DIABETES THERAPY CODING & REIMBURSEMENT GUIDE

Medtronic

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INTRODUCTION

This document reflects commonly billed codes for services associated with diabetes management therapies and their associated Medicare national reimbursement rates. This is not an all-inclusive list of possible coding nor does it replace advice from your coding or compliance departments. Documentation in the medical record must support the codes reported. The responsibility for correct coding lies with the provider of services.

DIAGNOSIS

CODES

Diagnosis codes are used by healthcare professionals and hospitals to document the indication for the procedure or service performed.

The following is a list of common ICD-10-CM[1] diagnosis codes that may be associated with diabetes mellitus. The codes on this list are provided for illustrative purposes only. This list is not intended to be exhaustive or all-inclusive. Refer to the Instructions for Use supplied with a product for indications, contraindications, side effects, warnings, and precautions.

Conditions	**ICD-10-CM[1] Diagnosis Codes: Diabetes Mellitus^**	
	Type 1 Diabetes: Category E10	**Type 2 Diabetes: Category E11**
Diabetes mellitus without complications		
with no complications	E10.9, Type 1 diabetes mellitus without complications	E11.9, Type 2 diabetes mellitus without complications
Diabetes mellitus with example complications%		
uncontrolled with hyperglycemia#	E10.65, Type 1 diabetes mellitus with hyperglycemia	E11.65, Type 2 diabetes mellitus with hyperglycemia
with hypoglycemia without coma	E10.649, Type 1 diabetes mellitus with hypoglycemia without coma	E11.649, Type 2 diabetes mellitus with hypoglycemia without coma
with kidney complication	E10.22, Type 1 diabetes mellitus with diabetic chronic kidney disease	E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease
with ophthalmic complication^^	E10.331-, Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	E11.331-, Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
with neurological complication	E10.42, Type 1 diabetes mellitus with diabetic polyneuropathy	E11.42, Type 2 diabetes mellitus with diabetic polyneuropathy
with circulatory complication	E10.51, Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
with foot ulcer	E10.621, Type 1 diabetes mellitus with foot ulcer	E11.621, Type 2 diabetes mellitus with foot ulcer
with other specified complication	E10.69, Type 1 diabetes mellitus with other specified complication	E11.69, Type 2 diabetes mellitus with other specified complication
Adjunctive codes with diabetes mellitus^^^		

Conditions	ICD-10-CM[1] Diagnosis Codes: Diabetes Mellitus^	
	Type 1 Diabetes: Category E10	Type 2 Diabetes: Category E11
Medication status^^^^	Z79.4, Long term (current) use of insulin	Z79.84, Long term (current) use of oral hypoglycemic drugs

^Other code categories are available for less common types of diabetes mellitus including: E08, Diabetes mellitus due to underlying condition; E09, Drug or chemical induced diabetes mellitus; E13, Other specified diabetes mellitus; and O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium (pre-existing and gestational).
%The codes shown are examples of specific types of complications within that subcategory. Other codes are available for different complications within the same subcategory. The table is for illustrative purposes only and is not an exhaustive or all-inclusive list of ICD-10-CM diabetes diagnosis codes.
#Diabetes characterized as uncontrolled, out-of-control, inadequately controlled, or poorly controlled diabetes is coded to hyperglycemia in ICD-10-CM, unless the lack of control refers to low blood sugar (hypoglycemia).
^^A seventh digit must be appended to the code to identify which eye is affected.
^^^Medication status is only coded in a secondary position, following the code for diabetes mellitus.
^^^^Code Z79.4 can also be assigned to a patient with type 2 diabetes mellitus who routinely uses insulin for control. If a patient is treated with both oral hypoglycemic agents and insulin, only Z79.4 is assigned.

HCPCS LEVEL II CODES

Healthcare Common Procedure Coding System (HCPCS) Level II[2] codes are a supplement to CPT® codes. Although some HCPCS level II codes are for procedures and services not classified in CPT, the majority of HCPCS level II codes are for supplies, durable medical equipment (DME), drugs, and medical devices. While CPT codes indicate the procedure performed, HCPCS II codes identify the specific device, supply, DME, or drug utilized in the procedure. In many situations, CPT and HCPCS II codes must be used together to completely describe a service.

The appropriate HCPCS code(s) are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. For insulin pumps and personal continuous glucose monitoring (CGM), this is typically a DME supplier.

