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RMHP Continuous Glucose Monitoring (CGM)

MCG Health
Ambulatory Care
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Link to Codes

- Clinical Indications for Procedure
- Alternatives to Procedure
- Evidence Summary
  - Background
  - Criteria
  - Inconclusive or Non-Supportive Evidence
- Reviewer Guidance
- Policy History
- References
- References
- Footnotes
- Codes

Clinical Indications for Procedure

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

A) MEDICARE Plans:

1) Medicare [Care Advantage (MA) and Dual Special Needs (DSNP)] plans - CGM is covered for members when medically necessary. The case will be pended for the reviewer to apply the current Medicare Local Coverage Determination and Article (LCD/LCA) guidelines then notify the requester of the decision per protocol. Effective 4/1/2022 A9276, A9277, A9278 are invalid for Medicare per https://www.cms.gov/files/document/r11292cp.pdf - see E2102, E2103, A4238, A4239

B) *RMHP PRIME (MEDICAID) Plans:*

1) RMHP PRIME (Medicaid) plan members **AGE 20 AND UNDER:** CGM is covered when meeting the medical necessity guidelines below.

2) RMHP PRIME (Medicaid) plan members **AGE 21 AND OVER: Void and Redirect to HCPF as a Wrap-around benefit.** Effective 7/1/2021 CGM is a **Wrap-Around Benefit** managed directly by Health First Colorado (HCPF), not RMHP form members age 21 and over. See Reviewer Guidance.

C) *Individual & Family Plans (IFP) and CHP PLUS Plans:*

1) Individual & Family Plans (IFP)and **CHP Plus** plans: CGM is covered for members when meeting the medical necessity guidelines below.

- Continuous glucose monitoring may be indicated for **1 or more** of the following(1)(2)(3)(4)(5):
    - The Member has **RMHP Individual & Family (IFP), CHP+,** or **PRIME (Medicaid) age 20 and under** health plan coverage and Type 1 or type 2 diabetes mellitus, and long-term continuous glucose monitoring needed, as indicated by **ALL** of the following(6)(7)(8) :
        - Intensive insulin regimen (3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump)(9)(10)
        - Patient consistently monitors blood glucose 3 or more times per day. [A] (25)
        - Patient is motivated and knowledgeable about use of continuous glucose monitoring, is adherent to diabetic treatment plan, and participates in ongoing education and support.(26)(27)(28)(29)(30)

Alternatives to Procedure

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

- Alternatives include self-monitoring of blood glucose with home glucose monitor.(3)(22)(28)

Evidence Summary

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

DEFINITIONS - Continuous Glucose Monitors (CGM)

The general term CGM refers to both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs. For the purpose of this document, the term “therapeutic” may be used interchangeably with the term “non-adjunctive.” Likewise, the term “non-therapeutic” may be used interchangeably with the term “adjunctive.”

A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. A non-therapeutic or adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions. On February 28, 2022, CMS determined that both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs may be classified as DME.

Background

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

Continuous glucose monitoring is accomplished by use of a small catheter inserted into subcutaneous tissue.(2)(3)(31)(26) **(EG 2)** Electrochemical sensors currently available commercially for measuring subcutaneous glucose levels are able to provide an adequate glucose signal for 7 to 14 days.(2)(31)(26)(32)(33) **(EG 2)** Continuous glucose monitoring devices are designed for either long-term use (also called "personal" or "real-time" monitors) or short-term use (also called "professional" or "retrospective diagnostic" monitors).(2)(32)(34)(35)(36) **(EG 2)** Long-term monitors are usually owned by the patient and display glucose levels in real-time, allowing the patient to adjust insulin dose or food intake. Short-term monitors are usually provided by a clinician and allow for collection of glucose levels over a period of a few days; glucose levels are not displayed to the patient, but are available for the clinician's review at the end of use.(2)(32)(34)(35) **(EG 2)**

Accuracy of continuous glucose monitoring devices is often expressed as the mean absolute relative difference (MARD), which is the average of the differences in glucose measurements between the device and a reference standard (typically serum glucose), reported as a percent of the reference value.(37)(21)(38)(39) **(EG 2)** A MARD of 10% or less has been proposed as an acceptable limit for safe use of continuous glucose monitoring devices.(37)(40)(41) MARD values may be influenced by study design, making inter-study comparisons of MARD values problematic.(38)(39)(40)

