NO. 91466-R11

CONTINUOUS GLUCOSE MONITORING AND INSULIN PUMPS

Effective date: 02/01/2026 **Last reviewed**: 11/2025

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

For details as to how to obtain a medically necessary continuous glucose monitoring (CGM) device/system (including transmitter, sensors, and receiver/monitor, with or without a continuous subcutaneous insulin infusion pump), through either pharmacy or durable medical equipment (DME), refer to the Priority Health Provider Manual: Continuous glucose monitors. Devices under warranty that require replacement are not a covered benefit.

Related policies:

- Infusion Services & Equipment No. 91414

SUMMARY OF CHANGES – R11

Changes:

- An implantable continuous glucose monitor (I-CGM; e.g., Eversense Continuous Glucose Monitoring System; Senseonics, Inc.) may be considered medically necessary for a commercial member when criteria are met

I. MEDICAL NECESSITY CRITERIA

A. Continuous glucose monitoring (CGM) devices/systems (including transmitters, sensors, receivers/monitors; and potentially combined with continuous subcutaneous insulin infusion pumps) may be considered medically necessary as follows:

1. **Commercial:**

a. **InterQual®:** The following may be considered medically necessary for a commercial member when corresponding InterQual® criteria are met **(CP:Durable Medical Equipment - *Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Technology*)**:
    i. Continuous glucose monitoring devices (CGM) (real time [rtCGM] and intermittently scanned [isCGM])
    ii. Continuous subcutaneous insulin infusion (CSII) pumps
    iii. FDA-approved technology devices which integrate CGMs and CSII pumps for sensor-augmented therapy
    iv. FDA-approved technology and devices which integrate CGMs and CSII pumps as an automated insulin delivery system for insulin suspension capability (low glucose suspend) or for suspending and adjusting basal insulin infusion (hybrid closed-loop, manual control of bolus dosing)
b. An **implantable continuous glucose monitor (I-CGM; e.g., Eversense Continuous Glucose Monitoring System; Senseonics, Inc.)** may be considered medically necessary for a commercial member when all of the following criteria are met:
    i. Member has a diagnosis of diabetes.
    ii. Member requires insulin with a complicated regimen (i.e., multiple doses daily and/or using an insulin pump).

2. **Medicaid**: Diabetic equipment and related supplies may be considered medically necessary for a Michigan Medicaid member when the criteria specified in the current Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual are met. Relevant sections are as follows:

    Coverage Conditions and Requirements:

    Diabetic Equipment and Related Supplies:

    Blood Glucose Monitoring Equipment and Supplies
    Continuous Glucose Monitoring Equipment and Supplies
    External Infusion (Insulin) Pump and Supplies

3. **Medicare**: A CGM device/system may be considered medically necessary for a Medicare member when the criteria specified in the Centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD) L33822 Glucose Monitors (CGS Administrators, LLC; Noridian Healthcare Solutions, LLC) are met.

    A continuous glucose monitor (GCM) may be integrated into an external insulin infusion pump. Such an integrated CGM system may be considered medically necessary when the member meets both the CGM coverage criteria (specified above) and the coverage criteria for administration of continuous subcutaneous insulin for the treatment of diabetes mellitus specified in the Centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD) L33794 External Infusion Pumps (CGS Administrators, LLC; Noridian Healthcare Solutions, LLC).

Therapeutic/non-adjunctive and non-therapeutic/adjunctive **implantable continuous glucose monitors (I-CGMs)** (e.g., Eversense Continuous Glucose Monitoring System; Senseonics, Inc.) are considered reasonable and necessary by Medicare when all of the coverage criteria specified in the governing Centers for Medicare & Medicaid Services (CMS) Local Coverage Determination (LCD) are met (see section Governmental Regulations).

