

DIABETES AND ENDOCRINE CENTER**Medicare Eligibility for Diabetes Education Services Certification Form**

CMS/PRO Regulations. A comprehensive plan of care must be established by the physician (or qualified non-physician practitioner treating the patient). Completion of this form and retaining a copy in the chart will assist the referring physician in meeting CMS/PRO documentation requirements for his/her office.

Medicare beneficiaries who have been diagnosed with diabetes are eligible for Diabetes Self-Management Education. Eligible Medicare beneficiaries may receive initial training of up to 10 hours and follow-up training of up to 2 hours in each calendar year after initial training is completed. Education can be authorized in the following ways: (Please check one)

- Initial Comprehensive Education Program:** To be eligible, the Medicare beneficiary must never have received comprehensive diabetes education under the new Medicare Regulations beginning 2/27/01. Comprehensive Diabetes Education is a "once in a lifetime" benefit and must be completed within 12 months of this order and not to exceed 10 hours total. The Initial Education and Skills Assessment is done in a 1:1 one hour session as allowed under Medicare rules. The individual will be offered the next available class reservation. The class series is composed of 4 classes over 4 weeks.
- Follow-up Education:** Available beginning in the calendar year following completed Comprehensive Education Program. Follow-up education limited to no more than 2 hours in each calendar year. The referring physician must specify the specific medical condition/subjects that the education should address: _____
- Insulin initiation:** CMS **allows** one additional hour to instruct the individual beginning to use insulin.

Education must be provided in group sessions unless:

1. The individual has special needs resulting from conditions that hinder effective group participation (e.g. severe vision, hearing or language limitations) Individual sessions are required because _____.
2. No group sessions are available within 2 months of the order (to be determined by the Diabetes & Endocrine Center)

▶▶ When this form is completed and the labs below are attached, send the form to the Diabetes & Endocrine Center. If an insurance referral is necessary, please attach it.

Note: The lab results below **MUST** be received, *before* the individual will be given an appointment.

- ▶ **HbA1c's** (done within 3 months of this order) required by CMS
- ▶ **Lipid panel** (done within last year) required by CMS
- ▶ **Urine microalbumin creatinine ratio** is appreciated so we may explain their risk of kidney failure.

▶▶ When the completed eligibility form and labs noted above are received by the Diabetes & Endocrine Center, the individual will be contacted and appointments for an initial assessment visit and classes per CMS guidelines will be made.

Plan of Care The Initial Comprehensive Education Program of the Diabetes & Endocrine Center for Medicare eligible individuals consists of an initial one hour 1:1 assessment and four group sessions of 2-3 hours over 4 weeks. Each session builds on the prior session so it is best for the individual to attend all sessions in order. The education includes: disease process and treatment options; nutrition and individualized meal plan; medications; monitoring; preventing detecting and treating acute complications; preventing detecting and treating chronic complications; behavioral goal setting, problem-solving; psychosocial adjustment to daily life with diabetes.

Follow-up Education consists of up to 2 hours of education in specific subjects listed above per Primary Care Physician's orders.

I am managing the diabetes care for (Individual's Name) _____ and he/she has diabetes. I feel that the education described in the plan of care is needed to ensure therapy compliance and/or to provide the individual with the skills and knowledge to help him/her manage his/her diabetes.

Patient's Address _____ Patient's Phone _____

Provider's Signature _____ Date _____

Print Providers Name _____ Phone _____ Fax _____