Journal of Diabetes Science and Technology
Volume 2, Issue 4, July 2008

A Look at the Current Reimbursement Environment for Continuous Glucose Monitoring (CGM): Understanding the Fundamentals

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Abstract

As reimbursement continues to decline for diabetes management technologies and practice overhead continues to rise, it is becoming increasingly important to understand the current reimbursement environment for new technological innovations in diabetes care. The current environment demands a strong partnership among providers, key stakeholder groups, and industry to advocate for favorable coding, coverage, and payment of these new advancements, in order to improve accessibility to the patient. This article describes trends in the current reimbursement environment for continuous glucose monitoring and provides recommendations on how to maneuver through the intricacies of coding and coverage related to this emerging category of glucose monitoring.

J Diabetes Sci Technol 2008;2(4):681-684

Historically, endocrinologists relied on patients to log their glucose value readings recorded from episodic monitoring, and from that data made various recommendations on patients' management of their disease. Although a minority of patients maintains excellent written logs of their glucose values, the data may not always be accurate or complete. A significant number of patients fail to present data at all. Additionally, while episodic monitoring can provide a "snapshot" of a patient's glucose value during a specific point in time, continuous glucose monitoring (CGM) provides a more comprehensive view of patients' overall glycemic control.

Trends in Coverage for Continuous Glucose Monitoring

In the case of an emerging category of technology, there is an educational period when payers must be properly convinced of the inherent value in providing the new technology to eligible patients. As continuous glucose monitoring continues to evolve, critical factors including clinical efficacy, improvement in net health outcomes, usability, and sustainability will play an important role in how payers respond to this evolving category of technology.

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Abbreviations: (CGM) continuous glucose monitoring, (CGMS) continuous glucose monitoring system, (CPT) current procedural terminology, (DME) durable medical equipment, (ED) emergency department, (E/M) evaluation and management, (HCPCS) Healthcare Common Procedure Coding System

Keywords: coding, coverage, continuous glucose monitoring, CPT, HCPCS, reimbursement

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In the early 2000s, several leading commercial payers provided an initial favorable response to some of the earlier CGM technologies. For example, most commercial plans provided coverage for retrospective, intermittent use of continuous glucose monitoring systems (CGMS) purchased by the physician. In 2007, Humana Inc., Cigna Corp., and Aetna Inc. all reaffirmed their positive decisions for retrospective CGMS in policy updates for the CGM category, but stopped short of expanding coverage to include patient-use CGM technologies in the home setting beyond a one-sensor life cycle.

As newer technologies intended for patients' use on a longterm basis in a home or outpatient setting have emerged in recent years, insurance providers are placing greater scrutiny in reviewing the CGM category before expanding existing coverage policies. For example, in December of 2003, the Blue Cross and Blue Shield Association Technology Evaluation Committee evaluated retrospective CGMS and determined at that time that it failed to meet their key technology evaluation criteria.[1] However, the majority of Blue Cross and Blue Shield local plans are currently covering retrospective CGMS, and some are approving claims for patient-use CGM technologies in the home setting, upon completion of a prior authorization process. Additional clinical outcomes data coupled with aggressive advocacy by both health care professionals and patients will be required to ensure expanded access to patient-use CGM devices and this evolving category of technology.

With respect to the federal payer environment, Medicare does not currently cover the durable medical equipment (DME) components of CGM intended for patient-use CGM. However, there is a growing trend in CGM coverage among certain state Medicaid programs among beneficiaries who meet specific eligibility criteria. Triggered by the recent establishment of the three new Healthcare Common Procedure Coding System (HCPCS) codes for CGM technologies, both the State of Indiana as well as the State of Texas have made recent updates to their existing Medicaid policies to reflect expanded reimbursement of the CGM category.[2,3]

Market research conducted in early 2008 suggests that demonstrating the ability of new CGM systems as effective tools in not only understanding trends in glycemic variation, but also in helping patients detect and avoid hypoglycemic and hyperglycemic events, will be key criteria in establishing a favorable coverage and payment environment. Additionally, over 70% of insurance plans surveyed believed they would provide coverage of CGM for members living with type 1 diabetes who met specific medical criteria, within the next 12–18 months.[4] This positive momentum indicates that insurers are beginning to understand the value of CGM for a targeted, insulin-using patient population. As clinical evidence continues to unfold, these coverage decisions will undoubtedly expand. The key factors that payers will consider when determining future coverage policies for continuous glucose monitoring include:

- Price of CGM systems and sensors
- Clinical evidence demonstrating superiority over current methods of glucose measurement and management, as well as improvement in overall net health outcomes
- Ability to detect and prevent severe hypoglycemic and/or hyperglycemic events that may otherwise have resulted in emergency room or hospitalization visits [The number of visits to the emergency department (ED) due to hypoglycemia in patients with diabetes grew from 1993 through 2005. From 1993 through 2005, hypoglycemia accounted for approximately five million visits to the ED, or an average of 380,000 visits annually.[5]]
- Target patient population (In the beginning, payers will tend to take a conservative perspective in terms of covering narrowly defined patient subpopulations who meet specific medical eligibility criteria.)
- Training, education, and support services necessary to ensure optimal chances of success for patients transitioning onto CGM
- Usability, userfriendliness of CGM systems
- Perspectives from key opinion leaders within the endocrinology and family physician arena

The last three factors emphasize the critical importance of patients and health care professionals in determining the future success of the CGM category. Improving the reimbursement environment for continuous glucose monitoring will be directly related to whether or not patients are properly educated and trained on how to use these sophisticated systems accurately and efficiently in order to optimize CGM as an effective tool in overall diabetes management.

