Carta Trámite

6 de marzo de 2025

A: Todos los proveedores Contratados por First Medical Health Plan, Inc., para el Plan Vital

Re: Carta Circular 25-0304 Bombas de Infusión de Insulina para Diabéticos tipo 1

Estimado(a) Proveedor(a):

Reciba un cordial saludo de parte de First Medical Health Plan, Inc., (FMHP).

Adjunto a este comunicado encontrará la Carta Circular 25-0304 de la Administración de Seguros de Salud de Puerto Rico, (ASES).

A través de esta Carta Circular, la ASES informa que, las bombas de insulina aprobadas por la Administración de Alimentos y medicamentos de Estados Unidos (FDA, por sus siglas en inglés), ya sean categorizadas como "desechables" o reconocidas como equipo médico durable (DME, por sus siglas en inglés) o bien sean mecanismos utilizado para la inyección de insulina directamente en el cuerpo (*medical supplies associated with the injection of insulin*) están cubiertas bajo el Plan Vital y se continuará cubriendo como DME, mientras la ASES no emita otra directriz.

Esto en conformidad a la Política Clínica ASES-OC-2024/P003-*Política de Equipo Médico Duradero & Servicios de Salud en el Hogar*, emitida el 1 de julio de 2024 y la Carta Normativa 23-0126, emitida el 26 de enero de 2023, titulada *Política Uniforme Operacionalización Ley 177 (2016) enmendada en enero 2020, sobre Pacientes con Diabetes Mellitus Tipo 1 (DMTJ).*

Para detalles específicos, sobre la información provista por la ASES, le exhortamos a leer detenidamente la Carta Circular 25-0304, así como el anejo Carta Normativa 23-0126 y la Política ASES-OC-2024/P003.

Si usted tiene alguna pregunta relacionada a este comunicado y/o necesita información adicional, siéntase en la libertad de comunicarse con nuestro Centro de Servicio al Proveedor al número libre de cargos 1-844-347-7802 de lunes a viernes de 7:00 a.m. a 7:00 p.m. También, puede acceder a nuestra página electrónica www.firstmedicalvital.com.

Cordialmente,

Departamento de Cumplimiento
First Medical Health Plan, Inc.

GOBIERNO DE PUERTO RICO
ADMINISTRACIÓN DE SEGUROS DE SALUD

Carta Circular 25-0304

4 de marzo de 2025

A: Aseguradoras, Compañías de Servicios de Salud Mental, Administrador del Beneficio de Farmacia, Farmacias, Grupos Médicos Primarios y Proveedores Participantes del Plan Vital

Re: Bombas de Infusión de Insulina para Diabéticos tipo 1

En la Administración de Seguros de Salud de Puerto Rico (ASES), estamos comprometidos en promover la salud y el bienestar de nuestros beneficiarios, asegurando la continuidad y el acceso a los servicios del Plan de Salud del Gobierno (Plan Vital). Siendo la diabetes una de las condiciones de mayor prevalencia en la isla, y que impacta una gran cantidad de nuestros beneficiarios la ASES ha emitido varias cartas normativas y políticas clínicas para garantizar el mejor cuidado, acceso a servicios y tratamientos conforme a las leyes creadas en beneficio y protección de quienes sufren esta enfermedad degenerativa.

Es por lo cual, la ASES tiene el deber de velar por el cumplimiento de la Ley Núm. 19 de 2020 y la Ley Núm.177 de 2016, las cuales inciden directamente sobre la cubierta de servicios de Plan Vital. Estas leyes aplican a todas las aseguradoras de seguros de salud en **PR,** entre otros.

