

Professional CGM **Reimbursement** Guide

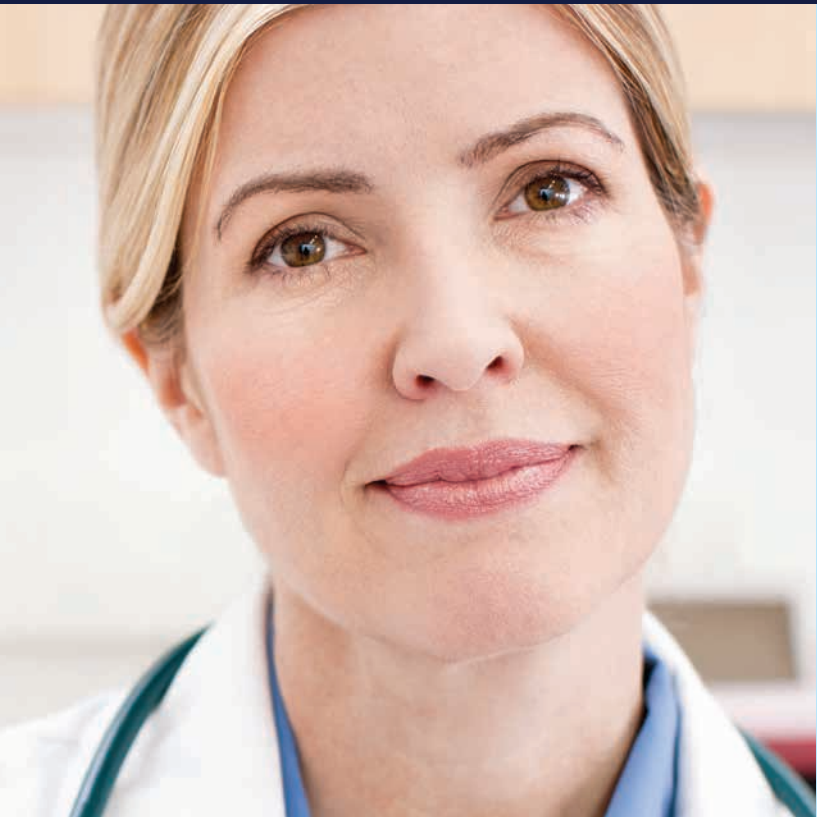


TABLE OF CONTENTS

Coding, Coverage and Payment.....	2
Coding and Billing	2
CPT Code 95250	3
CPT Code 95251	3
"Incident to" Billing for Physicians.....	5
Evaluation and Management (E/M) Codes.....	5
Modifiers with E/M Codes	6
ICD-10-CM Diagnosis Codes	6
Medicare Payment Reform Programs & Quality Metrics.....	9
Office Protocol and Coding	11
Coverage	12
Private Payer Coverage of Professional CGM.....	12
Prior Authorization Requirements.....	12
Steps for Prior Authorization	13
Medicare Coverage of Professional CGM	14
Claims Denial and Appeals	14
Payment	14
Medicare National Average Payments.....	15
Example CMS-1500 Form.....	16
Example UB-04 Form	17
Frequently Asked Questions	Inside Cover

Key learnings for your practice



Office

- Services on the same day as Professional CGM
- Developing an optimized office protocol
- Professional CGM and face-to-face encounters



Facilities

- Understanding coverage for your type of facility
- Technical vs. professional service codes
- Payment to facilities

More resources



Open this cover to learn more about:

- What to do in case a claim is denied
- How to troubleshoot other billing problems
- Answers to frequently asked questions



Medtronic Professional web site:

Designed to give you easy ways to simplify everyday tasks

- Coding & Reimbursement Look-Up tool
- Medicare Physician Fee Schedule
- Contact your Medtronic Representative

To learn more or register, visit:

professional.medtronicdiabetes.com

Claims Denial and Appeals Table

Possible Reasons	Possible Action
<p><i>Do not understand the denials. No reason given or reason undecipherable</i></p>	<p>Contact payer to obtain clarifications:</p> <ul style="list-style-type: none"> • Verify that the correct date(s) of service and provider number were included on the claim • Obtain additional details and/or reasoning about why the claim was denied • Learn the appeal options available and timing and documentation requirements • Verify that the claim was complete
<p><i>Payer may not have a formal policy for Professional CGM</i></p>	<p>File an appeal clearly delineating the reason that Professional CGM is medically necessary for the patient.</p>
<p><i>Health insurer may require Prior Authorization</i></p>	<p>Verify which payers in your area require Prior Authorization, and always check if it is needed before providing the service.</p>
<p><i>Patient does not meet criteria established by the payer</i></p>	<p>Confirm that diagnosis codes are appropriate. Ensure that the frequency of submissions are within policy limits (e.g. >1 per year). Always verify that a patient meets the payer's coverage criteria before performing the service.</p>
<p><i>Payer determines that the service is not medically necessary for the diagnosis submitted</i></p>	<p>Submit required supporting documentation, including the Professional CGM tracing, with an appeal letter to validate the need for the service.</p>
<p><i>Frequency of submissions could be beyond policy limits</i></p>	<p>Always verify frequency limits before performing the service. If claims are denied due to frequency, you can still submit an appeal letter to demonstrate the medical necessity of the additional service.</p>
<p><i>E/M code was provided on the same day as 95250 and/or 95251</i></p>	<p>Ensure that modifier -25 was appended to the E/M code if billed on the same day as 95250 and/or 95251. If necessary, provide documentation to substantiate that the E/M service was significant and separately identifiable as well as "above and beyond" the services associated with CGM.</p>
<p><i>Diagnosis code could flag the procedure as non-covered. For example, ICD-10-CM diagnosis codes E11.9 and E10.9 (diabetes without complications) may be denied</i></p>	<p>Verify accuracy of ICD-10-CM diagnosis code, including ensuring that the highest level of specificity was used.</p>

FREQUENTLY ASKED QUESTIONS

Can you bill an E/M code on the same day as CPT codes 95250 and/or 95251?

