

SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) sponsors Medicaid reimbursement for ambulatory (outpatient) Diabetes Management Services to Medicaid-eligible beneficiaries with Type 1, Type 2, or gestational diabetes.

Diabetes Management Services provide medically necessary, comprehensive diabetes management and counseling services to diabetics of any age who the primary care provider determines will benefit from diabetes management services. The program is intended to improve and/or maintain the health of beneficiaries by providing counseling, education, and instructions to beneficiaries in the successful health self-management of diabetes.

The primary objective of Diabetes Management Services is to help the Medicaid-eligible beneficiary adapt to the chronic diagnosis of diabetes by learning self-management skills.

Reimbursement for ambulatory (outpatient) Diabetes Management Services is restricted to services provided to Medicaid-eligible beneficiaries by enrolled Medicaid providers within the South Carolina Medical Service Area (SCMSA). Services rendered outside of the SCMSA are considered non-covered services. The SCMSA refers to the state of South Carolina and areas in North Carolina and Georgia that are within 25 miles of the South Carolina state border.

Medicaid enrollment will be extended to any diabetes management program that meets the program requirements indicated in the application process. All enrolled Diabetes Management Services providers must adhere to all program standards and requirements outlined in this manual.

Providers of Diabetes Management Services must be practitioners of the healing arts licensed by the State acting within the scope of their practice under State law (*e.g.*, physicians, pharmacists, nurse practitioners, registered dietitians, registered nurses, licensed master social

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PROGRAM DESCRIPTION

PROGRAM DESCRIPTION (CONT'D.)

workers, licensed baccalaureate social workers, licensed practical nurses and physician assistants)

The program, based on the target population's needs, must offer instruction in the following content areas:

- Monitoring blood glucose and urine ketones (when appropriate), and using the results to improve control
- Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)
- Describing the diabetes disease process and treatment options
- Incorporating appropriate nutritional management education
- Incorporating physical activities into the diabetic patient's lifestyle
- Utilizing medications (if applicable) for therapeutic effectiveness
- Preventing, detecting, and treating acute/chronic complications
- Preventing (through risk-reduction behavior) and detecting complications
- Goal setting to promote health and problem solving for daily living
- Integrating psychosocial adjustment into one's daily life

The program must use instruction methods and materials appropriate for the target population. The target population is any Medicaid-eligible beneficiary with diabetes who meets the criteria for participation in the Diabetes Management Services Program.

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PROGRAM REQUIREMENTS

PROVIDER ENROLLMENT

Each potential Diabetes Management Services provider must complete a Medicaid enrollment package. After the enrollment package is reviewed and approved by the program area, the provider will be enrolled as a Medicaid Diabetes Management Services Program by the Medicaid Claims Control System (MCCS) Provider Enrollment unit.

STAFF QUALIFICATIONS

Program must meet the requirements established by the South Carolina Department of Health and Human Services for enrollment and billing, which includes one of the following criteria:

- Program is managed by a Certified Diabetes Educator (CDE), or
- Program is an American Diabetes Association (ADA) recognized program, or
- Program is an American Association of Diabetes Educators (AADE) recognized program , or
- Program is recognized by the Indian Health Services (IHS).

In addition, all enrolled Diabetes Management Services Programs must adhere to the National Standards for Diabetes Self-Management Education. National Standards for Diabetes Self-Management Education may be found at the Web address below.

<http://care.diabetesjournals.org/cgi/reprint/23/5/682.pdf>

Copies of documentation to validate achievement of staff qualifications will be required as part of the enrollment package. Acceptable documentation would include certificates from one of the following institutions:

- National Certification Board of Diabetes Educators (NCBDE)
- American Diabetes Association (ADA)
- American Association of Diabetes Educators (AADE)
- Indian Health Service (IHS)

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PROGRAM REQUIREMENTS

DOCUMENTATION REQUIREMENTS

Clinical Records Clinical

The South Carolina Medicaid Program requires, as a condition of provider participation, maintenance of and access to clinical records that fully disclose the extent of services provided to the Medicaid-eligible beneficiary. The development of clinical documents and the maintenance of adequate records are regarded as essential for the delivery of appropriate services and quality medical care. These records are key documents for possible post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential that each Diabetes Services Management Program conduct periodic internal record reviews. The purpose of the internal record reviews is to ensure that services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policies and procedures.

Diabetes educators are required to maintain a clinical record on each Medicaid-eligible beneficiary that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid payment. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of services and progress toward treatment goals (see **Clinical Service Notes**). Clinical records should be arranged logically so that information may be easily reviewed, copied, and audited.

