Medicare Advantage Reimbursement Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Continuous Glucose Monitors – Medicare Advantage

Medicare Advantage Plan
☒ Medicare Plus Blue℠
☒ BCN Advantage℠

UM Committee Approval Date: N/A
Effective Date: 10/01/2024

Description

Continuous Glucose Monitors (CGM) are devices that measure glucose values in interstitial fluid at predetermined intervals, providing real-time data every 5 minutes. This technique provides data that show trends in glucose measurements, in contrast to the isolated glucose measurements of the traditional blood glucose devices. The glucose measurements and trends aid in the dosing of insulin required to achieve glycemic control in individuals with diabetes. Although devices measure glucose in interstitial fluid on a periodic rather than a continuous basis, this type of monitoring is referred to as continuous glucose monitoring.

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is not fully established, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

The following is applicable for this medical policy:

After searching the Medicare Coverage Database, it was determined that CMS **does** have NCD, LCD, LCA, and/or manual clinical guidance for coverage determination of the service or item related to the codes in the medical policy. This service may be medically necessary when the criteria in LCD L33822 are met.

Code	Description	NCD	DME MAC LCD/LCA	Additional Guidance
A4233	Replacement battery, alkaline (other than J Cell) for use with medically necessary home blood glucose monitor owned by patient, each	**None**	**CGS and Noridian** L33822, A52464 - Glucose Monitors	**N/A**
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each			
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each			
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each			
A4238*	Supply allowance for adjunctive, nonimplanted 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			
A4244	Alcohol or peroxide, per pint			
A4245	Alcohol wipes, per box			
A4246	Betadine or pHisoHex solution, per pint			
A4247	Betadine or iodine swabs/wipes, per box			
A4250	Urine test or reagent strips or tablets (100 tablets or strips)			
A4253	Blood ketone test or reagent strip, each			
A4255	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips			
A4256	Platforms for home blood glucose monitor, 50 per box			
A4256	Normal, low, and high calibrator solution/chips			
A4257	Replacement lens shield cartridge for use with laser skin piercing device, each			

*Not covered per Medicare LCD/LCA: L33822/A52464

The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website at https://www.cms.gov/medicare-coverage-database/search.aspx for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

BCBSM and BCN follows CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN uses to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Changes, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by applicable laws, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: The Medical Coverage Policies are reviewed by the BCBSM/BCN Utilization Management Committee. Policies in this document may be modified by a member's coverage document. The existence of the medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes. The medical policy is not intended to replace independent medical judgment for treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

Reimbursement Policy

Note: UAW Retiree Medical Benefit Trust (URMBT) members are excluded from preferred/non-preferred product requirements but are required to obtain a CGM from a durable medical equipment (DME) provider

Preferred CGM

Health plans may designate certain devices as preferred. Medicare Advantage plans *may, within specific categories of DME, limit coverage to certain DME brands, items, and supplies of preferred manufacturers…42 CFR § 422.100(l))*

- BCBSM/BCNA preferred CGM brands are Dexcom G6/G7 CGM system or Freestyle Libre
- All other brands are non-preferred

Preferred CGM Coverage Process

- Preferred CGM products can only be obtained through the pharmacy
- A preferred therapeutic continuous glucose monitor will be covered when the patient meets all coverage criteria as of the date of service on the initial claim
- Members who currently use insulin (have a pharmacy claim in the last 6 months) will be able to obtain the Dexcom or Freestyle Libre at the pharmacy without a prior authorization
- Any other indications for CGMs require a prior authorization including provision of medical records. Requests can be made using the pharmacy prior authorization form

Non-preferred CGM Coverage Process

- All non-preferred CGM products will require a prior authorization with medical record support providing rationale for why these products are indicated

- Non-preferred CGM products can only be obtained through the pharmacy
- When the monitor prescribed is a nonpreferred therapeutic CGM and when the patient meets all coverage criteria in effect on the date of service of the initial claim and.
- A non-preferred therapeutic continuous glucose monitor will be covered when the patient meets all coverage criteria as of the date of service on the initial claim, including why a nonpreferred CGM is required

Non-Covered Items

- Non-DME devices (smart phone, tablet, etc.) used as the display device, either separately or in combination with a receiver classified as DME; these are considered by Medicare to be non-medical items even if serving a medical purpose.
- Equipment or supplies/accessories obtained prior to Medicare eligibility
- Member cost share

The Dexcom G6, G7, Freestyle Libre and supplies fall under the Medicare DME benefit. Applicable member cost share, depending on the member's plan, applies to both the device and supplies.

Coding

Refer to LCA A52464 for billing and coding guidance.

Applicable HCPCS modifiers for glucose monitors and supplies:

CG - Policy criteria applied

EY - No physician or other licensed health care provider order for this item or service

KS - Glucose monitor supply for diabetic beneficiary not treated by insulin

KX - Requirements specified in the medical policy have been met

FDA product codes: QCD, MDS

Further Reimbursement Guidance

Participating providers

Use our Auth Request tool, which will direct your request for healthcare review. In many cases, an authorization number can be provided immediately. Authorization requests must be submitted annually for ongoing approval of pump supplies.

Non-participating providers

Request authorizations using the general Medical prior authorization form.
Go to the Authorizations section for details on Medicare non-coverage/PSODs

---

Regulatory Status

Continuous glucose monitors (CGMs) are class III medical devices that require premarket approval by the United States Food and Drug Administration (FDA). In order to be considered reasonable and necessary, the FDA approved indication must include use as a therapeutic CGM.1 The FDA recently approved expanding the indications of an implantable CGM (I-CGM) product to replace fingerstick blood glucose measurements for diabetes treatment decisions.

Multiple CGM systems have been approved or cleared by the FDA through the premarket approval process.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
10/01/2024	N/A	Medicare Advantage policy established
03/01/2025	N/A	Reimbursement Policy language to include language for URMBT Members