CMS Manual System

Pub. 100-02 Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 13 **Date: MAY 28, 2004**

CHANGE REQUEST 3185

I. SUMMARY OF CHANGES: This instruction revises the current Internet Only Manual (IOM) for diabetes self-management training (DSMT) (Section 300 through 300.5.1). The definition for diabetes mellitus has been changed based on the 2004 Medicare Physician Fee Schedule Regulation. Material that was not originally included from previous instructions has been added to these sections.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: June 28, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/300/Diabetes Self Management Training Services
R	15/300.1/ Coverage Requirements
R	15/300.2 /Certified Providers
R	15/300.3 /Coding and Frequency of Training
R	15/300.4/ Payment for DSMT
N	15/300.4.1/ Incident-To Provision
R	15/300.5/Bill Processing Requiring
N	15/300.5.1/Special Claims Processing Instructions for FIs

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 13	Date: May 28, 2004	Change Request 3185

SUBJECT: Diabetes Self-Management Training (DSMT) Services

I. GENERAL INFORMATION

A. Background: Effective January 1, 2004**,** the definition for diabetes mellitus has changed. This change is being incorporated into the new internet only manual.

B. Policy: This change is per volume 68, #216, November 7, 2003, page 63261/Federal Register.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Fiscal Intermediaries and Carriers shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3185.1 (Chapter 15, Section 300.1)	Fiscal Intermediaries and Carriers shall notify providers that Medicare has changed the definition of diabetes mellitus for diabetes self-management training (DSMT) services.	FIs and Local Part B Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date:** June 28, 2004 **Pre-Implementation Contact(s):** For Part A issues, contact Doris Barham at (410) 786-6146; for Part B issues contact Yvette Cousar at (410) 786-2160 and for policy issues contact Patricia-Brocato-Simmons at (410) 786-0261 **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions shall be implemented within your current operating budget.**

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev. 13, 05-13-04)

300 - Diabetes Self-Management Training (DSMT) Services

(Rev. 13, 05-13-04)

PM AB -02-151, B-01-40

300.1 - Coverage Requirements

(Rev. 13, 05-13-04)

PM AB -02-151, B-01-40

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes *self-management training (DSMT)* services when these services are furnished by a certified provider who meets certain quality standards. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the *treating* physician or *treating* qualified nonphysician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified nonphysician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. *The order must also include a statement signed by the physician that the service is needed as well as the following:*

- *The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);*
- *The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and*
- *A determination that the beneficiary should receive individual or group training.*

The provider of the service must maintain documentation in file that includes the original order from the physician and any special conditions noted by the physician.

When the training under the order is changed, *the training order/referral* must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file *in the DSMT's program records.*

NOTE: *All entities billing for DSMT under the fee-for-service payment system or other payment systems, facilities, federally qualified health centers (FQHCs), End-Stage Renal Disease (ESRD), rural health clinics (RHCs) or managed care organizations must meet all national coverage requirements.*

300.1 Beneficiaries Eligible for Coverage and Definition of Diabetes

(Rev. 13, 05-13-04)

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes.

Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria;

- *a fasting blood sugar 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 2 different occasions; or*
- *a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.*

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

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they have been certified as requiring initial training *or they may receive follow-up training when ordered even if Medicare does not have documentation that initial training has been received. In that instance, contractors shall not deny the follow-up service even though there is no initial training recorded.*

300.2 - Certified Providers

(Rev. 13, 05-13-04)

PM AB -02-151, B-01-40

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to the contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. The CMS is designating all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical

equipment suppliers as certified. *All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program.. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.*

The CMS will not reimburse services *on a fee-for-service basis* rendered to a beneficiary if they are:

- An inpatient in a hospital or skilled nursing facility (SNF);
- In hospice care;
- A resident in a nursing home; or
- An outpatient in a rural health clinic (RHC) or (FQHC)

  NOTE: While separate payment is not made for this service to RHCs or FQHCs, the service is covered but is considered included in the encounter rate.

All *DSMT programs* must be accredited as meeting quality standards by a CMS approved national accreditation organization. *Currently, CMS recognizes the American Diabetes Association and the Indian Health Service as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered. Certified providers may be asked to submit updated accreditation documents at any time or to submit outcome data to an organization designated by CMS.*

Enrollment of DMEPOS Suppliers

DMEPOS suppliers are reimbursed for diabetes training through local carriers. In order to file claims for *DSMT*, a DMEPOS supplier must be enrolled in the Medicare program with the National Supplier Clearinghouse (NSC). The supplier must also meet the quality standards of a CMS-approved national accreditation organization as stated above. *DMEPOS suppliers must obtain a provider number from the local carrier in order to bill for DSMT.*

The carrier requires a completed Form CMS-855, along with an *accreditation* certificate as part of the provider application process. After it has been determined that the quality standards are met, a billing number is assigned to the supplier. Once a supplier has received a *provider identification (PIN)* number, the supplier can begin receiving reimbursement for this service.

Carriers should contact the National Supplier Clearinghouse (NSC) according to the instruction in Pub 100-8, the Medicare Program Integrity Manual, Chapter 10, "Healthcare Provider/Supplier Enrollment," to verify an applicant is currently enrolled and eligible to receive direct payment from the Medicare program.

