



MEDICARE ADVANTAGE PROVIDER NEWSLETTER

SPRING 2011

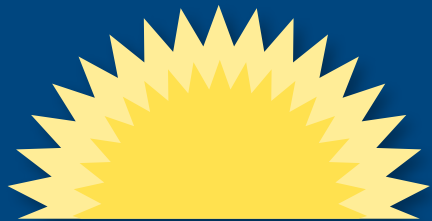
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NOTICE OF MEDICARE NON COVERAGE

The Notice of Medicare Non Coverage (NOMNC) is a form developed by the Centers for Medicare & Medicaid Services (CMS) to allow members advanced notice of the termination of services. This document is important because it informs members of their right to an immediate, independent review of the proposed discontinuation of services.

“Termination of services” is defined as the discharge or discontinuation of covered provider services, or the cessation of coverage at the end of a pre-authorized course of treatment.

All members currently receiving Medicare-approved services who will soon be released from a SNF, HH, or CORF should be given the NOMNC and asked to review and provide a signature.

Per CMS regulations, all providers are required to follow these steps for ADVANTAGE Health Solutions, Inc.SM (AHS) members in advance of but not more than two calendar days before the termination of services:

1. Print or copy the NOMNC form. You can obtain a copy of the NOMNC form on the AHS web site at: <http://www.advantageplan.com/advppo/Providers.aspx>
2. Complete the form in its entirety.
3. Explain the form to the member or his or her personal representative.
4. Gather signatures and dates from the member or his or her personal representative. If he or she refuses to sign the NOMNC, document the refusal on the form, including the date and time



of the refusal, the name(s) of the member and/or his or her personal representative, your name, and a statement indicating the form was explained to the member.

5. Provide a copy of the signed form to the member or his or her personal representative.
6. Retain the signed form in the member’s medical record and be prepared to fax it to the Plan upon request.

If you have questions about the NOMNC, please contact Nicole Boone-Poole at (317) 580-8457 or [npool@advantageplan.com](mailto:npoole@advantageplan.com). A copy of the NONMC is available on the ADVANTAGE Health Solutions, Inc.SM web site, by entering the following link into your Internet browser <http://www.advantageplan.com/advppo/Providers.aspx>. You may also find more information on the CMS web site at www.cms.gov.

PRIOR AUTHORIZATIONS

Prior Authorizations are required for certain “in network” services. The following items require a Prior Authorization:

- Inpatient Hospitalization
- Inpatient Psych Hospitalization
- Skilled Nursing Facility
- Comprehensive Outpatient Rehabilitation Facility
- Partial Hospitalization - 23 hour observation stays
- Home Health Care
- OT, PT and ST
- Mental Health and Psychiatric Services
- Ambulatory Surgery Center Procedures
- Outpatient Mental Health
- Outpatient Substance Abuse
- Cardiac Rehab
- Outpatient DME >\$500
- Renal Dialysis
- Polysomnography (Sleep Study)
- Outpatient Chemotherapy and Radiation Therapy

To request a Prior Authorization, please call:

General: (800) 748-2544

Community Health Network HMO only:
(800) 344-8672 or (317) 621-7575)

- 2 business days prior to the service or admission
- Within 48 hours after an emergency admission
- Monday – Friday; 8:00am – 5:00pm

NOTE: For Behavioral Health Services (mental health), contact ADVANTAGE Behavioral Health at (866) 468-8257, Monday-Friday, 8:00am - 5:00pm.

PROVIDER APPEALS PROCEDURES

An Appeal involves a request to reconsider an adverse organization determination, claim determination or a claim not paid in a timely manner. A Provider dispute is classified by the Provider initiating contact and voicing the specifics of their disagreement with the manner in which a claim was processed with the Provider Customer Service Department (888-445-8958). Some disputes are resolved with this process. In the event that the dispute is unable to be resolved, the Provider is advised to file an Appeal. Providers should submit their written Appeals on their own company letterhead, along with the reason for the Appeal and documentation to support their Appeal to:

ATTENTION: Medicare Advantage/ Provider Appeals
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 200
Indianapolis, IN 46240
Fax to: (317) 573-6218

An acknowledgement letter, confirming receipt of the Appeal request, will be sent within 3 business days of the Appeal being received by ADVANTAGE. The Appeal request should be submitted within 60 days of the initial claim determination. If the request is not within the 60 day filing limit, the Provider will be contacted and advised of the Appeal filing limit.