B. Other limitations/considerations:
    1. The mySentryTM Remote Glucose Monitor, a MiniMed accessory, is not a covered benefit.
    2. Software or hardware required for downloading data to a device, such as a personal computer, smart phone, or tablet, to aid in the self-management of diabetes mellitus is considered not medically necessary.
C. Priority Health will cover 72-hour continuous glucose monitoring for patients with labile blood sugars and the need for intensive short-term monitoring for improving blood glucose control.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below 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 for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
Diabetes Outpatient Self-Management Training 40.1 Home Blood Glucose Monitors 40.2 CAG-00161N Blood Glucose Testing 190.20 Infusion Pumps 280.14	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	Glucose Monitors L33822 A52464 External Infusion Pumps L33794 A52507 Implantable Continuous Glucose Monitors (I-CGM) L38662 A58127
First Coast Service Options, Inc.	Implantable Continuous Glucose Monitors (I-CGM) L38664 A58136
National Government Services, Inc	Implantable Continuous Glucose Monitors (I-CGM) L38623 A58116
Noridian Healthcare Solutions	Glucose Monitors L33822 A52464

	External Infusion Pumps L33794 A52507 Implantable Continuous Glucose Monitors (I-CGM) L38657 A58133 L38659 A58138
Novitas Solutions, Inc.	Implantable Continuous Glucose Monitors (I-CGM) L38617 A58110
Palmetto GBA	Implantable Continuous Glucose Monitors (I-CGM) L38743 A58277
WPS Insurance Corporation	Implantable Continuous Glucose Monitors (I-CGM) L38686 A58213

III. BACKGROUND

The two common types of diabetes are type 1 and type 2. Type 1 diabetes, known as insulin-dependent diabetes, is a chronic condition in which the pancreas produces little or no insulin. Insulin is a hormone needed to allow sugar (glucose) to enter cells to produce energy. Type 2 diabetes is the most common form of diabetes, in which your body does not use insulin properly.

According to the American Diabetes Association, 34.2 million Americans have diabetes. Of the 34.2 million Americans, 14.3 million are seniors aged 65 and older.

The complications of diabetes mellitus are far less common and less severe in people who have well-controlled blood sugar levels. Acute complications include hypoglycemia, hyperglycemia, diabetic coma, and nonketotic hyperosmolar coma. Chronic hyperglycemia, resulting from poorly controlled diabetes, may result in serious and life-threatening damage, including dysfunction and failure of the eyes, kidneys, nervous system and cardiovascular system.

Continuous glucose monitoring systems (CGMS) are minimally invasive or noninvasive devices that measure glucose levels in interstitial fluid. The devices provide continuous "real-time" readings and data about trends in glucose levels. This may allow people with diabetes to understand the level of their glucose, and to intervene by eating food or taking insulin to prevent glucose levels from going too high or too low. The device is most likely to benefit those patients who have:

- hypoglycemic unawareness, hypoglycemic seizures, or nocturnal hypoglycemia
- diabetes while pregnant or
- not reached optimal HbA1c target despite best efforts by the patient and the treating physician

The components of the CGMS are:

- Receiver
- Transmitter
- Sensor

The general term CGM refers to both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs. A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. A non-therapeutic or adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions. On

February 28, 2022, CMS determined that both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs may be classified as DME.

The American Association of Clinical Endocrinology (AACE) maintains a CGM Device Comparison table within its Guide to Continuous Glucose Monitoring (CGM).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Association of Clinical Endocrinology (AACE)	2023 AACE Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm 2022 Clinical Practice Guideline for Development of a Diabetes Mellitus Comprehensive Care Plan 2021 Clinical Practice Guideline for the Use of Advanced Technology in the Management of Persons with Diabetes Mellitus
American Diabetes Association (ADA)	Diabetes Technology: Standards of Care in Diabetes – 2025 (December 9, 2024)
Endocrine Society	Management of Individuals with Diabetes at High Risk for Hypoglycemia (December 2022)
Department of Veterans Affairs/Department of Defense (VA/DoD)	Clinical Practice Guideline for the Management of Type 2 Diabetes Mellitus (2023)
International Society for Pediatric and Adolescent Diabetes	2024 Clinical Practice Consensus Guidelines
National Institute for Health and Care Excellence (NICE)	Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes (December 19, 2023) Diabetes (type 1 and type 2) in children and young people: diagnosis and management (May 11, 2023) Type 1 diabetes in adults: diagnosis and Management (August 17, 2022) Type 2 diabetes in adults: management (June 29, 2022) Diabetes in pregnancy: management from preconception to the postnatal period (December 16, 2020) Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (July 23, 2008)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date
Minimed 780G system (Medtronic)	K251032	2025-07-01
Dexcom G7 15 Day Continuous Glucose Monitoring System (Dexcom, Inc.)	K243214	2025-04-09
Eversense 365 Continuous Glucose monitoring (CGM) System (Senseonics, Inc.)	K241335	2024-09-16
Dexcom G7 Continuous Glucose Monitoring System (Dexcom, Inc.)	K240902 K231081 K213919	2024-04-23 2023-05-15 2022-12-07
Freestyle Libre 3 Continuous Glucose Monitoring System (Abbott Diabetes Care, Inc.)	K233537 K223435 K222447 K223537 K213996 K212132	2024-04-23 2023-04-13 2023-03-03 2023-02-21 2022-05-26 2022-05-26
Freestyle Libre 2 Flash Glucose Monitoring System (Abbott Diabetes Care, Inc.)	K233537 K223435 K222447 K233537 K210943 K211102 K201761 K193371	2024-04-23 2023-04-13 2023-03-03 2023-02-21 2021-11-22 2021-08-11 2021-07-30 2020-06-12
Eversense Continuous Glucose Monitoring System (Senseonics, Inc.)	P160048 S029 P160048	2025-03-27 2018-07-24

