BECN 15279010758

BINSON'S Medical Equipment & Supplies Since 1953

Longwood, FL
Fax: 407-691-3021

Reset Form

Diabetes Supplies Detailed Written Order Prior to Delivery

Patient Name: _____ Order Date: _____

Account #: _____ Patient DOB: _____

☐ ***Face Sheet/Demographics Faxed***

☐ ***Chart Notes Attached***
(Chart notes must include the need for the equipment being ordered and ***MUST BE ATTACHED FOR OVER QUANTITY***)

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

DIAGNOSIS

ICD-10 Code: _____ Length of Need in Months: _____

TREATMENT TYPE

Is patient treated with insulin injections and/or insulin pump? ☐ Yes ☐ No

TESTING FREQUENCY (based on a three month order)

☐	1 time per day (100 strips and 100 lancets)	☐	4 times per day (400 strips and 400 lancets)
☐	2 times per day (200 strips and 200 lancets)	☐	5 times per day (450 strips and 500 lancets)
☐	3 times per day (300 strips and 300 lancets)	☐	Other _____

BLOOD GLUCOSE MONITOR

☐	Glucose Monitor (E0607) Brand: _____
☐	Glucose Monitor for Visually Impaired (E2100)

Visual Acuity: _____ (Necessary for Monitor for Visually Impaired)

ACCESSORIES (The accessories/supplies below are medically necessary) *CROSS OFF SUPPLIES NOT NEEDED*

☒	Test Strips (A4253)	☒	Lancets (A4259)
☒	Control Solution (A4256) (as requested 1 per 3 months)	☒	Batteries (as requested)
☒	Lancing Device (A4258) (as requested 1 per 3 months)		

Medicare non-insulin treated patients testing more than 1 time per day and Medicare insulin treated patients testing more than 3 times per day *ONLY*, will need valid chart notes every 6 months to support testing frequency. Chart notes must contain written information to support the medical need to test more frequently, information stating patient was evaluated for diabetes control within the 6 months and information documenting the physician has reviewed and noted in the patient's chart notes, the actual frequency, testing log from meter and provide an explanation of the specific frequency of testing.

Prescribing Physician's Information

Name & Credentials _____ NPI # _____

Telephone _____ Fax _____

Signature _____ Signature Date _____
(Stamped signature not accepted)

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CONTINUOUS GLUCOSE MONITOR (CGM)

CGM devices covered by Medicare under the DME benefit are defined in CMS Ruling 1682R as therapeutic CGMs. Refer to the Non-Medical Necessity Coverage and Payment Rules in the LCD-related Policy Article for additional information.

Therapeutic CGMs and related supplies are covered by Medicare when all of the following coverage criteria (1-5) are met:

1. The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,
2. The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
3. The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results; and,
4. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate their diabetes control and determined that criteria (1-3) above are met; and,
5. Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

When a therapeutic CGM (code K0554) is covered, the related supply allowance (code K0553) is also covered.

If any of coverage criteria (1-5) are not met, the CGM and related supply allowance will be denied as not reasonable and necessary.

The supply allowance (code K0553) is billed as 1 Unit of Service (UOS) per thirty (30) days. Only one (1) UOS of code K0553 may be billed to the DME MACs at a time. Billing more than 1 UOS per 30 days of code K0553 will be denied as not reasonable and necessary.

Therapeutic CGM devices replace a standard home blood glucose monitor (HCPCS codes E0607, E2100, E2101) and related supplies (HCPCS codes A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259). Claims for a BGM and related supplies, billed in addition to an approved CGM device (code K0554) and associated supply allowance (code K0553), will be denied. Refer to the Coding Guidelines in the LCD-related Policy Article for additional information.

All therapeutic CGM devices billed to Medicare using HCPCS code K0554 must be reviewed for correct coding by the Pricing, Data Analysis and Coding (PDAC) contractor. Continuous Glucose Monitor systems that are billed using HCPCS code K0554, but that are not listed on the Product Classification List for HCPCS code K0554, will be denied as incorrect coding. Refer to the Coding Guidelines in the LCD-related Policy Article for additional information.