Así mismo, tenemos la responsabilidad de mantener una cubierta uniforme entre todas las aseguradoras del Plan Vital. Es por esto, que de conformidad a nuestra Política Clínica: ASES-OC-2024/P003 del 1ro de julio de 2024 titulada *"Política de Equipo Médico Duradero & Servicios de Salud en el Hogar"*[1], así como lo establecido en la Carta Normativa 23-0126 de 26 de enero de 2023, titulada: *"Política Uniforme Operacionalización Ley 177 (2016) Enmendada en Enero 2020, Sobre Pacientes con Diabetes Mellitus Tipo 1 (DMTJ)* ", es la posición de la ASES recalcar que las bombas de insulina aprobadas por la Administracion de Alimentos y Medicamentos de Estados Unidos (FDA por sus siglas en inglés), ya sean estas categorizadas como "desechables" o reconocidas como equipo médico durable (DME, por sus siglas en inglés) o bien sean mecanismos utilizado para la inyección de insulina directamente en el cuerpo (*"medical supplies associated with the injeccion of insuline")* están cubiertas bajo el Plan Vital y se continuará cubriendo como DME, mientras la ASES no emita otra directriz.

[1] Favor hacer referencia a Carta Normativa 24-0828-1 de 28 de agosto de 2024

Las Organizaciones de Manejo Coordinado (MCO, por sus siglas en inglés) serán responsables de la pre-autorización inicial para evaluar la aprobación de los modelos de bombas de infusión de insulina, aprobadas por la FDA, que determine el endocrinólogo o endocrinólogo pediátrico en su orden médica, siempre que esté justificada conforme a las necesidades médicas del paciente con diabetes tipo **1.** Asimismo, de acuerdo con lo dispuesto en la Carta Normativa de la ASES 23-0126, los suministros para las bombas de infusión de insulina anteriormente mencionadas no requieren pre-autorización para ser despachados por los MCO.

Por tanto, los MCOs deberán realizar una revisión retroactiva de los casos previos y verificar si han denegado alguna bomba de insulina basándose en los criterios establecidos y remediar de conformidad a las políticas descritas en esta Carta Circular.

Agradecemos el cumplimiento estricto de esta política y su continua colaboración y esfuerzo en promover el bienestar de nuestros beneficiarios.

Cordialmente,

Milagros A. Soto Mejía
Gerente Principal de Operaciones Clínicas

Government Health Plan (GHP) - Plan Vital CLINICAL OPERATIONS AREA			
Policy:	**DURABLE MEDICAL EQUIPMENT & HOME HEALTH SERVICES**		
Number: ASES-OC-2024 /P003	**Review Date:**	**Effective Date: JULY 1st , 2024**	**Number of Pages: 11**
Approved By: Milagros A. Soto Mejía, MHSA, MMHC **Signature:** **Clinical Operations Director**			**Date: Aug**/28/2024
Approved By: Roxanna K. Rosario Serrano, BHE, MS **Signature:** **Executive Director**			**Date: Aug**/28/2024
Reference:	42 CFR. § 410.38, 42 CFR § 440.70		

I. PURPOSE

To expand available covered services of the of the Government Health Plan – Plan Vital (GHP-Plan Vital) by including access to certain Durable Medical Equipment and Home Health Services and to define a standard policy of coverage for these services available as a mandatory benefit under the Puerto Rico state plan.

II. DURABLE MEDICAL EQUIPMENT

For the purposes of this policy, ASES will abide by Medicare's definition of Durable Medical Equipment (DME) and other related terms as stated on 42 CFR Part 410.38, and 42 CFR Part 440.70.

III. DME COVERAGE ELEGIBILITY REQUIREMENTS, TYPES OF DME AND SUPPLIES, & INCLUSIONS/EXCLUSIONS

Durable Medical Equipment (DME) should be prescribed by a doctor as medically necessary due to a patient's illness or injury and intended to serve primarily a home-based purpose. DME should be designed for long-term use. Providers for DME or supplies must be certified to participate in Medicare.

