Priority Health	BILLING POLICY No. 059
BLOOD GLUCOSE MONITORS / CONTINUOUS GLUCOSE MONITORS	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial claims that are paid as a medical benefit. A rider could supersede the allowed limits
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

This policy outlines the payment guidelines for blood glucose monitors (BGMs), continuous glucose monitors (CGMs), and associated supplies.

MEDICAL POLICY

Continuous Glucose Monitoring and Insulin Pumps - 91466

PROVIDER MANUAL REFERENCE

https://www.priorityhealth.com/provider/manual/services/medical/cgms

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFICS

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Priority health follows the limits and bundling table listed below for the CGM/BGM monitors and associated supplies.

A4253 Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips One unit is 50 strips	4 Per Month, Age: 21-124 Insulin Use; 6 Per Month,
A4256 Normal, low, and high calibrator solution/chips one unit is 100 strips	3 Per 3 Months
A4259	2 Per Month

Lancets One unit is 100 lancets	Insulin Use: 3 Per Month
A4271 Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests	
A9276 Sensor; invasive (e.g., subcutaneous), disposable, for use with nondurable medical equipment interstitial continuous glucose monitoring system (CGM), one unit = 1 day supply	31 Per Month
A9277 Transmitter; external, for use with nondurable medical equipment interstitial continuous glucose monitoring system (CGM)	2 Per Year
E0607 Home blood glucose monitor	1 Per 3 Years
E2102 Adjunctive, nonimplanted continuous glucose monitor (CGM) or receiver	1 Per 3 Years
E2103 Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver	1 Per 3 Years
E2104 Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge	
A4238 Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge 1 month supply = 1 unit of service	Priority Health will allow up to a three-month supply. • Bill one unit with the same date of service in the “to” and “from” date on the claim line. • If billing for supplies for two or three months, use more than one unit and use a date span in the “to” and “from” date on the claim line.

A4239 Supply allowance for nonadjunctive, nonimplanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service A maximum of three units per 90 day are allowed at a time. A denial will occur if more than three units of CGM supplies are billed within 90-day timeframe.	Priority Health will allow up to a three-month supply. • Bill one unit with the same date of service in the “to” and “from” date on the claim line. • If billing for supplies for two or three months, use more than one unit and use a date span in the “to” and “from” date on the claim line.

A Column II code is included in Column I code when provided at the same time.

Column I	Column II
E0607	A4233, A4234, A4235, A4236
E2100	A4233, A4234, A4235, A4236
E2101	A4233, A4234, A4235, A4236
E2103	E0607, E2100, E2101, A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259
E2104	A4233, A4234, A4235, A4236

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs.

Modifiers

- KS Modifier: Reported to identify if member is treated with insulin when billing for home glucose monitors. Claims without applicable modifier will be denied.
- KX Modifier: Reported to indicate if member is insulin dependent and policy criteria is met. Claims without applicable modifier will be denied.

- KF: Item designated by FDA as Class III device

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made