Some items have more than one applicable code. For example, a device may have an E-code as well as an S-code. This phenomenon reflects payer preference, as only private payers use S-codes although private payers may also use E-codes. Further, a supply may have more than one A-code, which also reflects payer preference in that one A-code is not payable by certain payers but another A-code is accepted.

Product	HCPCS Level II Code[2]	Description
NON-MEDICARE		
Insulin pump	E0784	External ambulatory infusion pump, insulin
	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
Infusion sets, non-needle	A4230	Infusion set for external insulin pump, non-needle cannula type (each)
Infusion sets, needle	A4231	Infusion set for external insulin pump, needle type (each)
Pump reservoirs	A4232	Syringe with needle for external insulin pump, sterile, 3 cc

Product	HCPCS Level II Code[2]	Description
Remote monitor	A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified
CGM transmitter	A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
	S1036	Transmitter; external, for use with artificial pancreas device system
CGM sensors	A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply
	S1035	Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system
CGM receiver	A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
	S1037	Receiver (monitor); external, for use with artificial pancreas device system
Alcohol wipes	A4245	Alcohol wipes, per box
Betadine swabs, per box	A4247	Betadine or iodine swabs/wipes, per box
Test strips	A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
Lancets	A4259	Lancets, per box of 100
Adhesive, liquid, per ounce	A4364	Adhesive, liquid or equal, any type, per oz
Tape	A4450	Tape, nonwaterproof, per 18 sq in
Adhesive remover	A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per oz
Transparent film, 16 sq. in or less	A6257	Transparent film, sterile, 16 sq in or less, each dressing
Transparent film, more than 16 sq. in	A6258	Transparent film, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing
Home glucose monitor	E0607	Home blood glucose monitor
Replacement battery, pump, silver oxide (MMT-104)	K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
MEDICARE		
Insulin pump (13 month rental)	E0784	External ambulatory infusion pump, insulin
Infusion sets	A4224	Supplies for maintenance of insulin infusion catheter, per week
Pump reservoirs	A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile, each
Alcohol wipes	A4245	Alcohol wipes, per box
Betadine swabs, per box	A4247	Betadine or iodine swabs/wipes, per box
Test strips	A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
Lancets	A4259	Lancets, per box of 100
Adhesive, liquid, per ounce	A4364	Adhesive, liquid or equal, any type, per oz
Tape	A4450	Tape, nonwaterproof, per 18 sq in
Adhesive remover	A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per oz
Transparent film, 16 sq. in or less	A6257	Transparent film, sterile, 16 sq in or less, each dressing

Product	HCPCS Level II Code[2]	Description
Transparent film, more than 16 sq. in	A6258	Transparent film, sterile, more than 16 sq in but less than or equal to 48 sq in, each dressing
Home glucose monitor	E0607	Home blood glucose monitor
Replacement battery, pump, silver oxide (MMT-104)	K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
INSULIN		
Insulin	J1815	Injection, insulin, per 5 units
Insulin for insulin pumps	J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units

PHYSICIAN SERVICES
CODING AND PAYMENT

Physicians and hospitals use Current Procedural Terminology (CPT®) codes[3] to describe the service(s) provided during an encounter. The rate information provided reflects the Medicare national allowable amount published by CMS and does not include geographic adjustments nor Medicare payment reductions resulting from sequestration adjustments to the amount payable to the provider, as mandated by the Budget Control Act of 2011.[4]

DIABETES EDUCATION SERVICES

Diabetes education may consist of patient management to begin insulin pump therapy (also called continuous subcutaneous insulin infusion or CSII) as it relates to insulin, such as carb ratios, basal rates, sick day management, or insulin sensitivity for correction factor. Medical nutrition therapy specifically focuses on dietary intervention to ensure eating habits are appropriate for persons with diabetes. For Medicare, diabetes self-management training and medical nutrition therapy are completely separate benefits.

