

Medtronic

Diabetes

Technology and Therapy Reimbursement Guide

Physician & Other Healthcare Provider Resources

Guardian™ Continuous Glucose Monitor(s)

InPen™ Smart Insulin Pen System

MiniMed™ Automated Insulin Delivery System(s)

Infusions Sets, & more...

2025

Professional Services

Facility Services

Pharmacy

Durable Medical Equipment

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Introduction

The Diabetes Technology and Therapy Guide has been developed as an introductory reference guide to coding, coverage and payment for professional services providers, pharmacies and durable medical equipment (DME) suppliers in the care of patients with diabetes. The Guide outlines codes commonly used for billing in each setting; national average payment rates for physicians and DME suppliers; and coverage criteria under the Medicare Part B DMEPOS benefit. For reference, there is also a listing of potential ICD-10-CM diabetes diagnosis codes, and useful “Reimbursement Frequently Asked Questions”.

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.

Documentation in the medical record must support the coding used and billing submitted to the payer(s). Payer coverage guidelines may vary from Medicare criteria therefore, each payer should be individually consulted for specific requirements.

Electronic Navigation Instructions

To help you navigate this guide as a full and complete Diabetes Technology and Therapy Reimbursement Guide, simply select the section you wish to review in the Table of Contents above to navigate directly to the chosen section.

Disclaimer

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules, and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists, and/or legal counsel for interpretation of coding, coverage, and payment policies. 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 (e.g., 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.

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Office Visits (E/M) & Education Services

Current Procedural Terminology (CPT®) Codes

Physicians and hospitals use Current Procedural Terminology (CPT®) codes to describe the service(s) provided during an encounter. The [Medicare Physician Fee Schedule \(MPFS\)](#) and the [Outpatient Prospective Payment System \(OPPS\)](#) National Payment Rate (NPR) information provided reflects the Medicare national allowable amount published by the Centers for Medicare and Medicaid Services (CMS) and does not include geographic adjustments nor Medicare payment reductions resulting from sequestration adjustments to the amount payable to the provider. Please also consider appropriate modifier use where applicable.

In some instances, Physicians (MD, DO) and/or Equivalent Practitioners such as Nurse Practitioner (NP), Physician Assistants (PA), or Clinical Nurse Specialists (CNS) can file a claim in accordance with legal and state credentialing. Physician collaboration and supervision rules as well as all billing rules apply to all the above non-physician practitioners. Likewise, Staff or Other Non-Physicians may also perform services directly in accordance with legal and state credentialing. Staff or Other Non-Physicians may include Registered Nurses (RN), American Diabetes Association (ADA) recognized Certified Diabetes Care and Education Specialists (CDCDS), ADA recognized Registered Dietitians (RD), and Certified or Licensed Nutritionists. For further clarification and guidance, please consult your individual payer policy guidelines for details.

Medicare National Payment Rates Office Visits (E/M)

CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Office Visits				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS)				
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. (levels 2-5)	\$ 69.87	\$45.29	N/A
99203		\$109.01	\$79.25	N/A
99204		\$163.35	\$129.06	N/A
99205		\$215.75	\$175.64	N/A
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. (levels 2-5)	\$54.99	\$33.96	N/A
99213		\$88.95	\$63.72	N/A
99214		\$125.18	\$93.80	N/A
99215		\$175.64	\$138.77	N/A

* = Non-Medicare Code; Δ = Revised (2025); + = Add-on Code; ☆ = Telemedicine; ● = New Code

Telemedicine Services

As of January 1, 2025, new telemedicine services CPT codes are available for selection. Although CMS will not adopt the new CPT telemedicine codes (98000-98015), CMS will consider coverage for a Virtual Check-in Visit (see 98016). Please continue to utilize E/M codes (e.g., 99202-99215) reported using in-person with the following Modifiers to indicate telemedicine visits:

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

Note: For audio-only services, CMS expects audio-visual technology unless the patient lacks video capability or declines video use. In such cases, append Modifier 93 for telephone-only visits, and document the exception.

General documentation should include whether a telephone, secure two-way audio/video connection, or a telehealth platform was used and indicate patient consent to receive services via telehealth. Selection of the appropriate code is based on medical decision making (MDM) or total time on the date of the encounter. Since requirements for telehealth visits will vary by payer, please review your individual payer preferences to ensure documentation meets the payer's requirements.

CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Virtual Check-In Visits				
When performed by Physician (MD, DO), Equivalent Practitioner (NP, PA, CNS), Diabetes Education Staff or Other Non-Physicians (RN, CDCDS, RD)				
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care 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 nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion. Note: Patient-initiated and not provider-initiated.	\$15.85	\$14.56	N/A

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Diabetes Education Services

Diabetes education may consist of patient management to begin insulin pump therapy (also called continuous subcutaneous insulin infusion or CSII) as it relates to insulin, such as carb ratios, basal rates, sick day management, or insulin sensitivity for correction factor. Medical nutrition therapy specifically focuses on dietary intervention to ensure eating habits are appropriate for persons with diabetes.

For Medicare, [Diabetes Self-Management Training \(DSMT\)](#) and [Medical Nutrition Therapy \(MNT\)](#) are separate benefits. If the physician determines that receipt of both MNT and DSMT is medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. Please note, the incident-to requirements of section [1861\(s\)\(2\)\(A\) of the Social Security Act](#) do not apply to DSMT services. All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements. Please consult individual payer policy guidelines for additional details.

CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Education and Training, Diabetes Self-Management Training (DSMT)				
When performed by Diabetes Education Staff or Other Non-Physicians (RN, CDCDS, RD)				
G0108	Diabetes outpatient self-management training services, individual , per 30 minutes.	\$53.05	\$53.05	N/A
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.	\$15.20	\$15.20	N/A

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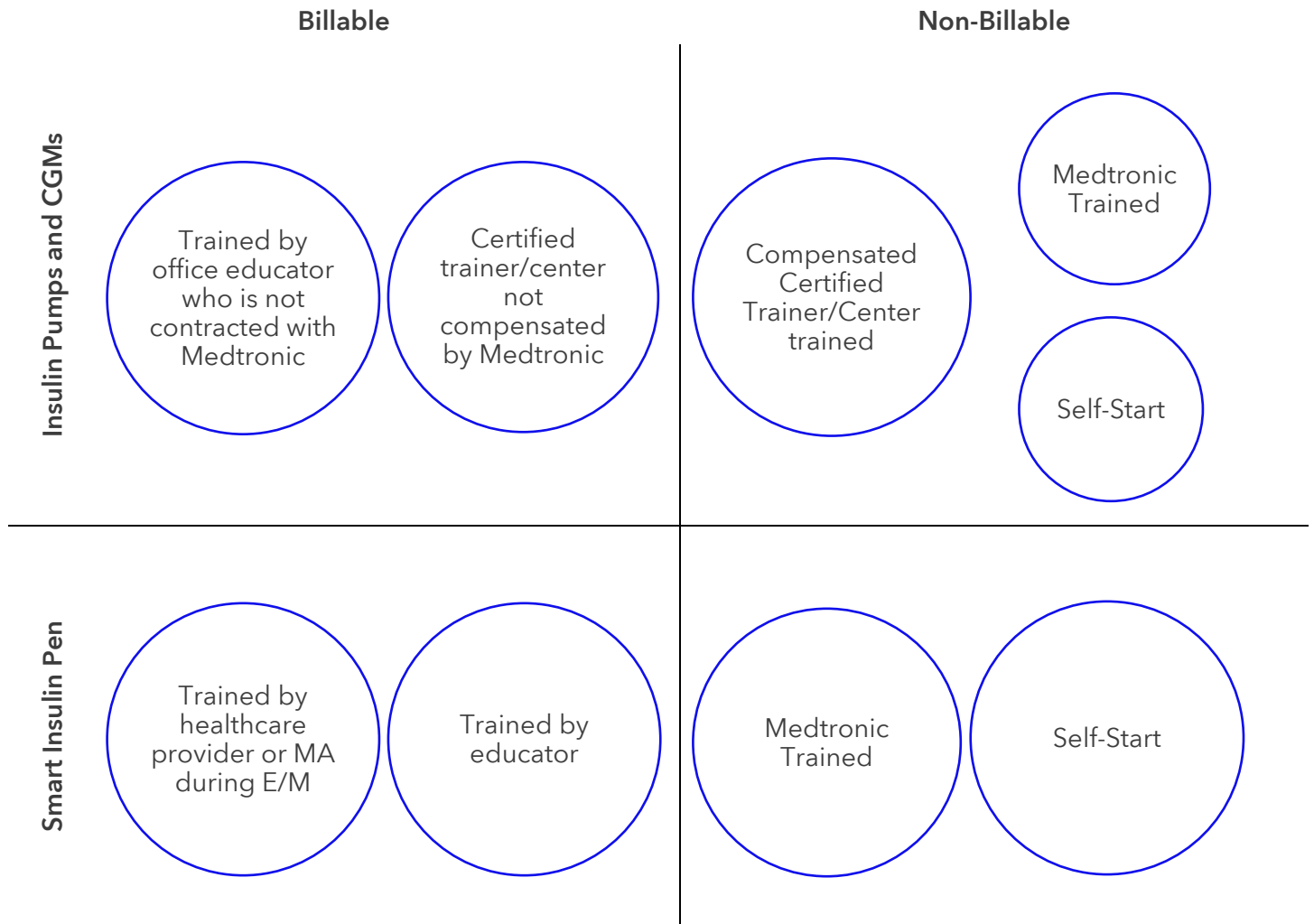
CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Education and Training, Diabetes Self-Management Training (DSMT)				
When performed by Physician (MD, DO), Equivalent Practitioner (NP, PA, CNS), or Diabetes Education Staff or Other Non-Physicians (RN, CDCDS, RD). Varies by payer.				
98960 Δ☆	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/ family) each 30 minutes; individual patient.	\$30.41	\$30.41	N/A
98961 Δ☆	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/ family) each 30 minutes; 2-4 patients .	\$41.56	\$14.56	N/A
98962 Δ☆	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/ family) each 30 minutes; 5-8 patients .	\$10.67	\$10.67	N/A
S9445*	Patient education, not otherwise classified, non-physician provider, individual , per session.	Payer Priced	Payer Priced	Payer Priced
S9446*	Patient education, not otherwise classified, non-physician provider, group , per session.	Payer Priced	Payer Priced	Payer Priced
Education and Training, Medical Nutrition Therapy (MNT)				
When performed by Registered Dietitian (RD) or Nutritional Professional (as defined by each state)				
97802 ☆	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	\$35.58	\$31.38	N/A
97803 ☆	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	\$31.05	\$26.52	N/A

