

Use of this template is voluntary / optional

## Home Blood Glucose Monitor and Supplies

### F2F Encounter Template Guidance

#### Purpose

This template has been designed to assist a physician or allowed Non-Physician Practitioner (NPP)<sup>1</sup> in documenting a face-to-face (F2F) encounter for Medicare home blood glucose monitor and supplies eligibility and coverage. A F2F encounter allows the provider, who is treating the diabetic patient, the opportunity to document and substantiate the need for the glucose monitoring device being prescribed and the frequency with which glucose monitoring tests should be performed. A F2F encounter between the Medicare beneficiary and the treating physician or allowed NPP is required for E0607 – home blood glucose monitor on the date of the written order or up to 6 months before the date of the written order. [§1834(a)(11)(B)] This template is available to the clinician and can be kept on file with the patient’s medical record or used to develop a template for use with the system containing the patient’s electronic medical record.

#### Patient eligibility

Eligibility for coverage of the home blood glucose monitor under Medicare requires a physician or allowed NPP to complete an in-person visit or F2F encounter prior to or at the time of prescribing the item(s) to document the patient was evaluated and/or treated for the diagnosis supporting the need for the Durable Medical Equipment (DME) ordered. The documentation substantiating the diagnosis of Diabetes Mellitus (DM) may include one or more acceptable blood glucose tests to confirm the patient’s diagnosis and to determine the most appropriate management of the patient’s Diabetes Mellitus [(ICD-9 codes 249.00 - 249.91, 250.00 – 250.93, and 648.00 – 648.04) (ICD-10 codes E08 -13.9 and O24.01 – O24.93)].

If the patient has a previous diagnosis of DM the provider only needs to indicate the diagnosis in the progress note.

If provider is confirming the diagnosis of Diabetes Mellitus on this visit, the provider may use the laboratory test report, the “Home Blood Glucose Monitor and Supplies Laboratory Test Results Template” or the laboratory results section of the progress note to record the blood glucose results. Diabetes Mellitus may be confirmed by, but is not limited to, using one of the following tests:

- Fasting plasma glucose level of 126 mg/dL or greater on 2 different occasions;
- Random plasma glucose level of 200 mg/dL or greater with symptoms of uncontrolled diabetes;
- A two-hour oral glucose tolerance test with a plasma glucose level of 200 mg/dL or greater; or
- A1c level of 6.5% or greater

Completing the “Home Blood Glucose Monitor and Supplies F2F Encounter Template” does not guarantee coverage. It does provide guidance in support of prescribing a home blood glucose monitor and frequency in the use of testing supplies indicated, ordered, and billed to Medicare by the DME supplier. This template may be used with the “Home Blood Glucose Monitor and Supplies Laboratory Test Results Template” and

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<sup>1</sup> A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

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“Basic Home Blood Glucose Monitor and Supplies Order Template” or “Specialty Home Blood Glucose Monitor and Supplies Order Template”.

### Basis for Ordering a Home Blood Glucose Monitor and Supplies

The patient’s medical record must contain sufficient documentation of the patient’s medical condition substantiating the need for a home blood glucose monitor. Information that is required by §1834(a)(11)(B), (e.g., E0607) for Medicare home blood glucose monitor eligibility and coverage includes the following:

- Diagnosis of Diabetes Mellitus;
- Physician or allowed NPP has concluded that the patient (or the patient’s caregiver) has sufficient training in using the monitor, related accessories and supplies prescribed;
  - E.g., instructions to the patient (or patient’s caregiver) on how to use the home blood glucose monitor, accessories, supplies, and the frequency of performing blood glucose testing in the management of the patient’s Diabetes Mellitus.

