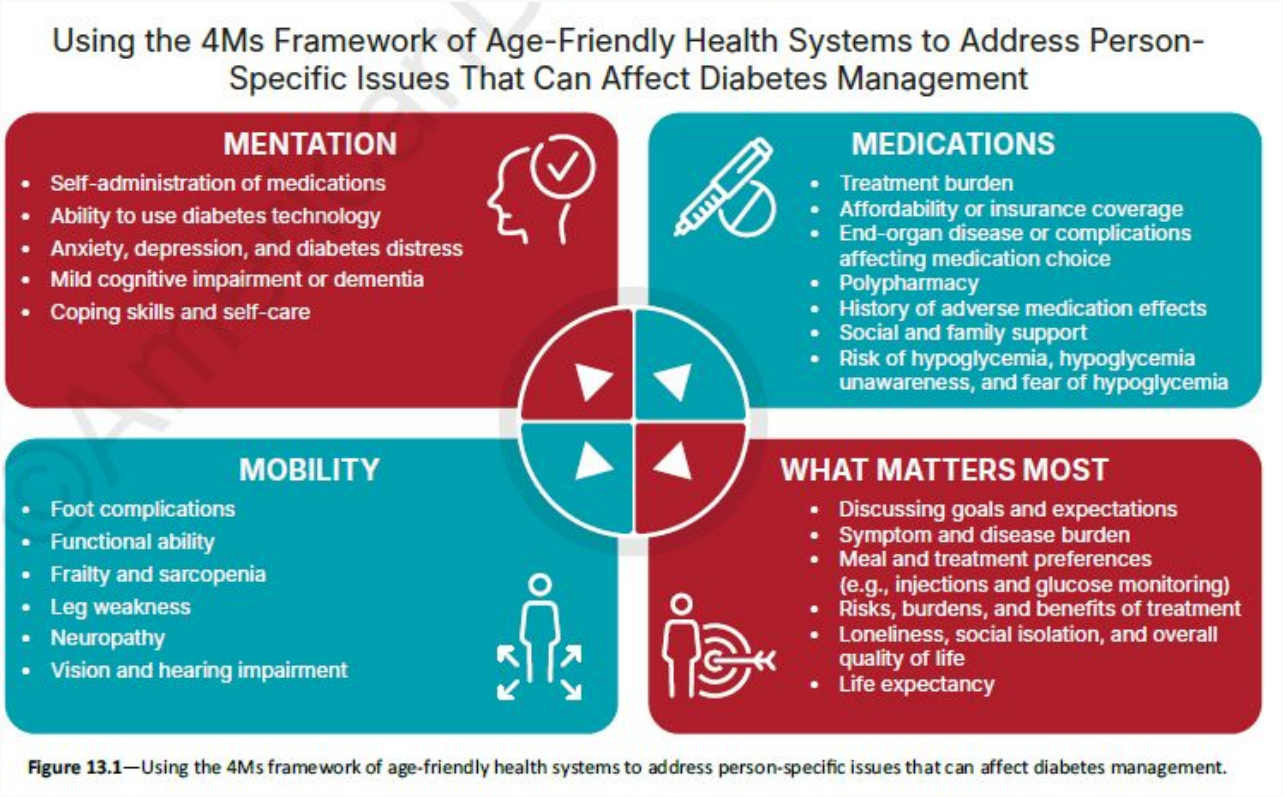

Figure 13.1—Using the 4Ms framework of age-friendly health systems to address person-specific issues that can affect diabetes management.