Criteria

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

For type 1 and type 2 diabetes mellitus, and need for long-term continuous glucose monitoring, A systematic review and other guidelines recommend continuous glucose monitoring for those who are able to use these devices on a near-daily basis.(3)(42)(43) **(EG 1)** A systematic review and individual patient data meta-analysis (1371 patients) compared real-time continuous glucose monitoring to self-monitoring of blood glucose in type 1 diabetes mellitus. It found modest, statistically significant reduction in HbA1c in patients older than 15 years using continuous glucose monitoring as compared with self-monitoring of blood glucose. No significant differences were noted in frequency of hypoglycemia or time in hypoglycemia.(44) **(EG 1)** A systematic review and meta-analysis that included 10 randomized controlled trials indicated that real-time continuous glucose monitoring is superior to SMBG in terms of lowering HbA1c levels without increasing the risk for severe hypoglycemia in persons with type 1 diabetes mellitus, particularly when patients are adherent to use of the monitoring device.(27) **(EG 1)** A multicenter randomized crossover trial of continuous glucose monitoring in 153 type 1 diabetes mellitus patients, ages 6 to 70 years, on insulin pump therapy found a significant reduction in HbA1c and less hypoglycemia as compared with standard self-monitoring after 6 months.(45) **(EG 1)** A multicenter randomized controlled trial compared continuous glucose monitoring (Dexcom G5) to self-monitored blood glucose in 203 type 1 diabetes mellitus patients, age 60 years and older. At 6-month follow-up, small but significant reduction in time spent in hypoglycemia (ie, glucose less than 70 mg/dL (3.89 mmol/L)) was observed in the intervention arm only, most notably in patients with worse baseline levels of hypoglycemia. Ten patients in the control arm experienced severe hypoglycemia requiring assistance as compared with one patient in the continuous glucose monitoring arm.(46) **(EG 1)** Two randomized trials in adults with type 1 diabetes using multiple daily insulin injections compared real-time continuous glucose monitoring to self-monitoring of blood glucose and reported improvements in HbA1c and increased normoglycemia in patients using continuous glucose monitors with good adherence as compared with self-monitoring of blood glucose.(47)(48) **(EG 1)** An industry-sponsored, multicenter, randomized controlled trial compared continuous glucose monitoring (Dexcom G5) to self-monitored blood glucose in 153 type 1 diabetes mellitus patients age 14 years to 24 years. Significant reduction in mean HbA1c occurred in the intervention arm only; adherence with the continuous glucose monitor at 26-week follow-up was 68%.(49) **(EG 1)** A 2-center randomized crossover trial using continuous glucose monitoring vs self-monitoring of blood glucose in adult type 1 diabetes patients with impaired hypoglycemia awareness reported significant decrease in severe hypoglycemia and improved time in normoglycemia during continuous glucose monitor use.(50) **(EG 1)** A randomized trial of 141 patients with type 1 diabetes mellitus who were treated with multiple daily insulin injections and had impaired hypoglycemia awareness or severe hypoglycemia found that, after 6 months, use of continuous glucose monitoring reduced the incidence of hypoglycemic events by 72%, as compared with self-monitoring.(51) **(EG 1)** A randomized controlled trial examining quality-of-life measures in 158 adults with poorly controlled type 1 diabetes mellitus found that the use of continuous glucose monitoring increased hypoglycemic confidence and decreased diabetes distress as compared with self-monitoring of blood glucose; however, there were no differences in well-being, health status, or hypoglycemic fear between the 2 groups.(52) **(EG 1)** A multicenter, open-label, randomized controlled trial evaluated continuous glucose monitoring vs self-monitored blood glucose alone in 215 pregnant patients with type 1 diabetes mellitus on intensive insulin therapy and reported a small, yet significant, reduction in HbA1c, less time in hyperglycemia, and more time in target glucose range in the continuous glucose monitoring arm. Both arms experienced similar hypoglycemia event rates and time in hypoglycemia. Neonatal secondary outcomes included fewer large-for-gestational age babies and reduced number of stays in neonatal intensive care lasting longer than 24 hours in the continuous glucose monitoring arm.(53) **(EG 1)** A retrospective chart review of 38 insulin-requiring diabetic patients age 65 years or older (31 of whom had type 1 diabetes) found that continuous glucose monitoring use was associated with a significant decrease in mean HbA1c from 7.6% (60 mmol/mol) to 7.1% (54 mmol/mol), which was comparable to results reported in younger patients, and a significantly lower rate of severe hypoglycemia.(54) **(EG 2)** A review of a registry of patients with type 1 diabetes mellitus reported that the mean hemoglobin A1c level was lower in continuous glucose monitor users across all age groups irrespective of the method of insulin delivery (ie, pump, multiple daily injections), even after adjusting for confounders.(55) **(EG 2)** A retrospective review of 396 children, adolescents, and adults with newly diagnosed type 1 diabetes found that initiation of continuous glucose monitoring within 1 year of diagnosis was associated with better glucose control and fewer diabetes-related emergency visits, irrespective of therapy with insulin pump or multiple daily injections.(56) **(EG 2)** A study of blinded early generation continuous glucose monitor use in 23 type 1 diabetes mellitus patients (ages 2 to 7 years) reported that only 32% of hypoglycemic events identified by continuous glucose monitoring were also identified by self-monitoring of blood glucose.(57) **(EG 2)** A 6-month trial of

