BECN 24061011228

BINSON'S Medical Equipment & Supplies Since 1953
26834 Lawrence
Center Line, MI 48015

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Reset Form

# Continuous Glucose Monitor (CGM) - Detailed Written Order Prior to Delivery

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

☐ Face Sheet/Demographics/Chart Notes Attached
- Chart notes must include the need for equipment being ordered and **MUST BE ATTACHED FOR OVER QUANTITY**
- **Date of visit prior to order**: _____

**MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:**
Reason for Medical Necessity (other than diagnosis): _____

**DIAGNOSIS**

ICD-10 Code _____ Length of Need in Months _____

**TREATMENT TYPE**

Is patient treated with insulin injections and/or insulin pump? ☐ Yes ☐ No

Is patient injecting insulin?
How many injections per day? _____ ☐ Yes ☐ No
*(Medicare requires 1 or more injections per day to qualify)*

Is patient currently using a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No

**CONTINUOUS GLUCOSE MONITORING BRAND**

☐ Preferred Brand: _____
***(If left blank, CGM dispensed will be based off insurance guideline)***

**CONTINUOUS GLUCOSE MONITORING SUPPLIES** (Check all for full kit to be sent to patient)

☐ Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor (E2103) 1 per 5-year period.

☐ Supply Allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories. 1-month supply = 1 unit (A4239)

**NOTES**

**PRESCRIBING PHYSICIAN'S INFORMATION**

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Signature Date _____
(Stamped Signature Not Accepted)


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**CONTINUOUS GLUCOSE MONITORS (CGMs)**

A non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. An adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions. On February 28, 2022, CMS determined that both non-adjunctive and adjunctive CGMs may be classified as DME.
Refer to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES and CODING GUIDELINES sections in the LCD-related Policy Article for additional information regarding classification of CGMs as DME.
To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the following initial coverage criteria (1)-(5):

1. The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,
2. The beneficiary's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription; and,
3. The CGM is prescribed in accordance with its FDA indications for use; and,
4. The beneficiary for whom a CGM is being prescribed, to improve glycemic control, meets at least one of the criteria below:
    A. The beneficiary is insulin-treated; or,
    B. The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following (see the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section of the LCD-related Policy Article (A52464)):
        - Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
        - A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia
5. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicare-approved telehealth visit with the beneficiary to evaluate their diabetes control and determined that criteria (1)-(4) above are met.

**CGM Continued Coverage**
Every six (6) months following the initial prescription of the CGM, the treating practitioner conducts an in-person or Medicare-approved telehealth visit with the beneficiary to document adherence to their CGM regimen and diabetes treatment plan.
When a CGM (code E2102 or E2103) is covered, the related supply allowance (code A4238 or A4239) is also covered. Supplies (code A4238) for an adjunctive CGM integrated into an external insulin infusion pump are covered when the beneficiary meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump. Refer to the External Infusion Pumps LCD (L33794) for additional information regarding billing a CGM receiver incorporated into an insulin infusion pump.
If any of the initial coverage criteria (1)-(5), or the continued coverage criterion are not met, the CGM and related supply allowance will be denied as not reasonable and necessary.
The supply allowance (code A4238 or A4239) is billed as one (1) unit of service (UOS) per thirty (30) days. Only one (1) UOS of code A4238 or A4239 may be billed to the DME MACs at a time. Billing more than one (1) UOS per thirty (30) days of code A4238 or A4239 will be denied as not reasonable and necessary. Refer to the CODING GUIDELINES section in the LCD-related Policy Article for additional billing instructions.

***Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.***