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CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Education and Training, Medical Nutrition Therapy (MNT)				
When performed by Registered Dietitian (RD) or Nutritional Professional (as defined by each state)				
97804 ☆	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes.	\$16.50	\$14.88	N/A
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual , face to face with the patient, each 15 minutes.	\$31.05	\$26.52	N/A
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes.	\$16.50	\$14.88	N/A

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Training Scenarios



Guardian™ Sensor System Continuous Glucose Monitoring (CGM) Services

Codes related to continuous glucose monitoring (CGM) differentiate between the technical service of sensor placement and patient training, performed by office staff, and the professional service of interpreting the CGM data, performed by clinicians. For the technical service, different codes are assigned depending on whether the patient or the physician practice owns the CGM equipment. Please consult individual payer policy guidelines for additional details.

CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Continuous Glucose Monitor Placement				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS); If performed by Office Staff or Other Non-Physicians (RN, CDCDS), billable under direct supervision.				
95249	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. Note: Do not report 95249 more than once for the duration that the patient owns the data receiver. Do not report 95249 in conjunction with 99091, 0446T.	\$64.05	\$64.05	\$11.88
95250	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. Note: Do not report 95250 more than once per month. Do not report 95250 in conjunction with 99091, 0446T.	\$139.41	\$139.41	\$128.87

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Remote Patient Monitoring (RPM/RTM/Data Analysis)

Remote Patient Monitoring (RPM) includes both remote physiological monitoring and remote therapeutic monitoring (RTM). Remote physiologic monitoring refers to the use of non-face-to-face technology to monitor and analyze a patient's physiological metrics. Examples include oxygen saturation, blood pressure, blood sugar, weight loss/gain and more. Remote physiologic monitoring must be collected for at least 16 days out of 30 days. Remote therapeutic monitoring (RTM) captures non-physiologic data related to a therapeutic treatment such as treatment adherence (e.g., medication compliance) and treatment response (e.g., pain management).

These services may be provided by health care personnel under the general supervision of the billing practitioner. Only one practitioner can bill for RPM per patient in a 30-day period. In addition, RTM data can be self-reported by the patient using the device. Information is transmitted using a medical device that is considered capable of transmitting data wirelessly (e.g., connected or smart devices) to other devices or networks. Some technologies will also include advanced analytical capabilities that interpret data via algorithms. Please consult individual payer policy guidelines for additional details.

CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Remote Insulin Dose Calculation and Monitoring System				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS)				
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education. Note: Do not report 0740T in conjunction with 95249, 95250, 95251, 98975, 99453.	Payer Priced	Payer Priced	\$59.40
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage , each 30 days. Note: Do not report 0741T in conjunction with 95249, 95250, 95251, 99091, 99454. Do not report 0741T for data collection less than 16 days.	Payer Priced	Payer Priced	\$37.29

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CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Remote Physiologic Monitoring (RPM)				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS)				
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. Note: Do not report 99453 more than once per episode of care. Do not report 99453 for monitoring of less than 16 days.	\$19.73	\$19.73	\$128.87
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.	\$43.02	\$43.02	\$37.29
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS); If performed by Office Staff or Other Non-Physicians (RN, CDCDS), billable under direct supervision.				
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month; first 20 minutes. Note: Do not report 99457 in conjunction with 93264, 99091. Do not report 99457 in the same month as 99473, 99474.	\$47.87	\$28.79	N/A
+99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure).	\$38.49	\$28.79	N/A

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CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Remote Therapeutic Monitoring (RTM)				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS)				
98975	Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment.	\$19.73	N/A	\$128.87
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes. Note: Excludes E/M Services; Includes Reporting once each 30 days; See +98981 for each additional 20 minutes of RTM treatment management in a calendar month.	\$50.14	\$29.44	N/A
+98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure). Note: Do not report 98981 for services of less than an additional increment of 20 minutes.	\$39.14	\$28.79	N/A

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CPT Code	Description	2025 Non-Facility NPR	2025 Facility NPR	2025 Hospital NPR
Data Analysis				
When performed by Physician (MD, DO) or Equivalent Practitioner (NP, PA, CNS)				
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report. Note: Professional Component. Do not report 95251 more than once per month. Do not report 95251 in conjunction with 99091.	\$33.32	\$33.32	N/A
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days. Note: Staff Exclusion, Physician or Other Qualified Healthcare Practitioner.	\$51.75	\$51.75	N/A

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Modifiers

Modifier	Description
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
59	Distinct Procedural Service
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
95	Synchronous telemedicine service via real-time audio and video telecommunications
FQ	Service furnished using audio-only communication technology
GC	This service has been performed in part by a resident under the direction of a teaching physician
GT	Via interactive audio and video telecommunication systems
GQ	Alaska and Hawaii only - asynchronous telecommunication system
KX	Used to indicate the services rendered are medically necessary
SA	Nurse practitioner rendering service in collaboration with a physician

Note: Additional modifiers may apply per individual coverage policy.

Payer Coverage Considerations

CMS' [National Coverage Determination \(NCD\) 280.14](#), section (B)(1)(e)2, defines the criteria under which Medicare covers Continuous Subcutaneous Insulin Infusion (CSII) Pumps (i.e., Automated Insulin Delivery systems). CMS' [NCD 40.1 Diabetes Outpatient Self-Management Training](#) refers to 42 CFR 410.140 - 410.146 for conditions that must be met for Medicare coverage. CMS' [NCD 180.1 Medical Nutrition Therapy](#) section [1861\(s\)\(2\)\(V\)](#) of the Social Security Act authorizes Medicare part B coverage of medical nutrition therapy services (MNT).

Commercial payer coverage policies may vary. Please contact the patient's health insurance company directly regarding their current policies for the intended service(s) as well as any prior authorization, pre-certification requirements or annual payment limits on codes.

InPen™ Smart Insulin Pen, Pharmacy

National Drug Codes (NDCs)

Please report the appropriately associated National Drug Code (NDC), National Reimbursement Code (NRC), and/or applicable Current Procedural Terminology (CPT) codes for products and services reimbursed through the pharmacy. This Guide should not be viewed as inclusive of all coding, coverage, or payment details. 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. Documentation in the medical record must support the coding used and billing submitted to the payer(s). Coverage guidelines may differ by payer and are therefore encouraged to consult each payer for specific requirements.

InPen™ Smart Insulin Pen System

If prescribing the InPen™ Smart Insulin Pen through an Electronic Medical Record (EMR), please note that the product is available in three (3) different colors and two (2) different models that are specific to the type of insulin being prescribed.



Product Name	InPen™, Grey NRC	InPen™, Pink NRC	InPen™, Blue NRC
InPen™ Humalog®	63000-0827-16	63000-0827-17	63000-0827-15
InPen™ NovoLog®/Fiasp®	63000-0827-19	63000-0827-20	63000-0827-18

Compatible Insulin Cartridges

Patients will require a separate prescription for the needles as well as the insulin cartridges/PenFill cartridges associated with their use of the InPen™ System. Refills are typically expected every 30 days. See NDC-formatted reimbursement numbers for compatible insulin cartridge below.

Product Name	Specification	NDC
Humalog®	U-100 Cartridge, 3mL	00002-7516-59
NovoLog®	U-100 Cartridge, 3mL	00169-3303-12
Fiasp®	U-100 Cartridge, 3mL	00169-3205-15

Humalog® is a registered trademark of Eli Lilly and Company. Fiasp® and Novolog® are registered trademarks of Novo Nordisk A/S.

