Piedmont Athens Regional
1199 Prince Avenue
Athens, Georgia 30606

Piedmont ATHENS REGIONAL

Diabetes Education Service
(706) 475-5600
(706) 475-5613 Fax

DT0005

Certificate of Medical Necessity For Diabetes Self-Management Education (DSME)

Patient Name:	**Date of Birth:**	**Insurance:**
Ordering Physician (Please Print):	**Appointment Date:**	**Appointment Time:**

DIAGNOSIS

☐ E119 DM Type 2	☐ E109 DM Type 1	☐ O99810 Gestational Diabetes
☐ E1165 DM Type 2, uncontrolled	☐ E1065 DM Type 1, uncontrolled	☐ O24919 DM complicating pregnancy
☐ R7302 Impaired Glucose Tolerance/Pre-diabetes	☐ R739 Hyperglycemia	☐ E162 Hypoglycemia
☐ Other	☐ R7301 Impaired Fasting Glucose	☐ E8881 Dysmetabolic Syndrome

MEDICAL STATUS AND/OR COMPLICATIONS

☐ Newly diagnosed	☐ Severe Hypo/hyperglycemia	☐ Vascular Disease	☐ Obesity
☐ New to Insulin	☐ Nephropathy	☐ Foot Problems	☐ Gastroparesis
☐ New to oral anti-diabetic agents	☐ Retinopathy	☐ Other:	

PLAN OF CARE: Please check desired components

Comprehensive Programs:

☐ Initial DSME (up to 10 hours)
- Assessment and goal setting
- Diabetes overview and treatment
- Meal planning
- Monitoring and problem solving
- Chronic & Acute complications
- Physical activity
- Medication
- Risk reduction

☐ Yearly DSME review (up to 2 hours)

☐ Obtain HbA1c every 3 months if not obtained in MD office (for ARHS employee program)

☐ Pre-diabetes education (IGT or IFG, 2 hours) – *includes:*
- Assessment and goal setting
- Basic meal planning
- Weight management

☐ Gestational diabetes education (GDM, 2 hours) – *includes:*
- Meal Plan _____
- BG Monitoring: ☐ Fasting & 2 hr PP ☐ Before meals and bedtime ☐ Other _____

☐ Initial Medical Nutrition Therapy: (MNT, 3 hours) ☐ Calorie level _____ ☐ Dietitian to determine calories
☐ Yearly MNT Review (2 hours) _____
☐ Insulin instruction or other injectable (1.5 hours); Insulin type(s), dose(s), & time: _____
☐ CGM initiation: _____
☐ Insulin pump instructions (6.0 hours); Specify model name: _____ ☐ Patient to continue oral medications? ☐ Yes ☐ No
☐ Please provide individual education sessions as patient unable to benefit from group classes due to severe impairment of sight, speech, language, or hearing; cognitive, physical or emotional limitations. (Please circle appropriate descriptor.)
☒ In case of hypoglycemia, follow outpatient hypoglycemia protocol.

RECENT RESULTS: Required by Medicare

FBG _____ FBG _____	A1C _____	Cholesterol _____ LDL _____ HDL _____
Date _____ Date _____	Date _____	Trig _____ Date _____

NOTE: Please include list of current medications.
For Medicare patients, documentation of diabetes diagnosis is required to determine medical necessity based on their National or Local Medical Review Policies.

The above orders are a medically necessary component of the patients' plan of care.

Physician Signature: _____

Date _____ **Time** _____

L64348 (09/15)

PATIENT LABEL