early generation continuous glucose monitor use in 23 children with type 1 diabetes mellitus who used an insulin pump or multiple daily injections and were younger than 4 years reported that hypoglycemia was infrequent and that parental satisfaction was high despite a lack of improvement in hemoglobin A1c and a high percentage of values in the hyperglycemic range.(58) **(EG 2)** Parents of type 1 diabetes mellitus children younger than 12 years reported a reluctance to adhere to glucose targets partly due to fears of hypoglycemia, use of looser glucose targets when the child was not under direct supervision, and challenges in insulin dosing due to variable food intake and activity.(59) **(EG 2)** A pragmatic randomized controlled trial evaluated continuous glucose monitoring with self-monitoring of blood glucose in 158 patients with type 2 diabetes mellitus treated with multiple daily insulin injections over a 6-month period. Greater HbA1c improvement and improved time in target range was observed in the continuous glucose monitoring arm at 24 weeks; severe hypoglycemia events were rare in both arms. The authors noted that the study protocol did not provide aggressive management to titrate insulin dosing and allowed usual care based on glucose results.(60) **(EG 1)** A subgroup analysis of a pragmatic randomized controlled trial included patients with both type 1 (34 patients) and type 2 (82 patients) diabetes mellitus age 60 years and older and compared continuous glucose monitoring with self-monitoring of blood glucose; greater improvement in HbA1c was found in patients in the continuous glucose monitoring arm. No severe hypoglycemia or diabetic ketoacidosis occurred in either arm.(61) **(EG 1)** Expert consensus statements and a clinical practice guideline recommend that continuous glucose monitoring be considered for all type 1 diabetes mellitus patients, as well as type 2 diabetes mellitus patients who are receiving intensive insulin therapy, in order to improve glycemic control and reduce hypoglycemia.(62)(63)(64)(65)(66) **(EG 2)** A consensus specialty society guideline recommends using continuous glucose monitoring in young children who have significant variability in glucose levels or difficulty in identifying hypoglycemic episodes.(67) **(EG 2)** A national guideline recommends the use of continuous glucose monitoring in children of all ages, including those who cannot communicate symptoms of hypoglycemia, who have unawareness of hypoglycemia, who have serious comorbidities that impact the ability to control glucose (eg, chronic steroid use), or who undertake elite levels of physical activity (eg, competition on a regional, national, or international level).(68) **(EG 2)**

For type 1 and type 2 diabetes mellitus, and need for short-term continuous glucose monitoring, A systematic review of 3 studies (157 participants) on the use of continuous glucose monitoring in adults with type 1 diabetes and impaired awareness of hypoglycemia concluded that after patients complete a structured educational program, continuous glucose monitoring can reduce rates of severe hypoglycemia and improve hypoglycemia awareness, without worsening glycemic control or restoring counter-regulatory hormone responses.(69) **(EG 1)** Short-term continuous glucose monitoring may help tailor therapy in patients with type 2 diabetes mellitus who are experiencing hypoglycemia or hypoglycemia unawareness.(70) **(EG 2)** Consensus statements and a national guideline indicate that short-term retrospective continuous glucose monitoring is useful as a diagnostic or therapeutic tool in the management of diabetes mellitus.(67)(68)(71) **(EG 2)** A specialty society guideline recommends the use of short-term continuous glucose monitoring in adults with type 2 diabetes mellitus who have HbA1c of 7% (53 mmol/mol) or greater.(3) **(EG 2)**