Payer Coverage Considerations

Medicare-covered insulin can be accessed in 2 ways:

1. Part D (Drug Coverage): Insulin covered by the Medicare Drug plan
Patients will pay \$35 per month (or less) for each covered insulin drug, and no deductible for covered insulin. For a 3-months' supply, patients will generally pay no more than \$105.
2. Part B (Medical Insurance) or Part C (Medicare Advantage): When insulin is delivered through a pump that's covered under the durable medical equipment (DME) benefit.
 - a. Note: Medicare supplement Insurance (Medigap) that pays Part B coinsurance, the plan should cover the \$35/month (or less) cost for each covered insulin.

Commercial payer coverage policies may vary. Please contact the patient's health insurance company directly regarding their current policies for the intended product(s) and/or service(s) as well as any prior authorization, pre-certification requirements or annual payment limits on codes.

Pharmacy Billing

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.

CPT Code	Description	Payment Rate
Medication Therapy Management (MTM) Services		
When performed by Pharmacist		
99605*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	Payer Priced
99606*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	Payer Priced
+99607*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	Payer Priced

* = Non-Medicare Codes; Δ = Revised (2025); + = Add-on Code; ☆ = Telemedicine; ● = New Code

Additional MTM Service Considerations

1. Pharmacists bill the appropriate CPT code along with the service modifier to receive the appropriate case rate reimbursement.
2. Targeted Disease States (e.g., Juvenile Diabetes): Modifier U1 - Medicaid level of care 1, as defined by each state
 - a. Medium-High Risk: Modifier U2 - Medicaid level of care 2, as defined by each state
 - b. Critical, High Risk: Modifier U3 - Medicaid level of care 3, as defined by each state
 - c. Exceptions: Modifier U4 - Medicaid level of care 4, as defined by each state
 - d. These codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.

For E-scribe information, click [here](#)

This Pharmacy guide has been developed as an introductory reference guide to coding, coverage, and payment for professional service providers, not inclusive of pharmacy and/or durable medical equipment (DME) supplies that may be required for the care of patients with diabetes. This document 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. Documentation in the medical record must support the coding used and billing submitted to the payer(s). Payer coverage guidelines may vary from Medicare criteria therefore, each payer should be individually consulted for specific requirements.

Medicare Durable Medical Equipment - Glucose Monitors

Guardian™ 4 Sensor System Coding and Medicare Coverage

The Medicare program pays for continuous glucose monitors (CGM), blood glucose monitors (BGM), as well as insulin pumps, also referred to as automatic insulin delivery (AID) systems and related supplies. Suppliers bill by Healthcare Common Procedure Coding System (HCPCS) codes to signify the equipment and supplies provided.

HCPCS Codes

HCPCS Code	Description
E0607	Home blood glucose monitor
E2102	Adjunctive, non-implanted continuous glucose monitor or receiver
E2103 [†]	Non-adjunctive, non-implanted continuous glucose monitor or receiver
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
A4245	Alcohol wipes, per box
A4247	Betadine or iodine swabs / wipes, per box
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	Normal, low and high calibrator solution / chips
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box of 100

[†]E2103 includes E0607, A4245, A4247, A4253 and A4259 (home Blood Glucose Monitor and related supplies).

Medicare Part B Clinical Coverage Criteria

Local Coverage Determination (LCD) - Glucose Monitors

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. In addition to the “reasonable and necessary” criteria outlined here, please consult your DME MAC website for applicable supplier manual information and any related coverage and payment articles. Patient medical record must fully document that patient meets all coverage requirements per Medicare policy.

Blood Glucose Monitors (BGM)

Coverage of home blood glucose monitors (non-disposable) and supplies (lancets (A4259), blood glucose reagent strips (A4253), glucose control solutions (A4256) and spring powered devices for lancets (A4258)) requires that the patient meets both criteria:

1. Has an ICD-10-CM code diagnosis of diabetes; and,
2. The treating practitioner has concluded that the patient / caregiver has sufficient training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.

If both criteria are not met the device and related supplies will not be covered.

