Clinical Policy: Continuous Glucose Monitoring

Reference Number: WA.CP.MP.501
Last Review Date: 08/25
Effective Date: 10/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for continuous glucose monitoring. Self-monitoring of blood glucose and continuous glucose monitoring (CGM) are two techniques that persons with diabetes use at home help them maintain blood glucose within a safe range. Real-time CGM is advanced technology that continuously measures insterstitial fluid glucose levels and can therefore provide current glucose level as well as the direction and rate of change. Some CGM systems are designed for short-term diagnostic or professional use. Other CGM systems are designed for long-term patient use. This policy addresses the latter.

Note: See also WA.PHARM.133. Libre monitors are Coordinated Care of Washington and Coordinated Care Corporation's preferred CGM.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, in accordance with the Health Care Authority's Health Technology Assessment and Health Care Authority Billing Guidelines, that long-term continuous glucose monitoring is considered **medically necessary** for the following categories of individuals as noted:

A. Children/adolescents less than 19 years old
B. Adults with Type 1 diabetes
C. Adults with Type 2 diabetes who have any of the following:
   1. Unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan for six months (intensive insulin therapy; testing blood glucose 4 or more times per day), or
   2. Suffering from one or more severe (blood glucose < 50 mg/dl or symptomatic) episodes of hypoglycemia despite adherence to an appropriate glycemic management plan (intensive insulin therapy; testing blood glucose 4 or more times per day), or
   3. Unable to recognize or communicate about symptoms of hypoglycemia.
D. Pregnant women who have any of the following:
   1. Type 1 diabetes, or
   2. Type 2 diabetes and on insulin prior to pregnancy, or
   3. Gestational diabetes and blood glucose is not well controlled (HbA1C above target or experiencing episodes of hyperglycemia or hypoglycemia) during pregnancy and require insulin.

Background

This policy is based on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
A4238	Supply allowance for adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver
E2103	Non-adjunctive, non-implanted continuous glucose monitor or receiver

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted. Previously WA.UM.25.01	07/19	10/19
Annual review. References updated	04/20	05/20
Annual review. Clarified policy is regarding long-term use of CGM. Removed criteria for pregnant woman who are not insulin-dependent to be consistent with state billing guideline. Removed CPT codes 95249-95251. Updated references.	03/21	04/21
Annual review. References updated.	03/22	03/22
Annual review. References updated. Updated all HCPCS	03/23	03/23
Annual review. References updated. Updated section I. and Background to include reference to HCA Billing Guidelines.	03/24	04/24
Annual review. Added "Coordinated Care Corporation". Updated references. Added note that Libre is our preferred CGM and referenced the Pharmacy policy.	03/25	08/25

References

1. Skelly A, Brodt E, Junge M, Schwartz N, Winter C, Ferguson A; Aggregate Analytics, Inc. Glucose Monitoring Update. Washington Health Technology Assessment. December 2017.

2. Skelly A, Schenk Kisser J, Mayfield J, Olson C, Ecker E; Spectrum Research, Inc. Glucose Monitoring: Self-monitoring in individuals with insulin dependent diabetes, 18 years of age or under. Washington Health Technology Assessment. January, 2011.
3. Washington State Health Care Authority. Home Infusion Therapy and Parenteral Nutrition Program Billing Guide. Home Infusion Therapy and Parenteral Nutrition Program Billing Guide Revision effective January 1, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.