Yes, both CPT 95250 and/or CPT 95251 can be billed on the same day as an E/M code, so long as a distinct and separate E/M service was medically necessary and was provided "above and beyond" the services associated with CGM. When an E/M code is billed by the same provider on the same day as another service, including CPT 95250 or 95251, the modifier -25 must be attached to the E/M code. The definition of the -25 modifier is "significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service." Be sure to clearly document both the CGM services and the separate E/M services that were provided in the patient's medical record.

How frequently can Professional CGM be performed?

Professional CGM should only be performed when the service is medically necessary. As defined in the CPT manual, CPT codes 95250 and 95251 should not be billed more than once per month per patient. However, payers are not obligated to cover CGM once per month. Payers can determine their own frequency limits for Professional CGM, and payer policies vary. Always verify how frequently the patient's insurance plan covers Professional CGM prior to performing the service.

When should 95250 be billed (at training/hook-up or at download of data)?

The AMA has published that code 95250 is billed at the time of hook-up.

Who can perform and bill for code 95250?

Code 95250 is for the technical service of Professional CGM and can be rendered by any qualified healthcare provider. This includes physicians and, consistent with state scope of practice, can also include physician assistants, nurse practitioners, certified diabetes educators (CDEs), registered and licensed practical nurses, registered dietitians (RDs), medical assistants (MAs) or laboratory technicians. Code 95250 may also be billed by outpatient diabetes centers and other facilities. Many payers do not recognize CDEs as providers for billing purposes, but if the CDE is employed by a diabetes center, code 95250 can be billed by the center.

Who can perform and bill for code 95251?

Code 95251 is for the professional service of Professional CGM. Physicians may perform and bill the services associated with code 95251, and may also bill for the services when performed by a staff member "incident to" the physician's service. Consistent with state scope of practice, mid-level practitioners such as nurse practitioners (NP) and physician assistants (PA) may also use code 95251. However, although it varies by state scope of practice and by payer, many payers do not recognize registered dietitians (RD) for professional billing purposes. Because facilities provide technical services only, professional code 95251 should not be billed by a diabetes center, hospital, or other facility.

It should be noted that professionals bill on a CMS-1500 form and facilities such as a diabetes center bill using a UB-04 claim form.

Who in My Office Should Use This Guide?

This guide is designed to help physicians, billing specialists, office managers and other office staff involved in coding, coverage and payment collection for Professional CGM services. iPro™2 Professional CGM is for use by clinicians.

The guide does not address Personal CGM (also called patient use or real-time CGM).

Use this assessment to identify your practice successes and opportunities in handling reimbursement with payers. Where the answer is “no,” look for ways to make changes or improvements in your practice processes and training.

Readers Will Receive Guidance On:

- Proper coding for iPro2
- The appropriate use of modifiers for iPro2
- Payer coverage criteria for iPro2
- Tips and tools to bill efficiently and correctly for iPro2
- Tips and tools on the prior authorization and appeals processes.

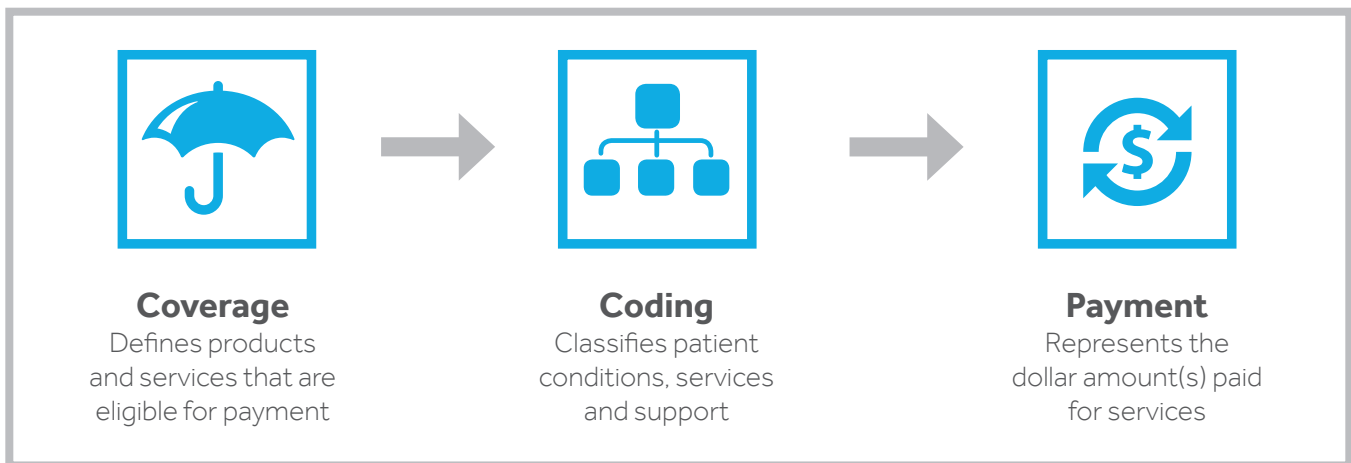
Strategic Assessment:

- Does your practice understand CPT codes for iPro2?
- Do you have a dedicated person in your office to work with payers?
- Do you know which payers in your area cover iPro2?
- Does your practice periodically re-assess its processes for prior-authorization for iPro2?
- Does your billing manager understand payers' requirements for prior authorization for iPro 2?
- Does your practice routinely audit your billing invoices for iPro2?

Coding, Coverage And Payment

Reimbursement has three components: coverage, coding and payment. This section discusses these topics as it relates to Professional CGM.