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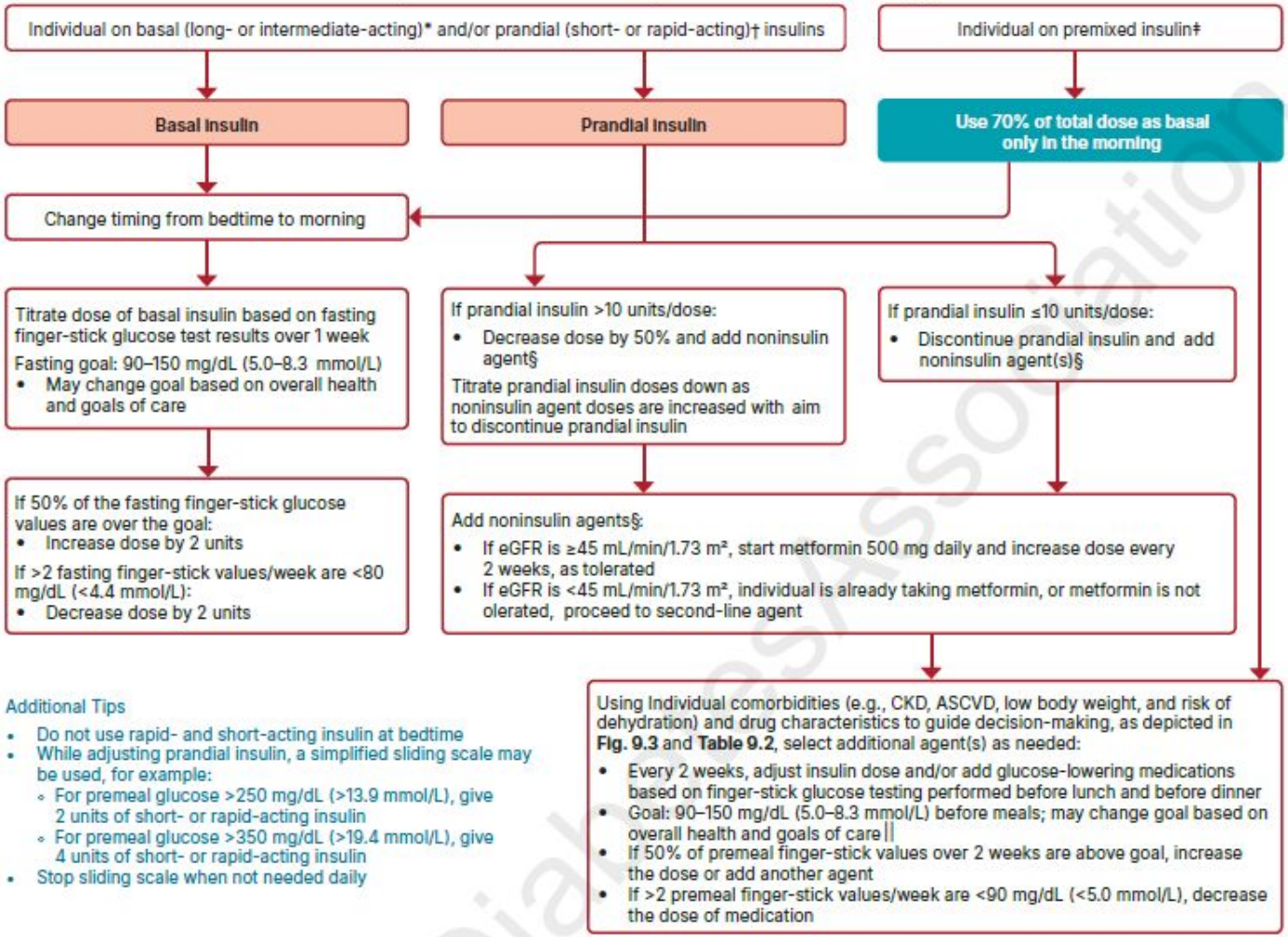
Simplification of Complex Insulin Therapy



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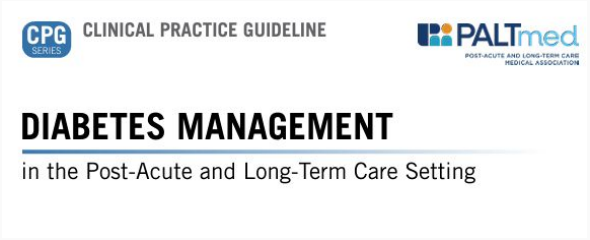
Highlights from PALTmed CPG

