

Diabetes Technology Billing and Coding Guide 2026

For MiniMed™ 780G
Insulin Pump System and
compatible Continuous
Glucose Monitors:

- Instinct sensor
- Simplera Sync™ sensor
- Guardian™ 4 sensor

Enter

This guide should not be viewed as inclusive of all coding, coverage, and payment information that may be needed. It does not replace advice from your coding, billing, compliance, legal, or other applicable departments. The responsibility for correctness lies with the provider or supplier of services.



Sensor made by Abbott



Introduction

The **Diabetes Technology Billing and Coding Guide** has been developed as an introductory reference guide to coding, coverage, and payment for professional services providers, pharmacies, and DME suppliers in the care of patients with diabetes.

The guide outlines the following information in relation to MiniMed's automated insulin delivery (AID) system and compatible CGMs:



Coverage considerations



HCPCS codes



CPT® codes



NDC



MTM coding



Diagnosis codes



Product support

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This document aids with FDA-approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA-cleared or approved labeling (eg, instructions for use, operator's manual, or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related services.

CPT = Current Procedural Terminology; DME = durable medical equipment; HCPCS = Healthcare Common Procedure Coding System; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; MTM = medication therapy management; NDC = National Drug Code; NRC = National Reimbursement Code.



Coverage Considerations

Coverage criteria for CGMs and insulin pumps will vary across different plans. While commercial plans follow the lead of Medicare, there may be nuances, so it is important to contact the payer directly to confirm requirements. The table below compares eligibility requirements across common payers. Some of the information may apply to State Medicaid and Managed Medicaid plans, but please contact the payer directly for details.

Coverage for CGMs

	Medicare NCD/LCD ¹	Medicare Advantage ²	Commercial Plans ²
Documented diagnosis	Include an ICD-10-CM code for either Type 1 or Type 2 diabetes		
FDA-approved indication	CGM is prescribed according to FDA labeling		
Insulin use requirement	No specific insulin dose required; covered if treated with insulin or has a history of problematic hypoglycemia (see below)	Typically follows Medicare criteria, but may require additional documentation Check with patient's plan for their definition of medically necessary	Patient is using insulin and/or has a history of problematic hypoglycemia (see below) Check with patient's plan for their definition of medically necessary
Hypoglycemia history	Recurrent level 2 hypoglycemia (glucose <54 mg/dL [3.0 mmol/L]) despite use of a noninsulin glycemic-lowering agent, OR History of 1 level 3 hypoglycemic event characterized by altered mental or physical state requiring third-party assistance		Typically follows Medicare criteria, but check with patient's plan for their definition of medically necessary
Diabetes training documentation	Provider must send evidence that patient or caregiver has sufficient training	Often requires provider documentation that patient has received instructions on device use or treatment plan	Often requires provider documentation that patient has received instructions on device use or treatment plan
Ongoing evaluation	Requires documented in-person or Medicare-approved telehealth visit within 6 months	Often required, criteria may differ, especially for patients with Type 1 vs Type 2 diabetes	Many plans require periodic review, but frequency differs from plan to plan

Continuing coverage requirements specific to Medicare^{1,2}: Every 6 months following the initial prescription of the CGM, the HCP has an in-person or Medicare-approved telehealth visit with the patient to document adherence to their CGM regimen and diabetes treatment plan. Documentation should be kept on file and may be requested by the payer.

Please see indications for use for MiniMed 780G on [page 20](#) and full [Important Safety Information with compatible sensors](#).


CGMs = continuous glucose monitors; FDA = US Food and Drug Administration; HCP = healthcare provider; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; LCD = Local Coverage Determination; NCD = National Coverage Determination.



