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2022 Continuous Glucose Monitoring (CGM) CPT Coding Reference Chart

Refer to the chart below for CPT codes and frequently asked questions.

Codes and descriptions	Medicare physician office fee schedule[1]	Medicare outpatient diabetes center[2]	Private payer (2021 averages)[3]	Relative value unit (RVU) non-facility[1]
CGM Services				
95249 Personal CGM - Startup/Training Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording. *Bill only once during the time period that the patient owns the device.**	$59.87	$56.85 APC 5733	$128	1.73
95250 Professional CGM Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording. *Do not bill more than 1x/month.**	$151.57	$121.35 APC 5012	$309	4.38
95251 CGM Interpretation Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report. *Do not bill more than 1x/month.**	$35.30	Paid under physician fee schedule	$97	1.02
Evaluation and Management (E/M)				
99212-99215 For an established patient in non-facility or office setting. Appropriate code to be determined by the office.	$57.45-$183.07	—	$87-$288	1.66-5.29

Keep in mind that Medicare adjusts payment to physicians based on where the service is performed. There are 89 different fee schedule localities in the country and payments vary significantly. You can obtain the geographically adjusted payment rate for any code paid under the physician fee schedule through Medicare's Physician Fee Schedule Lookup Tool.

In addition, to address budget constraints, Congress passed legislation in late 2021 allowing "sequestration," or a reduction in reimbursement, to go into place in 2022. This means that the national payment rates shown in this sheet will be in place from January-March of 2022. From April-June, the amount paid for by the Medicare program will be reduced by 1% and from July-December it will be reduced by 2%. The Medicare program pays for 80% of the total allowed amount and the 1% and 2% reductions apply only to that portion of the total allowed amount. The 20% coinsurance paid by Medicare beneficiaries will not be so reduced.

*Frequency may vary by individual payor. Check with individual payor for specifics.

CPT coding FAQs

Can providers bill remote monitoring codes 99091 and 99457?

If providers are performing remote monitoring beyond CGM, CPT codes 99091 or 99457 may be appropriate based on services provided. Providers should understand specific coverage criteria for billing remote monitoring (i.e. time required/frequency of billing/ patient consent).

How often can CPT code 95249 be billed?

This code can be billed only once during the time the patient owns the manufacturer-provided display device. This code may not be reported for subsequent episodes of data collection, unless the patient begins using a new generation of the manufacturer's (or different manufacturer's) CGM system or display device. Additionally, this code may not be billed unless at least 72 hours of CGM data is printed from the display device the patient was trained on.

What type of healthcare provider/physician can bill and perform CPT codes 95249, 95250 and 95251?

CPT codes 95249 and 95250 do not have any physician work RVUs (Relative Value Units); therefore, the associated services can be performed by a trained RN, PharmD/RPh, RD, CDE or MA (if within their scope of practice) and billed by the supervising physician advanced practitioner or hospital outpatient department. However, only providers such as Physician (MD), Nurse Practitioner (NP), Physician Assistant (PA) or Clinical Nurse Specialist (CNS) can perform and bill for services associated with CPT code 95251.

Do services associated with CPT codes 95249 and 95250 need to be provided face-to-face?

Yes, all of the services associated with CPT codes 95249 and 95250 must be provided face-to-face in order to bill for them. Services associated with CPT code 95251, however, may be a non-face-to-face service.[4]

If a patient starts using a Dexcom CGM System after previously using another manufacturer's CGM system, can the HCP bill CPT code 95249 again?

Yes, the code can be billed again for commercially insured and Medicare patients if the patient is using a different manufacturer's CGM system or a different model of a data receiver from the manufacturer's CGM system they are currently using.

If a patient has been using their Dexcom receiver and then switches to a compatible smart device† to display their glucose data, can the provider bill CPT code 95249 for this training?

It is highly unlikely any commercial payers would cover training costs for devices that are not reimbursed. (Medicare does not currently reimburse for a CGM system if a smart device is solely used to display glucose data. The patient must have a receiver to use in conjunction with the smart device.) However, providers should check with individual payers for specifics on billing when a patient switches to using a smart device for glucose data display.

Which insurance companies are paying for CPT codes 95249, 95250 and 95251? How do healthcare providers find out the specifics of each insurance company's CGM coverage policy and criteria?

The majority of commercial insurance plans have written positive coverage decisions for both personal and professional use of CGM. National payers such as Cigna, Humana, Aetna, United Healthcare and Anthem WellPoint are currently covering these CPT codes, although the coverage criteria may differ between personal and professional use of CGM. Coverage decisions may vary and limit coverage to specific patients (i.e. type 1) or may limit number of times per year CPT codes 95249, 95250 and 95251 may be covered. Work with your health plans to get copies of the most recent published CGM coverage decisions. As always, verify coding and payment with your local payers.

What is the difference between the Medicare physician fee schedule and the outpatient diabetes center payment?

Medicare physician payments are fee schedules based on relative value units (RVUs). Hospital outpatient services are paid under the outpatient prospective payment system (OPPS).

The Medicare fee schedules provided in the table are national averages. Where would healthcare providers find the local Medicare fee schedules for physicians in their state?

The Center for Medicare and Medicaid (CMS) has a website where you can find state and local fee schedules for all CPT codes: Physician Fee Schedule Lookup Tool.

†For a list of compatible smart devices, please visit dexcom.com/compatibility.

CPT coding FAQs | Continued

What should practices do if they get denied for CPT codes 95249 and 95250?

Claim denials can occur for a wide variety of reasons. It is important to understand why the claim was denied and as appropriate, know what options are available to resubmit or appeal the claim. Confirm that the ICD-10 diagnosis code(s) are specific and valid for services provided and that the specific codes and services of CPT codes 95249, 95250 and 95251 are covered services within each health plan.

Ensure that frequency of submissions is within the specific insurance policy limits. Modifier -25 should be added to Evaluation and Management code (E/M) if billed on the same day as CPT codes 95249, 95250 and 95251. Modifier -25 verifies that the E/M service was separate and identifiable from the CGM service. For insurance plans requiring prior authorization, ensure that the authorization has been obtained prior to the service being performed.

To learn more about Dexcom CGM, visit provider.dexcom.com today.

The reimbursement information provided is intended to assist you with billing for your services related to continuous glucose monitoring (CGM). It is intended for informational purposes only and is not a guarantee of coverage and payment. Providers are encouraged to contact their local payers with questions related to coverage, coding and payment. Rates provided under the Medicare PFS and OPPS are rounded to the nearest hundredth.

References:

1. CMS-1751-F Medicare Physician Fee Schedule Final Rule 2022 and the "Physician Fee Schedule Look-Up Tool," available at: https://www.cms.gov/medicare/physician-fee-schedule/search/overview.
2. CMS-1753-FC; Medicare Outpatient Prospective Payment System Final Rule 2022. Fee schedules are national averages and are not geographically adjusted.
3. PMIC Medical Fees Directory: UCR & Medicare Fees with RVUs for Over 9,000 CPT Codes. Numbers provided are the 50th percentile of the Usual and Customary (UCR) charges. Note that these are charges and not actual reimbursed amounts.
4. CPT 2021 Professional Edition. Chicago, IL: American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

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