

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

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**NC Medicaid  
Diabetes Outpatient  
Self-Management Education**

**Medicaid and Health Choice  
Clinical Coverage Policy No: 1A-24  
Amended Date: February 15, 2020**

|                                                |                                                                                                                                                |    |
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**This clinical coverage policy has an effective date of February 15, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of [COVID-19 Special Medicaid Bulletins](#) will remain in effect.**

#### **Related Clinical Coverage Policies**

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:  
1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring Policy

## **1.0 Description of the Procedure, Product, or Service**

Diabetes outpatient self-management education (DSME) is an interactive, ongoing process of teaching the knowledge, skills and abilities needed for diabetes self-care. The process combines the needs, goals, and life experiences of the diabetic beneficiary and certified diabetes educator(s) and is guided by evidence-based standards. This process includes

- a. Assessment of the individual's specific education needs
- b. Identification of the individual's specific diabetes self-management goals
- c. Education and behavioral intervention directed toward helping the individual achieve identified self-management goals
- d. Evaluation of the individual's attainment of identified self-management goals

The American Diabetes Association's (ERP) National Standards and the Diabetes Education Accredited Programs (DEAP) for DSME are designed to define quality DSME and to assist certified diabetes educators to provide evidence-based education. Diabetes education is effective for improving clinical outcomes and quality of life when programs incorporate behavioral and psychological strategies and include culturally and age-appropriate programs utilizing individual and group education.

### **1.1 Definitions**

None Apply.

## **2.0 Eligibility Requirements**

### **2.1 Provisions**

#### **2.1.1 General**

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. Medicaid  
None Apply.
- b. NCHC  
None Apply.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1. that is unsafe, ineffective, or experimental or investigational.
- 2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the

beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and NC Medicaid's clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

**3.1.1 Telehealth**

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance as found in Clinical Coverage Policy 1-H: *Telehealth, Virtual Communications, and Remote Patient Monitoring*.

### 3.2 Specific Criteria Covered

#### 3.2.1 Specific criteria covered by both Medicaid and NCHC

DSME is covered when:

- a. the beneficiary has a diagnosis of diabetes; and
- b. the program is developed and taught to the target population by certified diabetes educators. Refer to **Subsection 7.3** for staff requirements.

#### 3.2.2 Medicaid Additional Criteria Covered

None Apply.

#### 3.2.3 NCHC Additional Criteria Covered

None Apply.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria Not Covered

#### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

DSME is not covered if the beneficiary does not have a diagnosis of diabetes.

If the program does not meet the requirements for staff qualifications as recognized providers by the American Diabetes Association, or the Diabetes Education Accredited Programs DSME is not covered. Refer to **Subsection 7.3, Staff Qualifications**.

- a. diet therapy or dietary counseling as a separate charge is not covered; and
- b. meals provided during an Outpatient Diabetes Self-Care Program are not covered.

#### 4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

### **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### **5.1 Prior Approval**

Medicaid and NCHC shall not require prior approval for diabetes outpatient self-management.

#### **5.2 Prior Approval Requirements**

##### **5.2.1 General**

None Apply.

##### **5.2.2 Specific**

None Apply.

#### **5.3 Limitations or Requirements**

Physician certification is required. A physician referral will meet this qualification. A prescription signed by the referring physician will suffice as certification.

#### **5.4 Service Limitations**

Initially, up to 10 hours of DSME is covered within a continuous 12-month period (not necessarily within the same calendar year). DSME may be offered in any combination of individual or group counseling. For follow-up training, a maximum of 2 hours of training is covered each year, starting with the calendar year in which the beneficiary receives the initial training, in any combination of individual or group counseling.

Benefits are provided for diet therapy or dietary counseling when the services are included in the fee for the overall program.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

None Apply.

### **6.2 Provider Certifications**

None Apply.

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **7.1 Compliance**

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

### **7.2 Quality Certification and Documentation**

#### **7.2.1 American Diabetes Association (ERP) or the Association of Diabetes Care and Education Specialists (DEAP)**

The Certificate of Recognition from the American Diabetes Association (ERP), or the Association of Diabetes Care & Education Specialists (ADCES)( DEAP) which affirms recognized provider status for the education program, must be maintained by the provider and made available to NC Medicaid or its agent upon request.

