



March 25, 2014

# Montana Health Care Programs Notice

## Durable Medical Equipment

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**Update – Effective Immediately**

### Home Blood Glucose Monitors and Related Accessories and Supplies

This notice replaces previous provider notices on this topic. The purpose of this provider notice is to reinforce existing policy and rules in regard to home blood glucose monitors and the related accessories and supplies.

In accordance with Administrative Rules of Montana (ARM) 37.86.1802, Montana Medicaid has adopted Medicare coverage criteria for Medicare covered durable medical equipment as outlined in the Region D Supplier Manual, local coverage determinations (LCDs) and national coverage determinations (NCDs). For prosthetic devices, durable medical equipment, and medical supplies not covered by Medicare coverage will be determined by the Department.

The Department shall follow the criteria set forth in the LCD for glucose monitors (L196) which specifically states the following:

To be eligible for coverage of home blood glucose monitors and related accessories and supplies, the beneficiary must meet both of the following basic criteria (1)–(2):

1. The beneficiary has diabetes (ICD-9 codes 249.00-250.93); and
2. The beneficiary’s physician has concluded that the beneficiary (or the beneficiary’s caregiver) has sufficient training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.

For all glucose monitors and related accessories and supplies, if the basic coverage criteria (1)–(2) are not met, the items will be denied as not reasonable and necessary. The only exception to this policy would be for women with gestational diabetes.

The Medicare LCD is on the Noridian website at <https://www.noridianmedicare.com/dme/coverage>.

## Change in Maximum Units Allowed

Effective immediately, Montana Medicaid will also follow the allowable unit amounts set by Medicare for lancets and test strips.

### Usual Utilization

- For a beneficiary who is not currently being treated with insulin injections, up to 100 test strips and up to 100 lancets every 3 months are covered if the basic coverage criteria (1)–(2) (above) are met.
- For a beneficiary who is currently being treated with insulin injections, up to 300 test strips and up to 300 lancets every 3 months are covered if basic coverage criteria (1)–(2) (above) are met.

### High Utilization

- For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) – (c) below are met.
- For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) – (c) below are met.
  - Basic coverage criteria (1)–(2) listed above for all home glucose monitors and related accessories and supplies are met; and
  - The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary’s medical record the specific reason for the additional materials for that particular beneficiary; and
  - If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician’s records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary’s log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

Providers submitting claims with units considered “high utilization” must ensure **all** of the above requirements for high utilization are met. To process claims for high utilization members the procedure below shall be followed:

- Indicate any associated insulin use in the appropriate field using ICD-9 code (V58.67). If this code is not present, the claim will be denied.
- If the high utilization claim is for a **child** age birth through 20, a “1” must be entered in column H (EPSDT) on the CMS-1500 paper claim form or inserted into the appropriate field that corresponds to column H in the 837 electronic claim formats. This will enable the claim to bypass the edit for over the usual allowable units without rejecting or denying the claim first.

## Rejections

DME claims processed through a provider's Point of Sale (POS) system may post a rejection notice if certain limits are exceeded. These rejections are generated by your claims clearinghouse or billing agent (the company contracted to electronically submit your claims) based on edits that they have in place. Providers should contact their billing agent's help desk for the appropriate guidance if they receive a rejection after submitting the claim electronically.

## Contact Information

If you have any questions, please contact Donna Shorten at 406-444-5296 or [DShorten@mt.gov](mailto:DShorten@mt.gov).

For claims questions or additional information, contact Provider Relations at 1-800-624-3958 (toll-free, in/out of state) or 406-442-1837 (Helena) or via e-mail at [MTPRHelpdesk@xerox.com](mailto:MTPRHelpdesk@xerox.com).

Visit the Provider Information website at <http://medicaidprovider.hhs.mt.gov>.