Glucose Monitors Policy Pearls

Hello and welcome to Medicare Minute MD, a video and podcast series produced by the DME MACs for the benefit of physicians and healthcare providers. I’m Dr. Robert Hoover, medical director at CGS Administrators, the Jurisdiction C DME MAC. This series of videos, also available as a podcast, are tailored to provide important Medicare policy information for physicians and other healthcare providers who prescribe durable medical equipment items or services when treating Medicare beneficiaries.

Today we’re going to examine the glucose monitors policy. But first, the disclaimer. These video segments on the coverage of durable medical equipment, prosthetics, orthotics, and supplies or DMEPOS are designed to give the viewer an overview of the rules and regulations governing these items. It is not intended to replace the policies and guidelines contained in the local coverage determinations (LCDs) or Policy Articles. It's also important to note that for the DME MAC contractors, the LCDs and related Policy Articles are word-for-word the same in each jurisdiction.

I’m sure many of you over the past couple of years have seen an increase in the number of requests for your patient’s medical records if you’ve prescribed glucose monitoring supplies. And you’ve probably asked yourself why this is happening.

The simple answer is that the Medicare DME contractors have increased our audits of suppliers of diabetic testing supplies. There are a couple of reasons for this increased audit activity. First, glucose monitors and supplies are now #2 in Medicare expenditures in the area of DME, prosthetics and orthotics, second only to oxygen equipment. In 2013, Medicare paid almost $1 billion dollars in glucose monitors and associated supplies of which about $750,000 was in strips. By comparison, oxygen equipment payments totaled over
$1.6 billion.

So you might say “Dr. Hoover, what do you expect? Haven’t you watched the news or read the papers about the obesity epidemic in the US?” Obviously there are reasons for the increase in expenditures, particularly the increase in the numbers of non-insulin dependent or type 2 diabetes patients. And it’s this group of beneficiaries, the non-insulin dependent patients, that have been the primary focus of our audits.

Why is that? Medicare has no issues with paying for testing supplies - regardless of the amount – as long as they’re being used and being used appropriately. But it only takes driving down the street or looking in the classified ads to see postings that say “We buy test strips!” to question if testing supplier are being used appropriately. And why is that? Because we also know that patients are non-compliant with their testing.

I know, just like I used to say “But not my patients. They all test just like I tell them to” but the medical literature says otherwise. In the National Health and Nutrition Examination Survey or NHANES, conducted by the Centers for Disease Control, patients with diabetes were asked about their frequency of blood glucose testing. And the results were startling. According to the data, 29% of patients treated with insulin, 65% treated with oral agents, and 80% treated with diet alone had never monitored their blood glucose or monitored it less than once per month. Self-monitoring at least once per day was practiced by 39% of those taking insulin and only 5–6% of those treated with oral agents or diet alone.

And yet as Medicare contractors reviewing these claims, we see amounts of testing supplies that never vary, month after month after month. So either Medicare beneficiaries are the most compliant patients in the universe or there’s a fair amount of unused test strips. And based on the “We buy test strips” ads, I feel certain it's the later.

So consequently, we’re doing a lot of audits and suppliers are asking you for your medical records. So for your patients that ARE compliant with their testings, what kinds of things should you be writing in their charts? I’ll first cover orders and then coverage and then documentation.

Let’s begin with some general information about Medicare’s glucose monitors and supplies policy. Glucose monitors are covered under the statutory benefit category of durable medical equipment or DME. If you’ve watched the segment in this video series entitled
Benefit Categories, you’ll understand that there are CMS requirements to meet the DME benefit.

To be classified as DME, it must be designed for home use, as opposed to institutional equipment. It must be able to withstand repeated use. In other words it must be durable, with CMS defining durable as something that must last at least 3 years. The device must be primarily and customarily medical in nature and finally, it must be a device that is generally not useful in the absence of illness or injury.

So let’s turn to orders for glucose monitors. The majority of glucose monitors are coded as E0607, a standard glucose monitor. There are other types of monitors covered by Medicare but these have special features and we’ll get to those a little later in the video.