Figure A



Coding and Billing

CPT™ codes provide a uniform language for healthcare professionals to bill their services to payers. CPT codes are not technology or product specific, and are used to describe medical services by healthcare providers in all care settings. There are two CPT codes specific for continuous glucose monitoring, 95250 and 95251. The current descriptors for these codes are:

- **95250:** Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
- **95251:** Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report

Code 95250 is for the technical service, i.e., using the equipment, and code 95251 is for the professional service, i.e., interpreting the data.

Because codes 95250 and 95251 are defined as “a minimum of 72 hours”, neither code can be assigned or billed if CGM of less than 72 hours is provided.

Similarly, the codes cannot be reported more than once per month per patient regardless of the duration of CGM or the number of times CGM is provided in a single month.¹

It is important to note that although CPT codes define the service, payers are not obligated to extend coverage for CGM. If covered, payers may set their own coverage criteria and in particular, their own limits on frequency.

1. CPT Assistant, December 2009, p.7 AACE Position Statement: Coding Guidelines for Continuous Glucose Monitoring, Endocrine Practice, March/April 2010, p. 153.

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As described, CPT codes 95250 and 95251 may not be used more than once per month per patient. So, if medically necessary, clinicians could utilize these codes up to 12 times per year. However, insurance companies and payers may have more stringent limits on frequency, and therefore providers should always verify specific coverage criteria directly with each payer.

CPT CODE 95250

Who can perform and bill CPT code 95250?

Code 95250 is for placing the sensor, hook-up, monitor calibration, patient training, removing the sensor and printing out the recording. Although this represents the technical service, 95250 can be coded and billed by healthcare practitioners when they own and operate the devices. In general, if the HCP practice does not own the devices or has not performed most of the 95250-related services, they are not in a position to bill 95250.

Services associated with CPT code 95250 can be performed by any qualified healthcare provider including physicians, physicians assistants, nurse practitioners, certified diabetes educators (CDEs), registered and licensed practical nurses, registered dietitians (RDs), medical assistants (MAs) or laboratory technicians, consistent with each state's applicable scope of practice laws. In certain states and under some payer coverage requirements, non-physician clinicians performing the 95250 service must be working under a physician's general supervision. Code 95250 may also be billed by outpatient diabetes centers and other facilities.

As with other medical services, CPT 95250 can only be billed by a provider contracted with the patient's health plan.

Physician offices bill CPT 95250 on a standard CMS-1500 claim form for professional billing. Diabetes centers and other facilities bill 95250 on a standard UB-04 claim form for institutions.

Although CDEs may have a provider number and perform services associated with 95250 and medical nutritional therapy (MNT) or diabetes self-management education (DSMT), Medicare and most private payers do not recognize a CDE as a provider for the purpose of billing CPT code 95250. If a CDE is employed by an outpatient diabetes center, 95250 would be billed under the diabetes center's provider number on a UB-04 claim form.

CPT CODE 95251

Who can perform and bill CPT code 95251?

CPT code 95251 is for the interpretation of CGM data. Physicians may perform and bill the services associated with code 95251.

Consistent with state scope of practice laws, providers such as NPs and PAs may also use code 95251. Many payers will not consider an RD for payment for code 95251. This varies both by payer and by state laws.

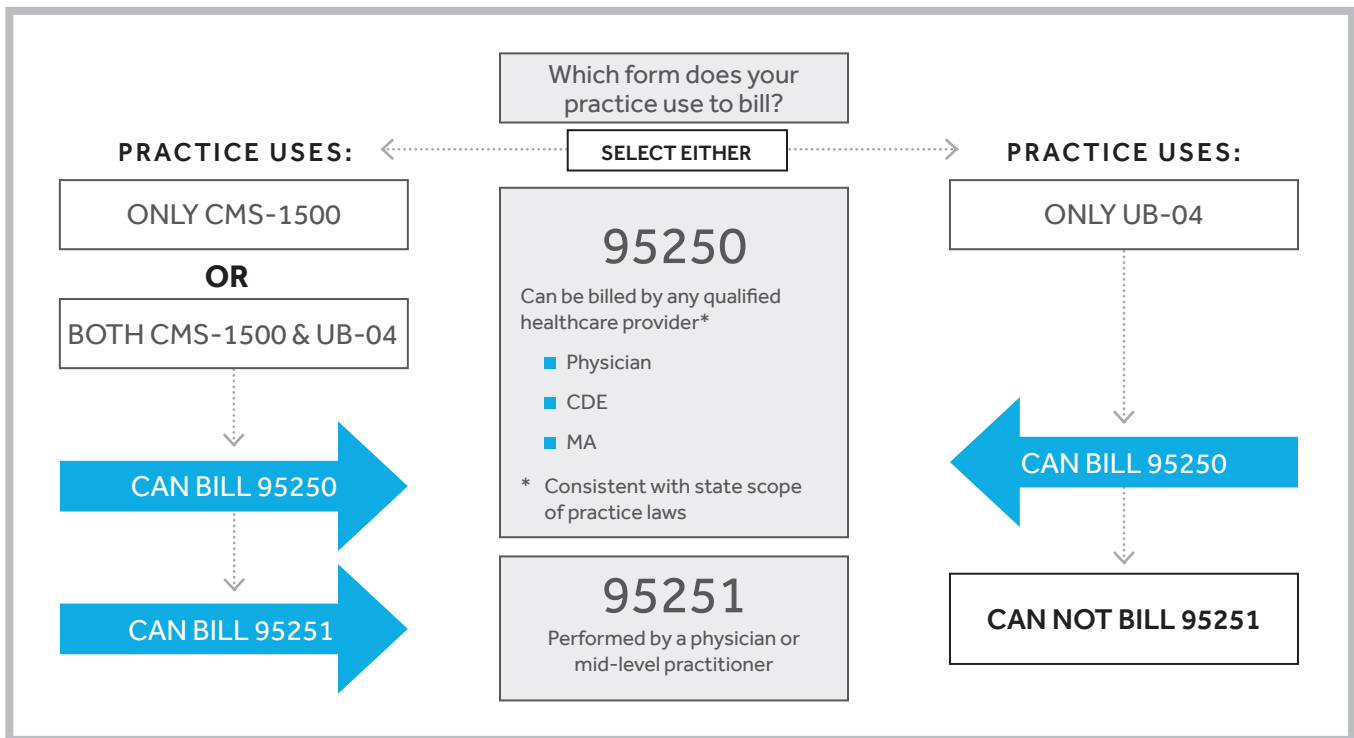
CGM REIMBURSEMENT CODING AND BILLING

The practitioner does not need to be face-to-face with the patient to assign and bill code 95251. Analysis of data obtained remotely is the same as analysis of data obtained during an in-person encounter. So CGM data may be remotely obtained without impacting the service of interpretation represented by 95251.²