Coverage Considerations (cont'd)

Coverage for Insulin Pumps

Medicare requires evidence of medical necessity for coverage of an external insulin pump for continuous subcutaneous insulin infusion (CSII) in the home setting. Patients with confirmed ICD-10-CM diagnosis of diabetes must meet either criterion A or B **AND** meet either criterion C or D.³

Criterion A or B	Criterion C or D
<p>Criterion A³:</p> <ul style="list-style-type: none"> ✓ Patient must satisfy one of the following C-peptide testing requirements: <ul style="list-style-type: none"> • Fasting C-peptide level is ≤110% of the lower limit of normal of the laboratory's measurement method • For patients with renal insufficiency and creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) ≤50 mL/minute: fasting C-peptide level ≤200% of the lower limit of normal of the laboratory's measurement method • Fasting blood sugar of ≤225 mg/dL is obtained at the same time as the C-peptide level <p style="text-align: center;">OR</p> <p>Criterion B³:</p> <ul style="list-style-type: none"> ✓ Beta-cell autoantibody test is positive <ul style="list-style-type: none"> • Test names vary by lab but examples include: Insulin Autoantibodies (IAA), Islet Antigen 2 (IA-2), Islet Cell Autoantibody (ICA), Zinc Transporter 8-ZnT1 (Lab ZN), or Glutamic Acid Decarboxylase Autoantibodies (GAD-65) 	<div style="text-align: center;"></div> <p>Commercial and Medicare Advantage plans often follow Medicare criteria.^{2,4} Commercial plans may require prior authorization and/or step therapy before covering an insulin pump. Most commercial plans do not require C-peptide or beta-cell autoantibody testing. Medicare Advantage plans may also require prior authorization or apply supplier restrictions.</p>

Continuing coverage requirements specific to Medicare: For continued coverage of an external insulin pump and supplies, the patient must be evaluated by physician at least every 3 months.³

Claims using the code for external ambulatory insulin pumps (E0784) with integrated continuous glucose sensor functionality are covered **only if both pump and CGM criteria are met under Medicare LCD policies.**³

Please see indications for use for MiniMed 780G on [page 20](#) and full [Important Safety Information with compatible sensors](#).

CGM = continuous glucose monitor; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; LCD = Local Coverage Determination.



Coverage Considerations (cont'd)

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Medicare requires evidence of medical necessity for coverage of an external insulin pump for continuous subcutaneous insulin infusion (CSII) in the home setting. Patients with confirmed ICD-10-CM diagnosis of diabetes must meet either criterion A or B **AND** meet either criterion C or D.³

Criterion A or B	Criterion C or D
	<p>Criterion C³:</p> <ul style="list-style-type: none"> ✓ Completed a comprehensive diabetes education program ✓ Multiple daily injections of insulin (≥3 per day) ✓ Documented glucose self-testing frequency of ≥4x per day during the 2 months prior to initiation of the insulin pump ✓ Meets one or more of the following criteria: <ul style="list-style-type: none"> • A1C > 7.0% • History of recurring hypoglycemia • Wide fluctuations in blood glucose before mealtime • Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL • History of severe glycemic excursions <p style="text-align: center;">OR</p> <p>Criteria D³:</p> <ul style="list-style-type: none"> ✓ Patient has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of ≥4x per day during the month prior to Medicare enrollment.



Commercial and Medicare Advantage plans often follow Medicare criteria.^{2,4} Commercial plans may require prior authorization and/or step therapy before covering an insulin pump. Most commercial plans do not require C-peptide or beta-cell autoantibody testing. Medicare Advantage plans may also require prior authorization or apply supplier restrictions.

Continuing coverage requirements specific to Medicare: For continued coverage of an external insulin pump and supplies, the patient must be evaluated by physician at least every 3 months.³

Claims using the code for external ambulatory insulin pumps (**E0784**) with integrated continuous glucose sensor functionality are covered **only if both pump and CGM criteria are met under Medicare LCD policies.**³

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CGM = continuous glucose monitor; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; LCD = Local Coverage Determination.



Coverage Considerations (cont'd)

Best practices for submitting claims are listed below. While you may use this as a guide, accurate submissions are not limited to these reminders as payer requirements vary across plans.

