Clinical Policy: Continuous Glucose Monitors

Reference Number: IA.CP.MP.500
Effective Date: 02.01.24
Last Review Date: 10.24
Line of Business: Medicaid

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

Description

This policy describes the medical necessity guidelines for continuous glucose monitoring. Self-monitoring of blood glucose and continuous glucose monitoring (CGM) are two techniques that persons with diabetes use at home help them maintain blood glucose within a safe range. Realtime CGM is advanced technology that continuously measures interstitial fluid glucose levels and can therefore provide current glucose level as well as the direction and rate of change. Some CGM systems are designed for short-term diagnostic or professional use. Other CGM systems are designed for long-term patient use. These criteria refer to outpatient chronic interstitial real-time CGM. They do not include acute CGM in a hospital setting.

Policy/Criteria

It is the policy of Iowa Total Care® that a CGM device is medically necessary when **ONE** of the following is met:

1. Member has a diagnosis of Type 1 or Type 2 diabetes mellitus and **ALL** the following are met:
   a. Requires the use of insulin daily or are on an insulin pump; **AND**
   b. The member (or their caretaker) has demonstrated the ability to use such a device and analyze the data to make adjustments; **AND**
   c. Treatment guidelines have been provided to the member (or their caretaker) that allows them to safely and effectively take advantage of the information provided by the device; **AND**
   d. The member has ONE of the following:
      1) Experiencing reoccurring episodes of hypoglycemia; OR
      2) Inadequate glycemic control, as demonstrated by HbA1c measurements 7.0% or greater, despite multiple alterations in self-monitoring and insulin administration regimens to optimize care; OR
      3) Type 1 diabetes and 18 years of age or younger; **OR**

2. Member has a diagnosis of gestational diabetes or any type of diabetes in pregnancy and **ALL** the following are met:
   a. The member (or their caretaker) has demonstrated the ability to use such a device and analyze the data to make adjustments; **AND**
   b. Treatment guidelines have been provided to the member (or their caretaker) that allows them to safely and effectively take advantage of the information provided by the device.

For members who are approved under criterion #2, continued approval for use of the device would default back to criterion #1.

Background
This policy is based entirely on Iowa DHHS Clinical Advisory Committee Policy DME-006.

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 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are CLINICAL POLICY Continuous Glucose Monitoring Page 2 of 4 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.

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

Reviews, Revisions, and Approvals	Revision Date	Plan Approval Date
Policy Developed	02/24	10/24
Medical Management Committee Review and Approval		12/24

Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
CGM: Continuous Glucose Monitor

References

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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.

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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. This clinical policy is not intended to recommend treatment for members. Members 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.

Note:

For Medicaid members, 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.

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