Test Strips (A4253) and Lancets (A4259)

Treated with Insulin (?)	A4253 per 3 months	A4259 per 3 months	Additional Criteria
No	100	100	None
Yes	300	300	None
No / Yes	>100/>300	>100/>300	Must document in medical record: A. Criteria 1 & 2 above; <i>and</i> , B. In-person or telehealth visit with treating practitioner within 6 months of order to evaluate glucose control and need for excess strips; <i>and</i> , C. Treating practitioner must verify adherence to the high utilization testing regimen prior to dispensing

For patients with visual impairment and/or manual dexterity impairment, glucose monitors with special features (E2100, E2101) may be covered. Consult the Medicare LCD for Glucose Monitors for more information.

Continuous Glucose Monitors (CGMs)

Definitions:

- **Adjunctive CGM (E2102):** Requires verification of glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions; devices that solely display results on a smartphone and do not have a stand-alone receiver or integration into an insulin infusion pump do not meet the definition of DME and will be denied as non-covered
- **Non-adjunctive CGM (E2103):** Can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results; devices that solely display results on a smartphone and do not have a stand-alone receiver or integration into an insulin infusion pump do not meet the definition of DME and will be denied as non-covered

Coverage of a CGM and related supplies requires that the patient meet the following criteria:

1. Has an ICD-10-CM code diagnosis of diabetes; and,
2. The treating practitioner has concluded that the patient / 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. To improve glycemic control, the patient meets at least one of the criteria below:
 - A. Patient is insulin-treated; or,
 - B. Patient has a history of problematic hypoglycemia with documentation of at least one of the following:
 - 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 telehealth visit with the patient to evaluate their diabetes control and to determine that criteria (1)-(4) above are met.

If any of the coverage criteria are not met, the CGM and related supplies will not be covered.

Continuing coverage of CGM:

Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person or telehealth visit with the patient to document adherence to their CGM regimen and diabetes treatment plan.

- Supplies (A4238) for an adjunctive CGM integrated into an external insulin infusion pump are covered when the patient meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump located in the External Infusion Pump LCD.
- Non-adjunctive CGM replace standard home BGMs and related supplies (HCPCS A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259). Claims for a BGM and related supplies, billed in addition to a non-adjunctive CGM device (E2103) and associated supplies (A4239), will be denied.
- Adjunctive CGMs do not replace home BGM. A4238 does not include a BGM and related supplies and may be billed separately.

Devices using E2102 or E2103 are required to be verified by the Medicare DME Pricing, Data Analysis and Coding (PDAC) unit prior to billing under these codes. See [DME PDAC](#) for more information.

Standard Written Order (SWO):

A SWO must be communicated to the supplier prior to a claim being submitted. A written order prior to delivery (WOPD) is required for the BGM and / or the CGM which requires that a signed SWO must be received by the supplier prior to delivery. The WOPD for the BGM / CGM must be received prior to the billing of any related supplies.

Refill Requirements:

- Refills are based on the prospective, and not retrospective need of the patient.
- Patient must be contacted no sooner than 30 days prior to the expected exhaustion of supplies to verify the need for additional supplies. Delivery of refills cannot occur sooner than 10 days prior to exhaustion of supplies.
- No more than a 3-month quantity of BGM testing supplies can be dispensed at a time
- *Refill requirements do not apply to codes A4238 or A4239.* The supply allowance (code A4238 or A4239) is a monthly allowance that may be billed up to a maximum of three (3) units of service (UOS) per 90 days of time. No more than a ninety (90) day supply may be dispensed at a time.

Modifiers Used for Billing Medicare:

Submission of claims to Medicare may require the use of modifiers. See page 26 of this guide and consult the DMEPOS supplier manual and Glucose Monitor LCD Articles for more information.

Medicare Durable Medical Equipment - Insulin Pump

MiniMed™ 780G Coding and Medicare Coverage

The Medicare program pays for continuous glucose monitors (CGM) as well as blood glucose monitors (BGM), insulin pumps, also referred to as automatic insulin delivery (AID) systems and related supplies. Suppliers bill by Healthcare Common Procedure Coding System (HCPCS) codes to signify the equipment and supplies provided.

HCPCS Codes

HCPCS Code	Description
A4224	Supplies for maintenance of insulin infusion catheter, per week
A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile, each
E0784	External ambulatory infusion pump, insulin
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
J1811	Insulin (fiasp) for administration through DME (i.e., insulin pump) per 50 units
J1813	Insulin (lyumjev) for administration through DME (i.e., insulin pump) per 50 units
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units

Medicare Part B Clinical Coverage Criteria

Local Coverage Determination (LCD) - External Infusion Pumps

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. In addition to the "reasonable and necessary" criteria outlined here, please consult your DME MAC website for applicable supplier manual information and any related coverage and payment articles.

Patient medical record must fully document that patient meets all coverage requirements per Medicare policy.