Common Reasons for Denial

- Medical necessity is not established due to lack of documentation or insufficient documentation
- Incomplete clinical records and/or missing lab results (A1C, Beta-cell autoantibodies, C-peptide)
- Incorrect or missing codes (ICD-10, HCPCS codes, CPT codes, NDC)
- Item frequency or quantity limits have been exceeded
- No documentation of patient training
- No evidence of ongoing HCP evaluation (history and physical, visit notes)

To Ensure Accurate HCPCS Billing

- Patient records should be specific and comprehensive to ensure accurate and timely payment
- Use HCPCS codes if the device is covered under the DME benefit
- Use NDC codes if it is covered under the pharmacy benefit
- Be aware of the replacement frequency of each component and do not bill beyond the health plan's policy limit

To Ensure Accurate CPT Documentation

- Patient records should be specific and comprehensive to ensure accurate and timely payment. Always code to the highest level of specificity
- Ensure continuity of diagnoses as patient condition changes
- Accurately document who performed each service
- Document the date span for CGM monitoring
- Document the time spent for the services provided
- Ensure inclusion of product type, name, and manufacturer as ordered/prescribed
- Use of these systems requires, among other things, adequate hearing and vision
- For CGMs, a compatible mobile device should be assessed, confirmed, and documented
- Do not bill **95251** (data analysis) more than once a month
- Other patient discussions should be billed with the correct Evaluation and Management (E/M) code
- Use **95251** for CGM data analysis; use **99091** for non-CGM remote therapy monitoring
- Include CGM data and signed medical outcomes reports



HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system that is used primarily to identify products, supplies, and services not included in CPT® codes, such as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Instinct sensor shown. Simplera Sync™ and Guardian™ 4 sensors are also compatible with this system.



Sensor made by Abbott

Insulin Pumps and CGM Receivers³

The combination of **E0784 plus E2102** is used to describe external ambulatory insulin infusion pumps with integrated adjunctive CGM receiver functionality.

- An adjunctive receiver is a glucose monitor that must be used alongside fingerstick testing to make a treatment decision

The combination of **E0784 plus E2103** is used to describe external ambulatory insulin infusion pumps that incorporate dose rate adjustment using nonadjunctive continuous glucose sensing.

- Nonadjunctive receiver is defined as a CGM that can be used on its own to make treatment decisions (ie, no fingersticks)

To Ensure Accurate Coding

- Use HCPCS codes if the CGM is covered under the DME benefit
- Use NDC codes if it is covered under the pharmacy benefit
- For CGMs, a compatible mobile device should be assessed, confirmed, and documented. This is applicable to both DME and pharmacy benefits when the plan does not follow Medicare
- Do not use E codes for disposable supplies (ie, sensors or transmitters); they are used for durable devices with a typical replacement frequency of 5 years
- Be aware of the replacement frequency of each component and do not bill beyond the health plan's policy limit



HCPCS Codes (cont'd)



Sensor made by Abbott

MiniMed™ 780G AID System

	HCPCS ⁵	Medicare National Average Payment Rate ⁶
External ambulatory insulin pump, insulin	E0784	\$558.48
Infusion sets, supplies for maintenance of insulin infusion catheter, per week	A4224	\$26.01
Reservoirs, syringe-type cartridge, sterile, each	A4225	\$3.48
Infusion set for external insulin pump, non-needle cannula ⁷	A4230	N/A
Infusion set for external insulin pump, needle type, each ⁷	A4231	N/A
Reservoirs, syringe with needle, sterile, 3 cc ⁸	A4232	N/A

Instinct sensor



	HCPCS ⁵	Modifier ⓘ	Medicare National Average Payment Rate ⁶
Nonadjunctive CGM	A4239		\$273.28
Receiver	E2103	NU	\$291.38
		RR	\$29.14

Receiver for CGM may be required through the DME channel under Medicare and specific other policies, not pharmacy. When E2102 or E2103 is covered, the related supply allowance (code A4238 or A4239) is also covered.

AID = automated insulin delivery; CGM = continuous glucose monitor; DME = durable medical equipment; HCPCS = Healthcare Common Procedure Coding System; KF = item designated by FDA as Class III devices; NU = new durable medical equipment purchase; RR = rental.



HCPCS Codes (cont'd)

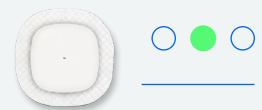


Sensor made by Abbott

MiniMed™ 780G AID System

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Infusion set for external insulin pump, needle type, each ⁷	A4231	N/A
Reservoirs, syringe with needle, sterile, 3 cc ⁸	A4232	N/A

Simplera Sync™ sensor



	HCPCS ⁵	Modifier ⓘ	Medicare National Average Payment Rate ⁶
Adjunctive CGM	A4238	KF	\$280.71
Receiver	E2102	NU, KF	\$227.74
		RR, KF	\$22.77

Receiver for CGM may be required through the DME channel under Medicare and specific other policies, not pharmacy. When E2102 or E2103 is covered, the related supply allowance (code A4238 or A4239) is also covered.

