Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-151 **Date: OCTOBER 25, 2002**

CHANGE REQUEST 2373

SUBJECT: Clarification Regarding Non-physician Practitioners Billing on Behalf of a Diabetes Outpatient Self-Management Training Services (DSMT) Program and the Common Working File Edits for DSMT & Medical Nutrition Therapy (MNT). (NOTE: APASS has received a waiver for this CR)

I - GENERAL INFORMATION (A – G)

A. Background:

This Program Memorandum (PM) serves several purposes. First, the PM confirms that Medicare non-physician practitioners, such as nurse practitioners or registered dietitians who are eligible to render other Medicare services, may bill on behalf of a DSMT program. Payment to non-physician practitioners billing on behalf of the DSMT program should be made as if rendered by a physician. Second, this PM instructs the Common Working File (CWF) to begin editing on DSMT and MNT effective April 1, 2003. Third, the PM clarifies some outstanding issues regarding DSMT and MNT.

B. Policy Clarification:

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 part of a multi-disciplinary team that provides DSMT services for the DSMT program. A dietitian may not be the sole provider of the DSMT service unless they are performing the service in a rural area as defined in 42 CFR 410.144. The accreditation organizations, the American Diabetes Association (ADA) or the Indian Health Service (IHS), will determine if the program can qualify to have a single-member team. The program may also include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. The benefit provided by the program may not be subdivided for the purposes of billing Medicare.

A hospital that has a DSMT program (accredited by the ADA or IHS) can be the biller without any reassignment. If a dietitian or certified diabetic educator has a DSMT program accredited under their name and they work for a hospital, then they would need to reassign their benefits to the hospital. If a physician is part of the DSMT program, (i.e., a physician advisor), he or she can be the certified provider and bill Medicare using the physician's Medicare provider number. A registered dietitian, who has a Medicare provider number and is part of the DSMT program, can bill on behalf of the DSMT program.

The MNT benefit is a completely separate benefit from the DSMT benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same time period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, they are not allowed to bill for both DSMT and MNT on the same date of service. In subsequent years the beneficiary can receive 2 hours of DSMT (with a referral) and 2 hours of MNT in subsequent years (with a referral).

Medicare covers 3 hours of MNT in the beneficiary's initial calendar year. There will be no carrying over of initial hours to the next calendar year. For example, if a physician gives a referral to a beneficiary for 3 hours of MNT but a beneficiary only uses 2 hours in November, the calendar year ends in December and if the 3rd hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Payment to non-physician practitioners billing on behalf of a DSMT program (G0108 or G0109) should be made at the full fee schedule rate and should not be paid at 85 percent of the fee schedule like other non-physician practitioner services. This is because the payment is for the DSMT program and is not being made for the services of a single practitioner.

Non-physician practitioners that bill on behalf of a DSMT program are subject to mandatory assignment.

C. CWF Edits

The CWF will begin to edit claims that are submitted for more than the number of hours allowed for DSMT and MNT beginning April 1, 2003.

The edit for DSMT will allow 10 hours of training in the first 12-month period a beneficiary receives DSMT. The edit will allow 2 hours of follow-up with another referral in subsequent years. If claims are submitted to CWF over the number of allowed hours for DSMT or MNT, CWF will reject these claims and return an error code to Medicare contractors.

The edit for MNT will allow 3 hours of therapy in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen, and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. (See below.) Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

D. Advance Beneficiary Notice (ABN)

The beneficiary is liable for services denied over the limited number of hours with referrals for DSMT or MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their State but who have not obtained Medicare provider numbers.

E. New MNT Codes:

Two new G codes have been created for MNT when there is a change in condition of the beneficiary:

G0270: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

G0271: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

The above new G codes for additional hours of coverage should be used after the completion of the 3 hours of basic coverage under 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours. Contractors should use dietary protocols from the ADA and the National Kidney Foundation as guides if local medical review limits are established for the additional hours of coverage. (The type of service for these two new codes is 1.)

These new codes will be part of the annual 2003 HCPCS update. Therefore, the codes will be effective for dates of service on or after January 1, 2003.

F. Provider Education

Contractors must notify providers, through an educational article, of these new MNT G codes and their use. This article must be posted as soon as possible on your Web sites and published in your next regularly scheduled bulletin.

Medicare carriers must also post information on their Web site informing registered dietitians that they are allowed to bill on behalf of an entire DSMT program (as long as they are part of the program). The following information should also be posted: Billers for DSMT services should note that any income from codes G0108 or G0109 will be accrued under their provider number and reported to the Internal Revenue Service.

G. Medicare Summary Notices (MSNs) and Remittance Advice Messages

Included in this PM for intermediaries and carriers are new MSNs that will apply when any claims for DSMT or MNT are denied because the services extend beyond the initial year or follow up hours. The new MSN messages are listed under the Part III, Supporting Information and Possible Design Considerations.

We suggest Medicare contractors use standard claim reason adjustment code 119, "Benefit maximum for this time period has been reached."