- To access the DME Coverage for the rental or purchase of eligible equipment, a prescription from the beneficiary's physician (PCP/Specialist) must be required along with a medical justification for the specific equipment. Prior authorization will be required for the initial request time when it comes to DME due to a permanent or chronic condition. In the case of a temporary condition that requires DME equipment, such DME will be authorized for a specific period with the possibility of renewal if it is deemed to be medically necessary. **Per 42 CFR part 440.70**, there must be a face-to-face or telehealth encounter between a provider and a beneficiary primarily related to the reason they need DME and must occur no more than 6 months prior to the start of services prior to payment being made. Providers must be certified to participate in Medicare. Per 42 CFR part 440.70, a beneficiary's need for DME should be reviewed at least annually.

  NOTE 1: *Children with Special Needs have enhanced coverage, and the limitations imposed on regular DME coverage do NOT apply. Regarding patients registered under Special Coverage due to special conditions, the coverage is similar to that of DME and Home Care for medical necessity, as the special coverage does not add additional benefits to the regular GHP-Plan Vital coverage.* DME coverage for a child may include customization and modification to meet developmental and medical needs, and to address mobility issues. Also, for support of educational aids and communication aids in school setting and daily activities.

Covered DME includes, but is not limited to:

- ***Audio Assistive Boards / Communication Devices***
- **Blood Sugar Monitors (Flash Glucose Monitors/ Non-invasive Glucose Monitors):** Higher-functioning blood sugar monitors may be excluded unless deemed medically necessary by a prescription from the member's endocrinologist.
- **Blood Sugar Test Strips**
- **Canes**
- **Commode chairs**
- **Continuous Glucose Monitors (CGM) as prescribed by the endocrinologist.**
- **Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BPAP) machines**
- **Crutches**
- **Hospital beds- semi electric**
- **Infusion pumps & supplies**
- **Nebulizers & nebulizer medications**
- **Oxygen equipment & accessories**
- **Patient Hoyer Lifts or hydraulic cranes** – for paraplegic or quadriplegic individuals, patients with mobility limitation, or obesity.
- **Pressure-reducing support surfaces for beds**
- **Suction pumps**: for patients with tracheostomies, respirators, or injuries that prevent or make it difficult to swallow.
- **Feeding pumps**: for patients with Percutaneous Endoscopic Gastrostomy (PEG), and special feeding due to dietary requirements.
- **Nutritional supplements**: specialized formulas and supplements for individuals unable to consume regular food by mouth and fed through PEG. This Policy does not cover supplements accessible over the counter such as "Ensure" or the like.
- **Traction equipment**
- **Walkers**

- **Wheelchair**
- **DMEPOS**: DME Prosthetics, Orthotics, Supplies (medical)
    - Prosthetic devices that replace all or part of an internal bodily organ
    - **Prosthetics,** like artificial legs, arms, and eyes
    - **Orthotics**, like rigid or semi-rigid leg, arm, back, and neck braces
    - **Certain medical supplies required for the use of the DME**, like medications to be used with nebulizers, lancets or testing strips for glucometers, etc.

NOTE 2: *GHP-Plan Vital will typically pay only for standard equipment to meet the justified medical need. Any special features or upgrades will NOT be covered, and the cost responsibility must rely entirely on the beneficiary demanding such features,* ***except under strict prior authorization and medical necessity criteria.***

Items that are for convenience or experimental are EXCLUDED:

- Equipment mainly intended to assist outside the home, like motorized scooters, segways, ramps, widened doors, **Except in pediatric patients**.
- Motorized scooters, segways; outdoors kneeler scooters **except in Achilles tendon rupture and or repair, and severe displaced and with minutes bone fractures of talus and ankle mortise**.
- Most items that are intended ONLY for convenience or comfort like (but not limited to) stairway elevators, grab bars, air conditioners, bathtub, and toilet seats.
- Disposable or single-use items that are not used with equipment. For example (but not limited to):
    - Underpads
    - Gloves
    - Catheters: **May be covered as prosthetics if patient has a permanent / chronic condition.**
    - Surgical facemasks
    - Compression leggings

- However, if a patient simultaneously receives (or as part of) home health care, some of those supplies will be covered, or with strict prior authorization or medical necessity criteria.

