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MLN Matters Number: MM5433 Revised **Related Change Request (CR) #: 5433**

Related CR Release Date: May 25, 2007 **Effective Date: July 1, 2007**

Related CR Transmittal #: R1255CP & R72BP **Implementation Date: July 2, 2007**

Important Note: Medicare will only pay claims for DME if the ordering physician and DME supplier are actively enrolled in Medicare on the date of service. Physicians and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If you are not enrolled on the date the prescription is filled or re-filled, Medicare will not pay the submitted claims. It is also important to tell the Medicare beneficiary if you are not participating in Medicare before you order DME. If you do not have an active record, please see the following fact sheet containing information on how to enroll, revalidate your enrollment and/or make a change: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf on the CMS website.

Note: The article was revised on December 21, 2015, to include the "Important Note" above. All other information remains unchanged.

Guidelines for Payment of Diabetes Self-Management Training (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.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5433 which corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings.

CAUTION – What You Need to Know

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes, and beneficiaries are eligible to receive 2 hours of follow-up training each calendar year following the year in which they were certified as requiring initial training. **DSMT must be ordered by the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition.**

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards, and CR 5433 corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. Note that no new codes are being created by CR5433. Also, 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 1/2 hour increments;
- With the exception of 1 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 to physicians and providers for outpatient DSMT is made as follows:

Type of Facility/Provider	Payment Method	Type of Bill
Physician/non-physician practitioner (billing carrier/MAC)	Medicare Physician Fee Schedule (MPFS)	N/A
Hospitals subject to Outpatient Prospective Payment System (OPPS)	Medicare Physician Fee Schedule (MPFS)	12x, 13x
Method I and Method II Critical Access Hospitals (CAHs) (technical services)	101% of reasonable cost	12X and 85X
Indian Health Service (IHS) providers billing hospital outpatient	Office of Management and Budget (OMB)-approved outpatient per visit all inclusive rate (AIR)	13X and revenue code 051X
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12X and revenue code 024X
IHS CAHs billing outpatient	101% of the all-inclusive facility specific per visit rate	85X and revenue code 051X
IHS CAHs billing inpatient Part B	101% of the all-inclusive facility specific per diem rate	12X and revenue code 024X
Rural Health Clinics (RHCs)	All-inclusive encounter rate	71X with revenue code 0520, 0521, 0522, 0524, 05225, 0527, 0528, or 0900
Federally Qualified Health Centers (FQHCs)*	All-inclusive encounter rate	73X with revenue code 0520, 0521, 0522, 0524, 0525, 0527, 0528, 0r 0900
Skilled Nursing Facilities (SNFs) **	Medicare Physician Fee Schedule (MPFS) non-facility rate	22X, 23X
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	Payment in accordance with the terms of the Maryland Waiver	12X, 13X
Home Health Agencies (can be billed if service is outside of the treatment plan)	MPFS non-facility rate	34X

* Effective January 1, 2006, payment for DSMT provided in an FQHC, that meets all the requirements as above, 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 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.

Advance 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 dieticians or nutrition professionals who are qualified to render the service in their State, but who have not obtained Medicare provider numbers.

Additional Information

For complete details, please see the official instruction, CR5433, issued to your FI, RHHI, and A/B MAC regarding this change. There are two transmittals related to CR5433, one which revises the *Medicare Benefit Policy Manual* and one that modifies the *Medicare Claims Processing Manual*. These transmittals are at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R72BP.pdf** and **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1255CP.pdf**, respectively.

If you have any questions, please contact your FI, RHHI or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Document History

Date	Description
December 21, 2015	The article was revised on December 21, 2015, to include the "Important Note" near the top of page 1.
August 24, 2012	This article was updated to reflect current Web addresses.
May 29, 2007	This article was revised to reflect changes made to CR5433, which was revised on May 25, 2007. The CR5433 was revised to show that hospitals subject to the OPPS will be paid under the Medicare Physician Fee Schedule when billing G0108 and G0109 on a type of bill 12X or 13X. The article was revised accordingly. Also, the CR transmittal numbers and release date and the web address for accessing CR5433 were revised.