Home Health Coding and OASIS Expert

Eligibility: Are Your Claims in Jeopardy Under this Diabetes LCD?

Only one MAC has these claims in the crosshairs, but you shouldn't rest easy just yet.

If your agency doesn't have a recent HbA1c on file when you report a diabetes diagnosis, you could be facing denied claims. Make certain you're crossing your t's and dotting your i's when it comes to documentation, or your reimbursement could pay the price.

Know What's Required

The **Palmetto GBA** Local Coverage Determination Home Health Plans of Care: Monitoring Glucose Control in the Medicare Home Health Population with Type II Diabetes Mellitus (L35413) took effect Dec. 30, 2014. The LCD states best practices for caring for Type II diabetes, including:

- Consider Metformin as a first-line therapy for Medicare beneficiaries requiring medications to achieve long-term control of glucose levels unless there is a specific contraindication to its use.
- Include documentation of the "specific structural or functional impairments, together with the related activity limitations" in the Plan of Care for patients who require a nurse to provide daily insulin injections because they are "either physically or mentally unable to self-inject insulin." You'll also need to document that "there is no other person who is able and willing to inject the beneficiary." Not including these details in the POC for patients with no other skilled services "will result in a claim denial."
- Include "the monitoring and reporting of not only intermittent capillary blood/serum glucose levels but also quarterly (and no less often than 120 days) HbA1c levels."

The HHH Medicare Administrative Contractor also asks HHAs to make certain their records for diabetic patients meet the following measures:

1. Documentation should show that patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient.

2. The results of the most recent HbA1c.

3. Documentation must be legible, relevant and sufficient to justify the services billed. This documentation must be made available to the A/B MAC upon request.

The LCD also requires you to report V58.67 (Long-term [current] use of insulin) for patients with Type II diabetes who are taking insulin, points out **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O,** consultant and principal of **Selman-Holman & Associates, Code Pro University and CoDR Coding Done Right** in Denton, Texas.

Here's The Kicker

While at first blush, this LCD may appear to apply primarily to patients requiring a nurse to provide daily insulin injections, it will actually affect a much larger group of patients. "This LCD applies to all patients with Type II DM," Palmetto explained in a response to comments about the LCD published in its December 2014 J11 HHH Medicare Advisory.

Bottom line: You'll need to make certain you have a recent HbA1c whenever you list a diabetes code on a claim. This "even applies if diabetes is secondary on a therapy-only case," Selman-Holman says.

What can you do if the physician doesn't order an HbA1c? Despite the fact that your agency has no control over what the

physician will or will not do, it's the agency's payment that will take the hit. Unfortunately, you can't simply document the physician's refusal, according to the **Texas Association for Home Care & Hospice's** Feb. 19 member newsletter. And you can't perform a fingerstick (POS) HbA1c yourself, either, the newsletter Q&A advises.

Palmetto has done some outreach toward educating physicians about this new requirement through social media, TAHC&H says. And the MAC plans to use the physicians on its Contractor Advisory Committee to help disseminate the LCD and its supporting information, as well as during in-person educational sessions hosted by the Provider Outreach and Education (POE) Department.

Palmetto has provided medical literature to support this new initiative and it has suggested that agencies should share the articles with physicians so that they can understand what is expected of them, Selman-Holman says. Medicare pays for the HbA1c every 90 days and they encourage physicians to monitor blood glucose levels with the test, she says.

The cost: Palmetto has clarified that agencies shouldn't even submit the claims if a current HbA1c isn't available, Selman-Holman says. "So it is in the agencies' best interests to educate the physicians, get an order for a venipuncture if necessary at SOC or recert, and report the results to the physician."

The episode(s) will be subject to denial if claims are submitted and an HbA1c is not available, Selman-Holman says. This applies to all Type II diabetics, not just the ones where diabetes is primary and not just to ones who use insulin, she says.

Caution: If you think you're in the clear because your agency isn't in Palmetto's jurisdiction, think again. "The other MACS could apply this requirement at any time," Selman-Holman warns. "Palmetto unofficially has stated they intend to revise the policy to include only type II diabetics who require insulin injections, but I think we should wait and see until that point and try to comply."

Note: For a PDF copy of the LCD, email the editor at janm@codinginstitute.com with the subject line "Palmetto Diabetes LCD."