II - BUSINESS REQUIREMENTS

- *use the word "must" to indicate a mandatory action*
- *use the word "will" to indicate an optional action*
- *Resp. column is optional*

Req. #	Requirements	Resp.
1.1	Medicare carriers need to revise any edits in order to pay claims submitted by registered dietitians on behalf of a DSMT program (G0108/G0109).	Carrier
1.2	Beginning April 1, 2003 and after, CWF must edit the number of hours for DSMT. Any DSMT claims for beneficiaries that contain more than the 10 hours in the initial year must be denied. (The initial year is defined as 12 months from the initial date that was posted on CWF. CWF should calculate this frequency beginning with the month after the month of the initial date.) (CWF has been capturing data on DSMT since April 02). The denial information will be sent to Medicare contractors via error codes.	CWF
1.3	Beginning April 1, 2003 and after, CWF must reject any DSMT claims for more than 2 hours of follow up visits in a 12-month calendar period. The denial information will be relayed to Medicare contractors thru error codes.	CWF

1.4	Beginning April 1, 2003 and after, CWF must edit the number of hours for medical nutrition therapy (MNT). Any MNT claims for beneficiaries that contain more than the initial 3 hours in a calendar year must be denied. (Error codes will be used to relay this information to Medicare contractors.) The exception would be if the MNT claim contains either G0270 or G0271 then CWF will bypass the edit logic and pay the claim. (The new G codes indicate a change in the beneficiary's medical condition.) (CWF has been capturing data on MNT services since April 02)	CWF
1.5	Beginning 04/01/03 and after, CWF must reject any MNT claims for more then 2 hours of follow up visits in a 12-month calendar period. (Error codes will be used to relay this information to Medicare contractors.)	CWF
1.6	Medicare systems must accept the two new G codes for MNT (G0270/G0271). These codes are effective 1/1/03 as part of the HCPCS update. The G Codes will be used by providers to indicate that there has been a change in the bene's condition and the bene is eligible to receive more than 3 hours of MNT or more than the 2 follow up hours.	FI/Carrier CWF
1.7	Payment for non-physician practitioners billing on behalf of a DSMT program should be the same as if rendered by a physician. Medicare carriers must bypass practitioner pricing logic when the detail procedure code equals G0108 or G0109. G0108 or G0109 must allow at the physician MPFSDB fee without a practitioner reduction.	Carrier

III - Supporting Information and Possible Design Considerations

A – Other Instructions:

X-Ref Req. #	Instructions
1.2	For claims denied for DSMT because the beneficiary has received more than 10 hours of training during the initial 12-month period, use the following message: (MSN#20.10) "This service was denied because Medicare only pays up to 10 hours of diabetes education training during the initial 12-month period. Our records show you have already obtained 10 hours of training."
1.2	(Mensaje del Resumen de Medicare 20.10) "Este servicio fur negado porque Medicare solamente paga hasta 10 horsa de entrenamiento enaleducatoin de la diabetes durante el periodo enicial de 12 meses. Nuestros expedients indican que usted ya obtuvo 10 horas de entrenamineto."

1.3	For claims denied for DSMT because the beneficiary has received more than 2 follow-up hours during the calendar year, use the following message: (MSN#20.11) "This service was denied because Medicare only pays 2 hours of follow-up diabetes education training during a calendar year. Our records show you have already obtained 2 hours of training for this calendar year." (Mensaje del Resumen de Medicare 20.11) "Este servicio fur negado porque Medicare solamente paga por 2 horas de continuacion del entrenamiento en la educacion de la diabetes durante un entrenamiento por este ano."
1.4	For claims denied for MNT because the beneficiary has received more than 3 hours of therapy during the initial 12-month period, use the following message: (MSN# 20.13) "This service was denied because Medicare only pays up to 3 hours of medical nutrition therapy during a calendar year. Our records show you have already received 3 hours of medical nutrition therapy."
1.4	Spanish Version, 20.13 "Este servicio fue negado porque Medicare solo paga hasta 3 horas por anode terapia medica nutricional. Nuestros expedientes indican que usted ya recibio 3 horas de terapia medica nutricional."
1.5	For claims denied for MNT because the beneficiary has received more than 2 follow-up hours of therapy during a calendar year, use the following message: (MSN#20.14) "This service was denied because Medicare only pays 2 hours of follow-up for medical nutrition therapy during a calendar year. Our records show you have already received 2 hours of follow-up services for this calendar year."
1.5	Spanish Version MSN#20.14 "Este servicio fur negado porque Medicare solo paga 2 horas al ano por servicios de seguimiento de la terapia medica nutricional. Nuestros expedientes indican que usted ya recibio 2 horas de servicios de seguimiento en este ano."

B – Design Considerations:

X-Ref Req. #	Recommendation for Medicare System Requirements

C - Interfaces:
D - Contractor Financial Reporting /Workload Impact:
E - Dependencies:
F - Testing Considerations:

Version: Draft 8/30/02 Implementation Date: 4/1/03 Discard Date: 4/1/04 Post-Implementation Contact: Appropriate Regional Office	Effective Date: 4/1/03 Funding: These instructions should be implemented within your current operating budget. Pre-Implementation Contact: Patricia Gill (410)-786-1297, Doris Barham (410) 786-6146, Mary Stojak (410) 786-6939