Inconclusive or Non-Supportive Evidence

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

For gestational diabetes, A review article states that large-scale studies are needed to evaluate whether continuous glucose monitoring in patients with gestational diabetes mellitus results in less macrosomia and fewer perinatal complications.(72) **(EG 2)** A systematic review of continuous glucose monitoring in pregnancy identified 5 studies limited to short-term use of continuous glucose monitoring in women with gestational diabetes; the authors note that more research is needed in this population.(73) **(EG 1)** A systematic review found 2 randomized controlled trials comparing continuous glucose monitoring with self-monitoring of glucose in women with gestational diabetes and observed no clear differences between the 2 methods regarding cesarean delivery rates, perinatal deaths, large-for-gestational age infants, and maternal glycemic control.(74) **(EG 1)**

For implantable sensor for continuous glucose monitoring, A 90-day, single-arm, blinded, prospective study evaluated the accuracy of an implantable glucose sensor in 90 adults with type 1 or type 2 diabetes; the mean absolute relative difference was 8.8% over a blood glucose range of 40 mg/dL to 400 mg/dL (2.2 mmol/L to 22.2 mmol/L), and 91% of sensors functioned through 90 days. The trial was limited by under-representation of non-Caucasian patients and by the lack of data on long-term effects, including the long-term impact of replacing the sensing device every 3 months.(75) **(EG 2)** In a multicenter, prospective, open-label trial of 35 adults

with type 1 or type 2 diabetes, the mean absolute relative difference of an implantable glucose sensor was 9.6% over 90 days, for a blood glucose reference range of 40 mg/dL to 400 mg/dL (2.2 mmol/L to 22.2 mmol/L); all sensors remained functional through the 90-day trial. The authors noted that further studies are needed to assess the accuracy and safety of serial insertions and removals of the device.(76) **(EG 2)** A review article focusing on the use of an implantable glucose sensor for continuous glucose monitoring noted that the device requires professional placement and that limited numbers of diabetologists are experienced with the procedure; study of the device in the pediatric population has been limited to exploratory evaluation.(77) **(EG 2)**

For pregnant women with type 2 diabetes mellitus, A systematic review of continuous glucose monitoring in pregnancy identified 4 studies that assessed continuous glucose monitoring in pregnant type 2 diabetes mellitus patients, which were limited to intermittent, short-term use and reported contradictory results.(73) **(EG 1)** A meta-analysis of 4 randomized controlled trials with 609 pregnant women with pre-existing diabetes mellitus (384 type 1 and 191 type 2) found that compared with intermittent glucose monitoring, continuous glucose monitoring was associated with a reduced composite risk of hypertensive disorders of pregnancy (eclampsia, preeclampsia, and pregnancy-induced hypertension); however, no differences were observed in the risk of preeclampsia alone, cesarean delivery, perinatal mortality, or large for gestational age outcomes with continuous vs intermittent glucose monitoring. The authors note that additional evidence from well-designed randomized trials is needed to evaluate the effectiveness of continuous glucose monitoring.(78) **(EG 1)**

Reviewer Guidance

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

1) **Medicare plans (MA & DSNP) - CGM** is covered for members when medically necessary. Apply the current Medicare Local Coverage Determination and Article (LCD/LCA) guidelines then notify the requester of the decision per protocol, noting that HCPCS codes **A9276, A9277, A9278 are invalid/non-covered for Medicare**. See HCPCS codes E2102, E2103, A4238, A4239.

3) **RMHP PRIME (Medicaid) members AGE 21 AND OVER** : All CGM requests are managed directly by HCPF as a **Wrap-Around Benefit** effective 7/1/2021. Direct the requester to the information below, then close the case with reason " **Void** " option " **Redirected Services** ."

