

Document ID#: 2126611  
 Subject: Continuous Glucose Monitoring Systems (CGMS)  
 Effective Date: October 12, 2011

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	RN/LPN

**Please Note: Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.**

### Overview

Continuous glucose monitoring systems (CGMS) are minimally invasive or noninvasive devices that measure glucose levels in interstitial fluid at frequent intervals over a period of several days. CGM systems are designed to obtain information regarding diurnal patterns in glucose levels that, when evaluated in real time or reviewed retrospectively by a physician, can guide adjustments to therapy, with the goal of improving overall glycemic control. The glucose measurements provided during continuous monitoring are not intended to replace standard self-monitoring of blood glucose (SMBG) obtained using fingerstick blood samples, but can alert the patient to the need to perform SMBG (Hayes, Inc, 2007).

### Coverage Guidelines

Tufts Health Plan may authorize the **\*coverage** of a continuous glucose monitoring system (CGMS) to be used by a member. All requests for prior authorization must be submitted on [Continuous Glucose Monitoring System Prior Authorization Request Form](#) completed by an endocrinologist, documenting that **both** of the following criteria are met:

- The Member has had a consultation with an endocrinologist **and**;
- The Member has Type I Diabetes Mellitus with the diagnosis of hypoglycemic unawareness characterized by **one** of the following:
  - A history of recurrent, severe bouts of hypoglycemia (severe is defined as a disabling episode requiring assistance of another individual to manage).
  - The first manifestation of hypoglycemia for the member is neuroglycopenic (warm, weak, confusion, tired or drowsy) as opposed to neurogenic (shaky, tremulous, heart pounding, sweaty, hungry, tingling)

Tufts Health Plan covers continuous glucose monitoring when used for up to 72 hours as a diagnostic test without prior authorization.

**\*Please Note: If coverage is approved, the authorization period for the purchase of the transmitter and receiver will be for six months. Sensors and supplies will be given a lifetime authorization.**

## Limitations

Tufts Health Plan will not cover CGMS in any if the following circumstances:

- The Member has Type II Diabetes Mellitus
- When CGMS is being used to promote improved diabetic control only.
- Tufts Health Plan does not cover the Gluowatch<sup>®</sup>.

## Codes

The following CPT codes are covered when medically necessary, without prior authorization:

Code	Description
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording

The following HCPCS codes **require prior authorization**:

Code	Description
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
S1030	Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use CPT code)
S1031	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use CPT code)

## References

Hayes, Inc. Continuous glucose monitoring systems. Hayes Medical Technology Directory. May 22, 2007.

## Approval History

Reviewed by the Medical Affairs Medical Policy Committee on September 5, 2008 for a January 1, 2009 effective date.

Subsequent Endorsement Date(s) and Changes Made:

- July 6, 2009: Tufts Health Plan 'Continuous Glucose Monitoring System Prior Authorization Request Form' approved and attached to MNG.
- October 1, 2009: Prior authorization requests must be submitted on the Tufts Health Plan Continuous Glucose Monitoring System Prior Authorization Request Form completed by an endocrinologist.
- November 19, 2009: Administrative process updated.
- December 2009: Clarification of device and sensor authorization periods.
- December 2010: Reviewed by Medical Affairs, Medical Policy. CPT code 95251 removed from MNG, this code is on non reimbursable list. Effective January 2011.
- October 12, 2011: Reviewed by Integrated Medical Policy Advisory Committee; no changes

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink<sup>SM</sup>.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.