Code 95251 should not be billed by a diabetes center, hospital or other facility. Medicare defines 95251 as a “professional component code only” meaning that it is restricted to use by practitioners. Facilities provide technical services only.

Analysis and interpretation should be clearly documented in the patient’s chart. In addition, it is useful to print Professional CGM reports and include them in the patient’s medical record.

Figure B: Summary of who can bill and perform Professional CGM services



2. CPT Assistant, December 2009, p.8

- AAACE Position Statement: Coding Guidelines for Continuous Glucose Monitoring, Endocrine Practice, March/April 2010, p. 153.

“Incident to” Billing for Physicians

When CGM services are performed in the office by auxiliary staff (i.e., non-physician clinicians), such as an office nurse, the services may be coded and billed under the physician’s provider number if they meet the “incident to” requirements.³

The physician must render the initial service in the course of the patient’s diagnosis or treatment. Auxiliary staff may then provide some services as an integral portion of the physician’s service, as long as the physician remains actively involved over the course of care.

There must also be an appropriate level of physician supervision over the auxiliary staff. This does not mean that the physician must always be in the same room when staff renders the service, but rather in most cases, the physician must be physically present in the same suite and immediately available (often referred to as “general supervision”).

Evaluation and Management (E/M) Codes

E/M codes are used for billing face-to-face, non-procedural services. The appropriate level of the E/M code billed is based on multiple components of time and complexity. The key components are history, physical examination and medical decision-making. E/M codes are usually assigned according to the formal Documentation Guidelines for Evaluation and Management Services for these key components.⁴

According to the guidelines, when counseling and/or coordination of care constitute over 50 percent of an encounter, time may be considered the key factor in determining the level of E/M code. The levels of E/M codes for established patients and the time associated with each are as follows:

Code:	99211	99212	99213	99214	99215
Time:	5 min	10 min	15 min	25 min	40 min
Type of outpatient visit:	Minimal	Straightforward	Low Complexity	Moderate Complexity	High Complexity

These E/M codes may be performed and billed by a physician. They may also be performed and billed by a mid-level practitioner, such as a nurse practitioner or physician assistant, who can bill and be paid separately under their own provider number. If the NP or PA is not billing separately and is instead providing services “incident to” the physician, the physician may bill for the specific E/M level performed.

3. See the Medicare Benefit Policy Manual, chapter 15, section 60. Be sure to seek guidance from legal advisors on “incident to” billing.

4. Medicare Learning Network™ Guidelines for E/M Services. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>

CGM REIMBURSEMENT CODING AND BILLING

Specifically, if the service is performed by a non-physician practitioner who cannot bill separately, such as a staff nurse and other auxiliary staff, then the physician may bill for these “incident to” services but is limited to billing only 99211.⁵

Whenever a non-physician practitioner like an NP or PA, or an employee like a staff nurse, provides services “incident to” the physician, the services must be performed under, at a minimum, the general supervision of the physician.

Facilities that are covered under the Medicare Outpatient Prospective Payment System, cannot bill for E/M services using codes 99211 to 99215. Instead, code G0463, defined as “Hospital outpatient clinic visit for assessment and management of a patient” may be assigned for the applicable services.

Modifiers with E/M Codes

An E/M service may be performed on the same day as services for 95250 and 95251, and can be billed separately in certain circumstances. Specifically, the documentation must substantiate that a significant, separately identifiable E/M service was medically necessary and was provided in addition to the CGM service. This requires the physician or mid-level practitioner to take a history, perform a physical examination, and engage in medical decision-making “above and beyond” the usual work associated with CGM.

If a separate E/M code is billed on the same day as a CGM code, modifier -25 must be used with the E/M code.

- -25 : Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service

For example, if the physician performs CGM data interpretation and also evaluates the patient face-to-face for diabetic symptoms, the physician can bill 9921X-25 plus 95251.

It is not necessary to have a different diagnosis for the E/M service and the CGM service. Also, in determining the level of the E/M code, none of the time or services performed for the CGM service can be counted towards the E/M service.⁶

ICD-10-CM Diagnosis Codes

ICD-10-CM diagnosis codes indicate why a service or procedure was performed. The appropriate diagnosis code(s) must be included on health care claims. Payers reference the ICD-10-CM diagnosis codes in considering whether the billed service is medically necessary, meets coverage criteria, and thus is eligible for reimbursement.

Providers should always bill the most specific ICD-10-CM code possible. For example, if a diagnosis code can go out to seven characters, then the code must be submitted with seven characters. If a patient has more than one condition, the healthcare provider should document all conditions in the patient’s medical record and include all of the relevant ICD-10-CM diagnosis codes on the claim form. For CGM, the ICD-10-CM diagnosis codes for diabetes are typically billed.

There are also codes for secondary diabetes, which arises due to another chronic condition or is drug-related. Although uncommon, the codes include E13.8, other specified diabetes mellitus with unspecified complications, E09.9, drug or chemical induced diabetes mellitus without complications, or E13.9, other specified diabetes mellitus without complications.

