CGM Billing and Reimbursement Guide

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.

### CGM Billing Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Who Can Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M codes 99212-99215</td>
<td>• Office visit for the evaluation and management of an established patient</td>
<td>Physicians, Physician Assistants, Nurse Practitioners</td>
</tr>
</tbody>
</table>
| 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. **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. **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. **Pre-CGM Evaluation**  
   E/M 99212 - 99215

2. **CGM Startup and Training**  
   CPT 95250

3. **CGM Data Interpretation**  
   CPT 95251

4. **Post-CGM Evaluation**  
   E/M 99212 - 99215

* For Personal CGM, the 95230 code should be used at the initial hookup and training. Check with the payer on coding for personal CGM, since reporting requirements may vary.

** 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** and **95251** require a minimum of 72 hours of data.


**Sample Claim Form**

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

**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: 250.03 (Diabetes without mention of complications; type 1, uncontrolled)

**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 number 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 “11” in 24E.

*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).