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.

Table of Contents

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 policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

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

a. <u>Medicaid</u>

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/

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 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 Medicaid

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.

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 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 **Section3.0;**

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 Medicaid

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.

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 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 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 .2.2of 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.
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, **Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."**
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	Subsection7.3	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 7th 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.

Date	Section Revised	Change
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 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 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). Add non-physician practitioners may provide DSME services and bill for as a component of their office visit codes when appropriate. 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

Date	Section Revised	Change
		reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
03/19/2021		Typo correction made on 03/19/2021 due to Table of Contents header date read "February 15, 2020" was corrected to February 15, 2021
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.
12/15/2023		Corrected NCHC language removal posting and amended date not changed.

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:

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	024.01
E10.622	E13.21	024.02
E10.628	E13.22	024.03
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	Telehealth Eligible Services
G0108	One unit = 30 minutes	Yes
G0109	One unit = 30 minutes	Yes
RC 942 + G0108	One unit = 30 minutes	No
RC 942 + G0109	One unit = 30 minutes	No

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/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/