

Clinical Policy: Continuous Glucose Monitors

Reference Number: CP.PMN.214

Effective Date: 12.01.19

Last Review Date: 11.25

Line of Business: HIM*, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**For Health Insurance Marketplace members, if request is for True Metrix[®] or Accu-Chek[®], this policy does not apply. The True Metrix meter is covered at no cost by the manufacturer by billing BIN # 018844, PCN # 3F, ID # TRPT5023493, Group # FVTRUEPORT50. Call 1-855-282-4888 for additional information. The Accu-Chek Guide and Accu-Chek Guide Me meters are covered at no cost by the manufacturer by billing BIN # 610524, PCN # 1016, ID # 029318512, Group # 40026479. Call 1-800-657-7613 for additional information.*

Description

Continuous glucose monitors (CGMs)* measure interstitial glucose, which correlates well with plasma glucose.

**If request is for a CGM that is also an insulin delivery system, additional approval criteria apply. Refer to CP.PHAR.534 Insulin Delivery Systems (V-Go, Omnipod, InPen).*

FDA Approved Indication(s)

CGMs are indicated for use in patients with diabetes mellitus to monitor blood glucose levels.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that CGMs are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Diabetes Mellitus (must meet all):

Replacement of functional features of an existing monitor for an upgrade is not considered medically necessary

1. Diagnosis of diabetes mellitus;
2. Frequent adjustments to the member's treatment regimen are necessary based on glucose testing results;*

**For Illinois HIM requests, this requirement does not apply as of 1/1/2026 per IL SB 3414*

3. Member meets one of the following (a, b, c, or d):*

**For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

- a. Member requires intensive insulin therapy as evidenced by one of the following (i or ii):
 - i. Requires insulin injections ≥ 3 times per day;
 - ii. Uses a continuous insulin infusion pump;

- b. Member has a diagnosis of type 2 diabetes that is currently managed with basal injections;
- c. Member has gestational diabetes;
- d. Member has a history of problematic hypoglycemia with documentation of at least one of the following (i or ii):
 - i. Recurrent level 2 hypoglycemic events (glucose < 54 mg/dL) that persist despite two or more attempts to adjust medication, modify the diabetes treatment plan, or both;
 - ii. A history of a level 3 hypoglycemic event (glucose < 54 mg/dL) characterized by altered mental or physical state requiring third-party assistance for treatment for hypoglycemia;
4. If age \geq 2 years, member must use FreeStyle[®] Libre;*
**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Request does not exceed health-plan quantity limit.

Approval duration: 12 months (1 receiver per 12 months only; other components [such as transmitters and sensors] may be replaced as needed – see Appendix D for examples)

B. Other diagnoses/indications: Not applicable

II. Continued Therapy

A. Diabetes Mellitus (must meet all):

Replacement of functional features of an existing monitor for an upgrade is not considered medically necessary. If the replacement request is due to change in clinical status and features of a different device type are medically necessary, the request should be reviewed using the initial approval criteria

1. Previously received the requested product via Centene benefit or member has previously met the initial approval criteria;
2. Documentation supports all of the following (a, b, and c):
 - a. If the request is for a new receiver: A replacement device is necessary due to one of the following (i, ii, or iii):
 - i. Loss, theft, or damage that is not covered by manufacturer warranty;
 - ii. Age of device makes it incompatible with available medically necessary software, components, or accessories required for function or integration and is not covered by manufacturer warranty;
 - iii. The reasonable and useful lifetime of \geq 5 years has passed;
 - b. Member is using the product properly and continues to benefit from it;
 - c. Ongoing physician or clinical specialist monitoring;
3. If age \geq 2 years, member must use FreeStyle Libre;*
**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
4. Request does not exceed health-plan quantity limit.

Approval duration: 12 months (1 replacement receiver per 12 months only; other components [such as transmitters and sensors] may be replaced as needed – see Appendix D for examples)

B. Other diagnoses/indications: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CGM: continuous glucose monitoring
FDA: Food and Drug Administration
SMBG: self-monitoring of blood glucose

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Blood glucose monitoring (either with self-monitoring [SMBG] or CGM) is a tool used to evaluate whether glycemic targets are being achieved. It enables evaluation of response to both pharmacologic therapy and lifestyle modifications and can therefore help guide treatment decisions and/or self-management.
- The American Diabetes Association, American Association of Clinical Endocrinologists, and American College of Endocrinology do not prefer any one blood glucose monitor brand over another.
- The choice of device should be made on the individual's circumstance, preferences, and needs.
- Examples of CGMs and their components include, but are not limited to, the following:
 - Dexcom G6[®] CGM System:
 - Receiver (Dexcom receiver*): replacement frequency not specified
**A personal smart device (e.g., smart phone, smart watch) may also be used, either instead of or in addition to the Dexcom receiver*
 - Transmitter (G6 transmitter): replaced every 3 months
 - Sensor (applicator with built-in sensor): replaced every 10 days
 - Dexcom G7[®] CGM System:
 - Receiver (Dexcom G7 receiver*): 3 years for typical use
**A personal smart device (e.g., smart phone, smart watch) may also be used, either instead of or in addition to the Dexcom G7 receiver*
 - Sensor (with built in transmitter): replace every 10 or 15 days
 - FreeStyle Libre 14 Day Flash Glucose Monitoring System:
 - Receiver (FreeStyle reader): replaced every 3 years
 - Sensor (sensor pack and sensor applicator): replaced every 14 days
 - FreeStyle Libre 3 Glucose Monitoring System:
 - Receiver (Reader*): replace every 3 years
**A personal smart device (e.g., smart phone, smart watch) may also be used instead of the receiver*

- Sensor: replaced every 14-15 days
- FreeStyle Libre 2 Glucose Monitoring System:
 - Receiver (Reader*): replace every 3 years
**A personal smart device (e.g., smart phone, smart watch) may also be used instead of the receiver*
 - Sensor (applicator with built-in sensor): replaced every 15 days

V. Dosage and Administration

Usage regimen is individualized based on patient goals.