5. Medicare Claims Processing Manual, chapter 12, section 30.6.4

6. Refer to the Medicare Claims Processing Manual, chapter 12, section 30.6.6.B for additional information.

Figure C: Examples of Diabetes ICD-10-CM Codes

Complication Examples	ICD-10-CM Diabetes Diagnosis Code Options			
		Type 1 Diabetes Category: E10		Type 2 Diabetes Category: E11
No complications	E10.9	Type 1 diabetes mellitus without complications	E11.9	Type 2 diabetes mellitus without complications uncontrolled
Hypoglycemia without coma	E10.649	Type 1 diabetes mellitus with hypoglycemia without coma	E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
Hyperglycemia (uncontrolled) ¹	E10.65	Type 1 diabetes mellitus with hyperglycemia	E11.65	Type 2 diabetes mellitus with hyperglycemia
With kidney complication (example) ²	E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
With ophthalmic complication (example) ²	E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema	E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
With neurological complication (example) ²	E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy	E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
With circulatory complication (example) ²	E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
Other specified complication	E10.69	Type 1 diabetes mellitus with other specified complication	E11.69	Type 2 diabetes mellitus with other specified complication
Unspecified	E10.8	Type 1 diabetes mellitus with unspecified complications	E11.8	Type 2 diabetes mellitus with unspecified complications

1 Uncontrolled (out-of-control, inadequately controlled, poorly controlled) diabetes is generally coded to hyperglycemia in ICD-10-CM.

2. The codes shown are examples of specific types of complications within that subcategory. Other codes are available for different complications within the same subcategory.

Illustrative purposes only. Table is not an exhaustive or all inclusive list of ICD-10-CM diabetes diagnosis codes. Other code categories related to diabetes include E08, E09, E13, E73, P70, O24, and Z79.

Medicare Payment Reform Programs & Quality Metrics

Effective January 1, 2017, the majority of physicians enrolled in the Medicare program and who bill Medicare for their services will be required to participate in the Merit-based Incentive Payment System (MIPS).

The MIPS program applies specifically to reimbursement of services for Medicare providers. Future payment to individual physicians by Medicare will be adjusted either positively or negatively, based on the physician's performance measures over a given time period. Please visit <http://qpp.cms.gov> for more information regarding this program, including how to submit your metrics.

Medtronic's Professional CGM products and services may be used to support the submission or attestation of meeting certain performance measures in the MIPS program. Currently, the performance measures affecting physician payment include Quality, Advancing Care Information, and Improvement Activities. Below are examples of quality measures specified for use in the MIPS program that may be relevant to use of Professional CGM¹

