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LCD for Blood Glucose Monitoring in a Skilled Nursing Facility (SNF) (L34834)

Contractor Information

Contractor Name: Novitas Solutions, Inc.

Contractor Number: 12502

Contractor Type: MAC B

LCD Information

LCD ID Number: L34834 Status: A-Approved

LCD Title: Blood Glucose Monitoring in a Skilled Nursing Facility (SNF)

Geographic Jurisdiction: Pennsylvania Other Jurisdictions

Original Determination Effective Date: 10/01/2015

Original Determination Ending Date:

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Revision End Date:

CMS National Coverage Policy:
This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for blood glucose monitoring in a skilled nursing facility. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for blood glucose monitoring in a skilled nursing facility and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

IOM Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Sections 80.1 and 80.6, and Section 1833 and 1861 of the Social Security Act provide for payment of clinical laboratory services under Medicare Part B, when in keeping with the requirements under Section 80.6 for ordering and following orders for diagnostic tests.
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 3, Section 190.20 Blood Glucose Testing.
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 90 Diabetes Screening.

Change Requests References:

- CMS Transmittal 80, Change Request 5743 of January 11, 2008

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Indications and Limitations of Coverage and/or Medical Necessity:

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

Blood glucose determination may be done using whole blood, serum or plasma. It may be sampled by capillary puncture, as in the finger stick method, or by vein puncture or arterial sampling. Meter assay of whole blood acquired through a finger stick using a device approved for home monitoring allows a patient to have access to blood glucose values on a digital display in a minute or less and has become a standard of care for control of blood glucose, even in the inpatient setting.

Routine glucose monitoring of diabetics is never covered in a SNF, whether the beneficiary is in a covered Part A stay or not. Glucose monitoring may only be covered when it meets all the conditions of a covered laboratory service including use by the physician in modifying the patient's treatment.

Medicare pays for a blood glucose test only when the service meets all of the conditions of payment for a test payable under the clinical laboratory fee schedule including that the test must be ordered by the physician who is treating the beneficiary and the physician must use the results in the management of the beneficiary's specific medical condition.

For payment to be made for a blood glucose test under Medicare Part B, a physician must certify that each test is medically necessary. A standing order for many tests over a time period is not sufficient documentation.

Repeated performance of finger-stick blood glucose tests to maintain standing orders for insulin injection or oral hypoglycemic agents does not meet the criteria for Part B payment in a SNF. Payment for nursing care glucose monitoring is encompassed under Medicare Part A and other payment methods. If the patient is in a skilled nursing facility, routine glucose monitoring (including any tests which are not promptly reported) is a part of routine personal care and is not a separately billed procedure (PM AB-00-108, December 2000).

The home glucose monitoring device is on the list of instruments that can be administered by providers registered under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), including providers registered with only a certificate of waiver. However, Medicare Part B may only pay for a glucose monitoring device and related disposable supplies under the durable medical equipment benefit if the equipment is used in the home or in an institution that is used as a home. A hospital or SNF is not considered a home under the SSA, Sect. 1861 (h).

Blood glucose values are often necessary for the management of patients with diabetes mellitus, where hyperglycemia and hypoglycemia are often present. They are also critical in the determination of control of blood glucose levels in the patient with impaired fasting glucose, the patient with insulin resistance syndrome and/or carbohydrate intolerance (excessive rise in glucose following ingestion of glucose or glucose sources of food), in the patient with a hypoglycemia disorder such as insulinoma, and in patients with a catabolic or malnourished state. In addition to those conditions already listed, glucose testing may be medically necessary in patients with tuberculosis, unexplained chronic or recurrent infections, alcoholism, coronary artery disease (especially in women), or unexplained skin conditions (including pruritis, local skin infections, ulceration and gangrene without an established cause).

Many medical conditions may be a consequence of a sustained elevated or depressed glucose level. These include comas, seizures or epilepsy, confusion, abnormal hunger, abnormal weight loss or gain, and loss of sensation. Evaluation of glucose may also be indicated in patients on medications known to affect carbohydrate metabolism.

The frequency of monitoring of blood glucose values should be determined by the physician on an individual basis while considering and documenting any of the following factors that affect glycemic control:

- Variations and degree of glycemic control as documented by hemoglobin A1C levels
- Treatment with insulin versus oral agents

- Frequency of symptoms of hypoglycemia
- Frequency of prior adjustments in therapy
- Motivation/ability for self-care and the presence of limitations such as language barriers and mental illness
- Presence of diabetic complications

Patients who have exhibited long-term control of blood glucose levels as evidenced by normal (per reference laboratory range) or steady A1C levels over a 6 month period, minimal or no changes in diabetic therapy, OR no complications of diabetes mellitus (to include retinopathy, neuropathy, or diabetic renal or vascular complications) do not require frequent blood glucose monitoring.

CMS Transmittal 80, Change Request 5743 of January 11, 2008, in keeping with the Medicare Benefit Policy Manual, Chapter 15, 80.1, states "Clinical laboratory services must be ordered and used promptly by the physician who is treating the beneficiary as described in 42 CFR 410.32(a), or by a qualified non physician practitioner, as described in 42 CFR 410.31(a)(3).

Sections 42 CFR 410.32 and 411.15 specify that for a laboratory service to be reasonable and necessary it must not only be ordered by the physician but the ordering physician must also use the result in the management of the beneficiary's specific medical problem. Implicitly, the laboratory result must be reported to the physician promptly in order for the physician to use the result and instruct continuation or modification of patient care; this includes the physician's order for another laboratory service. Compliance program guidance for laboratory services sets forth conditions under which a physician's order for a repeat laboratory service can qualify as an order for another covered laboratory service. A standing order is not usually acceptable documentation for a covered laboratory service.