Each clinical record must include the following:

- A Release of Information form signed by the beneficiary authorizing the release of any medical information necessary to process Medicaid claims. (This may be incorporated into a Consent for Treatment form.)
- Documentation of the primary care provider's referral for services
- Test results and evaluation reports
- A current and valid Individual Treatment Plan (ITP)

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PROGRAM REQUIREMENTS

Clinical Records (Cont'd.)

Any individual referenced in the clinical record should be identified by full name, title, and agency or provider affiliation at least once in each record.

Clinical Service Notes

A clinical service note is a written summary of each diabetes management service. Descriptions from the clinical service notes should clearly link information from goals and objectives to the interventions performed and progress made. These notes must:

- Provide a pertinent clinical description of the activities that took place during the session, including an indication of the patient's response to treatment as related to stated goals and objectives listed in the ITP
- Reflect delivery of a specific billable service as identified in the primary care provider's referral
- Document that the services rendered correspond to billing in regard to the date of service, type of service, and length of time of the services
- For group services, be specific to the individual patient's level of participation and response to intervention
- Be signed by the diabetes instructor with his or her name/initials, title, and date
- If an abbreviation or symbol is used in a given record, one of the following conditions must be met:
 - The full title must be written out with the abbreviation beside it the first time.
 - The provider must keep a key of accepted abbreviations, and this list must be made available for record reviews.
- Entries must be made by the provider delivering the service. Notations shall be accurate and complete, and must be recorded at the time the event took place.

Records Maintenance

All entries in clinical records shall be typed or handwritten using only black or dark blue ink. Photocopies are acceptable but must be completely readable. Originals must be available if needed. All entries must be legible

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PROGRAM REQUIREMENTS

Records Maintenance (Cont'd.)

and kept in chronological order. Copies are acceptable in extreme circumstances, as long as they are legible.

All entries must be dated (month, day, and year) and legibly signed by the appropriate signatory authority. The Diabetes Management Services providers must maintain a signature sheet that identifies all staff names, signatures, and initials.

It is essential that internal audits be conducted by the provider to ensure that the services provided are medically necessary and appropriate both in quality and quantity, and those services are being billed appropriately. Missing or incomplete documentation could result in recoupment of funds.

Error Correction Procedures

The beneficiary's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. The appropriate procedure for the correction of errors in legal documents must be followed when correcting an error in a clinical record. An error in the documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature/initials and date next to the correction. If warranted, an explanation of the correction may be appropriate.

BENEFICIARY REQUIREMENTS

Eligibility Requirements

Diabetes Management Services are available, in an outpatient setting, to Medicaid-eligible beneficiaries who the primary care provider determines will benefit from a diabetes management service. Beneficiaries with Type 1, Type 2, and/or gestational diabetes may be eligible for Diabetes Management Services.

In order to be eligible for Medicaid Diabetes Management Services, a person must:

- Be a South Carolina Medicaid-eligible beneficiary
- Have a diabetes diagnosis
- Be referred by their primary care provider

Diabetes is diabetes mellitus, a condition of abnormal

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PROGRAM REQUIREMENTS

Eligibility Requirements (Cont'd.)

glucose metabolism diagnosed using the following criteria:

- A fasting blood sugar level greater than or equal to 126 mg/dl on two different occasions
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dl on two different occasions
- A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

Documentation that the beneficiary is diabetic must be maintained in the beneficiary's medical record.

It is the responsibility of the provider to verify Medicaid eligibility before providing services. SCDHHS provides a free tool, the South Carolina Web-based Claims Submission Tool (aka the Web Tool), that providers can utilize to check beneficiary eligibility, submit claims, and check claims status. Once a provider returns a completed Trading Partner Agreement (TPA), SCDHHS will contact the provider with the Web site address and login information for the Web Tool.

A beneficiary is not eligible for Medicaid-reimbursable Diabetes Management Services while residing in an inpatient hospital or other institutional setting such as a nursing care facility or a residential care facility.

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PROGRAM REQUIREMENTS

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SERVICE DESCRIPTIONS

COVERED SERVICES

Diabetes Management Services consist of an Initial Assessment and Individual Treatment Plan, group and/or individual education, and follow-up.

Diabetes Management Services providers must use the procedure codes identified in Section 4 to bill for services rendered under the program. All services must be medically necessary and reflected in the documentation of services.

Disease Management Program

S0315 — Disease Management Program – Initial Assessment and Initiation of the Program

The Initial Assessment is performed to obtain and review all of the diagnostic information on a Medicaid-eligible beneficiary. The assessment will identify the level of diabetes awareness, strengths, weaknesses, needs, and resources of the beneficiary and his or her family.

The ITP is an integral part of the assessment and will be developed from the assessment through a coordinated effort by the diabetes management team. The ITP will include goals and objectives as well as the specific interventions and skills necessary for the beneficiary and family to achieve the goals. The ITP should be updated as needed.