- Home modifications such as handrails or grab bars installation, ramps or widened doors to improve wheelchair access.
- Equipment that is not suitable for use in the home. This includes some types of DME used in hospitals or Skilled Nursing Facilities (SNFs), like paraffin bath units and oscillating beds.
- Physical fitness or self-help equipment.
- Devices and equipment used for environmental control.

IV. DME Maintenance & Replacement

The costs for maintenance and repair of the assigned DME will depend on whether the equipment was rented or was purchased. GHP-Plan Vital may also cover replacement of the equipment according to generally accepted time frames. Will cover maintenance when it may be a safety issue resulting in injury due to the lack of such maintenance.

DME may be replaced after a minimum useful lifetime of five (5) years. If the equipment is worn out, GHP-Plan will only replace it if the beneficiary had the item in his/her possession for its whole lifetime. An item's lifetime depends on the type of equipment but, in the context of getting a replacement, it is never less than five years from the date the patient began using the equipment. Or less than five (5) years in some DME according to clinical coverage policy listing https://medicaid.ncdhhs.gov/5a-3-nursing-equipment-and supplies/download?attachment

> **NOTE 3:** *This five-year timeframe differs from the three-year minimum lifetime requirement that most medical equipment and items must meet in order to be considered DME by Medicare. The item must also be so worn from day-to-day use that it can no longer be fixed.*

- *DME for a child may be in perfect condition without wear or operational impact but it no longer "fits" a growing child with a large growth spurt in one (1) year or much less than 5 years.*

Replacing equipment means substituting one item for an identical or nearly identical item. For example, GHP-Plan Vital will cover the switch from one manual wheelchair to another, but it will not pay to replace a manual wheelchair with an electric wheelchair or a motorized scooter, unless deemed medically necessary through the prior authorization review process.

GHP-Plan Vital will pay to replace equipment that was rented or purchased at any time if it is damaged beyond repair, in an accident or a natural disaster (fire, flood, other), if the beneficiary presents proof of the damage. Also, in such cases, the beneficiary may be required to present a new certification of the medical need and a new order or prescription for the DME to be replaced. If the medical equipment provided to a beneficiary was stolen and the actual cost exceeds $250.00, the beneficiary must report the theft to the Police and obtain a complaint number. Additionally, it is the beneficiary's responsibility to provide a valid explanation for the replacement due to loss or theft, as well as to ensure the care, protection, and maintenance of the new item.

V. HOME HEALTH SERVICES

For this Policy, ASES will abide by Medicare's definitions and criteria related to Home Health Services, and as stated in the Code of Federal Regulations: **42 CFR part 440.70**. MCOs should work with their provider network as needed to ensure all areas of Puerto Rico can access home health services.

Home Health Services are a wide range of health care services that can be provided at the home (as defined on 42 CFR part 440.70) for the general goal of treating an illness or injury. Home health care is usually less expensive, more convenient, and just as effective as care provided in a hospital or a skilled nursing facility (SNF). Skilled home health services may include wound

care for pressure sores or a surgical wound, patient and caregiver education, intravenous or nutrition therapy, injections, or monitoring a serious illness and unstable health status. Home health care may help with a patient's recovery, regaining independence, becoming more self-sufficient, maintaining patient's current condition or level of function, or slowing decline.

Home health agencies must meet all licensure standards, including any home health aide supervision requirements. All services provided under the home health benefit need to have prior authorization, be deemed medically necessary, and be prescribed under an approved plan of care, including services for Physical Therapy, Occupational Therapy, and Speech Therapy and medical supplies. **Per 42 CFR part 440.70**, there must be a face-to-face or telehealth encounter between a provider and a beneficiary primarily related to the reason they need Home Health Services within the 90 days prior to or 30 days after the start of services prior to a payment being made.

Home health services are not covered when:

- Beneficiaries are in hospital inpatient settings.
- Furnished only to assist the beneficiary in meeting personal care needs.

