General Overview of the Medicare Diabetes Self-Management Training Benefit Coverage Guidelines

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Medicare Coverage Guidelines for DSMT*	**Individual and Group Diabetes Self-Management Training (DSMT) Initial and Follow-Up Episodes of Care** **REVISION DATE: FEBRUARY 1, 2017**
Coverage: In-Person	Ten self-care topics included; nutrition is one of 10 presented as broad overview of basic concepts.
Payable Places of Services	Outpatient settings that include hospital outpatient departments, private physician practices, registered dietitian nutritionist (RDN) practices, home health agencies, skilled nursing homes, pharmacies, durable medical equipment companies.
Excluded Places for Part B Payment	Rural health clinics are eligible to receive payment under Medicare's All-Inclusive Rate payment system. Federally qualified health clinics are eligible to receive payment under Prospective Payment System.
Excluded Places: 0 Payment	Hospital inpatient, nursing homes, renal dialysis facilities.
Utilization Limits and Format	Initial: 10 hours in 12 consecutive months, starting with date of first visit; once-in-a-lifetime benefit. Format of Initial DSMT: Nine of 10 hours to be provided in group. One hour may be used for individual visit(s) on any topic or topics. All 10 hours may be individual if criteria for individualized DSMT are met. • Criteria for individualized initial DSMT: o Treating provider orders "additional insulin training" on DSMT referral. o Treating provider documents a condition/conditions on DSMT referral that limit beneficiary's group learning (e.g., language, vision, hearing, cognitive, nonambulatory). o No group class is scheduled within 2 months of the date on the DSMT referral. Format of Follow-Up DSMT: Two hours in each year following year in which DSMT completed. May be group or individual; criteria not required for furnishing follow-up DSMT on individual basis. DSMT will not be reimbursed if furnished on same day as the medical nutrition therapy (MNT) benefit.
Billing Providers	*Individual* providers: RDNs, qualified nutrition professionals, physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and clinical psychologists. *Entity* providers: Outpatient hospital, clinics, physician practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes, durable medical equipment companies. Must be billing for other Medicare services and receiving payment. Only one individual or entity Medicare provider can bill for entire hours of training; benefit may not be subdivided for purposes of billing. Cannot be billed as "incident to" physician's services.
Reimbursement	*Nonparticipating* Medicare providers need not accept assignment; can bill beneficiary or his/her secondary insurance for difference between fee and Medicare's assigned reimbursement rate. However, fee is subject to Medicare's limiting charge. *Participating* providers are required to accept assignment for payment.
Beneficiary Copayment	Beneficiary is required to pay the 20% copayment. Medicare pays 80% of geographically adjusted allowed rate. Can access rates at www.cms.gov.
Facility Fee	No Medicare facility fee allowed, except if furnished as telehealth.