MEDICARE ADVANTAGE OFFERINGS

ADVANTAGE Health Solutions, Inc.SM (AHS), offers a Medicare Advantage PPO and HMO through our Medicare contract with the Centers for Medicare & Medicaid Services (CMS). We are proud of our Indiana roots and local provider ownership and we are invested in our Hoosier community and valued members. Below, please see a listing of our 2011 Medicare Advantage Plan Offerings:

PPO

- ADVANTAGE Preferred Plus PPO
- ADVANTAGE Preferred Plus Part D Enhanced PPO
- ADVANTAGE Enhanced Plus PPO

NOTE: Members must live in one of the following service areas: Allen, Boone, Delaware, Hamilton, Hancock, Hendricks, Howard, Johnson, Madison, Morgan, Shelby or St. Joseph Counties.

HMO

- ADVANTAGE Preferred Network Enhanced HMO – Community Health Network
- ADVANTAGE Preferred Network Enhanced HMO – St. Francis
- ADVANTAGE Preferred Network Enhanced HMO – Wishard
- Wishard Complete Care Basic

NOTE: Members choosing the Community Health Network or St. Francis must live in one of the following service areas: Hamilton, Hancock, Johnson, Marion and Morgan. Members choosing the Wishard HMO must live or Marion Counties.



MEDICARE ADVANTAGE CONTACTS & RESOURCES

CLAIMS SUBMISSION ADDRESS

ADVANTAGE Claims
PO Box 310
Dunmore, PA 18512
(888) 445-8958
Electronic Payor ID #: 77070

Community Network HMO Only:
PO Box 50407
Indianapolis, IN 46250
(800) 344-8672 or (317) 621-7565

PRIOR AUTHORIZATION

General: (800) 748-2544
Behavioral Health Prior Authorization: (866) 468-8257
Community Health Network HMO only: (800) 344-8672 or (317) 621-757

PROVIDER APPEALS

ATTENTION:
Medicare Advantage Provider Appeals
ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 200
Indianapolis, IN 46240
(317) 573-6218 FAX

MEMBER SERVICES

Local: (317) 573-7950
Toll Free: (800) 523-7533
TTY/TDD: (800) 743-3333
8:00 a.m. - 8:00 p.m.
7 days a week

PROVIDER RELATIONS

Angela C. Cooper
Provider Relations Specialist
Local: (317) 573-8258
Email: acooper@advantageplan.com

ADVANTAGE Health Solutions, Inc.SM
9045 River Road, Suite 200
Indianapolis, IN 46240
Website: www.advantageplan.com

MEDICARE COVERAGE OF BLOOD GLUCOSE MONITORS AND TESTING SUPPLIES



The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS), recently identified that a number of Medicare beneficiaries are receiving diabetic supplies (test strips and lancets) that exceed the Centers for Medicare & Medicaid Services (CMS) requirements and guidelines. ADVANTAGE Health Solutions, Inc.SM Medicare Advantage would like to take this opportunity to remind providers of the coverage, coding and documentation requirements, with a special emphasis on quantities of supplies that exceed the basic utilization guidelines, for blood glucose self-testing equipment and diabetic supplies.

CMS has issued an article that provides an overview of these requirements and guidelines that include what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries, how providers should be detailing prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record.

To view this article, please enter the link below into your Internet browser. A copy of these guidelines has also been provided with this newsletter.

<http://www.cms.gov/MLN MattersArticles/downloads/SE1008.pdf>



UPDATING YOUR PROVIDER INFORMATION

It is our goal to provide the most up to date and accurate information available to our members. As a courtesy to our members, ADVANTAGE Health Solutions, Inc.SM makes every attempt to give our members 30 days notice when their

Primary Care Physician or Specialty Care Physician is terminating their status as a participating provider. Please be sure to notify Medicare Advantage Provider Relations and/or your provider network with any changes to your

participation, such as opening or closing your practice to new patients, terminating participation, address, phone or fax changes; if a provider is joining or leaving your practice or if you are adding or removing a service location.