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
Diabetes Education by Staff or Other Non-Physician					
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	Office Nurse (RN) in ADA-recognized program Certified Diabetes	1.61	$56	HCPCS codes G0108-G0109 are required for Medicare CPT codes 98960-98962 and
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		0.45	$16	

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	Educator (CDCDS) in ADA-recognized program Registered Dietician (RD) in ADA-recognized program	0.8	$28	HCPCS S-codes are used by private payers. *Medicare does not recognize 98960-98962, but does publish reference RVUs and payment amounts for these codes.*
98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients		0.39	$14	
98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients		0.29	$10	
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session		-	-	
S9446	Patient education, not otherwise classified, non-physician provider, group, per session		-	-	
Diabetes Medical Nutrition Therapy					
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Registered Dietician (RD) Certified or Licensed Nutritionist	1.08	$38	For Medicare, the benefit is limited to 3 hours of one-to-one service the first year and two hours each subsequent year. Diabetes self-management
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes		0.93	$32	

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
97804	Medical nutrition therapy; group (two or more individual(s), each 30 minutes		0.49	$17	training and medical nutrition therapy cannot be reported on the same date for the same patient. HCPCS S-code A9452 is used by private payers only.
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes		0.93	$32	
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		0.49	$17	
S9452	Nutrition classes, non-physician provider, per session		-	-	
Diabetes Education by Physician or Equivalent Practitioner					
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Physician (MD, DO) Physician Assistant (PA) Nurse Practitioner (NP) Clinical Nurse Specialist (CNS)	2.12	$74	Physicians and equivalents report E/M codes for education services that they personally perform.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or		3.26	$114	

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
	examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.				
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter		4.87	$170	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.		6.43	$224	
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		0.66	$23	
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using		1.63	$57	

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
	time for code selection, 10-19 minutes of total time is spent on the date of the encounter				
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.		2.65	$92	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.		3.76	$131	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.		5.25	$183	
Other Physician Services					

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 Total RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
G0454	Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist	Physician (MD, DO)	0.26	$15	When DME, such as an insulin pump, is ordered by an NP or PA, the physician must countersign that the NP or PA had a face-to-face encounter with the patient prior to writing the order. When the physician personally performs the face-to-face encounter, the physician uses an E/M code.

CONTINUOUS GLUCOSE MONITORING (CGM) SERVICES

Codes related to continuous glucose monitoring (CGM) differentiate between the technical service of sensor placement and patient training, performed by office staff, and the professional service of interpreting the CGM data, performed by clinicians. For the technical service, different codes are assigned depending on whether the patient or the physician practice owns the CGM equipment.

CPT Code[3]	Code Description	Providers Who Can Perform the Service	CY 2021 RVUs (non-facility)[5]	CY 2021 Medicare National Unadjusted Amount (non-facility)[5]	Notes
CGM Sensor Placement and Patient Training: Patient-owned ("Personal" or "Real-Time" CGM)					Codes 95249 and 95250 are the technical service codes.
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-	Office staff, eg, RN or CDCES, "incident to" the physician service.	1.68	$59	

	provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording				
CGM Sensor Placement and Patient Training: Physician-owned ("Professional" or "Retrospective" CGM)					
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	Office staff, eg, RN or CDCES, "incident to" the physician service.	4.51	$157	
Interpretation of CGM Data					
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	Physician (MD, DO) Physician Assistant (PA) Nurse Practitioner (NP) Clinical Nurse Specialist (CNS)	1.02	$36	Code 95251 is the professional service code. The data analysis and interpretation need not be performed face-to-face with the patient.
Office Visit					
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter	Physician (MD, DO) Physician Assistant (PA) Nurse Practitioner (NP) Clinical Nurse Specialist (CNS)	1.63	$57	An office visit E/M code can only be billed separately on the same date as 95249, 99250, 95251 if a medically necessary, separately identifiable evaluation and management service takes place in addition to
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or		2.65	$92	

	examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.				the CGM service. Modifier -25 is appended to the E/M to indicate this. E/M codes may be used for pre-CGM and post-CGM office visits.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.		3.76	$131	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.		5.25	$183	
+99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual services, on the date of the primary services, each 15 minutes of total time. (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	(Same as above apply)	--	--	These are add on codes that must be billed with an appropriate base code.
+G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been	(Same as above apply)	0.96	$34	

	selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact. (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)				

INPEN™ SMART INSULIN PEN & I-PORT ADVANCE™
NDC-FORMATTED REIMBURSEMENT NUMBERS

Report National Drug Codes (NDCs)[6] for products reimbursed through the pharmacy channel.

If prescribing the InPen™ Smart Insulin Pen through an Electronic Medical Record (EMR)*, please note that the product is available in three (3) different colors and two (2) different models specific to the type of insulin being prescribed. In addition, patients will need a separate prescription for the insulin cartridges associated with their use of the InPen product. Refer to the NDCs for compatible insulin cartridges with the InPen™ Smart Insulin Pen below.

