Today’s Presenters

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- Questions may only be asked verbally via telephone. You must enter the assigned PIN into your telephone keypad.
- Cannot ask questions via computer microphone and speakers option
Objectives

- The purpose of this webinar is to review, and provide you with an understanding, of the glucose monitor and supplies medical policy, including documentation requirements.
Today’s PowerPoint Presentation

- Go To Webinar Handout
- Jurisdiction B: [http://www.NGSMedicare.com](http://www.NGSMedicare.com)
  - DME Supplier > Training > Webinars, Teleconferences & Events
- Jurisdiction C: [http://www.CGSMedicare.com](http://www.CGSMedicare.com)
  - DME MAC Jurisdiction C > Education > National DME Opportunities
- Jurisdiction D: [https://med.noridianmedicare.com/web/jddme](https://med.noridianmedicare.com/web/jddme)
  - Education & Outreach > Event Materials and Tutorials
Agenda

- Coverage and Medical Necessity
- ACA 6407
- Documentation Requirements
- Billing
- DME MAC Medical Review
- Resources
Coverage and Medical Necessity
To be eligible for coverage of home blood glucose monitors and related accessories and supplies, the patient must meet these basic criteria (1–2):

- The patient has diabetes which is being treated by a physician (refer to LCD for Glucose Monitors for list of diagnosis codes); and
- The beneficiary’s physician has concluded that the beneficiary (or the beneficiary’s caregiver) has sufficient training using the particular device prescribed as evidence by providing a prescription for the appropriate supplies and frequency of blood glucose testing.
Basic Coverage Criteria

- Home blood glucose monitor w/integrated voice synthesizer (E2100)
  - Severe visual impairment (20/200 or worse in both eyes)
- Home blood glucose monitor w/integrated lance/blood sample (E2101)
  - Severe visual impairment (20/200 or worse in both eyes)
  - Manual dexterity impairment
- Lancets (A4259) and test strips (A4253)
- Spring-powered devices (A4258)
  - No more than one per six months
- Laser skin piercing device (E0620) and related lens shield cartridge (A4257)
Typical Utilization Guidelines

- **Insulin Dependent Diabetic**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>UOS</th>
<th>Max. Allowance</th>
<th>Testing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4253</td>
<td>1 = 50</td>
<td>Up to 300 per 3 months</td>
<td>Maximum 3X/day</td>
</tr>
<tr>
<td>A4259</td>
<td>1 = 100</td>
<td>Up to 300 per 3 months</td>
<td>Maximum 3X/day</td>
</tr>
</tbody>
</table>

- **Noninsulin Dependent Diabetic**

<table>
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<td>1 = 100</td>
<td>Up to 100 per 3 months</td>
<td>Maximum 1X/day</td>
</tr>
</tbody>
</table>

*Anything above the average testing is considered over-utilization*
High Utilization Guidelines

a. Basic coverage criteria (1)–(2) are met; and,

b. The treating physician has seen the beneficiary and has evaluated their diabetes control within six months prior to ordering quantities of strips and lancets that exceed the utilization guidelines; and,

c. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician’s records that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed.

If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.
Affordable Care Act
Section 6407
Requirements for Certain DME Items
The ACA originally required a physician to document that a physician, nurse practitioner, physician assistant or clinical nurse specialist had a face-to-face encounter with the patient. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) eliminated the requirement for physicians to document face-to-face encounters conducted by allowed nurse practitioners, physician assistants, or clinical nurse specialists.

As revised by MACRA, a physician, nurse practitioner, physician assistant or clinical nurse specialist must document they have written the order for DME pursuant to a face-to-face encounter with the patient.
Prior to delivery of any specified item, supplier must have:
  ◦ Documentation of the face-to-face visit
  ◦ Detailed written order

Active enforcement by the DME MACs of the face-to-face requirement has been postponed until a future date to be announced by CMS
  ◦ Delay does not impact provisions related to written orders prior to delivery

The CERT contractor is enforcing the face-to-face requirement for dates of service on or after July 01, 2013

Enforcement of the WOPD requirement and the NPI requirement on orders for dates of service on or after January 01, 2014
Affected HCPCS Include

- Home blood glucose monitors
  - HCPCS Code E0607
- A full list of affected HCPCS is available in MLN8304:
Face-to-Face Exam