1. <https://qpp.cms.gov/measures/quality>

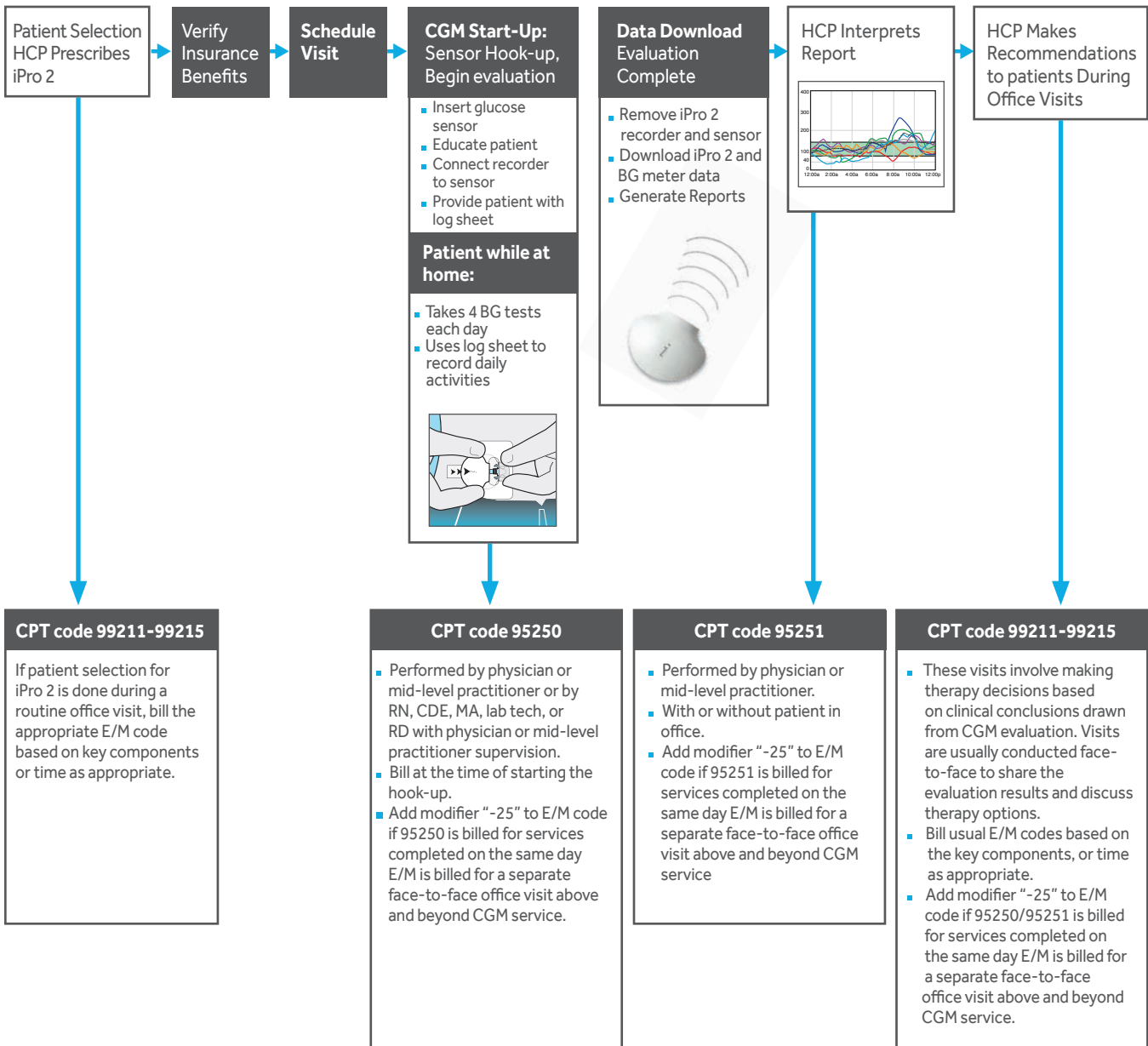
CGM REIMBURSEMENT CODING AND BILLING

Figure D: Quality Metrics

Metric Name	Metric Type	Description Excerpt Visit qpp.cms.gov for full descriptions
<p>"Diabetes: Hemoglobin A1c (HBA1c) Poor Control (>9%)"</p> <p>EMID: CMS 122v5</p>	<p>Quality</p> <p>High Priority Measure</p>	<p>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period</p>
<p>Glycemic Management Services</p> <p>Activity ID: IA_PM_4</p>	<p>Improvement Activities</p> <p>High Weighting</p>	<p>For outpatient Medicare beneficiaries with diabetes ...MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal...</p>
<p>Implementation of condition-specific chronic disease self-management support programs</p> <p>Activity ID: IA_BE_20</p>	<p>Improvement Activities</p> <p>Medium Weighting</p>	<p>Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.</p>
<p>Use of telehealth services that expand practice access</p> <p>Activity ID: IA_EPA_2</p>	<p>Improvement Activities</p> <p>Medium Weighting</p>	<p>Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.</p>
<p>Use of tools to assist patient self-management</p> <p>Activity ID: IA_BE_17</p>	<p>Improvement Activities</p>	<p>Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).</p>

Office Protocol and Coding

The chart below is an example of the key process steps for iPro2 Professional CGM and its respective coding information.



Coverage

Coverage policies describe which products and services are eligible for payment. Most payers, government and commercial, cover only services that are medically necessary and are not considered experimental or investigational. Payers institute specific coverage policies to ensure appropriate utilization and to control costs.

Your local Medtronic Diabetes representative can work with you to determine Medicare and commercial payer coverage information that is most relevant to your diabetes practice.

Private Payer Coverage of Professional CGM

Most private payers cover Professional CGM for specific patient populations, often based on type of diabetes and level of control. For example, many major health plans have written policies.

It is important to understand the specific coverage criteria for payers in your area, as each plan may have different criteria for patient selection and billing.

You might want to compile a coverage policy summary table that aggregates relevant coverage information from your top payers. This can become a useful reference for your practice for verifying medical benefits for individual patients. Since payers update coverage decisions on an ongoing basis, it's a good practice to check and update coverage at least quarterly to make sure it reflects any policy changes.

Prior Authorization Requirements

For Professional CGM, many private payers have prior authorization requirements. Since coverage varies by health plan, it is essential to contact your payers to learn about their Prior Authorization process.

Prior authorization for CGM may involve a phone call or submission of written documentation to the health plan before the Professional CGM service can be provided to the patient. It may be necessary to track Prior Authorization. See Figure E for an example of which details to record through the Prior Authorization process.

Figure E

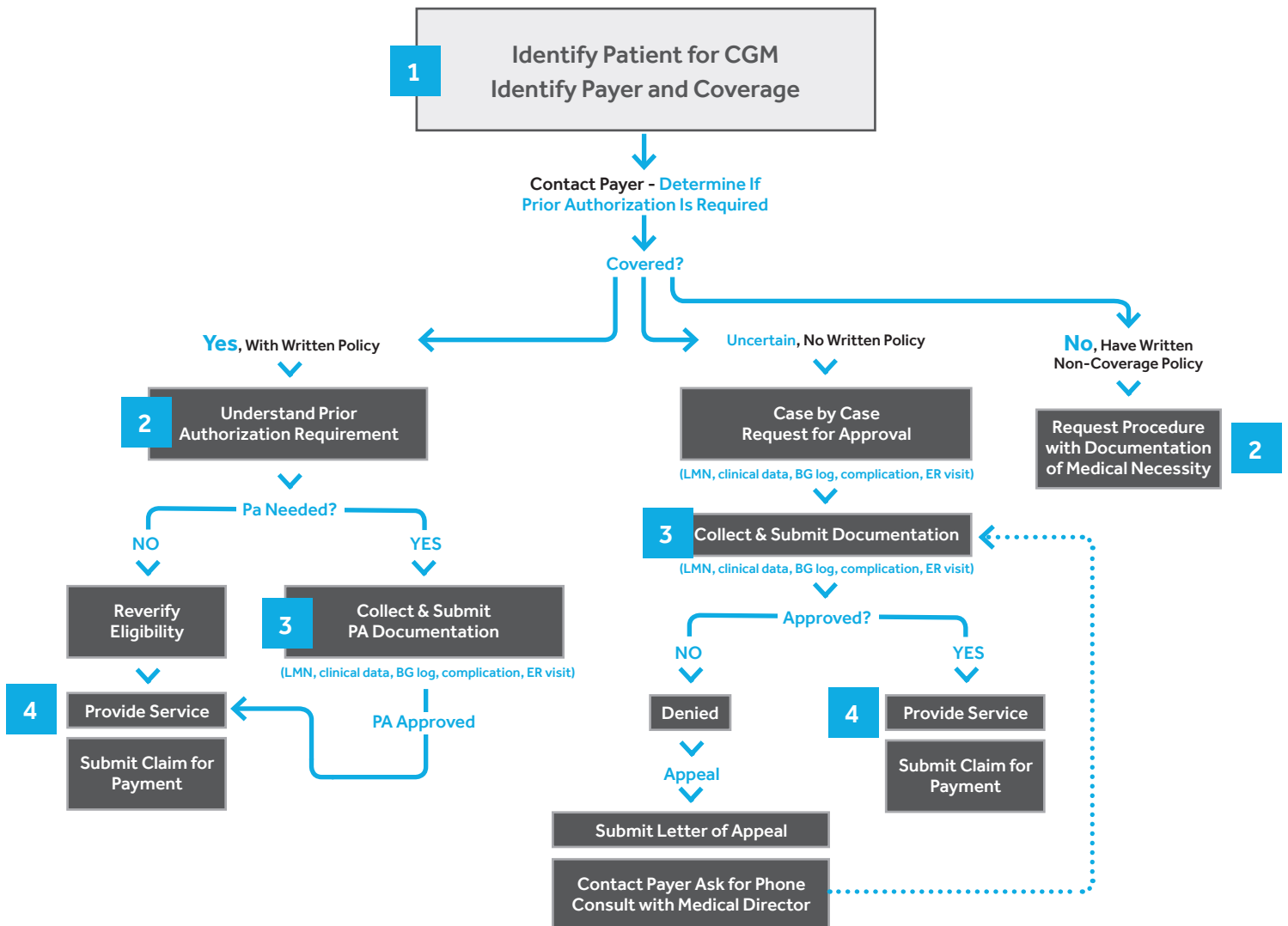
Patient Name	MR#	Provider	Provider Phone #	Request Date	ID	Auth Request Comments	Auth #	ID	Notification of approval request for appt to be scheduled	Appt. Date
May W	486443	MCL	555-5555	06/01/09	BN	No auth needed	80618580472	ST		06/17/09
Jo C	345843	JB	457-1255	06/02/09	BN	Approved 6/8	12548587451	BN	Email Jo 6/10	06/22/09

