Sentara Health Plans

Medicaid

Continuous Glucose Monitoring Systems, DME 10

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Coverage Policy	DME 10
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Continuous glucose monitoring measures glucose levels throughout the day with an electrode that is inserted under the skin. The electrode is connected to a transmitter that sends the information to a monitoring and display device that can notify the individual if their glucose is high or low.

Commonwealth of Virgina. Department of Medical Assistance Services. DMAS.gov. DMAS Memo. Continuous Glucose Monitoring (CGM) Coverage Update.

- Memo Date September 12, 2025. Effective Date July 1, 2025 - Continuous Glucose Monitoring (CGM) Coverage Update | MES
- Memo Date October 16, 2025. Effective Date July 1, 2025 - Continuous Glucose Monitoring (CGM) Criteria Update - Effective July 1, 2024 | MES

Criteria:

Continuous Glucose Monitoring Systems may be indicated for **1 or more** of the following:

- Type 1 or type 2 diabetes mellitus or gestational diabetes, and long-term continuous glucose monitoring needed, as indicated by **ALL** of the following:
  - Intensive insulin regimen (3 or more short acting insulin injections per day), or use of COMPATIBLE continuous subcutaneous insulin infusion pump
  - Individual consistently monitors blood glucose 3 or more times per day as documented on **ALL** of the following:
    - Medical record documentation
    - Personal blood glucose log showing consistent measurements over 2 weeks. Individual and/or caregiver is adherent, capable of using the devices safely (either by themselves or a caregiver), knowledgeable and able to follow a diabetic treatment plan, and participates in ongoing education and support.
- Replacement of Continuous Glucose Monitoring System is indicated with **ALL** of the following:
  - The problem(s) which limit the use of the current continuous glucose monitoring system is clearly identified (including misuse or abuse of the equipment)

    - There is documentation that the current continuous glucose monitoring system is not under warranty, including the date of warranty expiration.
- Continued coverage of Continuous Glucose Monitoring System devices are considered medically necessary with **ALL** of the following:
    - Member continues to meet above coverage criteria.
    - Non-Adherence to treatment has been addressed and documentation supports continued use.

There is insufficient scientific evidence to support the medical necessity any of the following as they are not shown to improve health outcomes upon technology review:

- Diabetes Management Software
- Hypoglycemic wristband alarm (e.g., Diabetes Sentry, GlucoWatch)
- Nesidioblastosis (primary islet cell hypertrophy), neonatal hypoglycemia, and for monitoring blood glucose in non-diabetic persons
- Personal Digital Assistant-Based Blood Glucose Monitor (e.g., TheraSense FreeStyle Tracker, Accu-Check Advantage Module)
- Remote glucose monitoring device (e.g., mySentry, MiniMed Connect, Dexcom SHARE)

Authorization request is limited to the following. Requests for equipment outside of recommended utilization must have supporting documentation:

- For Dexcom: 3 sensors per 30 days, 1 transmitter per 90 days
- For Freestyle: 2 sensors per 28 days
- Other FDA approved CGM system

Continuous Glucose Monitoring Systems are considered not medically necessary for any use other than those indicated in clinical criteria.

Document History:

Revised Dates:

- 2024: July – criteria updated references updated
- 2023: July
- 2021: August
- 2020: January
- 2019: September
- 2016: January, November
- 2015: August, October, November
- 2014: March, August, October
- 2013: April, March, October
- 2012: June, November
- 2011: June
- 2008: March, October

Reviewed Dates:

- 2025: June – Implementation date of September 1, 2025. No change references updated.
- 2022: July
- 2020: August
- 2019: March
- 2018: July
- 2017: January, May
- 2010: May
- 2009: May
- 2007: October

Origination Date: January 1994

Coding:

Medically **necessary** with criteria:

Coding	Description
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic
A4238	Supply allowance for adjunctive continuous glucose monitor (CGM), includes all supplies and accessories, 1
A4239	Supply allowance for nonadjunctive, nonimplanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service (authorization required – effective 1/1/2025)
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and
E2102	Adjunctive continuous glucose monitor or receiver
E2103	Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories,
K0554	Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system
S1030	Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use CPT code)

Considered **Not Medically** Necessary:

Coding	Description
	None

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should

discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
- **Documentation Requirements** DME Chapter IV (updated 5.23.25)_Final.pdf appendix-b-21-excel-version-with-all-categories-of-appendix-b-july-2025.xlsx
  - All durable medical equipment (DME) and supplies must be ordered by a practitioner on the form: CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed Certification of Medical Necessity (CMN).
  - The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days.
  - The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The CMN shall be valid for a maximum period of twelve (12) months for Medicaid individuals 21 years and older.
- **Repair vs. Replacement Guidelines**
  - If individual owned equipment needs to be replaced prior to the service limit (Per Appendix B) expiring the provider will be required to justify and obtain service authorization.
  - Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional documentation as stated below:
    - What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
    - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; and
    - If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- **Rental vs. Purchase Guideline**
  - When determined to be cost effective by SHP, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)
  - When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Continuous Glucose Monitoring, CGM, CGMS, MiniMed , shp dme, durable medical equipment 10, type 1 diabetes, type 2 diabetes, glycemic control, hypoglycemic, hyperglycemia, diabetes mellitus, Long-term continuous glucose monitoring, Short-term continuous glucose monitoring, gestational diabetes