VI. CODING

ICD-10 Codes that may support medical necessity

E08.00 – E08.9	Diabetes mellitus due to underlying condition
E09.00 – E09.9	Drug or chemical induced diabetes mellitus
E10.10 – E10.9	Type 1 diabetes mellitus
E11.00 – E11.9	Type 2 diabetes mellitus
E13.00 – E13.9	Other specified diabetes mellitus
O24.011 – O24.93	Diabetes mellitus in pregnancy, childbirth, and the puerperium

O99.810 – O99.815	Abnormal glucose complicating pregnancy, childbirth and the puerperium
Z46.81	Encounter for fitting and adjustment of insulin pump
Z79.4	Long term (current) use of insulin
Z90.410	Acquired total absence of pancreas
Z90.411	Acquired partial absence of pancreas
Z96.41	Presence of insulin pump (external) (internal)

CPT/HCPCS Codes

95250 Glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor (includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data). *No prior authorization required*.
95251 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report

A4224 Supplies for maintenance of insulin infusion catheter, per week *(not covered for Medicaid)*
A4225 Supplies for external insulin infusion pump, syringe type cartridge, sterile, each *(not covered for Medicaid)*
A4226 Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week *(not covered for Medicaid)*
A4230 Infusion set for external insulin pump, nonneedle cannula type
A4231 Infusion set for external insulin pump, needle type
A4232 Syringe with needle for external insulin pump, sterile, 3 cc
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
A4271 Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests
A4602 Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each *(not covered for Medicaid)*
A9274 External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories *(May only be covered under member's pharmacy benefit for some plans.)*
A9276 Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial Continuous glucose monitoring system, 1 unit = 1 day
A9277 Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278 Receiver (monitor); external, for use with interstitial continuous glucose monitoring system *(Not covered for Medicare or Medicaid)*

E0784 External ambulatory infusion pump, insulin
E0787 External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing *(not covered for Medicaid)*
E2102 Adjunctive, non-implanted continuous glucose monitor or receiver
E2103 Non-adjunctive, non-implanted continuous glucose monitor or receiver

E2104 Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge *(not covered for Medicaid)*

K0604 Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each *(not covered for Medicaid)*
K0605 Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each *(not covered for Medicaid)*

S1034 Artificial pancreas device system (e.g., low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices *(payable for Commercial only)*
S1035 Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system *(payable for Commercial only)*
S1036 Transmitter; external, for use with artificial pancreas device system *(payable for Commercial only)*
S1037 Receiver (monitor); external, for use with artificial pancreas device system *(payable for Commercial only)*
S9145 Insulin pump initiation, instruction in initial use of pump (pump not included*) (not separately payable)*

0446T Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training (covered for Medicare) [Eversense Continuous Glucose monitoring (CGM) System (Senseonics, Inc.)]
0447T Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision (covered for Medicare) [Eversense Continuous Glucose monitoring (CGM) System (Senseonics, Inc.)]
0448T Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation (covered for Medicare) [Eversense Continuous Glucose monitoring (CGM) System (Senseonics, Inc.)]

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

Note: The need for medical necessity review varies by line of business (Commercial, Medicaid, or Medicare) and benefit. See the Priority Health Provider Manual: Continuous glucose monitors for additional details.

To access InterQual® guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a

chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

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