eversense® 365
Continuous Glucose Monitoring System

Reimbursement Resource

Eversense 365 CGM System

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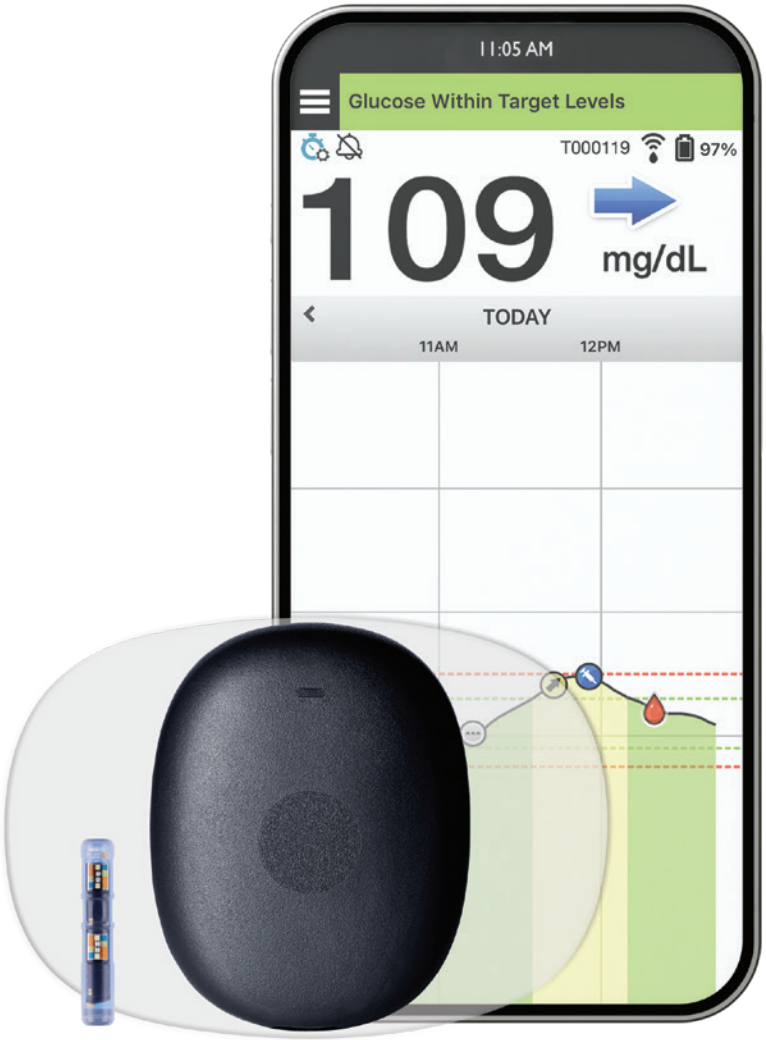
This document provides a reference on billing for the Eversense® 365 CGM System and related procedures.



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Eversense 365 CGM System Coverage and Availability

The Eversense 365 CGM System is covered by a broad range of payers. Each has its own policy on how to reimburse for both the Eversense 365 CGM system as well as the corresponding procedures. This is a summary to help navigate the types of available coverage.

Private Payer Coverage and Availability

Most private payers cover CGM for specific patient populations based upon diagnosis code. Most major commercial health plans have written policies that offer explicit guidelines for coverage.

It is important to understand that coverage may vary by payer and is dependent on the member benefit.

Medicare Coverage and Availability

There are Local Coverage Determinations (LCDs) in place that allow Medicare beneficiaries who meet medical criteria, to be able to access the Eversense 365 CGM System. Billing for Medicare beneficiaries follows the Bundled Payment pathway which is further discussed in the guide.

Claims Processing

Payers process provider claims for the Eversense 365 CGM in two main ways: Procedure Only or Bundled Payment, where the product is also billed by the provider. The billing process is determined by the policy of the payer and will inform the available rates at the time of the procedure.

1 Procedure Only

or

2 Bundled Payment

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Options for Billing Eversense 365 CGM System

Procedure Only

- Most Commercial Health Plans
- HCP is only responsible for billing for the procedure, not the product
- A DME or Pharmacy bills for the product and sends it to the office on behalf of the patient

Uninsured/Self-Pay: If a patient does not have insurance to cover the Eversense 365 CGM System, they may choose to purchase the product out of pocket. In those cases, the product shipment would come from a durable medical equipment (DME) supplier.