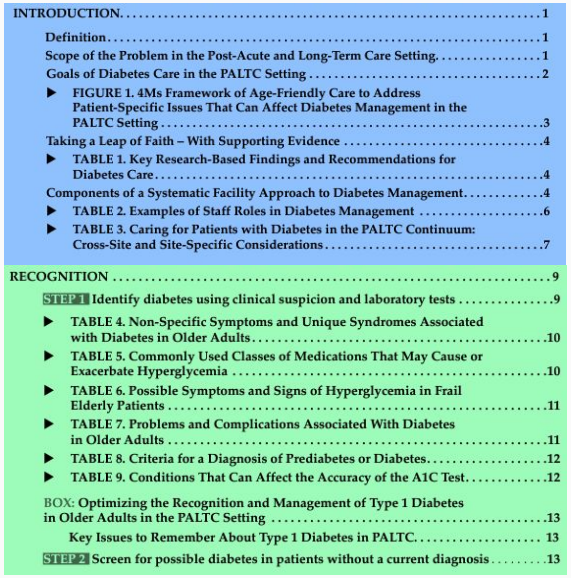

CPG SERIES CLINICAL PRACTICE GUIDELINE

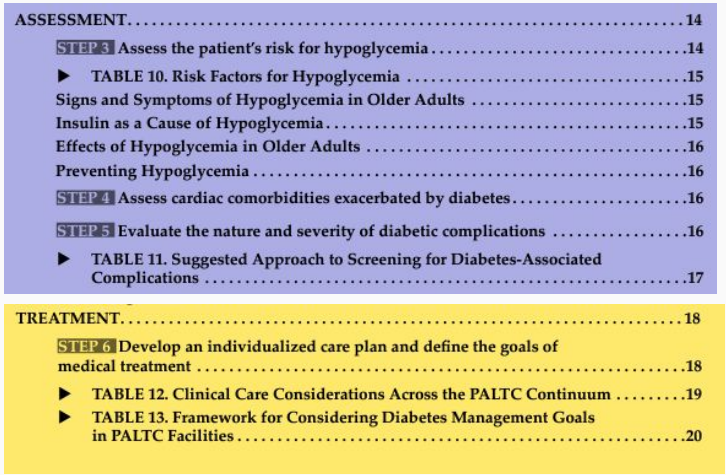
PALTmed POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

DIABETES MANAGEMENT

in the Post-Acute and Long-Term Care Setting

August 2024





https://paltmed.org/sites/default/files/2024-08/Diabetes_Text-August22-2024.pdf

Highlights from PALTmed CPG

https://paltmed.org/sites/default/files/2024-08/Diabetes_Text-August22-2024.pdf

Facility Approach to Diabetes

- Clarify roles of staff members (RN/LPN, CNA, Dietician, SW, PT/OT/SLP, etc.)
  - Change of Condition, Care of equipment, care transitions, psychosocial assessment, nutritional management, fall risk, oral care, etc.
- Staff education (ex: CGM and s/s of hypo-/hyper-glycemia)
- For all patients (review glucose trends, review meds, assessment of eyes/feet/mouth/skin, collaborate with dietician, education pts/families)
- Track facility-wide quality metrics

Clinical Care across PALTC Continuum

TABLE 12. Clinical Care Considerations Across the PALTC Continuum

LONG-TERM CARE			ALF
SKILLED REHAB	LTC	HOSPICE/PALLIATIVE	
Avoid reliance on A1C BG target 100–200 mg/dL (5.5–11.1 mmol/L) Potential for discharge Cognitive impairment Expressed wishes of patient Self care and function Community support	Avoid reliance on A1C Avoid hypoglycemia and symptomatic hyperglycemia Goals of care Cognitive impairment Glycemic goals Complications and comorbidities	Avoid hypoglycemia and symptomatic hyperglycemia Goals of care Clinical complexity Comfort Wishes of patient and family	Avoid hypoglycemia A1C below 8% if feasible Complications and comorbidities Cognition Functional ability Staffing capability BG monitoring/injections

ASSESS ALL PATIENTS FOR THE FOLLOWING:

- Hypoglycemic risk
- Renal function
- CV risks and complications
- Weight loss
- Frailty
- Prognosis

ALF, assisted living facility; BG, blood glucose; CV, cardiovascular; LTC, long-term care

Caveats/Cautions

TABLE 17. Additional Caveats and Cautions When Prescribing Diabetes Medications in PALTC

Medication	When to Avoid
Metformin	Decompensated HF eGFR less than 30 Hepatic disease Risk of dehydration If patient has diarrhea, consider ER formulation or alternative agent
GLP1-RA	Anorexia Chronic constipation Gastroparesis or other motility issues Unexplained GI symptoms Weight loss Preferred in presence of ASCVD or HF
SGLT2 inhibitor	Acute kidney injury Bedbound status Dehydration Dialysis Fractures Frequent UTI or genital yeast infection Inability to drink fluids independently Urinary incontinence Weight loss Stop 5 d prior to elective procedure Preferred in presence of CKD or HF
DPP-4 inhibitor	Severe anorexia Unexplained GI symptoms Do not use with concurrent GLP1-RA
Basal insulin	Hypoglycemia risk Injectable treatments not possible in care setting (e.g., some ALFs) Inconsistent BG monitoring Lack of caregiver support Stop sulfonylureas, SSI
Prandial insulin	Erratic meal consumption Hypoglycemia risk Injectable treatments not possible in care setting Inconsistent BG monitoring Lack of caregiver support Tube feeding Stop sulfonylureas, SSI
Sulfonylureas	Concurrent insulin use Dementia Hypoglycemia risk
TZDs	Bladder cancer HF or other edema Osteoporosis