Insulin Pumps

Administration of continuous subcutaneous insulin for the treatment of diabetes as evidenced by a qualifying ICD-10-CM diagnosis code is covered if criterion A or B is met and if criterion C or D is met:

- A. C-peptide testing requirement – must meet criterion 1 or 2 and criterion 3:
 1. C-peptide level is \leq 110 percent of the lower limit of normal of the laboratory's measurement method.
 2. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) \leq 50 ml/minute, a fasting C-peptide level is \leq 200 percent of the lower limit of normal of the laboratory's measurement method.
 3. A fasting blood sugar obtained at the same time as the C-peptide level is \leq 225 mg/dl.
- B. Beta cell autoantibody test is positive.
- C. Patient has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria (1 - 5) while on the multiple injection regimen:
 1. Glycosylated hemoglobin level (HbA1C) $>$ 7 percent
 2. History of recurring hypoglycemia
 3. Wide fluctuations in blood glucose before mealtime
 4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
 5. History of severe glycemic excursions
- D. The patient has been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

If criterion A or B is not met, and/or criterion C or D is not met, the pump and related supplies, and insulin will be denied as not reasonable and necessary.

Continued Coverage:

- Continued coverage of an external insulin pump (E0784) and supplies requires that the beneficiary be seen and evaluated by the treating practitioner at least every 3 months.
- In addition, the external insulin infusion pump must be ordered and follow-up care rendered by a practitioner who manages multiple beneficiaries on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

Insulin Pumps and CGM Receivers

Non-Adjunctive Receiver	Adjunctive Receiver
<p>The combination of E0784 plus E2103 is used to describe external ambulatory insulin infusion pumps that incorporate dose rate adjustment using non-adjunctive continuous glucose sensing.</p> <p>Coverage for this HCPCS code combination is only met if the patient meets all of the coverage criteria for insulin pumps and all criteria for CGMs as outlined in the respective Medicare LCDs.</p>	<p>The combination of E0784 plus E2102 is used to describe external ambulatory insulin infusion pumps with integrated adjunctive continuous glucose monitor receiver functionality.</p> <p>Coverage for this HCPCS code combination is only met if the patient meets all of the coverage criteria for insulin pumps and all criteria for CGMs as outlined in the respective Medicare LCDs.</p>

Supplies and Drugs:

- Supplies used with an insulin pump (A4225) are covered when the insulin pump is covered. A4224 and A4225 are covered when used with an insulin pump (A0784)
- Drugs may only be billed by the licensed entity who meets all regulatory requirements and is dispensing the drugs to the patient

Standard Written Order (SWO):

A SWO must be communicated to the supplier prior to a claim being submitted. A written order prior to delivery (WOPD) is required for the insulin pump which requires that a signed SWO must be received by the supplier prior to delivery. The WOPD for the insulin pump must be received prior to the billing of any related supplies.

Refill Requirements:

- Refills are based on the prospective, and not retrospective need of the patient.
- Patient must be contacted no sooner than 30 days prior to the expected exhaustion of supplies to verify the need for additional supplies. Delivery of refills cannot occur sooner than 10 days prior to exhaustion of supplies.
- No more than a 3-month quantity of supplies can be dispensed at a time

Modifiers Used for Billing Medicare - Insulin:

- For a 1 month or less supply of insulin, JK modifier must be added to codes J1811, J1813 or J1817
- For a 3-month supply of insulin, JL modifier must be added to codes J1811, J1813 or J1817

Submission of claims to Medicare may require additional use of modifiers. Consult the DMEPOS supplier manual and External Infusion Pump LCD Articles for more information.

2025 Medicare DMEPOS Fee Schedule by HCPCS Code

Diabetes devices and related supplies

This chart contains the 2025 Medicare national average payment amounts by HCPCS code. For payment amounts specific to a geography, please visit the CMS website at [DMEPOS Fee Schedule Files](#). Commercial insurance payment amounts will vary by carrier and any direct contracts.

The information below identifies MiniMed 780G Insulin Pump and Guardian 4 Sensor System (CGM) to help illustrate coding application by product. The information is also applicable to earlier iterations of Medtronic Diabetes products by category (e.g., Insulin Pump and Continuous Glucose Monitors).