AID = automated insulin delivery; CGM = continuous glucose monitor; DME = durable medical equipment; HCPCS = Healthcare Common Procedure Coding System; KF = item designated by FDA as Class III devices; NU = new durable medical equipment purchase; RR = rental.



HCPCS Codes (cont'd)



Sensor made by Abbott

MiniMed™ 780G AID System

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Infusion set for external insulin pump, non-needle cannula ⁷	A4230	N/A
Infusion set for external insulin pump, needle type, each ⁷	A4231	N/A
Reservoirs, syringe with needle, sterile, 3 cc ⁸	A4232	N/A

Guardian™ 4 Sensor and Transmitter



	HCPCS ⁵	Modifier ⓘ	Medicare National Average Payment Rate ⁶
Adjunctive CGM	A4238	KF	\$280.71
Receiver	E2102	NU, KF	\$227.74
		RR, KF	\$22.77
OR			
Sensor	A9276	Not covered by Medicare; may be utilized by non-Medicare payers. Please check with patient's individual plan.	
Transmitter	A9277	Not covered by Medicare; may be utilized by non-Medicare payers. Please check with patient's individual plan.	
Receiver (external monitor)	A9278	Not covered by Medicare; may be utilized by non-Medicare payers. Please check with patient's individual plan.	

Receiver for CGM may be required through the DME channel under Medicare and specific other policies, not pharmacy. When E2102 or E2103 is covered, the related supply allowance (code A4238 or A4239) is also covered.

AID = automated insulin delivery; CGM = continuous glucose monitor; DME = durable medical equipment; HCPCS = Healthcare Common Procedure Coding System; KF = item designated by FDA as Class III devices; NU = new durable medical equipment purchase; RR = rental.



CPT Codes

Current Procedural Terminology (CPT) codes are used to describe various medical services provided during a patient encounter in all settings. Some codes specify which qualified healthcare provider must perform the service (ie, physician, equivalent practitioners, or nonphysician staff). Reimbursement rates for services may differ by place of service and type of provider.

Use the tables on the following pages to code for clinical services related to AID systems and CGMs. Be sure to bill any Evaluation and Management (E/M) CPT codes for relevant services performed at the office or virtually.



To Ensure Accurate Coding

- Document who performed each service correctly
- Be sure to include the required monitoring period of the CGM by documenting the start and end dates of CGM data
- Do not bill **95251** (data analysis) more than once a month. If there are other patient discussions, use the correct E/M code instead
- Use **95251** specifically for CGM data analysis; use **99091** for non-CGM remote treatment monitoring
- Along with CGM data, be sure to include signed reports of the medical outcome of the analysis

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AID = automated insulin delivery; CGM = continuous glucose monitor.



CPT Service Codes (cont'd)

LEGEND (WHO CAN BILL)

Physicians

● MD

● DO

Equivalent practitioner

● NP

● PA

● CNS

Diabetes education staff or nonphysicians

● RN

● CDCES

● Diabetes education staff

● Registered dietician

CGM Placement and Education⁹

CPT Code	Description	Details
95249	<i>(Specific to patient-provided equipment)</i> 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, and printout of recording	<ul style="list-style-type: none"> ● Who can bill: ● ● ● ● If performed by office staff, registered nurses or Certified Diabetes Care and Education Specialists, this is billable under direct supervision ● Code can be used only once per month ● Cannot be billed in conjunction with CPT 99091 or 0447T
95250	<i>(Specific to healthcare professional-provided equipment)</i> 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, and printout of recording	

CPT Code Medicare National Average Payment Rates^{6,10}

CPT Code	2026 Nonfacility	2026 Facility	2026 Hospital
95249	\$69.81	\$69.81	\$60.27
95250	\$152.64	\$152.64	\$136.02

CDCES = Certified Diabetes Care and Education Specialist; CGM = continuous glucose monitor; CNS = Clinical Nurse Specialist; CPT = Current Procedural Terminology; DO = Doctor of Osteopathy; MD = Medical Doctor; NP = Nurse Practitioner; PA = Physician Assistant; RN = Registered Nurse.