OPTIONAL: Additional pertinent information not required for documentation of coverage may include, but is not limited to, the following:

- Duration of the patient’s condition;
- Clinical course;
- Use of insulin or oral agents;
- Height and weight by date;
- Prognosis;
- Nature and extent of glucose control;
- Results and date of last HbA1c or A1c (helps to establish ongoing medical need);
- Therapeutic interventions and results of those interventions;
- Past pertinent medical/surgical history or experience;
- Blood glucose test results (required when initially diagnosing Diabetes Mellitus and substantiating need for the base device);
- Blood pressure with corresponding dates;
- Other information:
  - Educational goals,
  - Assessment of educational needs,
  - Training goals,
  - Plan for follow-up assessment in achieving training goals,
  - Documentation of training assessment.

For any item to be covered by Medicare, a Detailed Written Order (DWO) must be received by the supplier before a claim is submitted. For some items to be covered by Medicare, a Written Order Prior to Delivery (WOPD) is required. The home blood glucose monitor, [represented by Healthcare Common Procedure Coding System (HCPCS) code E0607], is the only glucose monitor that requires a WOPD. Specialty glucose monitors for the visually impaired or patients with impairments of manual dexterity (HCPCS codes E2100 and E2101) require a DWO but are not required to have a WOPD. (77 Federal Register 68892)

### Frequency or “Usual Utilization” of Blood Glucose Home Testing

- Non-insulin treated Diabetes Mellitus
  - Once daily
  - Additional information in the medical documentation needs to substantiate the need for glucose testing more than once daily
- Insulin treated Diabetes Mellitus
  - Three times daily

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Additional information in the medical documentation needs to substantiate the need for glucose testing more than three times daily

### Who can complete the “Home Blood Glucose Monitor and Supplies F2F Encounter Template”?

The physician or allowed NPP who evaluates the patient and confirms the diagnosis of Diabetes Mellitus and the patient’s eligibility and need for the home blood glucose monitor and supplies.

Note: If this template is used:

- 1) CDEs in black Calibri are required
- 2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
- 3) CDEs in blue Times New Roman are recommended but not required