INSTRUCTIONS FOR SERVICES RENDERED IN PLACE OF SERVICE HOME

CMS Pub 100-04; Transmittal 2041; Change Request 6947

The Center for Medicare and Medicaid Services (CMS) has released the requirement that services payable under the Medicare PFS, as well as anesthesia services, are required to include the address where the service was performed in Item 32 on the CMS 1500 form.

Claims that are submitted on the CMS-1500 form on or after January 1, 2011 will be returned as unprocessable for services payable under the Medicare PFS and anesthesia services. This includes services that are rendered in all places of services (including home) if submitted without the address

of where the service was performed in Item 32 on the CMS 1500 form.

To view these instructions in more detail, please enter the following link into your Internet browser: <http://www.cms.gov/transmittals/downloads/R2041CP.pdf>

Background



News Flash – Follow CMS on Twitter to get the latest updates on information you need know about CMS (including Medicare Learning Network updates). Visit <http://www.twitter.com/CMSGov> and stay connected! (Twitter handle = @CMSGov)

MLN Matters® Number: SE1008 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Medicare Coverage of Blood Glucose Monitors and Testing Supplies

Note: This article was re-issued on May 5, 2010, to include additional information regarding special blood glucose monitors for patients with manual dexterity issues, and to clarify certain information regarding the content of orders and when new orders are needed.

Provider Types Affected

This article is informational for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for Medicare covered diabetes benefits provided to Medicare beneficiaries.

What You Need to Know

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in MLN Matters® article SE0738, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. **This article is informational only and represents no Medicare policy changes.**

Disclaimer

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Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity. For more information regarding medical necessity, see the section below titled 'Providing Evidence of Medical Necessity.'

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

See the Medicare Benefit Policy Manual, Chapter 15, at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for more information.

Coverage for diabetes-related Durable Medical Equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Prescribing/Ordering a Blood Glucose Monitor and Associated Accessories

Provider Requirements

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

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1. The item(s) to be dispensed;
2. The frequency of testing (“as needed” is not acceptable);
3. The physician’s signature;
4. The signature date; and
5. The start date of the order – only required if the start date is different than the signature date.

For beneficiaries who are insulin-dependent, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every 6 months.

For beneficiaries who are non-insulin dependent, Medicare provides coverage for up to 100 test strips and lancets every 3 months, and one lancet device every 6 months.

Note: Medicare allows additional test strips and lancets **if deemed medically necessary.** See the section below titled ‘Providing Evidence of Medical Necessity.’ Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has “authorized” this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors.

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to 3 months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate “start” and “end” dates. The “start” and “end” dates for each claim can span across 3 months. You can find CR 2363 at <http://www.cms.hhs.gov/Transmittals/Downloads/B03004.pdf> on the CMS website.

Suppliers may dispense most items of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing order must include: a description of the item, the beneficiary’s name, the physician’s name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the Medicare Program Integrity Manual, Chapter 5, at <http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf> on the CMS website.

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For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled ‘Providing Evidence of Medical Necessity.’

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You can review MLN Matters® articles related to CR 5971 and CR 6698 at <http://www.cms.gov/MLN MattersArticles/downloads/MM5971.pdf> and <http://www.cms.gov/mlnmattersarticles/downloads/mm6698.pdf> on the CMS website.

Home Blood Glucose Monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

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Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes;
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner.
In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician; and
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors; and
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: Section 1833(e) of the Social Security Act precludes payment to any provider of services "unless there has been furnished such information

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as may be necessary in order to determine the amounts due such provider..." See http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm on the Internet.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the Medicare National Coverage Determinations Manual, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf on the CMS website and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at <http://www.cms.gov/mcd/search.asp?from2=search.asp&> (search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

HCPCS Code	HCPCS Code Descriptor
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	50 test strips for a blood glucose monitor
A4256	Calibration solutions
A4258	Spring-powered lancing device
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

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Providing Evidence of Medical Necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
 - Justification for testing frequency; and
 - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
 - Names, dosages, and timing of administration of medications used to treat the diabetes;
 - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
 - Review of beneficiary-maintained log of glucose testing values;
 - Changes in the patient's treatment regimen as a result of glucose testing results review;
 - Dosage adjustments that the patient should make on their own based on self-testing results;
 - Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A_{1c});
 - Other therapeutic interventions and results;
- Documentation by the beneficiary of the actual frequency of testing.
 - Logs of self-testing values including the date, time, and results
 - Information about medication dosage adjustments related to the results is also helpful.