The keys to successful Prior Authorization and appropriate reimbursement from a payer include increased coordination and communication. Your practice should:

- 1** Identify a staff member to coordinate Prior Authorization with payers.
- 2** Know and follow the payer's conditions for coverage. They vary and are very specific.
- 3** Prepare a clear and concise letter of medical necessity as needed.
- 4** Educate the payer regarding CGM, as needed.

Verbal authorization may be given based on the above information. Written authorization is preferred. Whether authorization is verbal or written, obtain an authorization number. For written authorization, you will need to provide a letter of medical necessity and patient records or a narrative of the patient's history.

Steps for Prior Authorization



Step 1: Contact Payer. This should be done initially with each payer until the Prior Authorization process is established.

- Inquire about eligibility.
- Understand if the plan has a coverage policy for CGM. Before proceeding with the case-by-case coverage process, it is important to verify if the payer has a coverage decision.
- Determine if prior authorization is needed.
- Determine payer requirements for prior authorization.

Step 2: Collect information

- Collect all patient, payer and physician information.
- Identify all ICD-10-CM diagnoses and CPT codes.
- Create letter of medical necessity as needed.
- Patient Records (information about the patient's history may be included in your letter).

Step 3: Submit requested and other supporting information

- Gather all requested materials and mail or fax them to the individual or department responsible for the payer's prior authorization decisions.
- Include a letter of medical necessity for Professional CGM which may include:
 - Documented glycemic control problems (as evidenced by elevated HbA1c, frequent hypoglycemia, hypoglycemic unawareness, overnight hypoglycemia)
 - Hospitalizations for hypoglycemia or diabetic ketoacidosis (DKA)
 - Emergency room visits
 - Glucagon administrations
 - Diabetes complications whether early or advanced such as kidney problems, nerve damage, loss of feeling in feet and eye problems
 - Description of the patient's treatment plan (e.g., multiple daily injections or insulin pump, and frequency of self monitoring of blood glucose) and a record of adherence to the patient's care plan
- Cite private payer policies that outline coverage for Professional CGM.
- Follow up routinely with the payer until a coverage decision has been made.

Step 4: Re-verify eligibility

- When prior authorization has been granted, you may want to re-verify the patient's eligibility to ensure that the patient is still covered by this payer.

Step 5: Appeal (if prior-authorization is denied)

- Understand the reason for the denial.
- Understand the process for filing an appeal.

- Document if your state has a diabetes mandate that may impact coverage for Professional CGM.
- Submit your appeal, being sure to send it within the timeframe outlined by the payer.
- Be prepared and persistent. Seeking case-by-case coverage requires persistence. Make sure to be prepared and keep trying!
- If iPro 2 Professional CGM was completed, you might consider submitting the CGM tracings with the appeal and an explanation of the clinical value of the study and how the patient benefited from the evaluation.

Medicare Coverage of Professional CGM

Medicare has not established a national coverage policy for Professional CGM. This means that coverage is determined by each of the local contractors (also referred to as "carriers") who process Medicare claims. Currently, Professional CGM under CPT codes 95250 and 95251 is payable by Medicare in all 50 States. However, local policies may change as Medicare continues to consolidate its administrative contractors, so you should always check your local Medicare contractor's website to determine the most current policy in place for Professional CGM. The list of current Medicare contractors are provided on the CMS website.⁸

Claims Denial and Appeals

Claims denials can occur for a wide variety of reasons. It is important to understand why the claim was denied and what options are available to re-submit or appeal the claim, as appropriate. See the table on the back inside cover to understand and address reasons for denial.

Payment:

Payment for services may differ by place of service and type of provider. If CPT code 95250 or 95251 is billed from a "physician office" as the place of service, it is typically paid under the physician fee schedule. A fee schedule assigns a specific payment amount to each CPT code. Medicare and most private payers use fee schedules to pay for physician services. However, some payers may pay physicians based on billed charges or on a capitated basis. You must contact your payer's provider relations specialist regarding specific payment questions.

If 95250 is billed by a hospital-based outpatient diabetes center, the facility will be reimbursed under the payer's outpatient hospital payment system. Payers use a variety of mechanisms for reimbursing hospital outpatient services. Medicare and some private payers pay for hospital outpatient services based on Ambulatory Payment Classifications (APCs), which assign services to payment categories. Other private payers pay for hospital outpatient services based on billed charges or according to fee schedules.