For glucose monitors coded as E0607, they are subject to new requirements for orders, added as part of the Affordable Care Act. For orders written after July 1, 2013, the supplier of the glucose monitor must receive the written order prior to delivery of the monitor. What happens if the supplier doesn’t get a written order prior to delivery of the item? Because this is a statutory requirement, there is no ability for the supplier to “cure” this problem and the supplier may not bill for the item. The only solution is for another supplier to assume responsibility for obtaining a new written order and make the delivery to the beneficiary once the written order is received.

Note that this new requirement for a written order prior to delivery does not apply to supplies used with monitors such as lancets, test strips or control solutions. It also does not apply to the other types of glucose monitors in the policy, those with special features which I’ll talk about in a few moments.

On your screen you’ll see the elements required for an order for Medicare. A couple of things to point out here with orders. If you’re writing the order on your own prescription pad, you would typically fill in a date at the top and you won’t put a date next to the signature. That is acceptable for physician-created orders. If someone other than you, like the supplier of the DME creates the order, there must be an order date and you must also provide a signature date.

With frequency of use, Medicare does not allow “as needed” or what’s commonly called PRN frequency. There must be a specific frequency of testing on the order and Medicare
will only consider reimbursement for specific amounts of supplies.

A second topic is blanket orders. These are orders written order on a supplier’s stock form that lists a variety of equipment, accessories and supplies in a format that does not allow you to individualize the order for each beneficiary. A blanket order may either “bundle” supplies in a way that does not break out each separately billed item or may provide a list of items in a way that you cannot pick and choose the specific items being ordered for an individual beneficiary. This is a common practice of some medical equipment suppliers and you should read these orders very carefully to make sure you are only ordering what your patient needs.

On your screen now you see an example of both acceptable and unacceptable orders. This graphic comes from a frequently asked questions document from 2011 is available on the CGS web site. In addition, CGS published an article in April 2010, again available on the CGS web site that provides additional information about written orders.

Now let’s move to coverage. Medicare covers glucose monitors and testing supplies for any beneficiary diagnosed with diabetes, regardless of the type of diabetes. That is one of the two basic coverage criteria. The other criterion is that the beneficiary’s physician has concluded that the beneficiary (or the beneficiary’s caregiver) has sufficient training using the particular device prescribed. This second criterion is typically met when the treating physician provides a prescription for the appropriate supplies and frequency of blood glucose testing.

That’s pretty simple in terms of the basic coverage criteria. You have diabetes and your physician orders the appropriate supplies and testing regimen. Now I mentioned that Medicare covers glucose monitors with special features. There are two categories of monitors that meet these requirements.

The first is a monitor that talks. In other words, the monitor integrates a voice synthesizer. These monitors are coded E2100 and are covered for beneficiaries with sight impairment. To qualify for this type of monitor, the beneficiary must meet the general coverage requirements I just discussed. In addition, the treating physician must certify and document that the beneficiary has a severe visual impairment, defined as best corrected visual acuity of 20/200 or worse in both eyes and that they require use of this special monitoring system.
The second special monitor is one that integrates the lancing device and test strips into one unit. This category of devices is coded E2101. It is covered similar to the devices with voice synthesizers meaning you must meet the general coverage requirements AND have a severe visual impairment.

However, Medicare also covers this special integrated supplies monitor for beneficiaries with severe manual dexterity impairments. This is a criterion separate from visual impairment. In other words, you may qualify for a monitor coded E2101 if you only have manual dexterity issues and no visual impairment. Again, the treating physician must certify and document the manual dexterity issues in order to qualify for this special monitor. Now let’s turn to the coverage of testing supplies. The quantity of test strips and lancets that are covered depends on the usual medical needs of the beneficiary and whether or not the beneficiary is being treated with insulin. Note that I said the amount of test strips is based on whether or not they use insulin, not their diagnostic classification as having Type 1 or Type 2 diabetes mellitus.