Covered home health services include:

- **Medically necessary part-time or intermittent skilled nursing care**
    - The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician or allowed practitioner has determined that the services ordered are reasonable and

necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

- Part-time or intermittent home health aide care may be covered ONLY if also receiving oversight via skilled nursing care at the same time.

- **Evaluation, therapy and training** provided by a psychiatric/behavioral health trained nurse, if or when available.
- **Physical therapy**
- **Occupational therapy**
- **Speech-language pathology services**
  - Physical therapy, occupational therapy, and speech therapy are expected to support a beneficiary regaining their functional level and will operate with the same limitations as PT/OT/ST as defined in the Puerto Rico state plan that are not part of the home health benefit.
- **Education interventions** to foster independence at the beginning of coverage, and for up to three (3) total visits.
- **Medical social services:** These services may be covered ONLY when a doctor or allowed provider orders them to help the patient with social and emotional concerns, that may interfere with treatment or how quickly the person recovers. This might include counseling or helping find community resources. <u>However, it will NOT cover medical social services unless the patient is also receiving skilled care.</u>
- **Home infusion therapy**
- **Injectable osteoporosis drugs for women**
- **Enteral nutrition**
  - An initial prescription for enteral nutrition in the Plan of Care must be provided by a surgeon, a gastroenterologist, or an oncologist, <u>with the recommendation of a licensed dietitian or nutritionist</u>. For further prescriptions, a primary care

physician (PCP) may issue them. However, any changes in the enteral nutrition prescription should be based on the recommendation of a nutritionist.

- **Intravenous chemotherapy**
- **Pain management**
- **Durable medical equipment**
- **Medical supplies for use at home**
- **Incontinence supplies**:
    - The patient's physician must submit written justification to the MCO for approval of these supplies. In adult patients, a Urologist or OBGYN must justify the medical necessity due to a chronic or permanent condition. If a pediatric patient is diagnosed with bowel or bladder incontinence, EPSDT must cover appropriate home medical treatment for this condition, which typically includes diapers or other incontinence products. Diapers will NOT be covered for potty/toilet training. The patient's physician must submit written justification to the MCO for approval.
- **Disposable diapers**: Will be provided by the MCOs, according to the brands of this supply to which they have access. It will not be acceptable to require specific brands of diapers for a patient.
    - It is considered appropriate for the MCO to provide a maximum supply of 3 to 4 diapers per day, for a total of 90 to 120 diapers per month.
- **Urinary catheters**: As medically necessary. For example: patients with bladder outlet obstruction not correctable medically or surgically, intractable skin breakdown caused or exacerbated by incontinence, patients with neurogenic bladder and retention, palliative care for terminally ill or severely impaired incontinent patients for whom bed and clothing changes are uncomfortable. https://www.aafp.org/pubs/afp/issues/2000/0115/p369.html
- **Hygiene supplies such as (but not limited to) underpads, wet wipes, and over the counter ointments are NOT covered.**

Who May Benefit from Home Health Care Services?

GHP-Plan Vital beneficiaries with the following criteria may benefit from receiving Home Health Services:

- Having a "homebound status," as they have difficulty leaving their home without assistance due to illness or injury, or because leaving their home is not recommended given their medical condition; and those not in "homebound status" but with medical conditions that needs to be managed with Home Health Services as described.
- Needing part-time or intermittent skilled services from professionals like nurses, physical therapists, or occupational therapists. (Not solely needed for venipuncture for the purposes of obtaining blood sample). **Must have a specific plan of care duly ordered and supervised by a physician.**
    - The orders on the plan of care must indicate the type of services to be provided for the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.
- Where authorization of home health services is more cost effective than similar services delivered in an inpatient or other setting.

