PROVIDER POLICIES & PROCEDURES

CONTINUOUS GLUCOSE MONITORS (CGM)

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program with the information needed to support a medical necessity determination for continuous glucose monitors. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Real-Time Continuous Glucose Monitors (rtCGM)
Real-time continuous glucose monitors (rtCGM) continuously monitor and record interstitial glucose levels, glycemic trends and may provide reactive or predictive glucose alerts. The receiver component of the CGM system must be a CGM enabled insulin pump or stand-alone CGM monitor. A CGM that uses a smart device (e.g., smart phone, tablet, personal computer) as a receiver is not classified as durable medical equipment and therefore, is not covered by Medicaid. Reference: HUSKY Health Policy -Technology Features Integrated with Medical Devices.

Intermittently Scanned CGM (isCGM)
Intermittently scanned continuous glucose monitors (isCGM) continuously monitor and record interstitial glucose levels but require the user to purposely scan the sensor to obtain information. An isCGM that uses a smart device (e.g., smart phone, tablet, personal computer) as a receiver is not classified as durable medical equipment and therefore, is not covered by Medicaid.

CLINICAL GUIDELINE
Coverage guidelines for continuous glucose monitors for the treatment of diabetes are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Initial Authorization
CGMs and associated supplies may be considered medically necessary for:

A. Individuals with type 1 diabetes (inclusive of all sub-categories); or
B. Individuals with type 2 diabetes who are treated with insulin; or
C. Individuals with an insulin pump; or
D. Individuals with gestational diabetes or individuals who are pregnant and a CGM is recommended by their treating provider; or
E. Other conditions or scenarios resulting in patterns of hypoglycemia or hyperglycemia (will be reviewed on a case-by-case basis);

AND

F. The individual is managed by an endocrinologist or clinician with expertise in treating individuals with

diabetes.

Note: Initial authorization will be for the CGM device and twelve months of related supplies.

Reauthorization – 12 Month Intervals
Reauthorization of CGM and associated supplies is considered medically necessary if there is a signed prescription or order from the treating provider.

Replacement
Replacement of a CGM device is considered medically necessary:

A. If the device is malfunctioning, out of warranty (expiration of warranty alone is not considered an automatic reason for replacement), and can no longer be repaired; AND
B. A healthcare provider has assessed the individual within the last 12 months and recommends continued use of a CGM.

Upgrade
Upgrade to new technology is typically considered not medically necessary unless there is a documented medical need for enhanced technology (e.g., provider recommending a device with shorter warm-up time based on member's current condition, the manufacturer will no longer support the current technology).

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of continuous glucose monitors is required. Requests for coverage of continuous glucose monitors will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for continuous glucose monitors:

- Initial and replacement/upgrade requests: clinical information supporting medical necessity criteria as outlined in Clinical Guideline section
- Initial, reauthorization, and replacement/upgrade requests: signed prescription or order from the treating clinician
- Pricing information as outlined in DSS Pricing Policy for MEDS Items

EFFECTIVE DATE

This Policy is effective for prior authorization requests for continuous glucose monitors for individuals covered under the HUSKY Health Program beginning November 1, 2021.

LIMITATIONS

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on "For Providers" followed by "Benefit Grids". For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

N/A

CODES:

Code	Description
A4238*	Supply allowance for adjunctive 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
E2102*	Adjunctive continuous glucose monitor or receiver
E2103	Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver

*****Reference: DSS Provider Bulletin PB 2022-29 "Billing Guidance for Adjunctive (Non-Therapeutic) Continuous Glucose Monitor (CGM) Systems"

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service

is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- American Diabetes Association. 7. Diabetes Technology: *Standards of Medical Care in Diabetes—2020*. Diabetes Care 2020;43(Suppl. 1):S77–S88
- UpToDate; Glucose Monitoring in the Ambulatory Management of Nonpregnant Adults with Diabetes Mellitus. Topic last updated April 6, 2024.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	September 2021	Approved at the September 8, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on September 20, 2021. Approved by DSS on September 30, 2021.
Update	September 2022	Criteria update, for individuals with Type 1 diabetes, added "inclusive of all sub-categories". Change approved at the August 10, 2022 CHNCT Medical Reviewer meeting. Change Approved by the CHNCT Clinical Quality Subcommittee on September 19, 2022. Approved by DSS on September 28, 2022.
Update	October 2022	Coding update. Added HCPCS codes A4238 and E2102. Approv by DSS on 10/14/2022.
Update	January 2023	Coding update. Streamlined documentation requirements – removed need for proof of compliance and office note for reauthorization of supplies. Changes approved at the November 9, 2022, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on December 19, 2022. Approved by DSS on December 22, 2022.
Update	September 2023	Update to Clinical Guideline section. Removed "have patterns of hypoglycemia or hyperglycemia" from criteria. Added example to Upgrade section of criteria. Updates to Reference section. Changes approved at the September 13, 2023, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on September 18, 2023. Approved by DSS on October 2, 2023.
Update	August 2024	Update to Introduction section to include reference of the Technology Features Integrated with Medical Devices policy. Clinical Guideline section updated to clarify upgrades within the procedure for reauthorizations. Update to Reference section. Changes approved at the August 28, 2024, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on September 16, 2024. Approved by DSS on September 27, 2024.