DON'T GET STUCK ON DIABETIC TEST SUPPLIES

A Step-By-Step Guide to Ordering Diabetic Testing Supplies for Medicare Patients Using Home Glucose Monitors

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INTRODUCTION

Follow the simple steps on this document to ensure coverage for your patient.

Home glucose monitors and Diabetic Testing Supplies (DTS) are covered by Medicare for persons with a diagnosis of diabetes, when certain criteria are met.

Insufficient documentation is the top reason for improper payments for glucose monitors, which include DTS.

Top Reasons That DTS Claims Are Denied

- The practitioner failed to document in the medical record why it was medically necessary to test at the prescribed frequency.
- Documentation is missing to support that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's testing log).
- The medical record does not include documentation of a practitioner visit to evaluate the beneficiary's diabetes control within 6 months of an order for DTS that exceeds utilization guidelines. The documentation either does not include the required documentation or is not within the 6-month window.

STEP ONE: CONFIRM PATIENT ELIGIBILITY

Verify these two criteria are met before prescribing DTS:

1. The patient is diagnosed with diabetes.
2. The patient knows how to use the particular device.

STEP TWO: DETERMINE THE NUMBER OF TEST STRIPS & LANCETS

There are limits to how many strips and lancets a patient can receive in a 3-month period, depending on their diabetes treatment. Make sure to document quantity for every prescription.

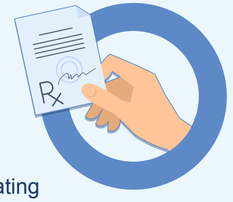
If a patient is eligible, per Step One, the usual utilization of testing strips and lancets is:

INSULIN TREATED:
UP TO 300
TEST STRIPS IN A 3-MONTH PERIOD

NON-INSULIN TREATED:
UP TO 100
TEST STRIPS IN A 3-MONTH PERIOD

If you need to prescribe higher quantities, the following criteria must also be met:

- The treating practitioner has an in-person visit with the beneficiary within the 6 months prior to ordering their supplies, to evaluate their diabetes control and determine their need for a specific quantity of supplies that exceeds the usual utilization.
- Every 6 months, for continued prescriptions that exceed the usual utilization amounts, the treating practitioner must verify the beneficiary's adherence to the high utilization testing regimen.



Note: Insufficient documentation with higher quantity prescriptions is the biggest reason for claim denial.

STEP THREE: ENSURE DOCUMENTATION REQUIREMENTS ARE MET

The medical record must contain the following:

- A dated and signed standard written order (SWO).
- Proof the beneficiary/caregiver has the necessary training on the device, which is met by the order above.
- Evidence that the patient has diabetes.

For patients testing more than usual, the medical record must also contain the following information:

- Documentation of an in-person visit within the 6 months prior to the prescription.
- Documentation to support their need for the specific quantity of supplies prescribed.
- Documentation that the practitioner verifies the patient's adherence to the testing regimen every 6 months for continued prescriptions.

Important – Once the medical record documentation is complete, provide the necessary documentation to the appropriate supplier or Medicare contractor if requested for an audit.

RESOURCES

1. **Find Your Medicare Administrative Contractor (MAC):** https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html
2. **Local Coverage Determinations (LCDs) for Noridian Healthcare Solutions, LLC** https://med.noridianmedicare.com/web/jddme/policies/lcd
3. **Local Coverage Determinations (LCDs) for CGS Administrators, LLC (CGS)** https://www.cgsmedicare.com/jc/coverage/lcdinfo.html
4. **Medicare Coverage Database:** https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
5. **Comprehensive Error Rate Testing (CERT): 2021 Medicare Fee-for-Service Supplemental Improper Payment Data** https://www.cms.gov/files/document/2021-medicare-fee-service-supplemental-improper-payment-data.pdf-0