CPT Service Codes (cont'd)

LEGEND (WHO CAN BILL)

Physicians

● MD

● DO

Equivalent practitioner

● NP

● PA

● CNS

Diabetes education staff or nonphysicians

● RN

● CDCES

● Diabetes education staff

● Registered dietician

CGM Data Analysis⁹

CPT Code	Description	Details
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report	<ul style="list-style-type: none"> Who can bill: ● ● ● ● If performed by office staff, registered nurses or Certified Diabetes Care and Education Specialists, this is billable under direct supervision Code can only be used once per month Do not use in conjunction with 99091
99091	Collection and interpretation of physiological data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified HCP, qualified by education, training, licensure/regulation (when applicable)	<ul style="list-style-type: none"> Analysis can only be performed by: ● ● ● ● Minimum 30 minutes, every 30 days

If an E/M service is performed on the same day as services for **95250** and **95251**, it can be billed under certain circumstances using Modifier 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. Submit documentation that confirms an MD, DO, NP, or PA performed a history and physical examination and engaged in medical decision-making "above and beyond" the usual work.

CPT Code Medicare National Average Payment Rates¹⁰

CPT Code	2026 Nonfacility	2026 Facility
95251	\$35.07	\$35.07
99091	\$55.45	\$47.43

CDCES = Certified Diabetes Care and Education Specialist; CGM = continuous glucose monitor; CNS = Clinical Nurse Specialist; CPT = Current Procedural Terminology; DO = Doctor of Osteopathy; ECG = electrocardiogram; MD = Medical Doctor; NP = Nurse Practitioner; PA = Physician Assistant; RN = Registered Nurse.



CPT Service Codes (cont'd)

LEGEND (WHO CAN BILL)

Physicians

● MD

● DO

Equivalent practitioner

● NP

● PA

● CNS

Diabetes education staff or nonphysicians

○ RN

○ CDCES

○ Diabetes education staff

○ Registered dietician

Diabetes Education Services⁹

CPT Code	Description	Details
G0108 (Individual)	Diabetes outpatient self-management training services, per 30 minutes	<ul style="list-style-type: none"> Who can bill: ○ ○ ○ ○
G0109 (≥2 patients)		
98960 (Individual)	Education and training for patient self-management by a nonphysician qualified healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/ family) each 30 minutes	<ul style="list-style-type: none"> Who can bill: ● ● ● ● ● ○ ○ ○ ○ These codes are telemedicine codes. Add Modifier 95-Telemedicine Service
98961 (2-4 patients)		
98962 (5-8 patients)		
S9445 (Individual)	Patient education, not otherwise classified, nonphysician provider, individual, per session	<ul style="list-style-type: none"> Who can bill: ● ● ● ● ● ○ ○ ○ ○ Note that these are non-Medicare codes
S9446 (Group)		

CPT Code Medicare National Average Payment Rates¹⁰

CPT Code	2026 Nonfacility	2026 Facility	Details
G0108	\$55.78	\$55.78	
G0109	\$16.03	\$16.03	
98960	\$32.70	N/A	B = Bundled Code. Payment for covered services are always bundled into payment for other services not specified N = Items and Services Packaged into APC Rate; None (payment calc). Payment included in APC payment rate
98961	\$15.40	N/A	
98962	\$11.70	N/A	
S9445	N/A	N/A	
S9446	N/A	N/A	

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CPT Service Codes (cont'd)

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Physicians

● MD

● DO

Equivalent practitioner

● NP

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Diabetes education staff or nonphysicians

○ RN

○ CDCES

○ Diabetes education staff

○ Registered dietician

Virtual Check-in⁹

CPT Code	Description	Details
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified healthcare professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days	<ul style="list-style-type: none"> Who can bill: ● MD ● DO ● NP ● PA ● CNS ○ RN ○ CDCES ○ Diabetes education staff ○ Registered dietician Cannot originate from a related E/M service from the previous 7 days Cannot lead E/M service or within the next 24 hours or soonest available appointment, 5 to 10 minutes of medical discussion