ALF, assisted living facility; ASCVD, atherosclerotic cardiovascular disease; BG, blood glucose; CKD, chronic kidney disease; DPP-4, dipeptyl peptidase 4; eGFR, estimated glomerular filtration rate; ER, extended release; GI, gastrointestinal; GLP1-RA, glucagon-like peptide-1 receptor agonist; HF, heart failure; SGLT2, sodium glucose transporter 2; SSI, sliding-scale insulin; UTI, urinary tract infection

Dealing with SSI

TABLE 20. Strategies for Replacing Sliding-Scale Insulin in PALTC Facilities

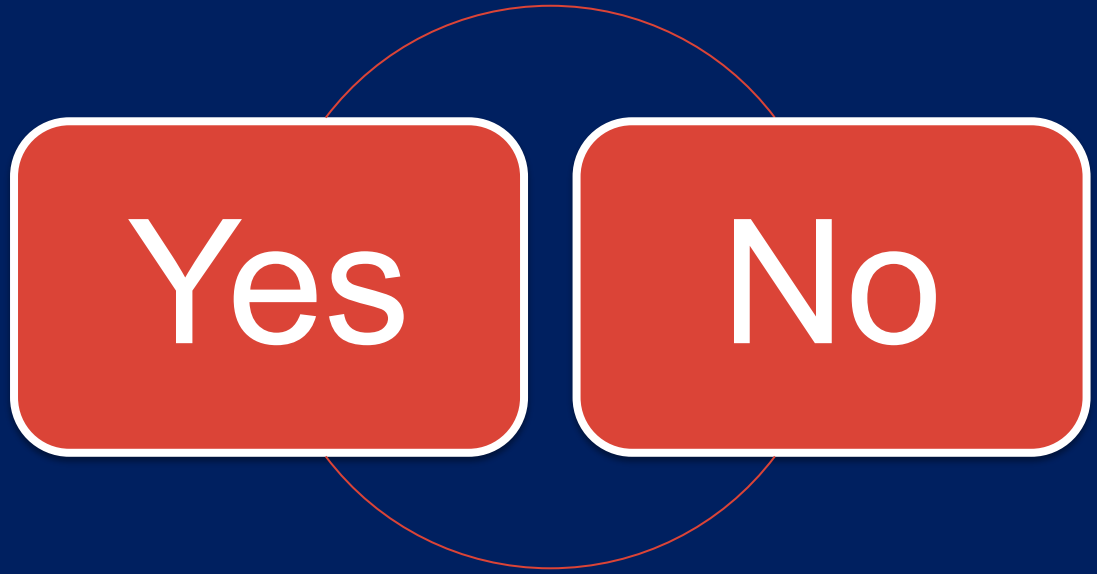
Current Regimen or Clinical Scenario	Suggested Steps
SSI is sole mode of insulin treatment	■ Give 50%–75% of the average daily insulin requirement over 5–7 d as basal insulin ■ Stop SSI ■ Use non-insulin agents or fixed-dose meal-time insulin for PPG as needed ■ Consider giving basal insulin in morning to reduce PPG and nocturnal hypoglycemia
SSI is used in addition to scheduled basal insulin	■ Add 50%–75% of the average insulin requirement currently given as SSI to the existing basal dose ■ Use non-insulin agents or fixed-dose meal-time insulin for PPG as needed
SSI is used in addition to basal and scheduled mealtime insulin (i.e., correction dose insulin)	■ If a correction dose is frequently required, add the average correction dose before a meal to the scheduled mealtime insulin dose at the ***preceding*** meal ■ If BG is consistently elevated before breakfast, requiring correction doses, increase the scheduled basal insulin dose by the average correction dose used
SSI is used short term due to illness or irregular dietary intake	■ Short-term SSI use is ***appropriate*** in cases of acute illness and irregular dietary intake ■ As health and BG stabilize, stop SSI, return to previous regimen as tolerated, and reduce monitoring frequency
Patient with cognitive decline or irregular dietary intake has widely fluctuating BG levels	■ Use scheduled basal and meal-time insulin based on individual needs with the goal of avoiding low BG ■ Consider using a simple scale such as "Give 4 units of prandial insulin if BG is higher than 300 mg/dL" ■ Keep patients hydrated when glucose levels are higher than 300 mg/dL

BG, blood glucose; PPG, postprandial glucose; SSI, sliding-scale insulin

Adapted from Munshi, 2016

Poll Question:

Have you started using CGM for your LTC or AL patients?