A) **Contact information for wrap-around benefits -**

- Keystone Peer Review Organization (Kepro) - ColoradoPAR: Health First Colorado Prior Authorization Request Program

- https://hcpf.colorado.gov/par

- Phone: 1-720-689-6340

- Fax: 1-800-922-3508

- https://hcpf.colorado.gov/our-providers

- https://hcpf.colorado.gov/provider-help

- https://hcpf.colorado.gov/our-providershttps://hcpf.colorado.gov/provider-help**The following Prior Authorization Requests (PAR) types:**AudiologyDiagnostic ImagingDurable Medical Equipment (DME) and SuppliesMolecular/Genetic TestingOut of State Inpatient AdmissionsOutpatient Physical and Occupational TherapyOutpatient Speech TherapyPediatric Behavioral TherapyPediatric Personal Care Services (PCS)Select Surgical Procedures (Aesthetic, Back, Bariatric)Select Transgender ServicesSolid Organ TransplantsSynagis (seasonal)Keystone Peer Review Organization (Kepro) - ColoradoPAR: Health First Colorado Prior Authorization Request Program web pagePhone: 1-720-689-6340 Fax: 1-800-922-3508

Effective 1/1/2023 HCPCS codes K0553, K0554 are deleted / obsolete / invalid. See E2012, E2103, A4238, A4239.

Health First Colorado (HCPF) guidance effective 1/1/23 updated Feb 2023, reviewed 2/24/2023 does not include or price E2102, E2103, A4238, A4239 on DME UPL or main Fee Schedules. It still contains obsolete K0553, K0554 as priced and has A9276, A9277, A9278 as manually priced. Therefore, not removing obsolete/deleted codes from this policy.

Policy History

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

Summary: 6/27/2021 Annual review and 7/1/2021 update that for Medicaid members age 21 plus CGM is a wrap-around benefit managed directly by HCPF. 6/30/2021 modified wrap-around contact information as provided by Prime Contract Manager. 4/9/2021 Annual review and updates to reflect current coverage of Medicare and Medicaid plan changes per CMS and Health First Colorado (Medicaid now covers A9276, A9277, A9278 for all ages, E0787 invalid for Medicare). 11/25/2019 Added A4226, E0787 new HCPCS code effective 1/1/2020 for pump/supplies to T-CGM. 10/10/2019 Annual review / updated LCD/LCA guidance. 8/27/2019 Upgraded to MCG 23rd edition guidelines customized for RMHP business categories to reflect current Medicaid and Medicare regulations. History Summary: 2/14/2013 MCG Guideline revised to add non-coverage information for Medicare and Medicaid. 1/30/2014 NTAG approval 2/25/2014 MAC approval 12/8/2014 Revisions approved by NTAG and MAC. Added recurrent episodes of hypoglycemia as a criterium. Added Medicaid and Medicare references. Added codes S1030, S1031. 12/7/2015 Reviewed by NTAG and MAC. No revisions. 11/8/2016 Reviewed by NTAG and MAC. No revisions. 3/1/17 clarified Medicaid Prime EPSDT benefit for members aged 20 and under, removed 72 hr monitoring codes that do not need preauth 4/12/17 Confirmed Medicaid Fee Schedule still shows NAB & Reviewed LCD & LC Article for same. Moved EPSDT instructions to reviewer guidance section. 5/16/17 Modified Reviewer Guidance section to reflect EPSDT coverage of CGM for Prime Members under 20 when deemed medically necessary by Medical Direction. 3/30/17 NTAG, 5/9/17 CMC, 7/19/17 MAC approved – removed unawareness from severe hypoglycemia and added new codes K0553, K0554 representing Therapeutic CGM as a benefit when medically necessary 8/4/17 Moved to 21st edition MCG. 6/27/2018 Added "Abbott Freestyle Libre, or equivalent system" in addition to Dexcom G5. 2018 Annual review – approved by committees with no changes. 1/25/2019 Modified policy to reflect that Medicaid now covers CGM for members under age 20. 2019 Annual review approved by relevant committees with no changes. See Archive versions. 1/8/2020 removed age 20 limit for Medicaid to reflect Health First Colorado Fee Schedule change - now allows Therapeutic CGM for all ages. 2020 Annual review by relevant committee hierarchy - no changes.

3/24/2022 Annual review and update to 25th edition MCG with the customizations for Medicare and Medicaid plans unchanged.

4/20/2022 Modified to show new Medicare guidance that all CGM is covered when medically necessary. Added new HCPCS codes E2102, A4238. Reflected that effective 4/1/2022 A9276, A9277, A9278 are invalid for Medicare per https://www.cms.gov/files/document/r11292cp.pdf. Added definitions of adjunctive and non-adjunctive CGM.

1/13/2023 Added new HCPCS codes E2103, A4239 effective 1/1/2023.

