Diabetic Testing, Insulin Pump, and Supplies
Detailed Written Order- Medicare

Please Fax Form with Provider's Signature to
AIM Plus Medical Supplies 1-866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth_____

Primary Phone: _____ Secondary Phone: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____ ID# _____

Contact Person: _____ Email: _____

REQUIRED INFORMATION FOR ALL PATIENTS - PLEASE FULLY COMPLETE THIS SECTION

Date of Last Office Visit: _____ Duration of Need: _____ mo. (12 unless noted)

____ Type 1 -IDDM ____ E 10.9 ____ E 10.65 ____ E 10.649 ____ Other: _____

____ Type 2- Pills, Diet, and/or Insulin Treated ____ E 11.9 ____ E 11.65 ____ Other: _____

Testing Frequency: _____ X per Day Using Insulin treatment to control? ____ Yes ____ No

Number of insulin treatments: _____ X Per Day HbA1c: _____ Currently Using a Pump? ____ Yes ____ No

Currently on CGM Therapy? ____ Yes ____No Fasting Hyperglycemia: _____

Fluctuation of Blood Glucose Values: _____ Low _____ High

PRODUCTS PRN- USE PER MANUFACTURERS RECOMMENDATION

____ CGM, Dexcom G6: Sensors, transmitter, receiver, prep wipes, adhesive remover, dressing

____ CGM, Dexcom G7: Sensors (transmitter included), receiver, prep wipes, adhesive remover, dressing

____ CGM, FreeStyle Libre 2: Sensors, reader, prep wipes, adhesive remover, dressing

____ Insulin Pump: ____ Tandem T-slim Control IQ ____ Tandem T-slim Basal IQ

____ Medtronic MiniMed 630 ____ Medtronic MiniMed 770G

____ Insulin Pump Supplies: Reservoirs, infusion sets, prep wipes, adhesive remover, dressing

____ Other: _____

****My signature below denotes, to the best of my knowledge, the patient/caregiver can follow instructions for controlling diabetes and is able to use the ordered items, which are designed for home use, including being able to hear and/or view alerts and respond as needed. The patient/caregiver has successfully completed training or is scheduled to begin training in using supplies or equipment ordered. I am a provider who manages patients with diabetes, insulin pump, or CGM therapy and works closely with a team including nurses, diabetic instructors, and dieticians knowledgeable in the use of subcutaneous insulin infusion therapy. For CGM renewals, the patient listed on this CMN is under my care and is followed by our clinic. I am writing to support the continued use and coverage of a Continuous Glucose Monitor (CGM) and supplies. A CGM remains medically necessary for this patient to have optimal blood glucose control. I certify this treatment is indicated and necessary and meets the guidelines for use as outlined by CMS.**

Provider Name (Print): _____ Provider NPI: _____

Provider Phone Number: _____ Provider Fax: _____

Provider Signature: _____ Date: _____

500 Patriot Pkwy, Ste B, Tuscaloosa, AL 35405 Phone: 866-919-1246 Fax: 866-496-7054

AIM Plus Medical Supplies
Medicare Checklist for CGMs LCD
Effective Date: April 16, 2023

Please provide documentation in office notes of the following:

To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the following initial coverage criteria (1)-(5):

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's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription; and,**
3. **The CGM is prescribed in accordance with its FDA indications for use; and,**
4. **The beneficiary for whom a CGM is being prescribed, to improve glycemic control, meets at least one of the criteria below:**

    A. **The beneficiary is insulin-treated; or,**
    B. **The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following:**

    - **Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,**
    - **A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia**

5. **Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicare-approved telehealth visit with the beneficiary to evaluate their diabetes control and determined that criteria (1)-(4) above are met.**

This checklist is provided for informational purposes in order to guide you in submitting supporting documentation. The checklist does not have to be signed by a provider or returned to AIM Plus Medical Supplies. Please email supporting documents to documents@aimplusonline.com or fax them to 866-496-7054 to the attention of the medical device team. Thank you for your referral. We will take excellent care of your patient!

Medicare Clinical Documentation Checklist for AIM Plus Medical Supplies
External Infusion Pump (Insulin Pump)
LCD Effective Date 4/1/23

Please provide documentation in office notes of the following:
Administration of continuous subcutaneous insulin for the treatment of diabetes mellitus. If criterion A or B is met and if criterion C or D is met.

A. **C-peptide testing requirement – must meet criterion 1 or 2 and criterion 3:**

    1. **C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method.**
    2. **For beneficiaries with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method.**
    3. **A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl.**

B. **Beta cell autoantibody test is positive.**

C. **The beneficiary has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria (1 - 5) while on the multiple injection regimen:**
    1. **Glycosylated hemoglobin level (HbA1C) greater than 7 percent**
    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**

D. **The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.**

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