Continuous Glucose Monitoring

The use of CGM technology offers several potential advantages in the PALTC setting, including

- Reducing staff time spent monitoring patients' blood glucose levels
- Detecting hypoglycemia (especially nocturnal hypoglycemia)
- Detecting glucose variability (i.e., fluctuations in blood glucose control throughout the day)
- Enabling online monitoring of the blood glucose levels of multiple patients in different parts of the facility
- Facilitating close monitoring of glucose levels in very sick patients on room isolation
- Reducing the burden of fingersticks in patients at the end of life

However, facilities' ability to use this technology depends on factors such as

- Facility characteristics (e.g., level of care, staff clinical competency, staffing shortages)
- Clinician knowledge of and familiarity with diabetes technology
- Insurance coverage for CGM
- Patients' overall and glycemic-specific goals of care
- Presence of comorbidities and diabetes complications

Although studies of CGM in PALTC settings are scant, data from the few studies that have been conducted suggest that the technology can identify previously unrecognized hypoglycemia and may improve the detection of both hypo- and hyperglycemic events compared with point-of-care testing.

Continuous Glucose Monitoring

Table 7.3—Continuous glucose monitoring devices

Type of CGM	Description
rtCGM	CGM systems that measure and display glucose levels continuously
isCGM with and without alarms	CGM systems that measure glucose levels continuously but require scanning for visualization and storage of glucose values
Professional CGM	CGM devices that are placed on the person with diabetes in the health care professional's office and worn for a discrete period of time (generally 7–14 days). Data may be blinded or visible to the person wearing the device. The data are used to assess glycemic patterns and trends. Unlike rtCGM and isCGM devices, these devices are clinic-based and not owned by the person with diabetes.
Over-the-counter CGM	CGM devices called biosensors, which measure glucose continuously and display the levels at various times, have insights rather than alarms and are indicated for people with prediabetes or with diabetes not on insulin.

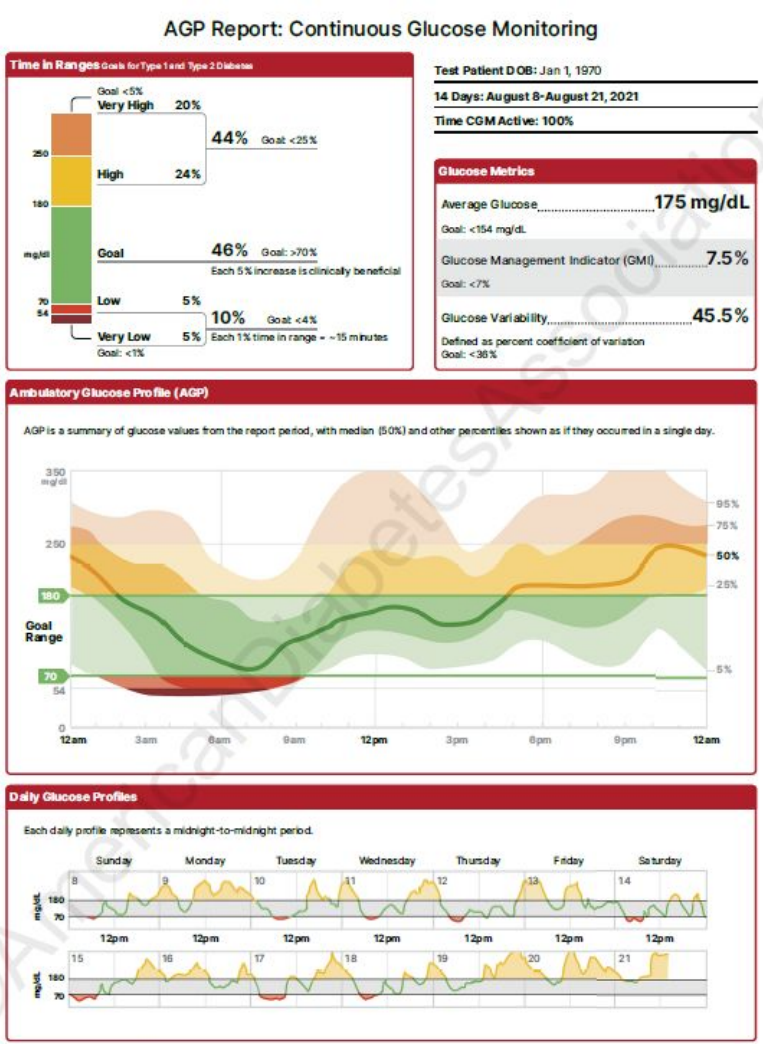
CGM, continuous glucose monitoring; isCGM, intermittently scanned CGM; rtCGM, real-time CGM.