Current Procedural Terminology Coding for Continuous Glucose Monitoring: 95250 and 95251

There are currently two Current Procedural Terminology (CPT) codes for CGM: 95250 and 95251. CPT 95250 is used

for the technical component of CGM, and covers patient training, glucose sensor placement, monitor calibration, use of a transmitter, removal of sensor, and downloading of data. CPT code 95250 may be appropriate for retrospective CGM and for the initial training, hookup, download, etc. on patient-use CGM. If the patient owns the glucose sensor, it is recommended that the provider add the modifier -52 to 95250 to indicate that the service is "reduced" (in order to prevent double billing for the cost of the sensor itself). While there are several modifiers, modifier -52 is used to indicate that a particular service or procedure was reduced or eliminated at the doctor's discretion. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Another important point to consider is the fact that if a registered nurse or a certified diabetic educator provides the services associated with CPT code 95250 under proper physician supervision, the supervising physician can bill for those services.

The CPT code 95251 is for analysis and interpretation of CGM data. This analysis does not need to be performed face-to-face with the patient. However, CPT 95251 is a professional code that is only billable by a physician or midlevel provider (i.e., nurse practitioner or physician assistant).

The national Medicare payment in 2008 for CPT code 95250 is $145, and CPT code 95251 is $38 (**Table 1**). This reimbursement can add significant economic value to a physician in an environment where cognitive services are typically undervalued. For example, CGM requires minimal upfront investment for the provider, and Medicare reimbursement for CGM ranges from $145-$180. In comparison, the Medicare reimbursement for a bone density study is $96 but may require significant upfront resources on behalf of the provider.

Given that CGM systems are available by prescription only, patients will likely visit their endocrinologist's or physician's office before pursuing continuous glucose monitoring as part of their individual diabetes management. If so, a face-to-face visit with the patient to review the glucose sensor data and make medical management decisions will be necessary. These visits are typically billed under the appropriate evaluation and management (E/M) code. However, codes 95250 and 95251 *could* be applied in addition to an E/M code, as long as the service for the evaluation and management is above and beyond the service provided in the context of these two CGM codes. Most Medicare carriers and commercial insurance companies reimburse physicians for these CGM CPT codes.

Table 1.
Current Reimbursement CPT Codes for CGM Physician Payment

CPT code	Service description	Medicare average[a]	Private payer[b]
95250 Patient initiation session	Patient wears CGM for 72 h: •Patient training •Hook-up/calibration •Sensor removal •Data download	$145	$290
95251 Physician interpretation and report	Physician reviews & interprets CGM data and generates report	$38	$55
99212-99215 Patent evaluation session	Office visit to discuss medical regimen based on CGM data	$37–121	$60–182

[a] Medical Fees in the United States, PMIC 2008
[b] Medical Fees in the United States, PMIC 2008, 50th percentile of Usual, Customary, and Reasonable

The CPT codes are for physician services associated with CGM. The device components for patients using CGM are processed under the HCPCS. As of January 1, 2008, there are specific HCPCS codes for the CGM components.

HCPCS Codes

The Centers for Medicare and Medicaid Services approved the use of three newly created codes effective January 1, 2008, to provide appropriate identification of the three primary components of a CGM system in the billing process. The descriptors and HCPCS codes are as follows.

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

These codes are intended for use by suppliers and distributors of DME who are authorized to provide CGM products to end users (whether they be patients or physicians). While codes do not ensure coverage or

appropriate payment for medical technologies, having specifically assigned HCPCS codes for DME and supplies establishes an important level of credibility for this category of technology. Additionally, the availability of specific HCPCS codes may reduce the potential risk of administrative claim denials that result in instances when official codes are not available and suppliers are forced to use miscellaneous codes that may automatically trigger a claim denial.

Conclusion

Efforts continue to establish coverage and payment for patient-use CGM devices. Numerous payers are scheduling technology assessment reviews in 2008 and several have written expanded coverage policies. Additionally, there has been a general increase in coverage trends at the local level for patient-use continuous glucose monitoring on a case-by-case basis, as a result of healthcare professionals being advocates for their patients pursuing the technology during the prior authorization process required for most health plans.

Other allies have also been identified in the quest for improved reimbursement of the CGM category. These allies may include employers who want their employees to stay healthy. Patients themselves may see the proven value of this monitoring and become their own greatest advocates. Finally, several leading professional societies and stakeholder associations are organizing strong lobbying efforts to further persuade payers to recognize that the technologies and services associated with continuous glucose monitoring are valuable to better patient care. Large clinical outcomes studies are also underway, and will further demonstrate the effectiveness of CGM.

Understanding the benefits of continuous glucose monitoring—and the coding and reimbursement environment for this technology category—is critical to ensuring the continued growth and innovation around diabetes management and improved glycemic control.

Acknowledgments:

Gary Bazalo and Rich Weiss, Principals of Managed Solutions, LLC, provided market research analysis that was cited in this article.

Disclosure:

Both authors are employed by companies that manufacture CGM technologies and, as such, have financial interests in the future success of this technology category.

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