Effective January 1, 2007, the Initial Assessment and the ITP must be **completed prior** to delivery of education or follow-up services for all new beneficiaries. Beneficiaries receiving Diabetes Management Services prior to January 1, 2007 are not required to have an assessment and an ITP completed to continue existing services. Any circumstances that delay the completion of the Initial Assessment and the ITP must be documented in the beneficiary's record.

The Initial Assessment and the ITP must be maintained in the beneficiary's record. Diabetes Management Services providers may only bill for the Initial Assessment once per provider per lifetime.

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SERVICE DESCRIPTIONS

Patient Education

Individual/Group Patient Education

S9445 — Patient Education, Not Otherwise Classified, Non-Physician Provider, Individual Per Session

S9455 — Diabetic Management Program, Group Session

Beneficiaries are allowed 10 hours of diabetes education per lifetime. The 10 hours of instruction may be conducted as either individual **OR** group instruction. The appropriate code to signify the type of education provided must be used for billing.

Diabetes education must cover the content areas as defined by the ADA and outlined in the National Standards for Diabetes Self-Management Education (DSME). The goal of the instruction is to provide the diabetic with skills and knowledge needed to become self-sufficient in the daily management of diabetes. Diabetes education, whether provided on an individual or group basis, should include the diabetic's family whenever possible.

Providers of Diabetes Management Services must be practitioners of the healing arts licensed by the State acting within the scope of their practice under State law (*e.g.*, physicians, pharmacists, nurse practitioners, registered dietitians, registered nurses, licensed master social workers, licensed baccalaureate social workers, licensed practical nurses).

Documentation of all education sessions will be maintained in the beneficiary's record.

Disease Management Program Follow-up/ Reassessment

S0316 — Disease Management Program Follow-up/ Reassessment

Diabetes Management Services providers may provide services to further evaluate the beneficiary's knowledge and to provide additional instruction as indicated. Areas of focus might include:

- Self-management of diabetes
- Continuation of behavioral and dietary changes
- Medication management
- Additional support and education

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SERVICE DESCRIPTIONS

Disease Management Program Follow-up/ Reassessment (Cont'd.)

Documentation of follow-up visits and instruction, to include an explanation of why the additional instruction is necessary, will be maintained in the beneficiary's record.

Beneficiaries are allowed a maximum of six follow-up hours per State fiscal year (July 1 through June 30).

Follow-up/reassessment instruction must be provided on an individual basis.

Procedural and Diagnosis Coding

Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology (CPT), Fourth Edition*, published by the American Medical Association, and the diagnosis codes as defined in the *International Classification of Diseases, Ninth Edition (ICD-9)*, provided by the U.S. National Center for Health Statistics.

In 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The S.C. Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. For assistance in billing, providers may access the CCI Edit information online at the CMS Web site, <http://www.cms.hhs.gov/>.

NON-COVERED SERVICES

This list is provided as a guide and is not intended to include all non-covered services. Contact your Medicaid program representative if you have questions regarding the types of services covered under this program or otherwise covered by Medicaid.

The following services are **not covered** by Medicaid under Diabetes Management Services:

- Information furnished to the beneficiary by the provider over the phone
- Assisting a potential Medicaid-eligible beneficiary with the Medicaid application process
- Canceled visits or missed appointments
- Any services not listed under covered services

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SERVICE DESCRIPTIONS

NON-COVERED SERVICES (CONT'D.)

- Medicaid eligibility determination and/or redetermination
- Duplication of services covered under the Medicaid Home Health Program or other Medicaid programs (*e.g.*, while residing in an inpatient hospital or other institutional setting such as a nursing care facility, or residential care facility, or when open to skilled home health services)
- Transportation of the diabetes management staff or beneficiary to or from the site of services. However, patient transportation services may be covered under the Medicaid Transportation Program. (For questions regarding patient transportation, you may contact the county SCDHHS office. A listing of those offices is located in Section 5 of the manual.)
- Administrative duties such as copying, filing, and mailing reports
- Time spent writing clinical notes

DIABETES EQUIPMENT AND/OR SUPPLIES

A Medicaid beneficiary may be eligible for diabetic equipment and/or related supplies based on medical necessity. If it is determined by the treating/ordering primary care provider that diabetic equipment and/or supplies are medically necessary for the diabetic, a Medicaid Certificate of Medical Necessity (MCMN) form (see the Forms section of this manual) must be completed.

A MCMN for medically justified diabetic supplies and/or equipment may be valid for up to twelve months. The treating/ordering primary care provider determines the duration of need on the MCMN. For additional information regarding the MCMN, please refer to Section 2 of the Durable Medical Equipment Manual. The beneficiary may take his or her prescription to an enrolled Medicaid Durable Medical Equipment (DME) provider of the beneficiary's choice.