So for each of these two groups, insulin-using and non-insulin using, there are monthly limits on the amount of testing supplies. These limits are based on medical literature and guidelines from clinical organizations that deal with diabetes management. The limits vary between these two groups. What’s more, Medicare also recognizes that there are some beneficiaries who need more testing supplies than the usual limits. This is most often seen with beneficiaries who have difficult to manage diabetes despite frequent physician visits for changes in their management regimen, beneficiaries who become ill and are placed on certain medications like steroids and beneficiaries that become pregnant. Most beneficiaries, particularly the larger group of diabetics that manage their disease with diet and exercise OR oral medications, and have stable blood sugar readings, can manage their blood sugars with the usual utilization frequencies.

So let’s look at those frequency or testing limits. Shown now are the Usual Utilization limits. You’ll note that the amount of testing supplies are divided into insulin using and non-insulin using and are described for a 3 month supply since most beneficiaries prefer to receive their supplies quarterly.

For those beneficiaries who are having difficulty controlling their blood sugar and for whom their physician recommends more frequent testing, some additional coverage criteria must be met to receive higher amounts of testing supplies. There are 3 criteria; howev-
er, the first one is meeting the general coverage criteria of having diabetes and getting an order for testing from the physician so I’ll only address these last two.

The key to coverage of extra testing supplies is physician documentation. Again, the necessity of extra supplies is predicated on something going on with the beneficiary’s diabetes that requires more intensive management. That concept is reflected in these two criteria. You need to see your physician within 6 months of ordering the higher testing supplies and the physician must document a specific reason why the extra supplies are necessary.

Note that I said specific reason, not just “hyperglycemia” or high blood sugar. Medicare expects that if a beneficiary continues to have high blood sugars that require them to test more often, their physician should be considering the reasons why the beneficiary’s blood sugars remain high and actively managing the beneficiary’s condition to work to lower their blood sugar.

Finally, the second criterion on the screen was about utilization. As I mentioned earlier, Medicare doesn’t mind paying for extra testing supplies as long as the supplies are necessary AND they’re being used. The second criterion simply requests that you query the beneficiary about their testing regimen and the frequency of the testing. This can be documented in a narrative statement or, as technology has advanced with glucose monitors, a download of the beneficiary’s testing log or testing results.

Again, if my reviewers are looking at your patient’s medical records, we’ll be looking to see if there’s some recognition on the part of the treating physician, you, of the patient’s testing frequency and, if they’ve been prescribed the “high utilization” amount, some medical reasoning for the continued testing at the higher frequency. This type of documentation is just good medical recordkeeping and is consistent with recommendations from major clinical organizations.

So what happens if some of these criteria for coverage aren’t met? If it’s the general coverage criteria - recall that’s the “You have diabetes” and “Your doctor ordered a monitor and testing supplies” - the monitor and supplies will be denied. If you meet the general coverage criteria but you don’t meet the two additional criteria for high utilization, then the supplies in excess of the usual 100 per quarter for non-insulin treated and 300 per quarter for insulin treated will be denied.
The finish line is close now, hang in there. You heard me mention the Affordable Care Act as it related to orders for the standard home glucose monitor. Another provision of the ACA requires that the treating physician must have conducted an in-person visit with the beneficiary within 6 months prior to writing the order. This visit must document a covered condition or reason for which the item of DME is ordered. So in the case of glucose monitors, reviewers would be looking for something in the record that indicates the beneficiary has diabetes.

This last slide has information for the physician that prescribes one of the items of DME to which these ACA requirements apply. I’m not going to read all of these point but I encourage you to go to the CGS web site and search for the bulletin article published in late May 2014 entitled Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act – Revised. Whew, that was a long one! But we’ve finished covering the highlights of the Glucose Monitor LCD and related Policy Article. I encourage you to read the entire LCD and related Policy Article for a complete description of the coverage, coding and documentation requirements.

That does it for this edition of Medicare Minute MD. I’m Dr. Robert Hoover. Thank you for watching and have a nice day.