Product Name	Specification	Reimbursement Number (NDC formatted)
InPen™ Humalog®	Blue	62088-0000-31
	Grey	62088-0000-32
	Pink	62088-0000-33
InPen™ Novolog®/Fiasp®	Blue	62088-0000-34
	Grey	62088-0000-35
	Pink	62088-0000-36
i-Port Advance™ Injection Port	6MM Cannula	76300-0100-10
	9MM Cannula	76300-0101-10

*If you are not prescribing InPen through an EMR, complete an online order form at [link to http://www.companionmedical.com/guides/inpen-start-orders.pdf] and email it to rx@companionmedical.com or fax to 877-444-2373.

InPen™ Smart Insulin Pen: Compatible Insulin Cartridges

Patients will need a separate prescription for insulin cartridges with their use of the InPen™ Smart Insulin Pen.

Product Name	Specification	NDC Code
Humalog®	U100 Cartridge	00002-7516-59
Novolog®	U100 Cartridge	00169-3303-12
Fiasp®	U100 Cartridge	00169-3205-15

FREQUENTLY ASKED
REIMBURSEMENT QUESTIONS

CODING & BILLING FOR CONTINUOUS GLUCOSE MONITORING (CGM) SERVICES

1. **Are physicians able to bill for training on Personal CGM devices?**
   Yes. CPT code 95249 is the code for CGM technical services, including patient training, for Personal or Real-Time CGM where the patient owns the CGM equipment.

2. **Are there specific ICD-10-CM diagnosis codes that are required to get paid for CGM?**
   Medicare and most payers limit CGM coverage to patients with diabetes and some require documentation that a patient's diabetes is uncontrolled. Specific ICD-10 diagnosis codes are listed in the coverage policy and may vary by payer.

3. **Can a home health agency bill for CGM?**
   CGM is not covered under the home care benefit, nor would separate reimbursement be available.

4. **Is CGM reimbursed in an assisted living or skilled nursing facility?**
   CGM services would not be separately reimbursed if performed in an assisted living or skilled nursing facility.

5. **Which types of healthcare providers can perform bill CPT codes 95249 and 95250?**
   Codes 95249 and 95250 are not valued for physician work under RBRVS. For Medicare, the services may be performed by a trained RN, CDCES, LPN, or MA under physician supervision and direction, and may then be billed by the physician "incident to" the physician service. This is also generally true for private payers but some may have restrictions related to licensure. Providers should verify requirements with each payer.

6. **Which healthcare providers can perform and bill CPT code 95251?**
   Only a physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist can perform the data analysis and interpretation service and only these types of providers may bill 95251.

7. **Can an Evaluation and Management (E/M) code be billed on same day as 95249, 95250 or 95251?**
   Yes, it may be appropriate for an E/M code to be billed for services provided on the same day as for codes 95249, 95250 or 95251, if the E/M code services were medically necessary and distinct from the CGM services, for example .Modifier -25 should be appended to the E/M code to identify it as a "significant, separately identifiable evaluation and management service" performed on the same day. Note that analysis and interpretation of the CGM data is counted toward code 95251 and may not be counted again for any E/M service.

8. **How often can CPT codes 95249, 95250 and 95251 be billed for a patient?**
   For Personal CGM, code 95249 can be reported just once during the time the patient owns the specific receiver. Placing a new sensor or new transmitter does not qualify; the receiver must be new to report 95249. For Professional CGM, instructions in the CPT manual state that code 95250 cannot be billed more than once a month, but utilization limits may vary by payer. Some payers may limit to twice a year and others may only require medical necessity but not have amount limits. Similarly, for professional data analysis and interpretation, CPT limits reporting code 95251 to once a month but payers may have their own utilization limits.

9. **Can a pharmacy bill for CPT codes 95250 and 95251?**
   If a pharmacy is a Part B Medicare provider, they may be able to bill for 95250. However, only a physician or mid-level practitioner can perform and bill for CPT code 95251.

10. **How do I bill if the sensor did not last 72 hours or if patient did not return to clinic for download?**
    It is important to document services that were provided, and if applicable, that a sensor did not last 72 hours. Some payers may suggest reduced service modifier such as -52 be used. Please check with your payer and their coverage rules here.

11. **Should 95250 be billed when a sensor is inserted or when sensor is removed and data is downloaded?**
    Descriptor code for CPT code 95250 includes insertion as well as removal of the CGM sensor, so typically billing may be done after the patient has the sensor removed.

