



Related MLN Matters Article #: MM5433

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Related CR #: 5433

Guidelines for Payment of Diabetes Self-Management Training (DSMT)

Note: MLN Matters article MM5433 was revised to reflect changes made to Change Request (CR) 5433, which was revised on May 25, 2007. The CR5433 was revised to show that hospitals subject to the OPPTS will be paid under the Medicare Physician Fee Schedule when billing G0108 and G0109 on a type of bill 12X or 13X. Also, the CR transmittal numbers and release date and the web address for accessing CR5433 have been revised. All other information remains the same.

Key Words

MM5433, CR5433, R1255CP, R72BP, Diabetes, DSMT

Provider Types Affected

Providers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for DSMT services provided in institutional settings to Medicare beneficiaries

Key Points

- The effective date of the instruction is July 1, 2007.
- The implementation date is July 2, 2007.
- The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of DSMT services when these services are furnished by a certified provider who meets certain quality standards, and Change Request (CR) 5433 corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings.

Note: There are no new codes being created by CR5433. In addition, deductible and coinsurance apply to these services.

- The DSMT 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.

Initial Training

- The initial year for DSMT is the 12-month period following the initial date, and Medicare will cover initial training that meets the following conditions:
 - DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109;
 - DSMT is furnished within a continuous 12-month period;
 - DSMT does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of one-half hour increments);
 - With the exception of one hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries; and
 - The one hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

- Medicare covers follow-up training under the following conditions:
 - No more than two hours individual or group training is provided per beneficiary per year;
 - Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
 - Follow-up training for subsequent years is based on a 12-month calendar after completion of the full 10 hours of initial training;
 - Follow-up training is furnished in increments of no less than one-half hour; and
 - The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

NOTE: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Examples

- **Example #1: Beneficiary Exhausts 10 hours in the Initial Year (12 continuous months)**
 - Beneficiary receives first service in April 2006.
 - Beneficiary completes initial 10 hours DSMT training in April 2007.
 - Beneficiary is eligible for follow-up training in May 2007 (13th month begins the subsequent year).
 - Beneficiary completes follow-up training in December 2007.
 - Beneficiary is eligible for next year training in January 2008.

- **Example #2: Beneficiary Exhausts 10 Hours Within the Initial Calendar Year**
 - Beneficiary receives first service in April 2006.
 - Beneficiary completes initial 10 hours of DSMT training in December 2006.
 - Beneficiary is eligible for follow-up training in January 2007.
 - Beneficiary completes follow-up training in July 2007.
 - Beneficiary is eligible for next year follow-up training in January 2008.

Coding and Payment of DSMT Services

- The following HCPCS codes should be used for DSMT:
 - G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes; and
 - G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.
- Payment information for physicians and providers for outpatient DSMT may be found in the table on page 4 of MLN Matters article MM5433 and lists the following:
 - Type of Facility/provider;
 - Payment Method; and
 - Type of Bill (TOB).
- Effective January 1, 2006, payment for DSMT provided in an Federally Qualified Health Center (FQHC), that meets all the requirements as listed in this table (page 4 of MM5433), may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73X, with HCPCS code G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.
- The Skilled Nursing Facility (SNF) consolidated billing provision allows separate Part B payment for training services for beneficiaries that are in skilled Part A SNF stays; however, the SNF must submit these services on a 22x bill type. Training services provided by other provider types must be reimbursed by the SNF.

NOTE: An End Stage Renal Disease (ESRD) facility is a reasonable site for this DSMT service; however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement.

Advanced Beneficiary Notices (ABNs)

- Providers should also be aware that the beneficiary is liable for services denied over the limited number of hours with referrals for DSMT.
- An ABN should be issued in these situations and absent evidence of a valid ABN, the provider would be held liable.

- However, 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.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5433.pdf> on the CMS website.

The official instruction (CR5433) issued regarding this change consists of two transmittals. One revises the *Medicare Benefit Policy Manual* and one modifies the *Medicare Claims Processing Manual*. These

transmittals are at <http://www.cms.hhs.gov/Transmittals/downloads/R72BP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1255CP.pdf>, respectively.