#### **7.2.2 Documentation of Program-Specific Quality Standards**

Documentation to support compliance with standards that address curriculum, beneficiary access, process, and measured goals and outcomes must be maintained and made available for review by NC Medicaid or its agent upon request. Based on the needs of the target population, the DSME program shall be capable of offering instruction in the following content areas:

- a. An overview of diabetes, which describes the disease process and treatment options.



- b. Development of personal strategies to address stress and psychosocial issues and concerns.
- c. Family involvement and social support.
- d. Incorporation of nutritional management into lifestyle.
- e. Incorporation of exercise and physical activity into lifestyle.
- f. Use of medication(s) safely and for maximum therapeutic effectiveness.
- g. Monitoring blood glucose and other parameters and interpreting and using the results for self-management and decision making.
- h. Relationships among nutrition, exercise, medication, and glucose levels.
- i. Prevention, detection, and treatment of acute complications.
- j. Prevention, detection, and treatment of chronic complications.
- k. Foot, skin, and dental care.
- l. Development of personal strategies—such as goal setting, risk factor reduction, and problem solving—to promote health and behavior change.
- m. Benefits, risks, and management options for improving glucose control.
- n. Preconception care, pregnancy, and gestational diabetes (NC Health Choice (NCHC) beneficiaries are excluded from preconception care, pregnancy, and gestational diabetes services. If eligible, NCHC beneficiaries who become pregnant shall be transferred to another appropriate Medicaid eligibility category that includes pregnancy coverage.)
- o. Use of health care systems and community resources.

The program shall use instructional methods and materials that are appropriate for the target population and the beneficiaries being served.

An individualized assessment shall be developed and updated in collaboration with each beneficiary. The assessment shall include relevant medical history, present health status, health service or resource utilization, risk factors, diabetes knowledge and skills, cultural influences, health beliefs and attitudes, health behaviors and goals, support systems, barriers to learning, physical limitations, and socioeconomic factors.

An individualized education plan based on the assessment shall be developed in collaboration with each beneficiary. The beneficiary's educational experience—including assessment, intervention, evaluation, and follow-up—shall be documented in a permanent medical or education record. There shall be documentation of collaboration and coordination among program staff, other providers, and the beneficiary.

The program shall offer appropriate and timely educational interventions based on periodic reassessments of health status, knowledge, skills, attitudes, goals, and self-care behaviors.

**Note:** A complete listing of the National Standards for Diabetes Self-Management Education Programs and information on the provider recognition application

process may be obtained by calling the American Diabetes Association at 1-888-232-0822.

### **7.3 Staff Qualifications**

It is the responsibility of the provider agency to verify in writing all staff qualifications for the provision of service and to maintain copies of this documentation and the Certificate of Recognition from the American Diabetes Association (ERP) or Diabetes Education Accredited Programs (DEAP).

Education shall be given by a recognized provider as defined by the American Diabetes Association (ERP) or Diabetes Education Accredited Programs (DEAP) These may include:

- a. Physicians.
- b. Nurse practitioners.
- c. Physician Assistant
- d. Certified nurse midwives.
- e. Clinical Pharmacist Practitioners (CPP)
- f. Hospital outpatient departments.
- g. Local health departments.
- h. Federally qualified health centers.
- i. Rural health clinics.

All of the above staff must meet the national standards for DSME programs, and their education program must be recognized by the American Diabetes Association (ERP) or the Diabetes Education Accredited Programs (DEAP)

Additionally, these providers may bill for the DSME services provided by the following employees

- a. Registered nurses;
- b. Certified diabetes educators (CDE);
- c. Behaviorists who are Ed.D. prepared; and
- d. Registered dieticians who are employed by physicians or entities

### **7.4 Medical Record Documentation**

Documentation certifying the need for DSME and documentation of the education provided must be maintained in the beneficiary's record.

