MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Director, Program Policy Division
Bureau of Medicaid Policy, Operations, and Actuarial Services

Project Number:	2302-DMEPOS	**Comments Due:**	March 30, 2023	**Proposed Effective Date:**	May 1, 2023

Mail Comments to: Lisa Trumbell

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Policy Subject: Revisions to Continuous Glucose Monitoring Systems (CGMS) Policy

Affected Programs: Medicaid, Children's Special Health Care Services (CSHCS), Healthy Michigan Plan, Maternity Outpatient Medical Services (MOMS)

Distribution: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Providers, Hospitals, Practitioners, Pharmacies, Medicaid Health Plans (MHPs), Integrated Care Organizations (ICOs)

Policy Summary: This policy describes changes to current Medicaid coverage of CGMS to incorporate coverage of new healthcare common procedure coding system (HCPCS) codes, update definitions, standards of coverage, documentation and prior authorization requirements.

Purpose: The purpose of this policy is to incorporate new HCPCS codes established by the Centers for Medicare and Medicaid Services (CMS) HCPCS workgroup and to align policy more closely with other payers.

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Providers, Hospitals, Practitioners, Pharmacies, Medicaid Health Plans (MHPs), Integrated Care Organizations (ICOs)

Issued: April 1, 2023 (Proposed)

Subject: Revisions to Continuous Glucose Monitoring Systems (CGMS) Policy

Effective: May 1, 2023 (Proposed)

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS), Healthy Michigan Plan, Maternity Outpatient Medical Services (MOMS)

This policy applies to Medicaid Fee-for-Service (FFS). MHPs and ICOs must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in a MHP or ICO, the provider must check with the beneficiary's MHP/ICO for prior authorization requirements.

The purpose of this bulletin is to inform providers of revisions to be made to the CGMS policy. The revisions indicated in this bulletin are effective May 1, 2023.

Definition

The following is added to the definition of CGMS to distinguish the difference between non-adjunctive/therapeutic and adjunctive/non-therapeutic CGMS:

> CGMS may be non-adjunctive/therapeutic (CGMS can be used to make treatment decisions without the need to confirm test results using a blood glucose monitor [BGM]); or adjunctive/non-therapeutic (beneficiary must use a BGM to test the results displayed on the CGMS prior to making a treatment decision).

Revised Standards of Coverage

Personal use CGMS are covered for beneficiaries with diabetes when all the following are met:

- The beneficiary is under the care of one of the following:
  - An endocrinologist; or
  - A physician or non-physician practitioner (nurse practitioner, physician assistant or clinical nurse specialist) who is managing the beneficiary's diabetes. (The provider must provide documentation that the beneficiary completed a Medicaid-covered

diabetes self-management education [DSME] training within one year prior to the written order).

- The beneficiary has diabetes requiring the administering of insulin or is currently using an insulin pump.
- The beneficiary's treatment plan recommends testing blood glucose a minimum of two times per day.
- The beneficiary or their caregiver is educated on the use of the device and is willing and able to use the CGMS.

Additions to Documentation

Documentation must be less than 90 days old and include all the following:

- Number of finger-stick tests prescribed per day;
- Frequency of insulin administered per day or indicate if the beneficiary is using an insulin pump; and
- Current treatment plan.

The initial order must be written for six months. If the beneficiary continues to utilize the CGMS, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and other separately billed supplies used with the CGMS (following frequency rules) may be written for a 12-month period.

All other documentation requirements indicated in current policy remain unchanged.

Revised Prior Authorization

Prior authorization is not required for the following if standards of coverage and documentation requirements are met:

- Type I diabetes.
- Diabetes in pregnancy, childbirth, and the puerperium period (insulin or non-insulin treated).

Prior authorization is required for all other conditions and clinical scenarios where use of CGMS may be beneficial, including but not limited to Type II diabetes.

Additions to Payment Rules

The sensor, transmitter and receiver are purchase-only items, except for Healthcare Common Procedure Coding System (HCPCS) codes K0554 and E2102 (may be purchased, rented or used items).

Michigan Department of Health and Human Services (MDHHS) covers the following HCPCS codes:

HCPCS Code	Description	Limit	Fee	Modifier
A4238*	Supply allowance for adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	1 per month	$207.24	NU
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial CGMS, 1 unit = 1 day supply	30 per month	$13.32	NU
A9277	Transmitter; external, for use with interstitial CGMS	2 per year	$525.51	NU
A9278	Receiver (monitor); external, for use with interstitial CGMS	1 per 3 years	$422.47	NU
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver	1 per 3 years	$176.61	NU
		10 per 3 years	$17.66	RR
		1 per 3 years	$132.46	UE
K0553** **New code effective January 1, 2023 A4239**	Supply allowance for therapeutic CGMS, includes all supplies and accessories, 1-month supply = 1 unit of service	1 per month	$236.34	NU
K0554 **New code January 1, 2023 E2103**	Receiver (monitor); dedicated, for use with therapeutic CGMS	1 per 3 years	$248.62	NU
		10 per 3 years	$24.86	RR
		1 per 3 years	$186.48	UE

*Adjunctive/non-therapeutic CGMS (E2102) require the beneficiary to use a BGM to test the results shown on the CGMS prior to making a treatment decision. The BGM and BGM supplies are not included in the allowance for the adjunctive/non-therapeutic CGMS supply (A4238) and may be billed separately (within BGM policy limits). HCPCS code A4238 is comprised of all items necessary to use the device (E2102), including CGMS sensors and transmitters.

**The following HCPCS codes are included in the allowance for K0553 (effective January 1, 2023 A4239 replaces K0553) and may not be billed separately: A4233, A4234, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100 and E2101.

HCPCS Coding Changes Effective January 1, 2023

The Centers for Medicare & Medicaid Services (CMS) HCPCS Workgroup made the following changes:

Deleted HCPCS Code Effective December 1, 2022:	New HCPCS Codes Effective January 1, 2023:
K0553 K0554	A4239 (replaces K0553) E2103 (replaces K0554)

For prior authorization requests approved for HCPCS codes K0553/K0554 on or before December 31, 2022, for authorization periods that span beyond May 1, 2023, providers must contact the MDHHS Program Review Division to change the end-dated HCPCS codes (K0553/K0554) to the new HCPCS codes (A4239/E2103). The provider may fax (517-335-0075) a change request with a listing of approved tracking numbers requesting HCPCS codes K0553/K0554 be changed to A4239/E2103, accordingly.

Providers should consult the Medicare Pricing, Data Analysis, and Coding (PDAC) contractor if unsure which HCPCS code is most appropriate for the CGMS. Refer to https://www.dmepdac.com/.

All other CGMS policy criteria indicated in current policy remain unchanged. (Refer to the Medical Supplier chapter of the MDHHS Medicaid Provider Manual.)