Medicare National Payment Rate

HCPCS Code	Description	Modifier	2025 NPR
A4224	Supplies for maintenance of insulin infusion catheter, per week.		\$25.34
A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile, each.		\$3.39
A4238	Supply allowance for adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service.	KF	\$275.21
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service.	KF	\$267.92 \$311.74
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips.	NU	\$8.32
A4256	Normal, low and high calibrator solution / chips.		\$3.38
A4258	Spring-powered device for lancet, each.		\$2.12
A4259	Lancets, per box of 100.		\$1.42
E0607	Home blood glucose monitor.	NU RR	\$93.87 \$9.38
E0784	External ambulatory infusion pump, insulin.	RR	\$543.94
E2102†	Adjunctive, non-implanted continuous glucose monitor or receiver.	NU, KF RR, KF	\$223.27 \$22.33

†CGMs (E2102 and E2103) and related supplies (A4238 and A4239) which are classified by the Food & Drug Administration as Class III devices must include the KF modifier.

HCPCS Code	Description	Modifier	2025 NPR
E2103 [†]	Non-adjunctive, non-implanted continuous glucose monitor or receiver.	NU	\$285.67
		RR	\$28.57
		NU, KF	\$317.14
		RR, KF	\$31.71
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each.		\$1.53
J1811*	Insulin (fiasp) for administration through DME (i.e., insulin pump) per 50 units.		\$7.900
J1813*	Insulin (lyumjev) for administration through DME (i.e., insulin pump) per 50 units.		\$15.476
S1034 [^]	Artificial pancreas device system (e.g. low glucose suspend feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices		N/A
S1035 [^]	Sensor; invasive (e.g. subcutaneous), disposable, for use with artificial pancreas device system		N/A
S1036 [^]	Transmitter; external, for use with artificial pancreas device system		N/A
S1037 [^]	Receiver (monitor); external, for use with artificial pancreas device system		N/A

* Patient co-pay for insulin not to exceed \$35 per month

†CGMs (E2102 and E2103) and related supplies (A4238 and A4239) which are classified by the Food & Drug Administration as Class III devices must include the KF modifier.

[^]"S" codes non-covered by Medicare; may be utilized by non-Medicare payers, consult specific payers for more information.

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
KX	Requirements specified in the Medical Policy have been met
JK	One month supply or less of drug or biological
JL	Three-month supply of drug or biological

Note: Additional modifiers may apply per individual coverage policy.

International Classification of Diseases 10th Edition Clinical Modifications (ICD-10-CM)

Possible diagnosis codes for a CGM and an insulin pump / AID system are listed here as examples only. For a complete list of diagnosis codes for CGM or insulin pump / AID system in Medicare Part B policy, please visit the links below or consult a certified coder.

Diabetes Related Diagnosis Codes: ICD-10-CM*

Conditions	Type 1 Diabetes: Category E10		Type 2 Diabetes: Category E11	
Diabetes Mellitus w/o complications	E10.9	Type 1 diabetes w/o complications	E11.9	Type 2 diabetes w/o complications
Diabetes mellitus with complications	E10.65	Type 1 diabetes with hyperglycemia	E11.65	Type 2 diabetes with hyperglycemia
	E10.649	Type 1 diabetes with hypoglycemia w/o coma	E11.649	Type 2 diabetes with hypoglycemia w/o coma
	E10.22	Type 1 diabetes with diabetic chronic kidney disease	E11.22	Type 2 diabetes with diabetic chronic kidney disease
	E10.331	Type 1 diabetes with moderate proliferative diabetic retinopathy with macular edema	E11.331	Type 2 diabetes with moderate proliferative diabetic retinopathy with macular edema
	E10.42	Type 1 diabetes with diabetic polyneuropathy	E11.42	Type 1 diabetes with diabetic polyneuropathy
	E10.51	Type 1 diabetes with diabetic peripheral angiopathy w/o gangrene	E11.51	Type 2 diabetes with diabetic peripheral angiopathy w/o gangrene
	E10.621	Type 1 diabetes with foot ulcer	E11.621	Type 2 diabetes with foot ulcer
	E10.69	Type 1 diabetes with other specified condition	E11.69	Type 2 diabetes with other specified complication
Medication Status (Adjunctive codes)^	Z79.4	Long term (current) use of insulin	Z79.84	Long term (current) use of oral hypoglycemic drugs

* This table is for illustrative purposes only and is not intended to be an exhaustive or all-inclusive list of ICD-10-CM diabetes diagnosis codes.

^ Code Z79.4 can be assigned to a patient with type 2 diabetes who routinely uses insulin for control. If a patient is treated with both oral hypoglycemic agents and insulin, only Z79.4 is assigned.

For more information and a list of ICD-10-CM diagnosis codes included in Medicare DMEPOS policy, please review the following documents, [Medicare External Infusion Pumps: Policy Article](#) and [Medicare Glucose Monitors: Policy Article](#).

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