Although CPT codes for telemedicine services have been created, CMS has not adopted these codes and will continue to use existing modifiers to indicate telemedicine visits. The only telemedicine code that CMS will cover is **98016 for a virtual check-in**. If E/M is performed virtually, use the following modifiers in conjunction with the E/M codes to indicate a telemedicine visit:

- Modifier **95** for audio-video visits
- Modifier **93** for telephone-only visits
- Place of service codes 02 (nonhome location) or 10 (home)

CPT Code Medicare National Average Payment Rates¹⁰

CPT Code	2026 Nonfacility	2026 Facility
98016	\$17.37	\$13.03

CDCES = Certified Diabetes Care and Education Specialist; CGM = continuous glucose monitor; CMS = Centers for Medicare & Medicaid Services; CNS = Clinical Nurse Specialist; CPT = Current Procedural Terminology; DO = Doctor of Osteopathy; E/M = Evaluation and Management; MD = Medical Doctor; NP = Nurse Practitioner; PA = Physician Assistant; RN = Registered Nurse.



NDC

If any of the components of the MiniMed AID system is covered by the pharmacy benefit, please report the appropriately associated National Drug Code (NDC) and/or applicable CPT codes for products and services reimbursed through the pharmacy.

NDC codes for MiniMed AID and compatible CGMs

Product	NDC Codes
MiniMed™ 780G insulin pump system	99150-0047-04
Instinct sensor	57599-0880-00
Simplera Sync™ sensor	63000-0956-40
Guardian™ 4 sensor	63000-0519-68

Add supplies as part of your prescription order. Due to the many options of infusion sets and reservoirs made available, the NDCs for these items have been excluded from this list; however, don't forget to include them.



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AID = automated insulin delivery; CGM = continuous glucose monitor; CPT = Current Procedural Terminology.



MTM Coding

Medication Therapy Management (MTM) is a service aimed at improving health outcomes for patients. It includes a variety of activities within a pharmacist’s role and can be provided alongside medication. MTM involves assessing drug needs, identifying therapy issues, planning care, and following up. Billing for these services requires using specific CPT codes based on the level of care and face-to-face time involved.



Additional codes for diabetes-related services and education are included in the [CPT section](#).

CPT Code ⁹	Description	Details
99605	For new patients MTM service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes	<ul style="list-style-type: none"> Billed by pharmacist Payer priced Note that this is a non-Medicare code
99606	For established patients MTM service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes	<ul style="list-style-type: none"> Billed by pharmacist Payer priced Note that this is a non-Medicare code
99607	Each additional 15 minutes	<ul style="list-style-type: none"> Billed by pharmacist Payer priced Note that this is a non-Medicare code

MTM coverage varies by contract, payer plan, and state credentialing. Please be sure to check with your local contractors, payers, and state credentialing to ensure the ability to submit for MTM reimbursement.

Additional verification for the following may also apply:

- Program application deadlines
- Certification requirements
- That the diagnosis/condition of diabetes applies

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CPT = Current Procedural Terminology.



Diagnosis Codes

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) are diagnostic codes that must be used for all healthcare services provided in the United States. Below are commonly used codes for diabetes. E10 is used to specify Type 1 diabetes whereas E11 is used for Type 2 diabetes. Individual codes are meant to qualify the type of diabetes and a related complication.

ICD-10-CM Codes for Type 1 and Type 2 Diabetes¹¹

ICD-10-CM Code (Type 1 Diabetes)	ICD-10-CM Code (Type 2 Diabetes)	Description
E10.9	E11.9	Without complications
E10.65	E11.65	With hyperglycemia
E10.649	E11.649	With hypoglycemia w/o coma
E10.22	E11.22	With diabetic chronic kidney disease
E10.311	E11.311	With unspecified diabetic retinopathy with macular edema
E10.42	E11.42	With diabetic polyneuropathy
E10.51	E11.51	With diabetic peripheral angiopathy w/o gangrene
E10.621	E11.621	With foot ulcer
E10.69	E11.69	With other specified complication

Medication Status (Adjunctive Codes)

ICD-10-CM Code	Description
Z79.4	Long-term (current) use of insulin
Z79.84	Long-term (current) use of oral hypoglycemic drugs



Product Support

MiniMed offers comprehensive online resources to support you throughout the prescribing, coverage, and reimbursement process for their diabetes technologies. Use the links below to find access to product information, additional reimbursement guidance, and financial assistance programs for patients.