- The face-to-face examination with the beneficiary must be conducted within the six months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered but doesn’t need to specify the item(s) ordered.
  - All Medicare coverage and documentation requirements for DMEPOS also apply (Refer to the specific medical policy).
- The prescriber must provide a copy of the face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item(s) can be delivered.
The treating practitioner that conducted the face-to-face examination does not need to be the prescriber of the item. However, the prescriber must have knowledge and documentation that the face-to-face examination was conducted.
Items on the DME List of Specified Covered Items require that the supplier obtain a detailed WOPD

All written orders must include the physician’s NPI in addition to the standard order requirements
When is a New Face-to-Face and Order Required?

- A face-to-face examination is required each time a new order for one of the specified items is necessary based on Medicare guidelines
  - A new prescription is required by Medicare:
    - For all claims for purchases or initial rentals
    - When there is a change in the prescription for the accessory, supply, drug, etc.
    - If a LCD requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
    - When an item is replaced
    - When there is a change in the supplier
Timing Requirements

- There are specific date and timing requirements:
  - The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than six months prior to the prescription date
  - The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed
  - The date of the written order must be on or before the date of delivery
  - The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items
Date Stamps

- A date stamp (or equivalent) is required which clearly indicates the supplier’s date of receipt of both the face-to-face record and the completed WOPD
  - A fax header can be used if it contains sufficient information to prove the documents were received by the supplier prior to delivery
- It is recommended that both documents be separately date-stamped to avoid any confusion
Prior to Delivery of Equipment

- If errors in the face-to-face visit documentation or WOPD are identified the supplier has two options:
  - The supplier may request that the treating physician amend the face-to-face visit notes or the WOPD, whichever is applicable, following the guidance in the CMS IOM Publication 100–08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.5, or
  - A new face-to-face examination may be conducted and/or a new WOPD may be created
Corrections and Amendments to Face-to-Face and WOPD

- After Delivery of Equipment
  - If errors in the face-to-face visit documentation or WOPD are identified the following rules apply:
    - Prior to Claim Submission: The original supplier may recover the delivered item(s), obtain a compliant, complete WOPD and/or face-to-face visit notes that describe a medical condition for which the DME is being prescribed, whichever is applicable, and then re-deliver the item(s) to the beneficiary; or
    - After Claim Submission: The original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements
Documentation Requirements
Supplier Standard #28

- A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
  - Seven years from the date of service
  - Provide upon request of CMS or a Medicare contractor
Dispensing Order

- Requirements
  - Beneficiary name
  - Description of the item(s)
  - Prescribing physician’s name
  - Date of the order and the start date, if the start date is different from the date of the order
    - Use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders)
  - Physician signature (if a written order) or supplier signature (if verbal order)
Detailed Written Order

- Beneficiary’s name
- Physician’s name
- NPI of ordering practitioner (E0607 only)
- Date of the order and the start date, if the start date is different from the date of the order
- Detailed description of the item(s)
  - Narrative description or a brand name/model number
  - Example – blood glucose monitor, test strips and lancets
- Physician signature and signature date
Detailed Written Order

- Items provided on a periodic basis (e.g., accessories and supplies) also require:
  - Quantity
    - Example – 30 test strips and lancets per month
  - Frequency of testing
    - Example – Test blood sugar 1 x per day
    - Use of “prn” or “as needed” are not acceptable
  - Duration of need (Number of refills)
    - Example – 12
New Orders

- A routine refill prescription is not required.
- A new order is required when:
  - There is a change in supplier
  - There is a change in the items(s), frequency of use, or amount prescribed
  - There is a change in the length of need or a previously established length of need expires
  - State law requires a prescription renewal
Continued Use

- Documentation supporting continued use
  - Timely documentation in the beneficiary’s medical record showing usage of the item, related option/accessories and supplies
  - Supplier records documenting the request for refill/replacement of supplies in compliance with refill documentation requirements
    - Sufficient to document continued use for the base item
  - Supplier records documenting beneficiary confirmation of continued use of a rental item
  - Timely documentation is defined as a record in the preceding 12 months when testing within policy parameters
  - Timely documentation is defined as a record in the preceding six months for a beneficiary testing over policy parameters
Documentation Requirements