Version R1.0b

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<b>Home Blood Glucose Monitor and Supplies Face-to-Face (F2F) Encounter Template</b>					
Patient information:					
Last name: _____ First name: _____ MI: _____					
DOB (MM/DD/YYYY): _____ Gender: ___M___F___Other Medicare ID: _____					
Provider (physician/NPP) who performed the face-to-face evaluation if different than signing provider:					
<i>Last name:</i> _____ <i>First name:</i> _____ <i>MI:</i> ___ <i>Suffix:</i> _____					
<i>NPI:</i> _____ Date of face-to-face encounter (MM/DD/YYYY): _____					
Is this a F2F encounter or in person visit for diabetes diagnosis / management? ___Yes ___No					
If No, purpose of the encounter: _____					
Patient diagnosis:					
Diabetes Mellitus: ___Insulin treated, ___Non-insulin treated					
Other (describe): _____					
Laboratory validation (if providing test results please include initial and confirmatory if applicable):					
___Separate template or test report(s) confirming diagnosis of Diabetes Mellitus or					
___confirmed by laboratory testing on (MM/DD/YYYY) _____ and _____					
Fasting plasma glucose ____/____ mg/dl or A1c ____/____ % or					
Random plasma glucose level ____/____ mg/dl or glucose tolerance level ____/____ mg/dl					
Chief complaint / history of present illness and associated signs / symptoms: _____					
_____					
_____					
Related past medical / surgical history: _____					
_____					
Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)					
RxNorm	Description	Dose	Frequency	Route	Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Other medications					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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Allergies (Include RxNorm if known)			
RxNorm	Description	RxNorm	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Review of systems (Significant as per history of present problem and need for home blood glucose monitoring):			
General:	<input type="checkbox"/> weight gain, <input type="checkbox"/> weight loss, <input type="checkbox"/> sleeping problems, <input type="checkbox"/> fatigue, <input type="checkbox"/> fever, <input type="checkbox"/> chills, <input type="checkbox"/> night sweats / diaphoresis <input type="checkbox"/> other: _____		
Skin:	<input type="checkbox"/> pressure ulcers, <input type="checkbox"/> rashes, <input type="checkbox"/> changes in nails/hair, <input type="checkbox"/> eczema, <input type="checkbox"/> pruritus, <input type="checkbox"/> other: _____		
Lymphatic:	<input type="checkbox"/> swollen glands/masses: <input type="checkbox"/> in the neck, <input type="checkbox"/> axilla, <input type="checkbox"/> groin, <input type="checkbox"/> other: _____		
Head:	<input type="checkbox"/> fainting, <input type="checkbox"/> dizziness, <input type="checkbox"/> headaches, <input type="checkbox"/> other: _____		
Eyes:	<input type="checkbox"/> diplopia, <input type="checkbox"/> glasses/contact lenses, <input type="checkbox"/> redness/discharge, <input type="checkbox"/> blurred vision, <input type="checkbox"/> glaucoma, <input type="checkbox"/> cataracts, <input type="checkbox"/> other: _____		
Ears:	<input type="checkbox"/> tinnitus, <input type="checkbox"/> discharge, <input type="checkbox"/> hearing loss, <input type="checkbox"/> other: _____		
Nose:	<input type="checkbox"/> epistaxis, <input type="checkbox"/> sinus infections, <input type="checkbox"/> discharge, <input type="checkbox"/> polyps, <input type="checkbox"/> other: _____		
Oral:	<input type="checkbox"/> dysphagia, <input type="checkbox"/> hoarseness, <input type="checkbox"/> teeth/dentures, <input type="checkbox"/> other: _____		
Neck:	<input type="checkbox"/> lumps, <input type="checkbox"/> pain on movement <input type="checkbox"/> other: _____		
Breast:	<input type="checkbox"/> masses/tumors, <input type="checkbox"/> tenderness, <input type="checkbox"/> discharge, <input type="checkbox"/> gynecomastia, <input type="checkbox"/> other: _____		
Pulmonary:	<input type="checkbox"/> cough, <input type="checkbox"/> shortness of breath, <input type="checkbox"/> pain, <input type="checkbox"/> wheezing, <input type="checkbox"/> hemoptysis, <input type="checkbox"/> sputum production <input type="checkbox"/> other: _____		
Cardiac:	<input type="checkbox"/> chest pain, <input type="checkbox"/> palpitations, <input type="checkbox"/> orthopnea, <input type="checkbox"/> murmur, <input type="checkbox"/> syncope <input type="checkbox"/> other: _____		
Vascular:	<input type="checkbox"/> edema, <input type="checkbox"/> claudication, <input type="checkbox"/> varicose veins, <input type="checkbox"/> thrombophlebitis, <input type="checkbox"/> ulcers <input type="checkbox"/> other: _____		
Gastrointestinal:	<input type="checkbox"/> swallowing problems, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> constipation, <input type="checkbox"/> diarrhea, <input type="checkbox"/> incontinence, <input type="checkbox"/> nausea, <input type="checkbox"/> vomiting, <input type="checkbox"/> ulcers, <input type="checkbox"/> melena, <input type="checkbox"/> rectal bleeding, <input type="checkbox"/> jaundice, <input type="checkbox"/> heartburn, <input type="checkbox"/> hematemesis <input type="checkbox"/> other: _____		