https://tcoyd.org/2022/03/dexcom-g7-gets-the-green-light-in-europe-and-freestyle-libre-3-available-via-nhs-in-the-uk/

https://diabetesjournals.org/care/issue/48/Supplement_1

Dexcom G7

FreeStyle Libre 3



ure 6.1—Key points included in a standard ambulatory glucose profile (AGP) report. Adapted from Holt et al. (20).

CGM – Meter Accuracy

Table 7.1—Comparison of ISO 15197:2013 and FDA blood glucose meter accuracy standards

Setting	FDA*	ISO 15197:2013*
Hospital use	95% within 12% for BG ≥75 mg/dL 95% within 12 mg/dL for BG <75 mg/dL 98% within 15% for BG ≥75 mg/dL 98% within 15 mg/dL for BG <75 mg/dL	95% within 15% for BG ≥100 mg/dL 95% within 15 mg/dL for BG <100 mg/dL 99% in A or B region of consensus error grid‡
Home use	95% within 15% for all BG in the usable BG range† 99% within 20% for all BG in the usable BG range†	

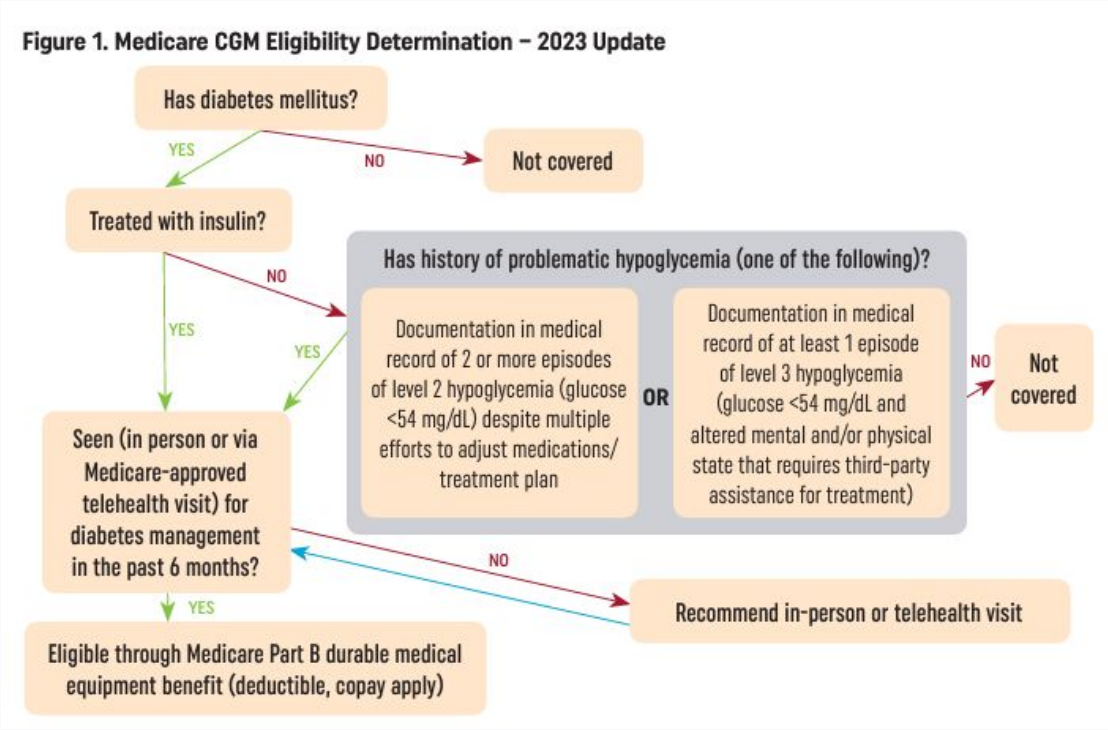
BG, blood glucose; FDA, U.S. Food and Drug Administration; ISO, International Organization for Standardization. To convert mg/dL to mmol/L, see endmemo.com/medical/unitconvert/Glucose.php. *Data shown in the FDA column are from the FDA (298). Data shown in the ISO column are from the FDA (299). †The range of blood glucose values for which the meter has been proven accurate and will provide readings (other than low, high, or error). ‡Values outside of the "clinically acceptable" A and B regions are considered "outlier" readings and may be dangerous to use for therapeutic decisions (300).