12. **What date should be used to bill 95251?**
    The date on which the provider performed the data analysis and interpretation and generated the report should be used as the date of service.

13. **Does code 95251 require a face-to-face visit?**
    No. The data analysis and interpretation may be performed as a remote, non-face-to-face service. Note that 99091 cannot be billed separately with 95251.

14. **What is the patient's out-of-pocket expense for receiving Professional CGM services?**
    Medicare has a 20% copayment for Professional CGM. Co-payments and deductibles will vary by commercial payer.

15. **Can a physician and/or hospital be paid for CGM when performed during inpatient stay?**
    Code 95250 for Professional CGM is not reimbursed separately to either a physician or hospital if performed during an inpatient stay. Physicians are precluded from billing 95250 because hospital staff, eg, nurses, perform the technical services for CGM during an inpatient stay. For hospitals, reimbursement for these services would be included within the inpatient DRG or case-rate payment to the hospital. However, the professional data analysis and interpretation could be separately reimbursable to the physician if performed by the physician during the stay.

PAYER COVERAGE OF CONTINUOUS GLUCOSE MONITORING (CGM) SERVICES

16. **Does Medicare cover Professional CGM?**
    Yes, Medicare does cover and reimburse for Professional CGM (CPT code 95250) as well as the data analysis and interpretation (CPT code 95251).

17. **Who covers CGM and have they listed CPT codes in their coverage policies?**
    Many private/commercial payers have established policies for Personal and Professional CGM. These payers include United Healthcare, Aetna and Cigna. Some payers list the CPT codes in thier policies. The coverage criteria may differ between Personal and Professional CGM. For specific details, reference the payer's policy for Continuous Glucose Monitoring. You should verify coding and payment with your applicable payers.

18. **What are some steps to take if denied for 95250 or 95251?**
    It is important to understand why the claim was denied, as these denials can occur for several reasons. For example: confirm that the most appropriate and accurate diagnosis was billed. Check with the payer's policy to verify that the amount of submissions for CGM services are within the payer's

specified limits. If the claim includes an E/M code for the same day, it may be appropriate to use modifier -25 on the E/M code to specify that the E/M code was a separate and identifiable service. Enter into a dialogue with your local payer to determine which options if any are available to address your claim question.

CODING FOR SERVICES ASSOCIATED WITH INSULIN PUMP THERAPY

19. Are there specific CPT codes for insulin pump starts?

There are no specific CPT codes for insulin pump starts. Separate from an insulin pump start or related training, however, Evaluation and Management (E/M) codes may be appropriate if health care services were provided by a physician (or other practitioner) to a patient before, during, or after the training. In addition, diabetes education codes such as G0108 and G0109 (for certified diabetes education centers) or general education codes 98960-98963 may also be appropriate. Some non-Medicare payers may accept S9145, Insulin pump initiation, instruction in initial use of pump (pump not included).

20. Is there a CPT code for reviewing CareLink data?

It depends on the data being reviewed.
- Review and interpretation of *CGM values* in CareLink is appropriately reported with code 95251.
- Code 95251 is not appropriate for review and interpretation of *pump values*.

21. Is there a CPT code for reviewing and interpreting pump data?

Providers may consider use of code 99091 for review and interpretation of pump values performed remotely. Payer policies may vary and providers should always verify coverage with the individual payer. Note that code 99091 can be billed only once a month and requires at least 30 minutes of cumulative provider time. Also note that codes 95249, 95250, and 95251 cannot be reported with 99091. Code 99091 is intended to represent a non-face-to-face service and cannot be assigned when pump values are reviewed during an office visit or in association with an office visit. When pump values are reviewed during an office visit or in association with an office visit, the service is included in the E/M assigned for the visit.

GENERAL REIMBURSEMENT QUESTIONS

22. Can a Cardiologist perform and bill for CGM?

Yes. Coverage and coding for CGM does not typically differ by physician specialty.

23. What is the difference between Medicare non-facility and facility fee schedules?

Non-facility rates are for services provided in a physician office or similar setting, and facility fees are for services provided in a hospital (outpatient or inpatient) or similar institutional setting.

24. Is there a reference for Medicare fees for a specific locality?

Yes, CMS has published the most recent Medicare Physician Fee Schedule at their website. They have created tool **https://www.cms.gov/apps/physician-fee-schedule/overview.aspx** to look up Medicare's published fees for specific CPT and HCPCS codes.

REFERENCES

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