Any laboratory study ordered on a continuing basis without a cutoff time frame and without documentation in the medical record supporting that any previously ordered study was evaluated, will be considered a standing order and therefore, not reimbursable. Examples of acceptable time frames are as follows: daily times 3 days, BID times 2 days, weekly FBS times 2 weeks.

It should be noted that this policy does not prohibit a nursing home's Medical Director from authorizing services or procedures in emergency situations in a manner consistent with the Medical Director's obligations under state or federal law. In such instances, however, there must be documentation as to why the circumstances warrant intervention into the attending physician's role of caring for the patient.

As stated above, for a laboratory test to be covered, the result must be reported to the physician promptly in order for the physician to use the result and instruct continuation or modification of patient care. The following are time frames for use in reporting the results of blood glucose testing “promptly” to the physician.

Reporting Abnormal Blood Glucose Results

When reporting the abnormal values listed below, the time frame in which the blood glucose result must be reported to the physician is dictated by that result.

When blood glucose values are 60-90 mg/dl (low) or 160-299 mg/dl (high), the physician must be notified of the results **within 12 hours**.

When blood glucose values are below 60 mg/dl (low) or over 300 mg/dl (high), the physician must be notified of the results **immediately**.

The above timeframes are appropriate for most patients. Depending on patient history and circumstances, shorter time frames may be clinically warranted.

When reporting an abnormal blood glucose value to the physician, the previous two or more results, as appropriate, should also be provided for trending purposes.

Reporting Blood Glucose Results within Normal Limits

In the absence of abnormal blood glucose results, the condition of the patient dictates the time frame for physician notification. The physician should be provided with a trending report consisting of the appropriate number of blood glucose values based on the frequency of monitoring.

Patient Category Timeframes for reporting to physician

Category A:

Blood glucose results must be reported to the physician **within 12 hours** for patients who have documented:

1. unstable diabetes mellitus with or without unstable glucose levels and are at risk for alterations in glucose levels, OR
2. fingerstick glucose monitoring performed at least two (2) times per day.

Category B:

Blood glucose results must be reported to the physician **within 24 hours** for patients who have documented:

1. diabetes mellitus which is not completely stable and are at some risk for alterations in glucose levels, although with less probability and/or lower magnitude of fluctuations, OR
2. fingerstick glucose monitoring performed less than two (2) times per day.

Effective January 1, 2005, the Medicare law expanded coverage to diabetic screening services. Some forms of blood glucose testing covered under this national coverage determination may be covered for screening purposes subject to specified frequencies. See 42 CFR 410.18 and section 90, chapter 18, of the Claims Processing Manual, for a full description of this screening benefit.

In addition, all other criteria for coverage as delineated in this LCD and Medicare regulations must be satisfied.

Limitations
Blood glucose measurements without prompt physician notification as outlined above are not covered as diagnostic laboratory tests.

As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs and condition.
    - Ordered and furnished by qualified personnel.
    - One that meets, but does not exceed, the patient's medical needs.
    - At least as beneficial as an existing and available medically appropriate alternative.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

22	Skilled Nursing - Inpatient (Medicare Part B only)
23	Skilled Nursing - Outpatient

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0300	Laboratory - General Classification
0305	Laboratory - Hematology
0306	Laboratory - Bacteriology & Microbiology
0307	Laboratory - Urology
0302	Laboratory - Immunology
0301	Laboratory - Chemistry
0303	Laboratory - Renal Patient (Home)
0304	Laboratory - Non-Routine Dialysis

0309	Laboratory - Other Laboratory

CPT/HCPCS Codes:

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

82947	GLUCOSE; QUANTITATIVE, BLOOD (EXCEPT REAGENT STRIP)
82948	GLUCOSE; BLOOD, REAGENT STRIP
82962	GLUCOSE, BLOOD BY GLUCOSE MONITORING DEVICE(S) CLEARED BY THE FDA SPECIFICALLY FOR HOME USE

ICD-10 Codes that Support Medical Necessity:

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

ICD-10-CM codes that support medical necessity are per the National Coverage Determination for Blood Glucose Testing which can be accessed in the CMS Internet-Only Manual (IOM), Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 3, Section 190.20.

or via the CMS Coverage Center at:

http://www.cms.gov/center/coverage.asp

XX000	Not Applicable

General Information

Associated Information

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. Documentation must be evident in the patient's medical record to substantiate the medical necessity of the testing performed. The ordering physician should retain in the patient's medical record, history and physical examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications.
5. Documentation must support that blood glucose monitoring was ordered by the physician and the laboratory result was reported to the physician promptly. The medical record must reflect the time the blood glucose result was obtained and the time the physician was notified. The documentation must also support that the results were used in the modification of care for the beneficiary's specific medical problem including changes/alterations in medications prescribed for the treatment of the patient's condition.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Sources of Information and Basis for Decision

Contractor is not responsible for the continued viability of websites listed.

Other Contractor Policies

Contractor Medical Directors

Original JL ICD-9 Source LCD L27475, Blood Glucose Monitoring in a Skilled Nursing Facility (SNF)

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
05/11/2017	R2	LCD revised and published on 05/11/2017 to add additional IOM references to the CMS National Coverage Policy section.
10/01/2015	R1	LCD revised to create uniform LCD with other MAC jurisdiction .