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Renal:	<input type="checkbox"/> dysuria, <input type="checkbox"/> frequency, <input type="checkbox"/> urgency, <input type="checkbox"/> hesitation, <input type="checkbox"/> flank pain, <input type="checkbox"/> hematuria, <input type="checkbox"/> incontinence, <input type="checkbox"/> nocturia, <input type="checkbox"/> polyuria, <input type="checkbox"/> other: _____
Musculoskeletal:	<input type="checkbox"/> pain, <input type="checkbox"/> swelling, <input type="checkbox"/> stiffness, <input type="checkbox"/> limitation of range of motion, <input type="checkbox"/> arthritis <input type="checkbox"/> gout, <input type="checkbox"/> cramps, <input type="checkbox"/> myalgia, <input type="checkbox"/> fasciculation, <input type="checkbox"/> atrophy, <input type="checkbox"/> fracture, <input type="checkbox"/> deformity, <input type="checkbox"/> weakness, <input type="checkbox"/> other: _____
Neurologic:	<input type="checkbox"/> seizures, <input type="checkbox"/> poor memory, <input type="checkbox"/> poor concentration, <input type="checkbox"/> numbness / tingling, <input type="checkbox"/> pins and needles sensation, <input type="checkbox"/> hyperpathia, <input type="checkbox"/> dysesthesia, <input type="checkbox"/> weakness, <input type="checkbox"/> paralysis, <input type="checkbox"/> tremors, <input type="checkbox"/> involuntary movements, <input type="checkbox"/> unstable gait, <input type="checkbox"/> fall, <input type="checkbox"/> vertigo, <input type="checkbox"/> headache, <input type="checkbox"/> stroke, <input type="checkbox"/> speech disorders <input type="checkbox"/> other: _____
Psychiatric:	<input type="checkbox"/> hallucinations, <input type="checkbox"/> delusions, <input type="checkbox"/> anxiety, <input type="checkbox"/> nervous breakdown, <input type="checkbox"/> mood changes <input type="checkbox"/> other: _____
Hematology:	<input type="checkbox"/> anemia, <input type="checkbox"/> bruising, <input type="checkbox"/> bleeding disorders (conditional) <input type="checkbox"/> other: _____
Endocrine:	<input type="checkbox"/> heat or cold intolerance, <input type="checkbox"/> diabetes, <input type="checkbox"/> lipid disorders, <input type="checkbox"/> goiter <input type="checkbox"/> other: _____
Other:	_____
Physical examination:	
Vital signs:	T= _____ P= _____ R= _____ BP= _____ / _____ Height= _____ Weight= _____
General appearance:	_____ _____
Head and neck:	_____ _____
Chest / lungs:	_____ _____
Cardiovascular:	_____ _____
Abdominal:	_____ _____
Musculoskeletal / extremities:	_____ _____

Neurological: \_\_\_\_\_  
\_\_\_\_\_  
Psychiatric: \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician or allowed NPP assessment / summary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the patient capable of being trained to use the glucose monitoring device prescribed in an appropriate manner? \_\_\_ Yes \_\_\_ No

If no, is there a responsible care giver? \_\_\_ Yes \_\_\_ No

Is the patient (or responsible caregiver) visually impaired severely enough to require a special monitoring system (voice, timer, special design) as documented in physical exam? \_\_\_ Yes \_\_\_ No

Does the patient (or responsible caregiver) have impairment of manual dexterity severe enough to require a special monitoring system (voice, timer, special design) as documented in physical exam?  
\_\_\_ Yes \_\_\_ No

Provider is certifying that a specialized glucose monitoring device is required to address the physical limitations of the patient or caregiver: \_\_\_ Yes \_\_\_ No

Is patient willing to perform blood glucose monitoring? \_\_\_ Yes \_\_\_ No

If no, is there a responsible caregiver? \_\_\_ Yes \_\_\_ No

Treatment plan:

*Monitoring schedule (If the patient and/or caregiver is willing to perform the glucose monitoring)*

*Non-Insulin Treated: \_\_\_ daily \_\_\_ >1 time daily: indication: \_\_\_\_\_*

*Insulin Treated: \_\_\_ up to 3x daily \_\_\_ >3x daily: indication: \_\_\_\_\_*

*Time of testing: \_\_\_ Fasting, Q AM \_\_\_ Before a meal (AM, Noon, Evening) \_\_\_ Before bedtime, Q HS*

*Other: \_\_\_\_\_*

Treatment plan (continued):

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Orders:

Medications: \_\_\_\_\_

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Supplies: \_\_\_\_\_

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Investigations (Diagnostic Testing): \_\_\_\_\_

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Consults: \_\_\_\_\_

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Other: \_\_\_\_\_

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Signature, Name, Date and NPI of physician or allowed NPP

Signature: \_\_\_\_\_

Name (printed): \_\_\_\_\_

Date (MM/DD/YYYY): \_\_\_\_\_ NPI: \_\_\_\_\_