## 8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 1989

### Revision Information:

| Date       | Section Revised                                | Change                                                                                                                                                                                                     |
|------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5/1/09     | Throughout                                     | Initial promulgation of current coverage.                                                                                                                                                                  |
| 7/1/2010   | Throughout                                     | Policy Conversion: Implementation of Session Law 2009-451, <b>Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”</b>                                                                 |
| 3/12/12    | Throughout                                     | To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1A-24 under Session Law 2011-145 § 10.41.(b)                                                                                      |
| 3/12/12    | Throughout                                     | Technical changes to merge Medicaid and NCHC current coverage into one policy.                                                                                                                             |
| 10/01/2015 | All Sections and Attachments                   | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.                                                                       |
| 10/01/2018 | Subsection 7.3                                 | Added Clinical Pharmacist Practitioner (CPP). Removed Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, and Pharmacists from non-physician practitioners section.                       |
| 10/01/2018 | Subsection 7.3                                 | Added “incident to” for non-physician practitioners may provide DSME                                                                                                                                       |
| 10/01/2018 | Attachment A: Claims -Related Information (B.) | Updated ICD 10 codes -deleted unspecific codes and added 7 <sup>th</sup> character where appropriate.                                                                                                      |
| 10/01/2018 | Attachment A: Claims -Related Information (B.) | Removed CPT codes 97802-97804,99078                                                                                                                                                                        |
| 03/15/2019 | Table of Contents                              | Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”                          |
| 03/15/2019 | All Sections and Attachments                   | Updated policy template language.                                                                                                                                                                          |
| 12/04/2019 | Table of Contents                              | Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.” |
| 12/04/2019 | Attachment A                                   | Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.                       |

| <b>Date</b> | <b>Section Revised</b>          | <b>Change</b>                                                                                                                                                                                                                                                                                                             |
|-------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01/01/2021  | Added Subsection 3.1.1          | As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.       |
| 01/01/2021  | Attachment A, letter D          | Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring. |
| 01/01/2021  | Attachment A, letter E          | Added column to the billing units code table indicating if the services were eligible for telehealth along with the following language: Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy                                       |
| 01/01/2021  | Attachment A, letter F          | Added language indicating telehealth codes should be filed with the provider's usual place of service code(s).                                                                                                                                                                                                            |
| 01/01/2021  | Section 1.0                     | Added to the Certificate of Recognition from the American Diabetes or the Diabetes Education Accredited Programs (DEAP)                                                                                                                                                                                                   |
| 01/01/2021  | Section 4.2<br>Subsection 4.2.1 | Specific Criteria Not Covered by Medicaid or NCHC. DSME not covered if staff qualifications do not meet the certification of one of two national accreditation of diabetic educators                                                                                                                                      |
| 01/01/2021  | Section 7.2<br>Subsection 7.2.1 | American Diabetes Association Education Specialists (ERP) and added the Diabetes Education Accredited Programs (DEAP)                                                                                                                                                                                                     |
| 01/01/2021  | Section 7.3                     | Staff Qualifications – Added to Certificate of Recognition from the American Diabetes Association ERP or Diabetes Education Accredited Programs (DEAP).<br>Add non-physician practitioners may provide DSME services and bill for as a component of their office visit codes when appropriate.<br>Removed “incident to”.  |
| 02/15/2021  | Added beginning of Policy       | Added the language “This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and                                                                                                                                           |

| <b>Date</b> | <b>Section Revised</b> | <b>Change</b>                                                                                                                      |
|-------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------|
|             |                        | reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.” |

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

### B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System Codes (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

| ICD-10- Code(s) |          |          |
|-----------------|----------|----------|
| E10.10          | E11.3311 | E13.3512 |
| E10.21          | E11.3312 | E13.3513 |
| E10.22          | E11.3313 | E13.3521 |
| E10.29          | E11.3391 | E13.3522 |
| E10.3211        | E11.3392 | E13.3523 |
| E10.3212        | E11.3393 | E13.3531 |
| E10.3213        | E11.3411 | E13.3532 |
| E10.3291        | E11.3412 | E13.3533 |
| E10.3292        | E11.3413 | E13.3541 |
| E10.3293        | E11.3491 | E13.3542 |
| E10.3311        | E11.3492 | E13.3543 |
| E10.3312        | E11.3493 | E13.3551 |
| E10.3313        | E11.3511 | E13.3552 |
| E10.3391        | E11.3512 | E13.3553 |
| E10.3392        | E11.3513 | E13.3591 |
| E10.3393        | E11.3521 | E13.3592 |
| E10.3411        | E11.3522 | E13.3593 |
| E10.3412        | E11.3523 | E13.37X1 |
| E10.3413        | E11.3531 | E13.37X2 |
| E10.3491        | E11.3532 | E13.37X3 |
| E10.3492        | E11.3533 | E13.36   |
| E10.3493        | E11.3541 | E13.371  |
| E10.3511        | E11.3542 | E13.372  |
| E10.3512        | E11.3543 | E13.373  |
| E10.3513        | E11.3551 | E13.39   |
| E10.3521        | E11.3552 | E13.41   |
| E10.3522        | E11.3553 | E13.42   |