VI. Product Availability

Monitor and test strip packaging vary by product and manufacturer.

VII. References

1. InterQual July 2025 Durable Medical Equipment Criteria, Therapeutic continuous glucose monitor (CGM) with supply allowance.
2. InterQual July 2025 Durable Medical Equipment Criteria, Adjunctive real time continuous glucose monitor.
3. American Diabetes Association. Standards of medical care in diabetes—2025. *Diabetes Care*. 2025; 48(suppl 1): S1-S352. Accessed August 5, 2025.
4. Samson SL, Vellanki P, Blonde L, et al. American Association of Clinical Endocrinology Consensus statement: Comprehensive type 2 diabetes management algorithm - 2023 update. *Endocr Pract*. 2023 May;29(5):305-340. doi: 10.1016/j.eprac.2023.02.001.
5. Grunberge G, SherrJ, Allende M, et al. American Association of Clinical Endocrinology clinical practice guideline: The use of advanced technology in the management of persons with diabetes mellitus. *Endocrine Practice*. 2021; 27: 505-537.
6. FreeStyle Libre 14 Day Flash Glucose Monitoring System User's Manual. ART39764-201 Rev. A 08/23. Available at <https://www.freestylelibre.us/support/overview.html>. Accessed July 18, 2025.
7. Dexcom G6 CGM System User Guide. AW-1000052-10 Rev 001 MT-1000052-10. Revision date: November 2022. Available at: <https://www.dexcom.com/guides>. Accessed July 18, 2025.
8. Dexcom G7 CGM System User Guide. AW00078-10 Rev 003 MT-00078-10. Revision Date: January 2025. Available at <https://dexcompdf.s3.us-west-2.amazonaws.com/en-us/G7-CGM-Users-Guide.pdf>. Accessed July 18, 2025.
9. FreeStyle Libre 3 Continuous Glucose Monitoring System User's Manual. ART48677-00. Rev. A 06/24. Available at https://freestyleserver.com/payloads/ifu/2025/q2/ART48677-001_rev-A-WEB.pdf. Accessed August 18, 2025.

Coding Implications

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 non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply
A9277	Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with non-durable medical equipment 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	Date	P&T Approval Date
4Q 2021 annual review: no significant changes; clarified that while only 1 receiver may be approved every 12 months, other CGM components such as transmitters and sensors may be approved more frequently; references to HIM.PHAR.21 revised to HIM.PA.154; added information about components of the Dexcom G6 and FreeStyle Libre CGMs to Appendix D; references reviewed and updated.	06.28.21	11.21
Per October ad hoc SDC, removed Commercial line of business; specified Freestyle Libre as the preferred product.	11.02.21	02.22
For HIM, revised notation that this policy applies only to formulary products to instead indicate that requests for True Metrix (non-formulary) can be covered by the manufacturer through specific billing per line of business owner.	05.19.22	
4Q 2022 annual review: revised to align with InterQual medical criteria as follows: <i>initial criteria</i> – removed requirements for a prescribing physician who has seen the member in person in the last 6 months, blood glucose testing 4 or more times per day, and in person visits every 6 months; added additional pathway to approval for members not receiving intensive insulin therapy (adults with type 2 diabetes); added requirement for participation in a comprehensive diabetes management program; <i>continued criteria</i> – added additional pathways to receive replacement devices based on the age/lifetime of the current device and added requirement for ongoing monitoring from a physician/clinical specialist; clarified that FreeStyle Libre redirection applies only to age ≥ 4 years; references reviewed and updated.	07.18.22	11.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2023 annual review: updated Appendix D with examples of Dexcom G7 and Libre 3; updated Appendix E with content area of “weight management” per ADA 2023 guidelines; references reviewed and updated.	08.07.23	11.23
4Q 2024 annual review: no significant changes; for continued therapy, added option for member to have previously met the initial approval criteria; references reviewed and updated.	7.30.24	11.24
Per SDC, removed requirement for participation in a comprehensive diabetes management program.	01.07.25	02.25
For HIM, updated billing information for True Metrix (non-formulary) for coverage by the manufacturer.	04.14.25	
Added Coding Implications section.	04.28.25	
4Q 2025 annual review: per August SDC, removed option for management with oral agents for type 2 diabetes; per GA regulation and August SDC, added options for gestational diabetes and history of problematic hypoglycemia; updated FreeStyle Libre redirection to apply to age ≥ 2 years; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated. For IL HIM per IL SB 3414, added bypass to requirement for frequent adjustments to the member’s treatment regimen based on glucose testing; removed requirement for age ≥ 18 years for type 2 diabetes.	10.23.25	11.25
Per SDC, revised HIM True Metrix notation to indicate that requests for Accu-Chek can also be covered by the manufacturer through specific billing.	05.04.26	

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.

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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.

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