The applicant is assigned specialty 87.

Any DMEPOS supplier that has its billing privileges deactivated or revoked by the NSC will also have the billing number deactivated by the carrier.

300.3 - Coding and Frequency of Training

(Rev. 13, 05-13-04)

A – Coding

The following HCPCS codes are used for DSMT:

- *G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes.*
- *G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.*

The type of service for these codes is 1.

B - Initial Training

Medicare will cover initial training that meets the following conditions:

- Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS G0108 or G0109.
- Is furnished within a continuous 12-month period.
- Does not exceed a total of 10 hours *for the initial training*. The 10 hours of training can be done in any combination of 1/2 hour increments. They can be spread over the 12-month period or less.
- With the exception of 1 hour *of individual training*, training is *usually* furnished in a group setting who need not all be Medicare beneficiaries.
- *The one hour of individual training may be used for any part of the training including insulin training.*
- Is furnished in increments of no less than one-half hour.

C - Individual Training

Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:

- No group session is available within two months of the date the training is ordered;
- The beneficiary's physician (or qualified nonphysician practitioner) documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing or language limitations *or other such special conditions as identified by the treating physician or non-physician practitioner*, that will hinder effective participation in a group training session; or
- The physician orders additional insulin training.
- *The need for individual training must be identified by the physician or non-physician practitioner in the referral.*

NOTE: If individual training has been provided to a Medicare beneficiary and subsequently the carrier or intermediary determines that training should have been provided in a group, down-coding the reimbursement from individual to the group level and provider education would be the appropriate actions instead of denying the service as billed.

D - Follow-Up Training

After receiving the initial training, Medicare covers follow-up training that meets the following conditions:

- Consists of no more than two hours individual or group training for a beneficiary each year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- Is furnished any time in a calendar year following a year in which the beneficiary completes the initial training *(e.g., beneficiary completes initial training in November 2003 therefore the beneficiary is entitled to 2 hours of follow-up training beginning in January of 2004)*;
- Is furnished in increments of no less than one-half hour; and
- The physician (or qualified nonphysician practitioner) treating the beneficiary must document in the beneficiary's medical record *that the beneficiary is a diabetic.*

300.4 - Payment for DSMT

(Rev. 13, 05-13-04)

PM AB -02-151, B-01-40

Payment to providers for outpatient diabetes self-management training is based on rates established under the *Medicare* Physician Fee Schedule.

- Payment may only be made to any provider that bills Medicare for other individual Medicare Services;
- Payment may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets;
- Other conditions for fee-for-service payment. The beneficiary must meet the following conditions if the provider is billing for initial training:
    - The beneficiary has not previously received initial *or follow-up* training for which Medicare payment was made under this benefit;
    - The beneficiary is not receiving services as an inpatient in a hospital, SNF, hospice, or nursing home; or
    - The beneficiary is not receiving services as an outpatient in an RHC or FQHC.

300.4.1 – Incident-To Provision

(Rev. 13, 05-13-04)

The "incident to" requirements of section 1861(s)(2)(A) of the Social Security Act do not apply to DSMT services. Section 1861 (s)(2)(S) of the Act authorizes DSMT in a stand alone provision. DSMT services are covered only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed and refers the patient to the DSMT program. The referral must be done under a comprehensive plan of care related to the beneficiary's diabetic condition. Training may be furnished by a physician, individual, or entity that meets the following conditions:

- *Furnishes other services for which direct Medicare payment may be made;*
- *May properly receive Medicare payment under 42CFR 424.73 or 424.80 which set forth prohibitions on assignment and reassignment of claims;*
- *Submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS under 42CFR 410.142 to meet one of the sets*

of quality standards described in 42 CFR 410.144; and

- *Provides documentation to CMS, as requested, including diabetes outcome measurements set forth at CFR 410.146.*

    - *Any certified providers or suppliers that provide other individual items or services under Medicare that meet CMS's quality standards and meet the conditions for CMS approval pursuant to 42 CFR 410.145, may receive reimbursement for diabetes training. Entities are more likely than individuals to bill for DSMT services. These certified providers must be currently receiving payment for other Medicare services.*

300.5 - Bill Processing Requirements

(Rev. 13, 05-13-04)

See Chapter 25 of the Medicare Claims Processing Manual for instructions for intermediaries, hospitals, and outpatient facilities.

See Chapter 26 of the Medicare Claims Processing Manual for instructions for carriers and physicians intermediaries, hospitals, and outpatient facilities.

Billing is to the "certified provider's" regular intermediary or carrier, i.e., there are no specialty contractors for this service. (See §300.2 above for definition of "certified provider" in this instance.

300.5.1 - Special Claims Processing Instructions for FIs

(Rev. 13, 05-13-04)

- *Coding and Payment Requirements*

The provider bills for DSMT on the CMS Form 1450 or its electronic equivalent. The cost of the service is billed under revenue code 942 in FL 42 "Revenue Code." The provider will report HCPCS codes G0108 or G0109 in FL 44 "HCPCS/Rates." The definition of the HCPCS code used should be entered in FL 43 "Description."

- *Applicable Bill Types*

The appropriate bill types are 12x, 13x, 34x (can be billed if service is outside of the treatment plan), 72x, 74x, 75x, 83x and 85x.