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Quality Standards	Program must have accreditation from American Association of Diabetes Educators or recognition from American Diabetes Association; this status is based on program meeting the current 10 National Standards for Diabetes Self-Management Education and Support and other application requirements.
Beneficiary Entitlement	*Initial DSMT:* Has Medicare Part B insurance and has not received initial DSMT ever. *Follow-Up DSMT:* Has Medicare Part B insurance. Beneficiary can receive follow-up without having received initial.
Allowed Referring Providers	Beneficiary's treating physician (MD, DO) or treating qualified nonphysician practitioners can refer (e.g., nurse practitioners, physician assistants, clinical nurse specialists). Treating means this person is medically managing the beneficiary's diabetes.
Beneficiary Eligibility: Referral	Must establish medical necessity for DSMT program by obtaining written or e-referral for DSMT by treating provider for both initial and again for follow-up DSMT. Referral must include narrative diabetes diagnosis or valid ICD-10-CM diagnosis code plus other required documentation: Date — Order for Initial or Follow-up (Subsequent Year) DSMT Beneficiary's name — Initial DSMT: If all 10 topics to be taught or only select topics (if latter, to be named) Provider's signature — Initial DSMT: If all 10 hours to be furnished or less than 10 (if latter, number to be specified) Provider's National Provider Identification Number The Academy has a Diabetes Services order form: http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/coding%20coverage%20compliance/diabetes-services-order-form.ashx
Beneficiary Eligibility: Diagnostic Laboratory Criteria	Same for type 1 (T1)/type 2 (T2) diabetes: Statutory language states there must be documentation of one of three laboratory tests that diagnoses T1/T2 diabetes: 1. Fasting blood glucose ≥126 mg/dL on two different occasions (time frame between not stipulated).** 2. Two-hour postglucose challenge test ≥200 mg/dL on two different occasions (time frame between not stipulated). 3. Random blood glucose test ≥200 mg/dL for person with symptom(s) of uncontrolled diabetes.** ** Cannot be obtained from home-based or inpatient (bedside) blood glucose meter. However, the statutory language of DSMT benefit does not state who has to have the documentation of the diabetes or renal eligibility laboratory value (i.e., treating physician or RDN furnishing MNT). Mary Ann's suggestion is to bring this issue to the attention of the entity's Medicare compliance officer, chief executive officer, or chief operating officer and ask this person to make the decision as to whether the DSMT program is to obtain the laboratory documentation.
Medical Unlikely Edits (MUEs): Sets limits on number of units of procedure code that can be billed to Medicare per beneficiary per day	**HCPCS Code** — **Outpatient Hospital Services MUE Values** — **Practitioner Services MUE Values** **G0108** Individual DSMT — 8 units = 4 hours — 6 units = 3 hours **G0109** Group DSMT — 12 units = 6 hours — 12 units = 6 hours

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DSMT Telehealth Coverage **References:** **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf** **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r140bp.pdf** **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf**	Individual and group DSMT (initial and follow-up) can be provided as telehealth services. Telehealth services use a real-time audiovisual telecommunication system as a substitute for an in-person encounter between the Medicare beneficiary and the provider, who are at different sites. Medicare's specific telehealth coverage guidelines for billing and payment are: 1. The beneficiary must be at an "originating site" at the time the service being furnished. 2. Originating sites must be located in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. a. However, entities that participate in a federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. 3. The originating sites authorized by law are: a. Offices of physicians or qualified nonphysician practitioners b. Hospitals c. Critical Access Hospitals (CAHs) d. Rural Health Clinics (RHCs) e. Federally Qualified Health Centers (FQHCs) f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites) g. Skilled Nursing Facilities h. Community Mental Health Centers 4. The provider is at "distant site" at the time the benefit is being furnished. 5. Individual Medicare providers who are allowed to furnish the DSMT telehealth benefit are: • Physicians (MDs, DOs) • Physician assistants (PAs) • Nurse practitioners (NPs) • Clinical nurse specialists (CNSs) • Certified nurse midwives (CNMs) • Clinical psychologists • Clinical licensed social worker (CLSWs) • Registered dietitian nutritionists (RDNs) and nutrition professionals The statutory language of the DSMT telehealth benefit states: *".....Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), clinical psychologist, clinical social worker, or registered dietitian or nutrition professional."** *Source: 190.3.6 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16), Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners (Rev. 3678, 08-12-16) 6. An interactive audio and video telecommunications system that is HIPAA compliant must be used that permits real-time communication between the provider at the distant site and the beneficiary at the originating site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. a. Asynchronous "store and forward" technology is permitted only in federal telehealth demonstration programs conducted in Alaska or Hawaii. 7. Claims for telehealth services are submitted using the appropriate HCPCS code along with the telehealth modifier GT, "via interactive audio and video telecommunications system" (e.g., G0108 GT). By using the GT modifier, the distant site provider certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