8. CMS A/B MAC Jurisdictions. https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/A-B_MAC_Jurisdictions.html

Medicare National Average Payments

The 2017 Medicare national average physician and hospital outpatient payment amounts for 95250, 95251 and E/M codes are provided in Figure F. The Medicare information provided is the National Average Allowable. Actual rates will vary by geography. The amounts shown for the physician are for services performed in the office setting. The Medicare allowable amounts also include any patient deductible and co-insurance amount. The Medicare physician fee schedule amounts can also be found on the Medtronic Diabetes Healthcare Professional Website.

Figure F

Description	Medicare RVU ⁹	2017 Medicare Physician Fee Schedule ⁹	2017 Medicare Hospital Outpatient Prospective Payment System ¹⁰
95250 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording. [Do not report more than once per month]	4.45	\$159	\$105 (APC 5012)
95251 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report. [Do not report more than once per month.]	1.24	\$44	Not payable to hospital
Evaluation and Management Codes			
99211 Established Patient Visit, minimal	0.57	\$20	OPPS does not use the CPT E/M codes. See code G0463 (APC 5012)
99212 Established Patient Visit, straightforward	1.23	\$44	
99213 Established Patient Visit, low complexity	2.06	\$73	
99214 Established Patient Visit, moderate complexity	3.03	\$108	
99215 Established Patient Visit, high complexity	4.08	\$146	

The physician fee schedule payments shown are paid to physicians when they personally render the CGM service, or when, as permitted, it is rendered by auxiliary staff "incident to" the physician's service.

If the CGM service is rendered by mid-level practitioners such as a nurse practitioner or physician assistant who are billing separately under their own provider numbers, payment is typically made at 85% of the physician amount.

9. 2017 Medicare Physician Fee Schedule. Does not include Medicare payment negative adjustments (such as sequestration adjustment). Total RVU for 95250 includes 0.00 Physician Work RVUs, 4.41 Practice Expense RVUs, and 0.04 Malpractice RVUs. Total RVU for 95251 includes 0.85 Physician Work RVUs, 0.34 Practice Expense RVUs, and 0.05 Malpractice RVUs.

10. 2017 Hospital Outpatient Prospective Payment System, Addendum B. Code 95251 is not payable to hospitals because it is a professional service and hospitals provide technical services

Example CMS-1500 Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA							
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH MM DD YY		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME			
c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, complete items 9, 9a, and 9d.		PERSON'S SIGNATURE I authorize undersigned physician or supplier for			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		17b. NPI		FROM MM DD YY TO MM DD YY		20. OUTS...			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)		ICD Ind.		22. RESU...		23. PRIOR...			
A. E1065		B.		C.		D.			
E.		F.		G.		H.			
I.		J.		K.		L.			
24. A. DATE(S) OF SERVICE From To		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	
95251		99213		25		1		S CH.	
26. PATIENT'S AC...		29. AMOUNT PAID		30. Rsvd for NUCC Use		32. SERVICE FAC...		IDENTIFIER INFO & PH #	
a. NPI		b. NPI		a. NPI		b. NPI		b. NPI	

Item 21 (Diagnosis Codes)
 Note the primary diagnosis in box 21
 Examples of possible diagnosis codes include:

- E10.65, Type 1 diabetes mellitus with hyperglycemia
- E10.9, Type 1 diabetes mellitus without complications
- E10.8, Type 1 diabetes mellitus with unspecified complications

Item 21 (ICD Indicator)
 If ICD-10-CM diagnosis codes are used, use indicator "0"

Item 24E (Diagnosis Pointer)
 Specify the position of the diagnosis within box 21 that relates to the procedure code(s) listed in Box 24D.
 If only one diagnosis code is listed in box 21, then that is the diagnosis code that should be referenced in Box 24E

Item 24D (Product/ Procedure Codes)
 For CGM services, utilize either CPT 95250 or 95251

- 95250 is for the technical service
- 95251 is for professional interpretation.

As appropriate, also use the E/M code for a face-to-face visit, assigning the level consistent with the visit complexity or time.

Item 24D (Modifier)
 Append modifier "-25" to E/M code if 95250/95251 is billed for services completed on the same day E/M is billed for a separate face-to-face office visit above and beyond CGM service

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

This sample form is intended as a reference for coding and billing of Professional CGM. It is not intended to be directive nor does the use of the codes above guarantee reimbursement. Physicians and staff may deem other codes more appropriate. Providers should select the coding options that most accurately reflect their internal system guidelines, payer requirements, practice patterns, and the services rendered.

Example UB-04 Form

Form Locator 42 and 43 (Revenue Code + Description)
Use the most appropriate revenue code for setting where services were performed (e.g. 0510, clinic)

Form Locator 44 (Procedure Codes)
For CGM services, utilize CPT 95250
 ■ 95250 is for the technical service
 As appropriate, also use codes for a face-to-face visit, assigning the level consistent with the evaluation complexity or time.
Note: CPT code 95251 cannot be billed on a UB-04 claim form

Form Locator 47 (Total Charges)
Record clinic's charges for the CGM services performed.

Form Locator 67 (Diagnosis Codes)
Note the primary diagnosis
 Examples of possible diagnosis codes include:
 ■ E10.65, Type 1 diabetes mellitus with hyperglycemia
 ■ E10.9, Type 1 diabetes mellitus without complications
 ■ E10.8, Type 1 diabetes mellitus with unspecified complications

This sample form is intended as a reference for coding and billing of Professional CGM. It is not intended to be directive nor does the use of the codes above guarantee reimbursement. Physicians and staff may deem other codes more appropriate. Providers should select the coding options that most accurately reflect their internal system guidelines, payer requirements, practice patterns, and the services rendered.

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