Table 7.4—Continuous glucose monitoring device interfering substances

Medication	Systems affected	Effect
Acetaminophen		
>4 g/day	Dexcom G6, Dexcom G7	Higher sensor readings than actual glucose
Any dose	Medtronic Guardian	Higher sensor readings than actual glucose
Ascorbic acid (vitamin C), >500 mg/day	FreeStyle Libre 14 day, FreeStyle Libre 2, FreeStyle Libre 3	Higher sensor readings than actual glucose
Ascorbic acid (vitamin C), >1,000 mg/day	FreeStyle Libre 2 Plus, FreeStyle Libre 3 Plus	Higher sensor readings than actual glucose
Hydroxyurea	Dexcom G6, Dexcom G7, Medtronic Guardian	Higher sensor readings than actual glucose
Mannitol (intravenously or as peritoneal dialysis solution)	Senseonics Eversense	Higher sensor readings than actual glucose
Sorbitol (intravenously or as peritoneal dialysis solution)	Senseonics Eversense	Higher sensor readings than actual glucose

https://diabetesjournals.org/care/issue/48/Supplement_1

CGM – Medicare Coverage



https://www.aafp.org/pubs/fpm/issues/2024/0100/continuous-glucose-monitoring.pdf

https://www.aafp.org/family-physician/patient-care/care-resources/continuous-glucose-monitoring.html

CGM – Medicare Coverage

Medicare Eligibility Requirements for Personal CGM

- Diagnosis of diabetes;
- Beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed;
- The CGM is prescribed in accordance with its FDA indications for use;
- The beneficiary meets are least one of the criteria below:
    - Is insulin-treated; or,
    - Has a history of problematic hypoglycemia with documentation of at least one of the following:
        - Two or more level 2 hypoglycemic events (glucose <54 mg/dL) that persist despite multiple modifications to the treatment or medication plan,
        - One level 3 hypoglycemic event (glucose <54 mg/dL) characterized by altered mental and/or physical state requiring third-party assistance for treatment.
    - Seen for diabetes management in past 6 months.
    - For **continuing eligibility**, all of the above must continue to be met.

https://www.aafp.org/pubs/fpm/issues/2024/0100/continuous-glucose-monitoring.pdf

https://www.aafp.org/family-physician/patient-care/care-resources/continuous-glucose-monitoring.html

CGM – Medicare Coverage

How to Order CGM by Brand

Abbott Freestyle Libre 2 System

Step 1: Complete the Medicare Standard Written Order. Please note that even though this order asks for the prescribed glucose tests per day, this is no longer a Medicare requirement.

Step 2: Fax the Order and chart notes to a Freestyle Libre 2 DME supplier listed on the Medicare Standard Written Order link above.

Note: FreeStyle Libre 2 must be used for Medicare, as the FreeStyle Libre 3 is not covered by Medicare (it does not have a separate reader as required by Medicare).

Find information at FreeStyleFoundations.Abbott.

Dexcom

Step 1: Complete the Medicare Detailed Written Order. Check the box to order the receiver even if the patient will also use their smartphone.

Step 2: Fax Order and chart notes to ASPN Pharmacy: (866) 879-8150; they will help determine a participating DME supplier.

You can also find clinic resources on Dexcom's website.

Eversense

Eversense requires that the transmitter be implanted; it is recommended that you seek preauthorization for the implantation procedure before ordering.

Use the Eversense website to find information on ordering or becoming an Eversense provider.

