



Title: Blood Glucose Monitors, Part 2  
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## AUDIO TRANSCRIPT

DR. ROBERT HOOVER: Hello and welcome to the second and final installment of our two-part Medicare Minute video series on Home Blood Glucose Monitors and Supplies local coverage determination and actions that CGS Medical Review will be taking in response to over utilization of diabetic testing supplies. Part 1 covered the order and the type of records necessary to support the beneficiary's testing frequency. In Part 2 today, I'll provide details about the refill request, proof of delivery and glucose testing education.

**Before we get started, one important note. This presentation IS NOT a substitute for reading the entire LCD and policy article. I'll only be highlighting the key documentation requirements but there are other important elements of this policy that will NOT be covered in this video so I strongly encourage you to read the policy in its entirety. We'll provide a link at the end of this presentation to the policy so have your pen and paper ready.**

Jurisdiction C Medical Review will be initiating prepayment medical review of randomly selected claims for glucose monitor test strips, HCPCS code A4253 and lancets, code A4259. The review will focus on non-insulin treated beneficiaries, identified by the use of a KS modifier, who are receiving quantities of supplies that exceed the utilization guidelines defined in the LCD. For non-insulin treated patients, the guidelines are:

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- Test strips. 2 units of service or 100 strips in a 90 day period; and,  
Lancets 1 unit of service or 100 lancets in a 90 day period.

Suppliers who have submitted claims selected for review will receive a documentation request letter in the mail asking for specific documentation that must be returned within 30 days of the date of the letter or the claim will be denied as not medically necessary.

So let's continue discussing this documentation starting with proof of request for refills. As noted in the glucose monitor LCD, when products are supplied as refills to an original order, suppliers must contact the beneficiary prior to dispensing the refill. This is done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order.

There are also rules from the Centers for Medicare & Medicaid Services or CMS that govern this communication with the beneficiary for refills. Contact with the beneficiary or their designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date.

Documentation may be a reply card signed and dated by the beneficiary and mailed to the supplier or a phone conversation with the beneficiary. For a phone contact, the documentation should include the beneficiary's name, the date of the contact, a statement indicating that the beneficiary was nearly out of their supplies and the initials or name of the employee who took the message. Because of the time frames specified in the Program Integrity Manual, a request for a refill that is made shortly after the prior delivery is not acceptable.

Now let's move on to proof of delivery. Again the CMS Program Integrity Manual and the Jurisdiction C Supplier Manual contain specific requirements to document proof of delivery. Since suppliers have several options for delivering supplies, there are several methods of documenting those deliveries.

For deliveries made directly by the supplier, there should be a delivery slip signed and dated by the beneficiary or their designee that includes, at a minimum:

- 1) The patient's name;
- 2) quantity delivered;
- 3) detailed description of the item being delivered;
- 4) brand name and/or serial number (if applicable);

Note that if a designee signs for the supplies, the delivery slip must clearly indicate the name of the designee and their relationship to the beneficiary.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary as a form of proof of delivery. This is acceptable as long as the information concerning the DMEPOS item (that is the patient's name, the quantity, detailed description, brand name and serial number) as well as the required signatures from the beneficiary are included on this invoice as well.

If you use a shipping service or mail order, an example of proof of delivery would include the service's tracking slip and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's specific package ID number. This tracking slip should reference each individual package, the delivery address, the corresponding package ID number given by the shipping service and if possible, the date delivered.

Finally, if you use a shipping service or mail order, the shipping date will serve as the date of service on the claim.

Now let's turn to a frequently forgotten element of the glucose monitor policy - Documentation of patient or caregiver education and competence in blood glucose testing.

Many suppliers and physicians are not aware that there is a national coverage policy for glucose monitors and that the DME MAC local coverage determination mirrors this national coverage determination closely. The NCD and the LCD both contain coverage guidance about the training and competency of the beneficiary or their caregiver to use a glucose monitor properly.

To meet this national policy requirement, the following documentation must be submitted:

- Evidence that the patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and,
- Evidence that the patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control.

According to the national policy, this training and competence must be documented by the treating physician.

That completes part 2 of our two-part series on documentation requirements for glucose monitors and supplies for the beneficiaries who are not treated with insulin but are using quantities of testing supplies greater than the usual amount listed in the DME MAC policy. If you receive a letter from Medical Review based

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on a claim submitted for glucose monitor supplies, remember that you'll have 30 days from the date of the letter to respond with the information requested. For Medicare Minute, I'm Dr. Robert Hoover.

[http://www.cignagovernmentservices.com/jc/coverage/mr/glucose\\_monitors.html](http://www.cignagovernmentservices.com/jc/coverage/mr/glucose_monitors.html)

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