Note: As of review date 2/24/2023, Health First Colorado (HCPF) guidance effective 1/1/23 updated Feb 2023 still does not include or price E2102, E2103, A4238, A4239 on DME UPL or main Fee Schedules. It still contains obsolete K0553, K0554 as priced and has A9276, A9277, A9278 as manually priced. Therefore, not yet removing obsolete/deleted codes from this policy.

References

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

A) Health First Colorado (Medicaid) Fee Schedules effective 1/1/2023 and most current DME upper payment fee schedule (2022) - reviewed 2/24/2023.

B) The Center for Medicare and Medicaid Services (CMS) Local Coverage Determination (LCD) Glucose Monitors (L33822) Original Effective Date 10/01/2015, Revision Effective Date 1/1/2023, reviewed 2/24/2023.

C) The Center for Medicare and Medicaid Services (CMS) Local Coverage Article (LCA) Glucose Monitor - Policy Article (A52464) Original Effective Date 10/01/2015, Revision Effective Date 1/1/2023, reviewed 2/24/2023.

D) CGS Medicare JC DME 2023 – 1st Quarter Colorado DMEPOS Fee Schedule, reviewed 2/24/2023.

E) The Center for Medicare and Medicaid (CMS) CGS Jurisdiction C Local Coverage Determination (LCD) External Infusion Pumps L33794, Original Effective Date 10/01/2015, Revision Effective Date 1/1/2023, Reviewed 2/24/2023.

F) The Center for Medicare and Medicaid (CMS) CGS Jurisdiction C Local Coverage Article (LCA) External Infusion Pumps A52507, Original Effective Date 10/01/2015, Revision Effective Date 1/1/2023, Reviewed 2/24/2023.

G) The LCDs and LCAs above are online at CGS Medicare JC listed at www.cgsmedicare.com under Glucose Monitors and External Infusion Pumps.

H) The Department of Health and Human Services Center for Medicare and Medicaid Services CMS Rulings, Ruling No.: CMS-1862-R Date: January 12, 2017 cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf, reviewed 2/24/2023.

I) The July 2017 KB update which added codes K0553, K0554 for therapeutic CGM. (Codes deleted from HCPCS effective 1/1/2023).

J) The Guidance for Therapeutic CGM being a covered benefit for Medicaid plans when medically necessary was given to Pauline Casey by Dana L Batey at the state and interpreted by Tammy Tway on 8/2/17 1:47 p.m. email. Guidance for CHP+ coverage included in the string 7/24/17 1:03 p.m.

K) Announcement https://www.dexcom.com/news/medicare-announces-criteria-covering-dexcom-g5-mobile-cgm-for-all-people-with-diabetes-on-intensive-insulin added 7/14/17.

L) Article https://www.dexcom.com/faq/medicare added 10/10/2019.

M) Guidance from Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries for Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS), Public Meeting Agenda Item 13, Application 19.128, pages 42 - June 11, 2019.

N) RAE/Prime Contract Number 19-107507A7 (Amendment 7) [Effective 7/1/21], Exhibit M-7, Prime SOW, 14.3. Exclusions, 14.3.13. The following types of Durable Medical Equipment: wheelchair lifts for vans or automobiles, hot tubs, jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities, continuous glucose monitors for ages 21 and above. Provided by RMHP Prime Contract Manager 6/29/2021.

O) Wrap-around benefit contact information provided by RMHP Prime Contract Manager 6/30/2021.

P) The Department of Health and Human Services (DHHS) CMS Manual System Pub 100-04 Medicare Claims Processing Transmittal 11292, Dated March 10, 2022 Change Request 12654 showing A9276, A9277, A9278 are invalid for Medicare effective

4/1/2022 and showing added HCPCS codes A4238, E2102 effective 4/1/2022 document found online at https://www.cms.gov/files/document/r11292cp.pdf

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Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

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Footnotes

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

[A] Self-monitoring of blood glucose is required to calibrate most continuous glucose monitoring systems(11)(12)(13) and to assist in making acute treatment decisions when using most continuous glucose monitoring devices.(14)(15)(16)(17) [A in Context Link 1]

Codes

Return to top of *RMHP Continuous Glucose Monitoring (CGM) - AC*

HCPCS: A4238, A4239, A9276, A9277, A9278, E2102, E2103, K0553, K0554

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