Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-99 **Date: OCTOBER 24, 2000**

CHANGE REQUEST 1407

SUBJECT: Glucose Monitoring Note

This Program Memorandum (PM) briefly notes Medicare policy for glucose monitoring for a patient whose stay is not covered by Medicare Part A but who is eligible for services under Medicare Part B. Another PM will be issued, Change Request 1362, Glucose Monitoring, to describe further coverage, payment and billing instructions for this service. Glucose monitoring measures blood sugar levels for the purpose of managing insulin therapy (shots, medication, and diet). The service often involves the use of an inexpensive hand-held device to evaluate a small sample of the patient's blood acquired through a finger stick. The device(s) was added to the list of instruments that can be administered by providers registered under the Clinical Laboratory Improvement Amendments (CLIA) including providers registered with only a certificate of waiver. The Current Procedural Terminology (CPT) code that most often describes the service is 82962 *Glucose, blood by glucose monitoring device(s) cleared by the FDA (Food and Drug Administration) specifically for home use.*

Section 1862(a)(1)(A) of the Social Security Act requires the service to be reasonable and necessary for diagnosis and treatment in order to be covered by Medicare. Sections 42 Code of Federal Regulations (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 so that the physician can 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 permits, but with strict limits, the conditions under which the physician's order for a repeat laboratory service can qualify as an order for another covered laboratory service.

A national coverage policy on blood glucose monitoring has not been promulgated. Carriers and intermediaries have been responsible for making coverage determinations and many have developed a local coverage policy to assist with payment determinations. Section 541 of the Skilled Nursing Facility (SNF) Manual explains that when a reasonable and necessary laboratory service is administered for a Part B only patient, the laboratory service is separately payable either on a reasonable cost basis (if the patient is in a certified bed) or under the clinical laboratory fee schedule (if the patient is in a non-certified bed). If a Part B only patient resides in a nursing home certified bed, a Uniform Bill-92 (UB92) using TOB 22x and revenue code 30x is submitted to the intermediary. The laboratory cost center of the cost report must reflect the corresponding glucose monitoring costs and charges even when the provider is registered for laboratory testing with only a certificate of waiver from CLIA. The beneficiary is liable for the deductible and coinsurance. If a Part B only patient resides in a non-certified bed, payment is made under the clinical laboratory fee schedule. A UB92 is submitted using TOB 23x and revenue code 30x to the intermediary. The beneficiary is not liable for a deductible or coinsurance.

A glucose monitoring service must meet the reasonable and necessary coverage criteria to qualify for separate payment under the Medicare laboratory benefit. If a glucose monitoring service meets the criteria to be a covered laboratory service for a Part B only patient, regardless of whether the nursing home patient resides in a certified or non-certified bed, payment must be made. Denial of payment for a Part B covered laboratory service cannot be made on the basis that the service is routine care. Routine care determinations are applicable for Part A nursing home services.

NOTE: Claims must be processed in accordance with current local medical review policy.

The effective date for this PM is November 1, 2000.

The implementation date for this PM is November 1, 2000.

These instructions should be implemented within your current operating budget.

For questions regarding this document, contact Anita Greenberg on (410) 786-4601. For questions regarding §541 of the SNF Manual, contact Jackie Gordon on (410) 786-4517.

This PM may be discarded after December 31, 2001.