- Diagnosis code for condition necessitating need for glucose testing on each claim
- Documentation of the training requirement is met by evidence of the treating physician providing the beneficiary with a prescription for the appropriate monitor, supplies, and frequency of glucose testing
Insulin Treated versus Noninsulin Treated Diabetics

- KS – Not treated with insulin
- KX – Treated with insulin

Additional documentation requirements apply to:
- Beneficiary who is not insulin treated and whose prescribed frequency of testing is more often than once per day; or,
- Beneficiary who is insulin treated and whose prescribed frequency of testing is more often than three times per day.
Continued Medical Need

- Documentation that supports continued need
  - A recent order by the treating physician for refills
  - A recent change in prescription
  - Timely documentation in the beneficiary’s medical record showing usage of the item
  - Timely documentation is defined as a record in the preceding 12 months when testing within policy parameters
  - Timely documentation is defined as a record in the preceding 6 months for a beneficiary testing over policy parameters
Refill Requirements

- Suppliers must have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items.
- Contact must take place no sooner than 14 calendar days prior to the delivery/shipping date.
- Delivery of refills may occur no sooner than ten calendar days prior to the end of usage for the current product.
- Must not dispense a quantity of supplies exceeding a beneficiary’s expected utilization.
- Must not dispense more than a three-month quantity at a time.
- Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.
Request for Refill

- For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or copy of the itemized sales receipt is sufficient documentation of a request for refill.
- For items delivered to the beneficiary, the refill record must include:
  - Beneficiary’s name or authorized representative if different than the beneficiary.
  - A description of each item that is being requested:
    - Must be detailed regarding each item being provided.
  - Date of refill request.
  - Information documenting that the beneficiary’s remaining supply is approaching exhaustion by the expected delivery date:
    - Must be a quantity of the amount remaining.
Proof of Delivery Methods

- Direct delivery to the beneficiary
  - Method 1
- Shipping service
  - Method 2
Proof of Delivery – Method 1

- Proof of delivery record (signed delivery slip) must include:
  - Beneficiary’s name
  - Delivery address
  - Sufficient description to identify item(s) delivered
  - Quantity delivered
  - Date delivered
  - Beneficiary signature (or designee signature)

- Date the DME was received by the beneficiary would be the date of service on the claim billed to Medicare
Proof of Delivery – Method 2

- National mail order suppliers only
- Proof of delivery record must include:
  - Beneficiary’s name
  - Delivery address
  - Delivery service package ID number, supplier invoice number or other method that links supplier documents with delivery service records
  - Sufficient description to identify item(s) delivered
  - Quantity delivered
  - Date delivered
  - Evidence of delivery
Proof of Delivery – Method 2

- When using a shipping service, the shipping date must be the date of service on the claim billed to Medicare
- Suppliers may use a return postage-paid invoice from the beneficiary/designee
  - This type of delivery record must contain the information outlined on the previous slide
Billing
Modifiers

- **Pricing modifier**
  - Glucose Monitor requires – NU, UE or RR modifier
  - Test strips requires – NU modifier
  - Lancets, control solutions, and spring-powered devices are considered supplies, do not require NU, UE, or RR

- **Mail-order Modifier**
  - KL – DMEPOS item delivered via mail
    - A4233–A4236, A4253, A4256, A4258–A4259
KS versus KX Modifier

- Informational modifiers:
  - KS – Glucose monitor and supplies for diabetic beneficiary not treated with insulin
  - KX – Glucose monitor and supplies for diabetic beneficiary treated with insulin
Span Dates

- Span date required for testing supplies
  - A4253, A4259, A4255, A4256
    - “From” and “To” date must be different
      - ANSI denial CO–16, remark code N64
      - The date span on the claim will generally not be the same as the actual dates of use by the beneficiary.
Diagnosis Coding

- Claims may not contain both ICD–9 and ICD–10 diagnoses codes
- Diagnosis code on claim is based upon “From” date on claims that span ICD–10 implementation date of 10/1/15
  - Claims with “From” dates prior to 10/1/15 require ICD–9 diagnosis codes
  - Claims with “From” dates on or after 10/1/15 require ICD–10 diagnosis codes
- LCDs have been updated to include ICD–10 codes
Billing Tips