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Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the Medicare Program Integrity Manual, Chapter 5 (Items and Services Having Special DME Review Considerations) at

<http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf> on the CMS website, and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at <http://www.cms.gov/mcd/search.asp?from2=search.asp&> (search "Glucose Monitors").

Additional Information

You can find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf> on the CMS website.

You can also find The Guide to Medicare Preventive Services at

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf and the Medicare Preventive Services Brochure at <http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvc.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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Diabetic Testing Supplies

Quick Reference Guide for Billing Medicare



PSC for DMERC Region A



GENERAL COVERAGE REQUIREMENTS

- Glucose monitor coverage criteria must be met (see Medical Policy)
- Order is renewed every 12 months
- Patient or caregiver must specifically request each refill- no automatic shipping
- Patient has nearly used their current supply

VALID ORDER CONTENTS

- Item(s) to be dispensed
- Quantity of items to be dispensed
- Specific Frequency of testing
- Whether the patient has insulin-treated or non-insulin-treated diabetes
- Treating physician's signature
- Date of the treating physician's signature
- Start date of the order, if it is different than the signature date

BASIC UTILIZATION GUIDELINES

<p>NON-INSULIN TREATED (EVERY 3 MONTHS) 100 TEST STRIPS (1X/DAY TESTING) 100 LANCETS (1X/DAY TESTING) Modifier: KS*</p> <div style="display: flex; align-items: center;"><div style="display: flex; flex-direction: column; gap: 5px;"><div style="border: 1px solid black; padding: 2px; text-align: center;">50 TEST STRIPS A4253</div><div style="border: 1px solid black; padding: 2px; text-align: center;">50 TEST STRIPS A4253</div><div style="border: 1px solid black; padding: 2px; text-align: center;">100 LANCETS A4259</div></div><div style="margin-left: 20px;"><p>A4253 2 UNITS A4259 1 UNIT</p></div></div>	<p>INSULIN TREATED (EVERY 3 MONTHS) 300 TEST STRIPS (3X/DAY TESTING) 300 LANCETS (3X/DAY TESTING) Modifier: KX*</p> <div style="display: flex; align-items: center;"><div style="display: flex; flex-direction: column; gap: 5px;"><div style="border: 1px solid black; padding: 2px; text-align: center;">50 TEST STRIPS A4253</div><div style="border: 1px solid black; padding: 2px; text-align: center;">50 TEST STRIPS A4253</div><div style="border: 1px solid black; padding: 2px; text-align: center;">50 TEST STRIPS A4253</div><div style="border: 1px solid black; padding: 2px; text-align: center;">100 LANCETS A4259</div><div style="border: 1px solid black; padding: 2px; text-align: center;">100 LANCETS A4259</div></div><div style="margin-left: 20px;"><p>A4253 6 UNITS A4259 3 UNITS</p></div></div>
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HCPCS CODES

A4253- Test Strips (1 UNIT= 50 strips) A4259- Lancets (1 UNIT= 100 lancets)

* The correct modifier must be added to the HCPCS code

ADDITIONAL DOCUMENTATION REQUIREMENTS FOR QUANTITIES OF SUPPLIES THAT EXCEED BASIC UTILIZATION GUIDELINES:

- Physician has seen and evaluated the patient within 6 months prior to the date of service
- Physician has documented the specific reason for higher testing frequency
- Physician or patient has documented the actual testing frequency

Supplier created data collection forms are not sufficient by themselves to document medical necessity. Any information that they contain must be corroborated by documentation in the patient's medical record.

Orders, additional documentation for excess quantities (if applicable), and documentation of refill request from the patient must be available to the DMERC upon request.

Refer to the Glucose Monitor medical policy for more information on coverage, coding, & documentation requirements.