References

1. CMA-Guide-to-DME.pdf (medicareadvocacy.org)
2. "Durable medical equipment (DME) coverage," Medicare.gov, last accessed May 2, 2023, https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage.
3. "Durable medical equipment (DME) coverage."
4. "Equipment and supplies excluded from Medicare coverage," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/equipment-and-supplies-excluded-from-medicare-coverage.
5. "Eligibility for DME coverage," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/eligibility-for-dme-coverage.
6. "DME supplier basics," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/dme-supplier-basics.
7. "Original Medicare DME costs," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/dme-costs-when-you-are-not-affected-by-competitive-bidding.
8. Medicare Benefit Policy Manual Chapter 7 - *Home Health Services, last revision* in 2023; https://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf.
9. Medicare Benefit Policy Manual Chapter 7 - *Covered Medical and Other Health Services*, revised 2024; https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/bp102c15.pdf

GOBIERNO DE PUERTO RICO
ADMINISTRACIÓN DE SEGUROS DE SALUD
Directora Ejecutiva | Edna Y. Marín Ramos | emarin@asespr.org

Carta Normativa 23-0126

26 de enero de 2023

A: **Organizaciones contratadas de Manejo Coordinado de Salud (MCO), Grupos Médicos Primarios (GMP), y Proveedores Participantes del Plan Vital**

RE: **POLÍTICA UNIFORME OPERACIONALIZACIÓN LEY 177 (2016) ENMENDADA EN ENERO 2020, SOBRE PACIENTES CON DIABETES MELLITUS TIPO 1 (DMT1)**

El propósito de esta Carta Normativa es aplicar de manera uniforme las disposiciones relacionadas con la Ley Núm. 177 de 13 de agosto de 2016 que establece la obligatoriedad de cubrir glucómetros, monitores de glucosa, bombas de infusión y suplidos, tanto a la Aseguradoras comerciales privadas como al Plan de Salud del Gobierno de Puerto, ***Ley para Obligar a las Aseguradoras de Servicios de Salud a Incluir el Suministro de un Monitor de Glucosa a Todos los Pacientes Diagnosticados con Diabetes Mellitus Tipo 1***, según enmendada (Ley Núm. 19 del 12 de enero de 2020).

Esta Ley obliga a las aseguradoras y las organizaciones de servicios de salud reguladas bajo a el *Código de Seguros de Puerto Rico*, planes de seguros que brinden servicios en Puerto Rico y cualquier otra entidad contratada, e incluye expresamente a la Administración de Seguros de Salud de Puerto Rico, a ofrecer beneficios de salud en Puerto Rico a que incluyan, como parte de su cubierta básica:

- el suministro de un monitor de glucosa cada tres (3) años con reemplazo de equipo dañado,
- el suministro de una (1) inyección de glucagón y reemplazo de la misma en caso de su uso o por haber expirado,
- y un mínimo de ciento cincuenta (150) tirillas y ciento cincuenta (150) lancetas
- bomba portátil de infusión de insulina para pacientes diagnosticados con Diabetes Mellitus tipo 1, ordenada por un médico especialista en endocrinología pediátrica o endocrinólogo, *siempre y cuando los mismos cumplan con los criterios de cualificación para un paciente diabético que requiera el uso de dicha bomba, de conformidad con lo establecido por el CMS; para establecer autorización para el establecimiento de copagos y/o deducibles, establecer reglamentación, formas de dispensación, penalidades y vigencia; y otros fines relacionados.*

A continuación, se describen los procesos que deben darse de manera uniforme entre todas las Aseguradoras contratadas bajo Plan Vital:

- **Pre-autorización inicial para evaluar aprobación de:**
    - **Glucómetro:** Debe proveerse uno (1) cada tres (3) años, con reemplazo de equipo dañado. Para evaluación inicial, deberá mediar una orden médica junto con la documentación que sustenta el diagnóstico de Diabetes Mellitus Tipo 1.
      Dicha documentación deberá suministrar la información siguiente: Resultados recientes de laboratorio de Hemoglobina glucosilada *(A1c),* evidencia de intervención del especialista,

evidencia de tratamiento previo con insulina (si aplica), régimen de insulina, evidencia de evaluación de un especialista donde recomiende el registro de glucosas.
Se entiende que al adquirir el glucómetro este incluye las baterías requeridas (*La reposición de baterías no está cubierta por Medicaid).*

- La orden médica debe especificar la marca del glucómetro
- **Reposición de Glucómetro dañado/perdido:** Cuando un glucómetro se reporta como dañado o averiado se tendrá que entregar el glucómetro averiado, para verificar si está bajo garantía o no. En el caso de que se reporte perdido, se podrá sustituir por uno de la misma marca, y modelo, luego de que la aseguradora efectúe su cernimiento del historial de reemplazo, para cada caso, considerándose inapropiado un reemplazo por pérdida mayor a uno (1) por vida del beneficiario.