|          |          |         |
|----------|----------|---------|
| E10.3523 | E11.3591 | E13.43  |
| E10.3531 | E11.3592 | E13.44  |
| E10.3532 | E11.3593 | E13.49  |
| E10.3533 | E11.36   | E13.51  |
| E10.3541 | E11.39   | E13.52  |
| E10.3542 | E11.41   | E13.59  |
| E10.3543 | E11.42   | E13.610 |
| E10.3551 | E11.43   | E13.618 |
| E10.3552 | E11.44   | E13.620 |
| E10.3553 | E11.49   | E13.621 |
| E10.3591 | E11.51   | E13.622 |
| E10.3592 | E11.52   | E13.628 |
| E10.3593 | E11.59   | E13.630 |
| E10.36   | E11.610  | E13.638 |
| E10.39   | E11.618  | E13.641 |
| E10.41   | E11.620  | E13.649 |
| E10.42   | E11.621  | E13.65  |
| E10.43   | E11.622  | E13.69  |
| E10.44   | E11.628  | E13.9   |
| E10.49   | E11.630  | O24.011 |
| E10.51   | E11.638  | O24.012 |
| E10.52   | E11.649  | O24.013 |
| E10.59   | E11.65   | O24.02  |
| E10.610  | E11.69   | O24.03  |
| E10.618  | E11.9    | O24.12  |
| E10.620  | E13.00   | O24.13  |
| E10.621  | E13.10   | O24.01  |
| E10.622  | E13.21   | O24.02  |
| E10.628  | E13.22   | O24.03  |
| E10.630  | E13.29   | O24.11  |
| E10.638  | E13.3211 | O24.12  |
| E10.649  | E13.3212 | O24.13  |
| E10.65   | E13.3213 | O24.410 |
| E10.69   | E13.3291 | O24.414 |
| E10.9    | E13.3292 | O24.415 |
| E11.00   | E13.3293 | O24.420 |
| E11.01   | E13.3311 | O24.424 |
| E11.10   | E13.3312 | O24.425 |
| E11.11   | E13.3313 | O24.430 |
| E11.21   | E13.3391 | O24.434 |
| E11.22   | E13.3392 | O24.435 |
| E11.29   | E13.3393 | O24.811 |
| E11.9    | E13.3411 | O24.812 |
| E11.3211 | E13.3412 | O24.813 |
| E11.3212 | E13.3413 | O24.82  |
| E11.3213 | E13.3491 | O24.83  |
| E11.3291 | E13.3492 |         |
| E11.3292 | E13.3493 |         |
| E11.3293 | E13.3511 |         |

### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service codes.

#### Unlisted Procedure or Service

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

### D. Modifiers

Non-Telehealth Claims: Providers shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

### E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

| HCPCS Procedure Code | Unit                  | <u>Telehealth Eligible Services</u> |
|----------------------|-----------------------|-------------------------------------|
| G0108                | One unit = 30 minutes | <u>Yes</u>                          |
| G0109                | One unit = 30 minutes | <u>Yes</u>                          |
| RC 942 + G0108       | One unit = 30 minutes | <u>No</u>                           |
| RC 942 + G0109       | One unit = 30 minutes | <u>No</u>                           |

Note: Telehealth eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

### F. Place of Service

Physician's office, outpatient hospital department, physician diagnostic clinic, local health department, rural health clinic, federally qualified health center.

Telehealth claims should be filed with the provider's usual place of service code(s)



### **G. Co-payments**

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

### **H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>