Diabetic Testing, Insulin Pump and Supplies,

and CGM Detailed Written Order - **Medicare**

AIM PLUS MEDICAL SUPPLIES

Please fax form with Physician's signature to

1-866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

Contact person (if other than patient): _____

REQUIRED INFORMATION FOR ALL PATIENTS

PLEASE COMPLETE THIS SECTION IN FULL

Date of Last Office Visit: _____

Duration of Need (12 months unless other wise noted): _____

Type 1— IDDM

- ☐ E10.9
- ☐ E10.65
- ☐ **Other** _____

Type 2—Pills, Diet, and/or Insulin Treated

- ☐ E11.9
- ☐ E11.65
- ☐ **Other** _____

HbA1c: _____

Currently using a pump? ☐ YES ☐ **NO**

Currently on CGM Therapy? ☐ **YES** ☐ **NO**

Fasting Hyperglycemia: _____

Testing Frequency: _____

Fluctuation of blood glucose values:

Using insulin shots to control? ☐ **Yes** ☐ **No**

Low: _____ High: _____

Number of injections a day: _____

- ☐ Test Strips

Product Name:

_____

- ☐ Lancets

Product Name:

_____

- ☐ Lancing Device **PRN**
- ☐ Ketostix
- ☐ Alcohol Wipes
- ☐ Meter Battery **PRN**
- ☐ Control Solution **PRN**
- ☐ Meter **PRN**
- ☐ Transparent Tape
- ☐ Prep Wipes
- ☐ Adhesive Remover
- ☐ Infusion Sets
- ☐ Reservoirs
- ☐ Omnipod Insulin Pump PDM
- ☐ Omnipod Pods
- ☐ Other: _____
- ☐ Other: _____

CGM Products

DEXCOM G6

- ☐ Receiver: Dispense 1: DME Only : 1/5 years
- ☐ Sensors: Quantity 13 boxes (units): DME Only**:** 9 units/90 days
- ☐ Transmitter Dexcom G6 (3 month use): 4/365 Days

FREE STYLE LIBRE 2

- ☐ Receiver: Dispense 1: DME Only: 1/5 years
- ☐ Sensors: Quantity 26.00 units: 6 units/90 days

USE PER MANUFACTURER RECOMMENDATIONS

My signature below denotes to the best of my knowledge the patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of supplies or equipment ordered. I am a provider who manages patients with diabetes, insulin pump, or CGM therapy and work closely with a team including nurses, diabetic instructors, and dietitians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

Physician Staff Contact:

_____

Provider Name (print): _____ **Provider NPI #** _____

Provider Phone Number: _____ **Provider Fax:** _____

Provider Signature: _____ **Date:** _____

6521 Hwy 69 S, Ste N, Tuscaloosa, AL 35405 Phone 866-919-1246 Fax 866-496-7054

MEDICARE CLINICAL DOCUMENTATION CHECKLIST FOR AIM PLUS MEDICAL SUPPLIES, LLC

The following must be completed and signed by the physician with supporting documentation.

CONTINUOUS GLUCOSE MONITORS (CGM) PREREQUISITE CRITERIA

***Please check all that apply and include supporting documentation.**

Therapeutic CGMs and related supplies are covered by Medicare when all of the following coverage criteria (1-6) are met:

☐ The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,

☐ The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a Medicare-covered continuous subcutaneous insulin infusion (CSII) pump; and,

☐ The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results; and,

☐ 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 (1-4) above are met; and,

☐ 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.

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.

INSULIN PUMPS COVERAGE CRITERIA

***Please check all that apply and include supporting documentation.**

☐ Must have completed a comprehensive diabetes education program.

☐ Must have a diagnosis of diabetes

☐ Must be injecting at least 3X per day and adjusting insulin dose

☐ Lab work is required

☐ Must be testing4X per day (or on a CGM) and meet one of the following criteria:

1. HbA1C greater than 7%
2. History of recurring hypoglycemia
3. Wide fluctuations in blood glucose before mealtime
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
5. History of severe glycemic excursions

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by CMS. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

_____ _____

Prescribing Practitioner Signature (Required) Date

Stamps/copies of the physician's signature will not be accepted.