The provider may bill the patient directly for the cost of the procedure.

or

Bundled Payment

- Medicare Part B (aka Red White & Blue) – with or without a supplement
- All Medicare Advantage Plans
- SOME Commercial Health Plans

The **Bundled Payment Model** is a single billing code that is inclusive of both the product and procedure. This simplifies reimbursement by allowing the provider to submit one claim to the payer. In this model, the provider purchases the Eversense 365 CGM System directly from a distributor or via consignment, pursuant to agreed-upon terms. Once the sensor procedure is completed, the provider files a claim with the payer and receives a bundled reimbursement for both the Eversense 365 product and the procedure.

CPT Billing Codes Available to Bill for Eversense 365

Please Note: The billing code is the same for both procedure only and bundled payments.

Billing Codes	Code Descriptions
CPT® Code 0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training.
CPT® Code 0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision.
CPT® Code 0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation.

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Steps to Confirm Provider Reimbursement

Prior to accepting a patient for the insertion procedure, we recommend your office verifies the reimbursement you will receive from a specific payer, which is based on your specific provider contract with that payer.

For Commercial and Medicare Advantage Plans

Obtain the rates specific to each payer for the appropriate CPT, using your login information:

- Payer specific portal
- Availity or other similar system you may use

If you have questions or concerns, contact the payer's Network Provider Representative.

For Medicare Part B Fee Schedule

Go to **https://www.cms.gov/medicare/physician-fee-schedule/search** to determine the reimbursement for your specific MAC locality.

Steps for Understanding Your Reimbursement Under Bundled Payments

CONFIRM YOUR **REIMBURSEMENT RATE for the Appropriate CPT for Your Patient's Insurance Plan**

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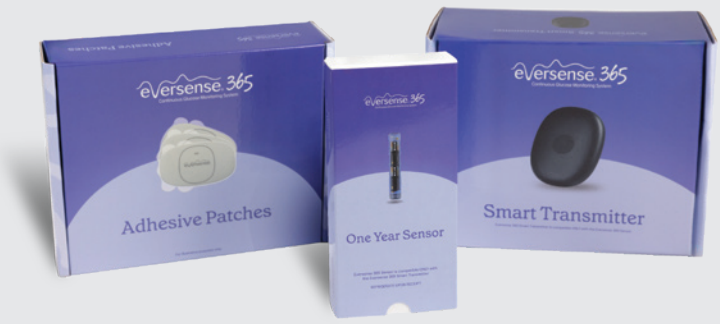
CONFIRM YOUR **PRODUCT COST**

↓

CALCULATE YOUR **NET PAYMENT** (REIMBURSEMENT – COST)



Prior to the procedure, the Sensor, Transmitter and Adhesive Patches will be sent to your office for your patient.

The procedure kit and tool kit will also be delivered for provider use during the insertion.

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Prior Authorization for the Procedure

Medicare

- Prior authorization is not required.

Private Payers

- Private Payers, including Commercial and Medicare Advantage, MAY have prior authorization requirements for CGMs.
- Since coverage varies by health plan, it is recommended best practice to contact the payer to learn about their prior authorization process for the Eversense 365 CGM.
- If a health plan indicates "No Prior Authorization Required," ensure that the CPT is a valid billable code according to the plan.

REMINDER: If you do not submit for a PA before the procedure, the claim may be denied and no payment received.

Claims Denials and Appeals

A claim denial 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. Specific areas to verify are:

- Confirming the ICD-10-CM diagnosis codes are specific and valid for services provided.
- Verifying the specific CPT codes for the services covered within each health plan.
- Ensuring that the submission frequency is within the specific insurance policy limits.

If there are questions specific to the reconciliation of claims, it is recommended the office consult the Provider Handbook or contact a Provider Relations representative.

How to Appeal a Denial

Payers have documented appeals processes for reconsidering denials.

Notes:

DISCLAIMER

This is for informational purposes only and does not constitute legal advice or official guidance from payers. This resource is not intended to provide clinical practice guidelines or to increase or maximize reimbursement by any payer. The information provided is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, policies, and payment amounts. While we have made every effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. Health care providers are ultimately responsible for verifying insurance coverage and billing policies and should contact the payer regarding the most recent billing, coding, and coverage policy information, as well as discuss any reimbursement inquiries.

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