Priority Health	BILLING POLICY No. 059

CONTINUOUS GLUCOSE MONITOR (CGM) SUPPLIES

Effective date: Aug. 25, 2025 **Date of origin: Nov. 12, 2024**	**Review dates: 2/2025, 6/2025**

APPLIES TO

- Commercial claims that are paid as a medical benefit. A rider could supersede the allowed limits
- Medicare follows CMS policies, NCD, and LCD unless otherwise defined below.
- Medicaid follows MDHHS unless otherwise defined below.

DEFINITION

Continuous glucose monitors (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.

MEDICAL POLICY

- Continuous Glucose Monitoring (#91466)

POLICY SPECIFIC INFORMATION

Billing requirements

The supply allowance codes are A4238 and A4239. Once a member is approved for a CGM, the related supply codes are also approved and covered.

HCPCS codes A4238 and A4239 include all the accessories and supplies needed per month for the CGM. Priority Health will allow up to a three-month supply.

- **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

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.

- 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.

Place of service

Review specific information regarding DME Place of Service billing requirements in our Durable Medical Equipment (DME) place of service (POS) billing policy.

Documentation requirements

- A Standard Written Order (SWO) that lists the base item and all the associated options, accessories and/or supplies.
- Proof of delivery (POD)

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.

REFERENCES

- Glucose Monitors – L33822 (CMS)

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
Feb. 14, 2025	Added "Disclaimer" section

June 19, 2025	Effective Aug. 25, 2025, a maximum of three units of CGM supplies per 90 day will be allowed at a time. A denial will occur if more than three units are billed within 90-day timeframe. • 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.