

Forms, Forms, and More Forms

John E. Brunner, MD

With all the challenges of modern health care practices, the proliferation of certification for medical necessity (CMN) forms and other documentation requirements has become an increasing distraction from conversing with, examining, and critically thinking about patients. In particular, CMNs for self-monitoring of blood glucose

(SMBG) have become a major impediment.

In 2011, diabetes care providers were notified by the Center for Medicare and Medicaid Services (CMS) about new regulations to obtain coverage for blood glucose monitoring strips for individuals with diabetes. Those using only oral agents are allowed 100 strips for 90 days; those using insulin

are allowed up to 100 strips per month.

This will suffice for many Medicare-covered patients. However, those of us who scrupulously review glucose diaries and meter downloads and use this information to adjust intensive regimens or to help complicated patients achieve their glucose goals know there are many patients for whom these restrictions will

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not work. Many seniors or disabled individuals are prone to hypoglycemia because of extreme insulin deficiency or erratic dietary intake. Many require multiple injections of adjustable-dose insulin or use insulin pumps. Performing SMBG three times per day will not suffice for these patients. Furthermore, impaired dexterity can often result in dropped strips. When initiating a new oral agent, more frequent SMBG is needed to appropriately and safely adjust the medication. Obsessive adherence to these rules also will not allow individuals to perform additional SMBG between clinic visits when they are sick, undergoing dietary changes, changing their physical activity regimens, or making changes to other medications that may affect glucose levels to treat such common disorders as heart, renal, or chronic obstructive pulmonary disease.

CMS may argue that patients can pay out of pocket for the extra strips they need. Unfortunately, fixed-income patients who are chronically ill and must take multiple medications with multiple co-payments may decide to stop checking their blood glucose because of these expenses. This often results in more emergency department visits and hospitalizations for severe hypo- or hyperglycemia that could have been managed through outpatient services had glucose strips been available for more frequent SMBG.

OK, quit whining, write a prescription for strips, and indicate the International Classification of Disease (ICD) code for diabetes, the mode of treatment, and monitoring frequency. Simple? Not quite.

Once a patient takes the presumed fully compliant prescription for strips to the durable medical equipment (DME) company, that company begins sending a flurry of high-priority faxes (sometimes daily)

requiring the provider to fill in its own forms with the ICD code, monitoring frequency, mode of treatment, last A1C, and date of last clinic visit, as well as whether this prescription is for personal use and how long the patient will be performing SMBG. In our practice of 10 providers, shoveling out from under these forms requires nearly the full-time effort of one employee.

Because most of our referral patients fit the category of high-frequency SMBG, we then receive a blizzard of requests for additional information. We are warned that, to obtain supernumerary strips, our providers' progress notes must re-document the reason for more frequent SMBG, how frequently patients perform SMBG, and how often SMBG is prescribed. Some DME companies require us to send them copies of the progress notes from patient charts. This entails copying and faxing the records to DME companies across the United States with whom physicians do not have HIPAA (Health Insurance Portability and Accountability Act) agreements. Sending patient notes to these companies without heavy redacting is the equivalent of publicly disclosing private medical information to people who do not have reason to have access to it.

In addition to filling out the annual CMN form, a new form must be filed every time a DME company calls and convinces a patient to switch to a free, non-finger-poking, talking meter.

Many patients also forget or lose their meters and glucose diaries. Can health care providers state honestly that their patients are performing SMBG as directed without having absolute proof? What about individuals who are supposed to perform SMBG four times daily but do not meet this goal on every visit? Do we now take their strips away, denying

them enough strips in case they want to improve their adherence? Will a health care provider risk a CMS sanction by continuing to order four strips per day for such patients?

Ridiculous, you say? The government is watching you. Earlier this year, the adult endocrinologists in our practice received a letter identifying them as providers who ordered an unusually high number of glucose strips. Seriously?

When signing CMNs, do not forget that your signature must be both legible and dated. You cannot use a stamp for the date or signature. Sometimes this is interpreted to mean that electronic signatures from electronic medical record systems are not legal either.

Preventing fraud, waste, and abuse is a laudable goal. Blood glucose strips are expensive, and there are individuals who fraudulently hoard and resell strips on the Internet. There are placards posted at busy street corners offering to buy unused glucose strips. There are unscrupulous DME companies that profit from oversupplying strips to living and dead patients. The government should focus on these criminals.

Diabetes care is difficult enough. There is a looming shortage of health care providers; 30 million more people are going to be eligible for insured medical care; and there is a building tidal wave of diabetes prevalence. Requiring more forms and more documentation will force some providers to run for higher ground. When this happens, the patients will be left to drown in their own high blood glucose levels.

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