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	a. In the case of federal telemedicine demonstration programs conducted in Alaska or Hawaii, providers use the telehealth modifier GQ, "via asynchronous telecommunications system" (e.g., G0108 GQ) 8. For DSMT telehealth services, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs training must be furnished during the year following the initial DSMT service if the beneficiary is prescribed this type of drug therapy. The injection training may be furnished through either individual or group DSMT services. 9. Providers at the distant site can bill either the Medicare Carrier or the Part A/Part B Medicare Administrative Contractor (MAC) for telehealth MNT and DSMT. Reimbursement rates are the same as when MNT and DSMT services are delivered face-to-face. In addition, the originating site that owns the specialized audiovisual equipment can bill the Medicare Carrier or A/B MAC a facility fee, as described by HCPCS code Q3014 (telehealth originating site facility fee). The facility fee is a separately billable Part B payment. To claim the facility fee, the originating site must bill HCPCS code Q3014 "telehealth originating site facility fee" in addition to the procedure code. Beneficiary pays unmet deductible and coinsurance on facility fee. The 2017 Medicare facility fee = 80% of lesser of actual charge or $25.40. Type of service is "9" on claim form ("other items and services"). Originating site facility fee is a Part B payment. Medicare pays it outside of current fee schedule or other payment methodologies. Place of service (POS) code is "02": location where health services and health-related services are provided or received through telecommunication technology.
***References**	1. Chapter 12 – Physicians/Nonphysician Practitioners. Section 190. Medicare Payment for Telehealth Services. 190.3.6 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service. *Medicare Claims Processing Manual.* Washington, DC: Centers for Medicare & Medicaid Services. 2. Expanded Coverage of Diabetes Out-Patient Self-Management Training, June 15, 2001. PM B-01-40; www.cms.hhs.gov/manuals/pm_trans/B0140.pdf. 3. American Association of Diabetes Educators. *AADE Reimbursement Primer.* 2000. www.aadenet.org. 4. American Association of Diabetes Educators. *Diabetes Education Services, Reimbursement Tips for Primary Care Practice, Revised June 2010.* http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf. 5. Daly A, Leontos C. Legislation for health care coverage for diabetes self-management training, equipment, and supplies: past, present, and future. *Diabetes Spectrum.* 199;12(4):222–230. 6. Department of Health and Human Services, Health Care Financing Administration. *Program Memorandum Carriers: Expanded Coverage of Diabetes Out-Patient Self-Management Training Transmittal B-01-40.* June 15, 2001. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/B0140.pdf. Accessed March 1, 2017. 7. Medicare Program; Expanded Coverage for Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements; Final Rule and Notice. *Federal Register.* December 29, 2000. https://www.federalregister.gov/documents/2000/12/29/00-32703/medicare-program-expanded-coverage-for-outpatient-diabetes-self-management-training-and-diabetes. Accessed March 1, 2017. 8. Websites: a. Centers for Medicare and Medicaid Services: www.cms.gov b. Academy of Nutrition and Dietetics: www.eatrightpro.org/resources/practice/getting-paid c. American Diabetes Association: www.diabetes.org d. American Association of Diabetes Educators: www.aadenet.org e. ICD10Data.com: http://www.icd10data.com/ f. The Medicare Learning Network®: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNgeninfo/

Procedure Codes Required by Medicare for DSMT

HCPCS Code	Description	Utilization Limits in Initial Episode of Care and Provision of Hours	Utilization Limits in Follow-up Episode of Care and Provision of Hours
G0108	Diabetes outpatient self-management training DSMT; individual visit, face-to-face with the patient, each 30 minutes of training. DSMT program must be accredited as meeting current 10 National Standards of DSME by either ADA or AADE.	10 hours in first consecutive 12 months upon written referral by treating physician (MD or DO) or treating qualified nonphysician practitioner; 9 hours to be in group, unless: • Barriers that hinder group learning documented by referring provider. • No DSMT program scheduled within 2 months of referral date or • Referring provider orders additional insulin training.	2 hours in subsequent calendar years, starting with calendar year following year in which beneficiary completed initial 10 hours of DSMT upon another written referral by treating physician (MD or DO) or treating qualified nonphysician practitioner. 2 hours may be individual or group; documentation of learning barriers not required in order to provide individual follow-up DSMT. Beneficiary can receive follow-up DSMT without having received initial DSMT.
G0109	DSMT; group session (2–20 individuals*), face-to-face with patients, each 30 minutes. *Note: 2–20 individuals must be registered patients; not all patients in group need to be Medicare beneficiaries.		

HCPCS: Healthcare Common Procedure Coding System
AADE: American Association of Diabetes Educators
DSMT: diabetes self-management education/training
ADA: American Diabetes Association