

Clinical Policy: Continuous Glucose Monitors

Reference Number: OR.CP.PMN.214

Effective Date: 09.17.25

Last Review Date: 11.25

Line of Business: Medicaid – Trillium Oregon Health Plan

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal 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 Trillium Community Health Plan that CGMs are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Type 1 Diabetes Mellitus (must meet all):

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

1. Diagnosis of type 1 diabetes mellitus;
2. Member meets one of the following (a, b or c):
 - a. Age less than 21 years;
 - b. Age \geq 21 years of age and one of the following (i, ii, iii, iv, or v):
 - i. Uses a continuous insulin infusion pump;
 - ii. Baseline HbA1c level greater than or equal to 8.0%;
 - iii. Frequent or severe hypoglycemia;
 - iv. Impaired awareness of hypoglycemia (including presence of these conditions prior to initiation of CGM);
 - v. Pregnant or planning to become pregnant within 6 months;
3. If age \geq 4 years, member must use FreeStyle[®] Libre;
4. 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. All Other Types of Diabetes Mellitus (must meet all):

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

1. Diagnosis of one of the following (a, b, or c):
 - a. Type 2 diabetes;
 - b. Diabetes due to underlying conditions and drug or chemical induced diabetes;
 - c. Gestational diabetes;
2. Member uses insulin injections (including fast, rapid, intermediate-acting, or long-acting insulin);
3. The member has one of the following at time of CGM therapy initiation (a, b, c, or d):
 - a. Baseline HbA1c levels greater than or equal to 8.0%;
 - b. Frequent or severe hypoglycemia;
 - c. Impaired awareness of hypoglycemia (including presence of these conditions prior to initiation of CGM);
 - d. Diabetes-related complications (i.e. peripheral neuropathy, end-organ damage);
4. If age \geq 4 years, member must use FreeStyle[®] Libre;
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)

C. Glycogen Storage Disease Type 1a (must meet all):

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

1. Diagnosis of glycogen storage disease type 1a;
2. If age \geq 4 years, member must use FreeStyle[®] Libre;
3. 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)

D. Other diagnoses/indications: Not applicable

II. Continued Therapy

A. Diabetes Mellitus (All Types) and Glycogen Storage Disease Type 1a (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 ≥ 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 ≥ 4 years, member must use FreeStyle Libre;
 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 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 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. Continuous Glucose Monitoring. Oregon Health Plan Prioritized List of Health Services Guideline Note 108. Available at: <https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx>. Accessed September 17, 2025.
2. InterQual March 2024 Durable Medical Equipment Criteria, Therapeutic continuous glucose monitor (CGM) with supply allowance.
3. InterQual March 2024 Durable Medical Equipment Criteria, Adjunctive real time continuous glucose monitor.
4. American Diabetes Association. Standards of medical care in diabetes—2024. *Diabetes Care*. 2024; 47(suppl 1): S1-S322. Accessed July 30, 2024.
5. 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.
6. 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.
7. 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 19, 2024.
8. 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 19, 2024.
9. Dexcom C7 CGM System User Guide. AW00078-10 Rev 003 MT-00078-10. Revision Date: April 2024. Available at <https://dexcompdf.s3.us-west-2.amazonaws.com/en-us/G7-CGM-Users-Guide.pdf>. Accessed July 19, 2024.
10. FreeStyle Libre 3 Continuous Glucose Monitoring System User's Manual. ART41641-001. Rev. A 04/24. Available at https://freestyleserver.com/payloads/ifu/2024/q2/ART49385-001_rev-A_Web.pdf. Accessed July 19, 2024.

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
Policy adapted from CP.PMN.214 and Guideline Note 108 of the Oregon Prioritized list; created due to less restrictive State coverage requirements.	09.17.25	10.14.25
Updated section B.2. to remove oral agents	10.24.25	11.18.25

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.

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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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