healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Continuous Glucose Monitoring (CGM)- Billing Guidelines		
Policy Number:	PO-RE-103v2		
Effective Date:	06/01/2024	**Last Approval Date:**	04/21/2025

I. Policy Description

Healthfirst provides reimbursement for Continuous Glucose Monitoring (CGM) devices for members diagnosed with diabetes, including Gestational diabetes, Type 1 and Type 2 diabetes. This policy outlines the criteria for reimbursement, billing requirements, and guidelines for healthcare providers to ensure effective monitoring and management of diabetes through CGM devices.

A CGM is a minimally invasive device that is designed to measure and record glucose levels continuously and automatically in a patient. The device measures glucose values in the interstitial fluid of subcutaneous tissue. The goal of CGM devices is to record patterns of glucose levels and use these patterns to guide patient management and improve overall glycemic control.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)*
- Medicare Advantage
- Medicare PPO
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)*

Policy Scope

This policy applies to Healthfirst members diagnosed with diabetes who meet the specified criteria. It is intended for use by healthcare providers prescribing CGM devices.

Reimbursement Guidelines

CGM devices are considered reimbursable for members with:

1. Gestational Diabetes
2. Type 1 or Type 2 Diabetes, who meet all the following conditions:
   - The member is compliant with regular visits to review CGM data with their provider.
   - The member is on an insulin treatment plan or uses an insulin pump.

- The member or caregiver can hear, view, and appropriately respond to CGM alerts**.**

Billing Requirements

1. General Billing Guidelines
   - Providers must have seen the member within the last six months.
   - Claims must be submitted with an appropriate diabetes diagnosis code (Gestational, Type 1, or Type 2).
   - Providers must verify and document that the member meets the manufacturer's recommendations (e.g., age, calibration, and fingerstick requirements).

2. Non-Therapeutic (adjunctive) CGM Systems
   Adjunctive continuous glucose monitoring does not replace traditional home blood glucose monitoring for making treatment decisions but may be authorized as a warning or alert system for individuals with insulin-dependent diabetes and a history of hypoglycemia. These CGMs use HCPCS codes A4238, E2102.

3. Therapeutic CGM (non-adjunctive) Systems
   Therapeutic CGM systems replace traditional home blood glucose monitoring because treatment decisions can be made based on the CGM. Therapeutic CGM systems are considered medically necessary for insulin-dependent members with frequent adjustments to insulin dosing based on blood glucose test results.

   Therapeutic CGM systems that are classified as Class III devices by the FDA include, but are not limited to, the Eversense E3. These devices **must be** billed with the **KF modifier**.

   Members with therapeutic CGM systems require infrequent traditional home blood glucose testing. The therapeutic CGM supply allowance (A4239) includes all supplies needed for use of the CGM system for one month, including CGM sensors, transmitters, and necessary traditional home blood glucose testing supplies. The receiver (E2103) is durable medical equipment and should last three years or more.

4. Billing for Supplies and Equipment

Code	Description	Max Units/Frequency
A4238	Supply allowance for adjunctive, non-implanted CGM (1 month supply = 1 unit)	1 unit/month
A4239	Supply allowance for non-adjunctive, non-implanted CGM (1 month supply = 1 unit)	1 unit/month
E2102	Adjunctive, non-implanted CGM receiver	1 unit/3 years
E2103	Non-adjunctive, non-implanted CGM receiver	1 unit/3 years

Acceptable Modifiers

Modifier	Description
CG	Use this modifier only if all of the therapeutic CGM coverage criteria 1-6 in the Glucose Monitor Local Coverage Determination (LCD) (L33822) are met. **Do not use the CG modifier if any of the coverage criteria are not met
KF	Indicates a Class III device
KS	Glucose monitor supply for diabetic beneficiary **NOT** treated with insulin.
KX	Glucose monitor supply for diabetic beneficiary treated with insulin.
NU	indicates that the DME is purchased new
RR	indicates that the DME is a rental
UE	indicates that the DME is purchased used

Provider Responsibilities:

- Actively monitor patients for adherence to treatment plans.
- Ensure that CGM data is documented and used for clinical decision-making.
- Avoid prescribing new equipment when current equipment is operational unless medically necessary and outside the manufacturer's warranty.

Device Limitations:

- Ancillary devices (e.g., phones, tablets) are not covered.
- Only one type of CGM device (therapeutic or non-therapeutic) will be covered per member.

Supply Allowance:

- Includes all necessary supplies such as sensors and transmitters.

Limitations and Exclusions:

1. *Medicaid Members:
   - NYS Medicaid members enrolled in mainstream Managed Care Plans (MMC), or Personal Wellness Plan (PWP)/Health & Recovery (HARP) Plans receive pharmacy benefits through the NYRx Pharmacy Program. This program covers diabetic diagnostics, glucose testing supplies, and insulin syringes. Providers billing for these services must submit their claims directly to Medicaid Fee-For-Services (FFS) for reimbursement.

2. Equipment Replacement:
   - Replacement is covered only for medically necessary reasons, excluding recent technology upgrades.

3. Non-Coverage:
   - Claims for supplies and monitors without a diabetes-related diagnosis will be denied.

Adjudication and Appeal Process

1. Claim submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

2. Reimbursement for services will be based on the provider's contract with Healthfirst.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

5. Corrected claim submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.

II. Applicable Codes

Code	Description	Comment
A4238	Supply allowance for adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	
A4239	Supply allowance for nonadjunctive, nonimplanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver	
E2103	Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver	

III. Definitions

Term	Meaning
CGM	Continuous Glucose Monitoring
Class III Device	Medical devices that are considered to be the highest risk and are subject to the most stringent regulations from the Food and Drug Administration (FDA). Therapeutic CGM systems that are classified as Class III devices by the FDA require daily calibration
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
Modifier KF	Item designated by FDA as Class III device
NDC	National Drug Code

IV. Related Policies

Policy Number	Policy Description
PO-RE-074	Reimbursement Policy PO-RE-074 Remote Patient Monitoring and Remote Therapeutic Monitoring
PO-RE-088	REIMBURSEMENT POLICY-NDC billing requirements_final.docx (sharepoint.com)
CLINICAL POLICY – MP-065	Continuous Glucose Monitoring & Insulin Pump Coverage

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Glucose Monitors - JA DME - Noridian
Classify Your Medical Device | FDA
LCD - Glucose Monitors (L33822)

Article - Glucose Monitor - Policy Article (A52464)
Medicaid Update Special Edition Part Three: NYRx Pharmacy Benefit Transition Volume 39 Number 4

VI. Revision History

Revision Date	Summary of Changes
12/1/2024	Removed NDC requirements and added new requirements for Medicaid Managed Care and Personal Wellness Plan (PWP)/Health & Recovery (HARP)

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.