Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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REFER TO CHANGE REQUEST 1455

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--*EFFECTIVE DATE: February 27, 2001*
IMPLEMENTATION DATE: July 17, 2001

Section 436, Diabetes Outpatient Self-Management Training Services, is a new section that incorporates and revises instructions issued in Program Memoranda (PM) AB-98-36, dated June,1998; AB-99-46, dated May, 1999; and AB-00-66, dated July, 2000, Change Request 199.

The following corrections/revisions have been made:

- . Providers will be paid reasonable cost comparable to the fee schedule varying among geographic areas.
- Providers that bill for the education training must be certified by the American Diabetes Association (ADA) or have a Certificate of Recognition from a HCFA approved entity.
- Training can be furnished in one-half hour increments.
- Services cannot be in excess of the allowable 10 hours of initial training during a twelve-month period and 2 hours of follow up training annually for each beneficiary.

NOTE: Appropriate provider education is needed to implement these instructions.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER IV
BILLING PROCEDURES

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436. DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

A. Coverage Requirements.—Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards. This program is intended 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 outpatient self-management training services may be covered by Medicare only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. Services must be done under a comprehensive plan of care related to the beneficiary's diabetic condition, to ensure the beneficiary's compliance with the theraphy, or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's conditions. The training must be ordered by the physician or qualified nonphysician practitioner treating the beneficiary's diabetes. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for the 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. 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 change must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file at the provider of the training.

Medicare Part B covers one course of initial training for a beneficiary who has one or more of the following medical conditions present within the 12-month period before the physician's order for the training:

(1) New onset diabetes.

(2) Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HbA1C) level of 8.5 percent or more on two consecutive HbA1C determinations 3 or more months apart in the year before the beneficiary begins receiving training.

(3) A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

(4) High risk for complications based on inadequate glycemic control (documented acute episodes of severe hyperglycemia occurring in the past year during which the beneficary needed emergency room visits or hospitalization).

(5) High risk based on at least one of the following documented complications:

- Lack of feeling in the foot, or other foot complications such as foot ulcers, deformities, or amputation.
- Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye.
- Kidney complications related to diabetes, when manifested by albuminuria, without other cause, or elevated creatinine.

NOTE: Beneficiaries with diabetes, becoming newly eligible for Medicare, can receive the diabetes outpatient self-management initial training.

B. Certified Providers.—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. HCFA is designating all providers and suppliers that bill Medicare for other individual services, (such as hospital outpatient departments, renal dialysis facilities, and durable medical equipment suppliers). HCFA will not reimburse services rendered to a beneficiary if they are:

- An inpatient in a Hospital or Skilled Nursing Facility.
- In hospice care
- A resident in a Nursing Home.
- An outpatient in a Rural Health Clinic or Federally Qualified Health Center.

All certified providers must be accredited as meeting quality standards by a HCFA approved national accreditation organization. During the first 18-months after the effective date of the final rule, providers may be recognized by the American Diabetes Association (ADA) as meeting the National Standards for Diabetes Self-Management Education as published in Diabetes Care, Volume 23 Number 5.

C. .Frequency of Training.—

1. Initial Training - Medicare will cover initial training that meet the following conditions:

- Is furnished to a beneficiary who has not previously received initial training under the G0108 or G0l09 code.

- Is furnished within a continuous 12-month period.

- Does not exceed a total of 10 hours. (The 10 hours of training can be done in and combination of 1/2 hour increments. They can be spread over the 12 month period or less.)

- With the exception of 1-hour, training is furnished in a group setting. (The group need not all be Medicare beneficiaries).

- Is furnished in increments of no less than one-half hour.

- May include 1 hour of individual training: One-half of this hour should be used to assess the beneficiary and one-half should be for insulin training. **Exception**: Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:

  - No group session is available within 2 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, that will hinder effective participation in a group training session; or

  - The physician orders additional insulin training.

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

- Consists of no more than 2 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. **NOTE**: If individual training has been provided to a Medicare beneficiary and subsequently it is determined that training should have been provided in a group, reimbursement will be downcoded from individual to the group level and provider education would be the appropriate actions instead of denying the service as billed.

- Is furnished any time in a calendar year following a year in which the beneficiary completes the initial training.

- Is furnished in increments of no less than one-half hour.

- The physician (or qualified nonphysician practitioner) treating the beneficiary must document, in the referral for training and the beneficiary's medical record, the specific medical condition that the follow-up training must address.

D. Payment for Outpatient Diabetes Self-Management Training.--

1. Payment for outpatient diabetes self-management training is based on rates established under the physician fee schedule.

2. Payment may only be made only to any provider that bills Medicare for other individual Medicare services.

3. 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 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.

- The beneficiary is not receiving services as an outpatient in an RHC or FQHC.

E. Coding and Payment Requirements. Bill for the diabetes outpatient self-management training services on the HCFA-1450 or its electronic equivalent. The cost of the service is billed under revenue code 942 in FL 42 "Revenue Code." 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".

- G0108 – Diabetes outpatient self-management training services; individual session, per 30 minutes of training.

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

The actual payment amounts will vary among geographic areas to reflect differences in cost of practice, as measured by the Geographic Practice Cost Indexes. Deductible and coinsurance will be applied.

NOTE: All providers are eligible to receive retroactive payment for this service back to the later of February 27, 2001 or the date of recognition by the ADA.

F. 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.