Healthcare Professional Resources



Find additional information on 780G AID system, including product details for the insulin pump, Instinct, Simplera Sync, Guardian 4 sensor, and CareLink, a diabetes management software for HCPs

[Learn More](#)



Additional **reimbursement resources** are available online for all MiniMed diabetes devices

[Healthcare Provider Reimbursement](#)



Download user guides and manuals for MiniMed's full portfolio of integrated diabetes devices

[User Guides & Manuals](#)

Patient Access Support

MiniMed offers **financial aid, pharmacy co-pay support, and AID payment programs** for eligible patients. Read the terms and conditions to see if your patient qualifies for support.

[Financial Support Programs](#)

Support & Services

MiniMed is your partner in diabetes care management. Whether in person or virtually, customer service representatives and clinical diabetes educators and trainers can provide technical support, training, and education to support your diabetes management goals with patients.

Contact us anytime: 1-800-646-4633

[Contact Us](#)



Indications for Use

[MiniMed™ 780G system with SmartGuard™ technology with Instinct sensor](#)

The MiniMed™ 780G system is intended for continuous delivery of basal insulin at selectable rates, and the administration of insulin boluses at selectable amounts for the management of type 1 diabetes mellitus in persons seven years of age and older requiring insulin as well as for the continuous monitoring and trending of glucose levels in the fluid under the skin. The MiniMed™ 780G System includes SmartGuard™ technology, which can be programmed to automatically adjust insulin delivery based on the continuous glucose monitoring (CGM) sensor glucose values and can suspend delivery of insulin when the sensor glucose (SG) value falls below or is predicted to fall below predefined threshold values.

[MiniMed™ 780G system with SmartGuard™ technology with Simplera Sync™ sensor or Guardian™ 4 Sensor](#)

The MiniMed™ 780G system is intended for the continuous delivery of basal insulin at selectable rates, and the administration of insulin boluses at selectable rates for the management of type 1 diabetes mellitus in persons 7 years of age and older, and of type 2 diabetes mellitus in persons 18 years of age and older requiring insulin. The system is also intended to continuously monitor glucose values in the fluid under the skin. The MiniMed™ 780G system includes SmartGuard™ technology, which can be programmed to automatically adjust insulin delivery based on continuous glucose monitoring (CGM) sensor glucose values and can suspend delivery of insulin when the SG value falls below or is predicted to fall below predefined threshold values.

Please see additional [Important Safety Information](#) for MiniMed™ 780G and its compatible sensors.



References

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11. Centers for Medicare & Medicaid Services. ICD-10. Updated February 4, 2026. Accessed February 6, 2026. <https://www.cms.gov/medicare/coding-billing/icd-10-codes>

Please see indications for use for MiniMed 780G on [page 20](#) and full [Important Safety Information](#) with compatible sensors.



HCPCS Codes (cont'd)



Sensor made by Abbott

MiniMed™ 780G AID System

	HCPCS ⁵	Medicare National Average Payment Rate ⁶
External ambulatory insulin pump, insulin	E0784	\$558.48
Infusion sets, supplies for maintenance of insulin infusion catheter, per week	A4224	\$26.01
Reservoirs, syringe-type cartridge, sterile, each	A4225	\$3.48
Infusion set for external insulin pump, non-needle cannula ⁷	A4230	N/A
Infusion set for external insulin pump, needle type, each ⁷	A4231	N/A
Reservoirs, syringe with needle, sterile, 3 cc ⁸	A4232	N/A

Modifiers



Submission of claims to Medicare may require the use of modifiers

Modifier	Description
NU	New durable medical equipment purchase
RR	Rental (Use the 'RR' modifier when DME is to be rented)
KF	Item designated by FDA as Class III devices

AID = automated insulin delivery; CGM = continuous glucose monitor; DME = durable medical equipment; HCPCS = Healthcare Common Procedure Coding System; KF = item designated by FDA as Class III devices; NU = new durable medical equipment purchase; RR = rental.