- Append appropriate KS or KX modifier
  - Never bill both to the same claim line
- Submit claim with correct units of service
  - Test strips: A4253 – one unit of service is equal to 50 test strips
  - Lancets: A4259 – one unit of service is equal to 100 lancets
- Span dates of service as required
Quantity Ordered Exceeds Policy Parameters

- Excess quantities not supported by documentation
  - Excess quantity billed as an upgrade
  - Properly execute ABN for excess quantity
  - Total quantity dispensed with modifier GA on one claim line
  - Reasonable and necessary quantity allowed per policy with GK modifier on following claim line
  - Claim lines must be billed in this specific order
Quantity Ordered Exceeds Policy Parameters

- Line 1: A4253KSGA – 6 UOS
  - Charges associated with this line are total charges for the entire 300.
- Line 2: A4253KSGK – 2 UOS
  - Charges associated with this line are for the 100 allowed per policy.
- Line 3: A4259KSGA – 3 UOS
  - Charges associated with this line are total charges for the entire 300.
- Line 4: A4259KSGK – 1 UOS
  - Charge associated with this line are for the 100 allowed per policy.
DME MAC Medical Review
Medical Review Purpose

- Identify and prevent inappropriate payments
  - Review claims on a pre/post payment basis following:
    - NCD, LCD, and CMS manuals/regulations
    - Reviews performed by DME MAC medical review nurses

- Goal:
  - Reduce payment error by preventing the initial payment of claims that do not comply with Medicare’s coverage, coding, payment, and billing policies
Widespread Prepayment Review

- Widespread prepayment reviews
  - Notification of review sent to DMEPOS supplier community via email update
  - ADR letters are sent to the payee address on file with the NSC
  - Documentation must be returned within 45 days of the date on the request letter
    - Failure to respond claim denied
      - ANSI N102
  - Results of review sent to DMEPOS supplier community via email update
Jurisdiction A Resources

- Website: [http://www.medicarenhic.com/dme](http://www.medicarenhic.com/dme)
  - Decision Desktop
  - Provider Services Portal
  - Physician’s Corner
  - Newsletter and Supplier Manual
  - Educational Events and Offerings
  - ListServe Subscription
  - Live Line Chat

- Provider Customer Service
  - Provider IVR: 866–419–9458
  - Provider CSR: 866–590–6731
Jurisdiction B Resources

- [http://www.NGSMedicare.com](http://www.NGSMedicare.com)
  - Span Date Billing Guide
  - Documentation Checklist
  - Dear Physician Letter
  - Diabetic Testing Supplies Quick Reference Billing Guide

- [http://www.medicareuniversity.com](http://www.medicareuniversity.com)
  - DME–C–0008: Glucose Monitors and Supplies
Jurisdiction C Resources

- Medical Review Service–Specific Quarterly Reports
  http://www.cgsmedicare.com/jc/mr/reports.html
- Glucose Monitors & Supplies Claim Audit Resources
  http://www.cgsmedicare.com/jc/mr/glucose_monitors.html
- MR Wizard
  http://www.cgsmedicare.com/medicare_dynamic/jc/denials.asp?wb48617274=5F9C1F93
- myCGS Web Portal Information
  http://www.cgsmedicare.com/jc/mycgs/index.html?wb48617274=5F9C1F93
Jurisdiction D Resources

- LCD/Policy Article
  - https://med.noridianmedicare.com/web/jddme/policies/lcd/active

- Supplier Manual

- “Dear Physician” letters
  - https://med.noridianmedicare.com/web/jddme/policies/physician-resources

- Documentation Checklist
  - https://med.noridianmedicare.com/web/jddme/policies/documentation-checklists

- Endeavor
  - https://med.noridianmedicare.com/web/jddme/topics/portal
Test Your Knowledge
1) There must be documentation in beneficiary’s record that he/she has received training on use of the glucose monitor.
   a) True
   b) False
Question 2

2) An order alone is sufficient to support coverage if it contains a covered diagnosis code.
   a) True
   b) False
Question 3

3) A detailed written order is required prior to delivery of a glucose monitor.
   a) True
   b) False
Question 4

4) Any supplier may be reimbursed by Medicare for testing supplies delivered to a beneficiary’s home via company vehicle.
   a) True
e) False
Question 5

5) Which modifier must be appended to the claim to indicate the beneficiary is treated with insulin injections?
   a) KS modifier
   b) KX modifier
   c) KL modifier
   d) KS and KX modifier
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