Clinical Policy: Continuous Glucose Monitors

Reference Number: NE.CP.MP.01
Date of Last Revision: 06/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Continuous glucose monitors are indicated for use in members with diabetes mellitus to monitor blood glucose levels. This policy describes the medical necessity requirements for continuous glucose monitors for Nebraska Total Care's Medicaid members.

Policy/Criteria

I. It is the policy of Nebraska Total Care that *initial* coverage of a continuous glucose monitor (CGM)is **medically necessary** when all of the following criteria are met:
- A. Member has diagnosis of diabetes mellitus;
- B. Member meets one of the following:
  1. Requires insulin injections;
  2. Has a history of problematic hypoglycemia with documentation of at least one of the following:
     a. More than one hypoglycemic event with blood glucose < 54mg;/dL (3.0mmol/L) that persist despite more than one attempt to adjust medication(s) and/or modify the diabetes treatment plan;
     b. History of one hypoglycemic event with blood glucose < 54mg/dL (3.0mmol/L) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia;
- C. Member is being assessed every six months by the prescribing healthcare practitioner for adherence to a comprehensive diabetes treatment plan;
- D. One of the following:
  1. Request is for Dexcom or Freestyle Libre product on the formulary;
  2. Request is for Medtronic CGM product on the formulary and member is currently using a Medtronic Insulin Pump.

Note: Approval duration: Six months

II. It is the policy of Nebraska Total Care that *continued therapy* with a continuous glucose monitor (CGM) is **medically necessary** when at least one of the following criteria is met:
- A. Request is for a renewal of authorization and both of the following criteria are met;
  1. Request is for a product currently on the plan formulary;
  2. Member is being assessed every six months by the prescribing healthcare practitioner for adherence to the CGM and diabetes treatment plan;
- B. Request is for a replacement and one of the following criteria is met:
  1. The device has exceeded the warranty period, is malfunctioning and the required repairs would exceed the cost of replacement;
  2. The device is at least five years old (this must be adjusted to the life of the specific model being covered).

Note: Approval duration: 12 months

III. It is the policy of Nebraska Total Care that current evidence does not support CGM using an implantable glucose sensor e.g., Eversense CGM system (CPT codes 0446T, 0447T, and 0448T) due to insufficient evidence of clinical efficacy and long-term health outcomes.

IV. It is the policy of Nebraska Total Care that the use of continuous glucose monitors for any non-FDA approved indications, unless there is sufficient documentation of efficacy and safety, is considered **not medically necessary**.

Background

Monitoring glucose levels is necessary to determine appropriate treatment of individuals with type 1 and type 2 diabetes. Over the past 100 years, there have been numerous innovations in glucose monitoring needs, including recent advances focused on continuous glucose monitoring (CGM) technologies.[2]

A non-adjunctive CGM can be used to make treatment decisions without confirmation of results with a blood glucose monitor (BGM). An adjunctive CGM requires user verification of glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions.[4]

Despite numerous advances in medications, glucose monitoring technologies, and insulin delivery systems, diabetes control remains a challenge for many individuals. There have been various barriers to care, including restrictive eligibility criteria for coverage of continuous glucose monitoring. Nebraska Total Care is one of a few state Medicaid programs that covers continuous glucose monitors.[3] Under Legislative Bill 698, Nebraska Medicaid began CGM coverage for all eligible beneficiaries with a prescription who met medical necessity criteria for a device on or after January 1, 2023.[1,3]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
95249	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording
95250	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified healthcare professional-

CPT® Codes	Description
	(office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
95251	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report

HCPCS Codes	Description
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver
E2103	Non-adjunctive, non-implanted CGM or receiver
A4238	Supply allowance for adjunctive, non-implanted CGM, includes all supplies and accessories, 1 month supply + 1 unit of service
A4239	Supply allowance for non-adjunctive, non-implanted CGM, includes all supplies and accessories, 1 month supply +1 unit of service

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created.	6/24	

References

1. Nebraska Department of Health and Human Services. Provider bulletin 22-22; CGM Coverage by Medicaid. https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2022-22.pdf. Published December 29, 2022. Accessed June 11, 2024.
2. Galindo RJ, Aleppo G. Continuous glucose monitoring: The achievement of 100 years of innovation in diabetes technology. *Diabetes Res Clin Pract*. 2020;170:108502. doi:10.1016/j.diabres.2020.108502
3. Anderson JE, Gavin JR, Kruger DF. Current Eligibility Requirements for CGM Coverage Are Harmful, Costly, and Unjustified. *Diabetes Technol Ther*. 2020;22(3):169-173. doi:10.1089/dia.2019.0303
4. Local coverage determination: glucose monitors (L33822). Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33822. Published October 1, 2015 (revised April 1, 2024). Accessed June 11, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria

set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.