Medtronic CGM

Reference Medtronic's healthcare professional website for their most current resources.

https://www.aafp.
issues/2024/0100
lucose-monitoring

MEDICARE DETAILED WRITTEN ORDER

☐ K0554 Receiver (Monitor), dedicated, for use with therapeutic Continuous Glucose Monitor system - 1 unit Dexcom receiver

☐ K0553 Supply allowance for therapeutic Continuous Glucose Monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service

EST. LENGTH OF NEED (# OF MONTHS):	ORDER DATE:
PATIENT INFORMATION	
Patient Name:	Date Of Birth:
Patient Address:	Phone:
City/State/Zip:	
Primary Insurance Name:	Primary Insurance Member ID:
Secondary Insurance Name:	Secondary Insurance Member ID:
PHYSICIAN INFORMATION	
Physician Name:	
Phone #:	Fax #:
Address:	Hospital/Clinic:
City/State/Zip:	NPI #:

STATEMENT OF MEDICAL NECESSITY

Currently on CGM Therapy? ☐ Yes ☐ No	# SMBG _____ per day	# Daily Insulin Administrations: _____
Date of Last Visit (Must be within 6 months of this order):		On Insulin Pump? ☐ Yes ☐ No
Diagnosis Code:		ICD-10 Code: ☐ E10.65 ☐ E10.9 ☐ E11.9 ☐ Other _____
Frequently adjusting insulin dosage based on BGM/CGM reading: ☐ Yes ☐ No		

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring System, Dexcom sensors, Dexcom replacement transmitter or Dexcom replacement receiver, and all associated diabetes supplies to be provided by Dexcom or an authorized distributor.

I certify that I am the physician identified on the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge.

Signature:	**Date:**

Please fax this form to one of the distributors listed on the other side or have a prescription sent to the patient's preferred pharmacy.

Medicare Detailed Written Order

FreeStyle Libre 14 day
FLASH GLUCOSE MONITORING SYSTEM

Instructions

1. Complete all fields on this Detailed Written Order.
2. Use the Noridian November 2017 Physician Resource Letter (Continuous Glucose Monitors) to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier that provides the FreeStyle Libre 14 day system.

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

Physician Information

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

Order Detail

Order Date: _____ / _____ / _____

K0554 (FreeStyle Libre 14 day Reader)	K0553 (FreeStyle Libre 14 day Sensors)
1 Reader/1095 Days Length of Need: Lifetime-unless specified otherwise:	1 Unit/30 Days (1 Unit = 1 month of sensors and supplies) Length of Need: Lifetime-unless specified otherwise:

Diagnosis (ICD10):

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Prescribed Number of Glucose Tests Per Day: _____

Current Insulin Regimen:

☐ Insulin Pump ☐ Multiple Daily Injections-Number Per Day: _____ ☐ Other: _____

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____

It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Abbott does not guarantee that the use of any information provided in this form will result in coverage or payment by any third-party payer. Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided.

See reverse for Indications and Important Safety Information.

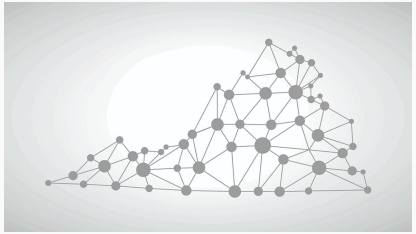
References

1. The Post-Acute and Long-Term Care Medical Association (PALTmed). Diabetes Management in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: PALTmed 2024. https://paltmed.org/sites/default/files/2024-08/Diabetes_Text-August22-2024.pdf
2. ADA Diabetes Care 2025 Standards of Care, https://diabetesjournals.org/care/issue/48/Supplement_1
3. 2023 AACE Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm, https://www.endocrinepractice.org/issue/S1530-891X(22)X0008-6#
4. AAFP CGM Resource Page. https://www.aafp.org/family-physician/patient-care/care-resources/continuous-glucose-monitoring.html

Poll

For admissions paperwork do your facilities use highly trained clinicians to fill in gaps?

A. **Yes**
B. **No**



Open Forum

Any questions or ideas from the talk?

Share a unidentifiable case to discuss

Driving between Virginia facilities? Get some CME-

GeriPal PODCAST

https://geripal.org/geripal-podcast/

Registration Open: Are you presenting at a meeting? Let us know!

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	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
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1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: *within **5** days of the event)* **#####**

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

Thank you for joining us!

Updates and News - See News Updates via email

Next Monthly Forum: **Wednesday, January 15, 4-5 pm**

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at vcoa@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu