Changes to continuous glucose monitor prior authorization requirement

Frequently asked questions

Beginning Sept. 1, 2024, UnitedHealthcare® Medicare Advantage plans, including Medicare and Medicaid Dual Special Needs Plans (D-SNPs), will require prior authorization for personal long-term continuous glucose monitors (CGMs) for members with any diagnosis other than Type 1 diabetes. When the durable medical equipment (DME) vendor receives a physician order for a CGM, the DME provider must obtain prior authorization for both the device and the supplies. The prior authorization will be effective for a consecutive 12-month period.

This aligns with the Centers for Medicare & Medicaid Services **Local Coverage Determination (LCD) L33822.** It allows members who require insulin or have problematic hypoglycemia to appropriately receive a CGM in accordance with Medicare guidelines.

Exclusions

The new requirement doesn't apply to the following:

- Ohio D-SNP
- Tennessee D-SNP
- Tennessee Fully Integrated Dual Eligible (FIDE-SNP) plans

In addition, this requirement **doesn't apply to members with Type 1 diabetes** because these members meet the clinical criteria for CGMs. Providers don't need to request prior authorization to fill CGM and supply orders for these patients. If a DME provider submits a prior authorization for a CGM for a member with Type 1 diabetes, they'll receive a message that prior authorization isn't necessary.

Applicable codes

This new requirement applies to the following Healthcare Common Procedure Codes (HCPCs):

- 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
- E2102: Adjunctive, non-implanted continuous glucose monitor or receiver
- E2103: Non-adjunctive, non-implanted continuous glucose monitor or receiver

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Frequently asked questions

Which plans does this new requirement apply to?

Prior authorization requirements for the above codes apply to the following:

Medicare Advantage plans

- Individual
- Group
- Optum® at Home
- Preferred Care Partners
- Peoples Heath
- Employer Group Waiver Plans
- United Retiree Solutions
- Massachusetts Community Plan D-SNP
- Iowa/Illinois Unity Point Health System
- Catholic Health Initiatives Health Partners (CHI HP) PHO in Nebraska

UnitedHealthcare Community Plan

- D-SNP
- Fully Integrated Dual Eligible (FIDE)
- Non-FIDE

Do Type 1 diabetics require prior authorization?

No, this requirement doesn't apply to members with Type 1 diabetes because these members meet the clinical criteria for CGMs outlined in the LCD. Providers don't need to request prior authorization to fill CGM and supply orders for these patients. If a DME provider submits a prior authorization for a CGM for a Type 1 diabetic, they'll receive a message that prior authorization isn't necessary.

Are the clinical criteria outlined in the LCD guidelines?

Yes, the clinical criteria are aligned with CMS LCD guidelines. Our approach will allow members who are insulin dependent or have a problematic hypoglycemia diagnosis to receive coverage for a CGM, in accordance with the CMS LCD.

How does this prior authorization requirement affect members?

Members with Type 2 diabetes or other diagnoses may no longer be eligible to receive coverage for a CGM, according to the clinical criteria in the LCD.

How does this affect members who receive a denial for CGM coverage?

If we deny the prior authorization for supplies, the member can use the finger stick with a blood glucose meter to monitor their blood sugar. Per the Medicare coverage criteria, not all members may be covered who want a CGM. For more information, see the **Glucose Monitor – Policy Article** on cms.gov.

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What happens if a member wants to appeal a denial?

If a member appeals and states that they require insulin, we'll still require prior authorization as well as documentation from their provider to indicate that they meet the clinical criteria outlined in L33822.

What happens if a provider wants to appeal a denial?

If there is a clinical denial, we'll include documentation about how to appeal in our correspondence.

How is a prior authorization request submitted and who can submit a prior authorization for CGMs and supplies?

For detailed information, see the DME section in our **Prior Authorization and Notification interactive guide.**

Will these prior authorization requirements apply for members already receiving CGMs and supplies (e.g., transmitters, receivers/readers and sensors)?

Yes. We require prior authorization for all CGMs and supplies received on or after Sept. 1, 2024. If a member joins a UnitedHealthcare plan and was currently receiving a CGM through a previous payer, there will be a 90-day transition period.

Questions?

If you have questions, please reach out to your network contact.

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