- **Monitor continuo de Glucosa**: Uno (1) cada tres (3) años. Presentar evidencia (similar y no limitada a los ejemplos aquí mencionados) de que se trata de embarazada con DMT1 descontrolada, paciente con diagnosticada con DMT1 con hipoglucemia recurrente grave (nivel de glucosa en sangre <50mg/dl), pacientes con DMT1 candidatos a uso de bomba de insulina que requiere determinar niveles de insulina basal.

  - **Reposición de Monitor de Glucosa dañado/perdido:** Cuando un monitor de glucosa se reporta como dañado o averiado se tendrá que entregar el monitor averiado, para verificar si está bajo garantía o no. En el caso de que se reporte perdido, se podrá sustituir por un monitor de la misma marca, y modelo; luego de que la aseguradora efectúe su evaluación del historial de reemplazo, para cada caso, considerándose inapropiado un reemplazo por pérdida mayor a uno (1) por vida del beneficiario.

- **Bomba de infusión de insulina**: Deberá ser ordenada por un endocrinólogo o endocrinólogo pediátrico e incluir el modelo específico seleccionado por el especialista, el cual debe estar aprobado por la FDA.

  - Congruente con la Carta Normativa de ASES 19-1023, los pacientes autorizados a utilizar bomba de insulina no están sujetos a que se realice proceso de pre-autorización para adquirir los suplidos de dicho equipo. La orden médica sometida por el médico que prescribe la bomba debe establecer una cantidad mensual (o trimestral) de cada uno de los suplidos. En caso de que la orden médica exceda la cantidad de suplidos que se establecen en la Carta Normativa de ASES, entonces se validará la cantidad solicitada en excedente mediante proceso de pre-autorización.

- **Tirillas y Lancetas**: La frecuencia de en la orden médica de este tipo de suplido puede variar de acuerdo con la necesidad mensual del paciente.
  - La receta *debe* incluir el diagnóstico que *justifique* el suplido.
  - Como la receta tiene vigencia de un (1) año, tiene que indicarse en la misma las repeticiones para cubrir el año.

- **Registro de pacientes con diagnóstico DMT1 y equipos aprobados asignados y otros procedimientos para evitar fraude, desperdicio y abuso de recursos:**

    - Todo paciente diagnosticado con DMT1 deberá estar identificado en el sistema.
    - Las Aseguradoras deberán mantener un registro con los equipos entregados a cada paciente, particularmente los monitores de glucosa y las bombas de infusión de insulina, incluyendo cualquier reemplazo otorgado. **El registro debe contener los siguientes campos**: marca, modelo, número de serie, año de fabricación, fecha de entrega al beneficiario, y firma del beneficiario o custodio legal de recibo del equipo.
    - Los pacientes que soliciten reemplazo por motivo de daño a su equipo deberán entregar la unidad dañada.
    - Los pacientes que soliciten reemplazo por motivo de pérdida del equipo deberán presentar un historial describiendo la fecha, que notó la ausencia, último lugar donde lo vio, y reporte de incidencia si este ocurre en un lugar público donde se sospecha de hurto o apropiación.

Se le requiere a cada una de las aseguradoras contratadas que incorporen esta política a sus procedimientos operacionales, que eduquen a los proveedores sobre la misma y que velen por su fiel cumplimiento.

Cordialmente,

Edna Y. Marín Ramos, MA
Directora Ejecutiva