2015 CGM BILLING AND REIMBURSEMENT GUIDE

Medtronic

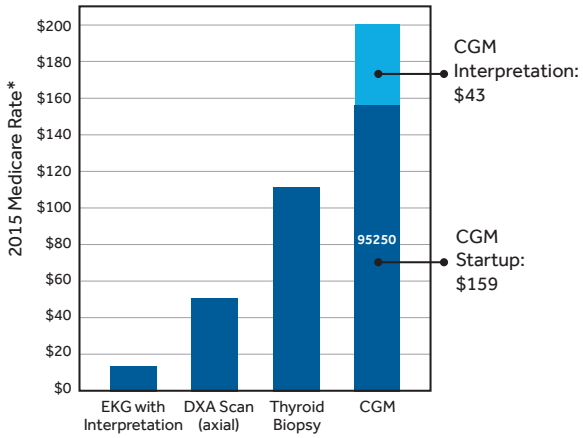
Reimbursement coverage for Continuous Glucose Monitoring (CGM) is continuing to expand. This document provides general guidance on billing for Professional and Personal CGM.

CGM Reimbursement Facts

- Approximately 92% of commercial covered lives in the U.S. are covered by an insurer with a written policy for Personal and Professional CGM.
- All local Medicare contractors currently cover Professional CGM.

Sources: Internal Data on File.

Medicare Rates for Common Procedures



* 2015 Medicare national average fee schedule amount for office procedures. Note: Medicare rates only apply to Professional CGM; Personal CGM is not covered by Medicare and does not meet Medicare Benefit Category requirements. Source: Medicare Physician Fee Schedule, December, 2014.

CGM Billing Codes

Codes	Description	Who Can Bill
E/M codes 99212-99215	■ Office visit for the evaluation and management of an established patient	Physicians, Physician Assistants, Nurse Practitioners
CPT® code 95250	■ Sensor Placement ■ Hook-up and Calibration ■ Patient Training ■ Sensor Removal and Printout of Recording	Any qualified staff member under the direct supervision of a physician, a physician assistant, or a nurse practitioner
CPT® code 95251	■ CGM Data Interpretation	Physicians, Physician Assistants, Nurse Practitioners

CGM Billing Protocols

The following billing protocols can be used for Professional and Personal CGM. Criteria for Professional and Personal CGM may differ, so always verify coverage policy directly with the payer.

Professional CGM

1. **Office Visit (Pre-CGM Evaluation)** E/M 99212 - 99215
2. **CGM Startup and Instruction** CPT 95250
3. **CGM Removal and Download** No Billing
4. **CGM Data Interpretation** CPT 95251
5. **Office Visit (Post-CGM Evaluation)** E/M 99212 - 99215

Billing Notes

- Use modifier "-25" with an E/M code when billing 95250 or 95251 on the same day.
- E/M can only be billed separately on the same day when a significant and separately identifiable service took place above and beyond the services associated with CGM.
- CGM data interpretation (95251) can be billed on an ongoing basis, but should not be billed more than once per month, per patient.**

Personal CGM*

1. **Office Visit (Pre-CGM Evaluation)** E/M 99212 - 99215
2. **CGM Startup and Training*** CPT 95250
3. **CGM Data Interpretation** CPT 95251
4. **Office Visit (Post-CGM Evaluation)** E/M 99212 - 99215

* For Personal CGM, the glucose sensor must be provided at the expense of the billing provider in order for the provider to bill 95250. Check with the payer on coding for personal CGM, since reporting requirements may vary. Personal CGM is not covered by Medicare and does not meet Medicare Benefit Category requirements.

** Payers may have varying coverage policies for 95251 and are not obligated to pay on a monthly basis, so always check with payers to verify coverage and limits on frequency.

CGM Billing Guidance from the AMA

The American Medical Association (AMA) published an article in CPT® Assistant in December 2009 that clarified the following use of CPT® codes 95250 and 95251 for Professional and Personal CGM.

- **95250** can be billed for Professional and Personal CGM at the time of hook-up.
- **95250** and **95251** can be used for Professional and Personal CGM.
- **95251** does not require a face-to-face (in person) visit.
- **95250** and **95251** should only be reported once monthly per patient.
- **95250** requires that the service period be at least 72 hours.
- **95251** requires at least 72 hours of CGM data from a patient.

Source: American Medical Association. "Continuous Glucose Monitoring." CPT Assistant. 2009:19(12) as amended by 2010:20(2).
Personal CGM is not covered by Medicare and does not meet Medicare Benefit Category requirements. For Personal CGM, the glucose sensor must be provided at the expense the billing provider in order for the provider to bill 95250.

Sample Claim Form

The following steps indicate the key information on the CMS-1500 claim form when billing for CGM.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 1

A. | B. | C. | D.
E. | F. | G. | H.
I. | J. | K. | L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE (2)	C. EMG (3)	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS (4)	MODIFIER	E. DIAGNOSIS POINTER (5)	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	XX	XX	XX	XX	XX	XX	11		95251		A				NPI
2	XX	XX	XX	XX	XX	XX	11		99213	25	A				NPI
3															NPI
4															NPI
5															NPI
6															NPI

**Note: This example features a portion of a sample CMS-1500 claim form. This sample claim form is intended as a reference for CGM coding and billing and is not intended to be directive nor does the use of the recommended codes guarantee reimbursement. Providers should select coding that most accurately reflects their billing guidelines and services rendered.
Source: APPROVED OMB-0938-1197 FORM CMS-1500 (02-12).

Step 1 - Diagnosis Codes (Box 21)

- Document the primary diagnosis code and the appropriate ICD indicator based on the Date of Service.
- Example diagnosis code: E10.65 (Type 1 diabetes mellitus with hyperglycemia)

Step 2 - Place of Service (Box 24B)

- Specify the location where the service was performed.
- Examples: 11 = Office
  22 = Outpatient Hospital

Step 3 - Procedure Codes (Box 24D)

- Document the startup and initiation of CGM with 95250.
- Document CGM data interpretation with 95251.
- If relevant, enter the appropriate E/M code for separately identifiable visit(s) concurrent with CGM (eg. for diagnosis and/or therapy changes).

Step 4 - Modifiers as Needed (Box 24D)

- Use the -25 modifier on an E/M code to distinguish a significant and separately identifiable E/M service, above and beyond the services associated with CGM, provided on the same day.

Step 5 - Diagnosis Pointer (Box 24E)

- Specify the diagnosis code reference from Box 21 (1, 2, 3, or 4) that relates to the procedure code(s) listed in Box 24D.
- If only 1 diagnosis code is listed in Box 21, then list "A" in 24E.

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