Medicare Coverage Guidelines for Diabetes Self-Management Training Benefit: Guidelines Summarized in the Word "P.A.R.T.I.C.I.P.A.T.I.N.G." *Updated: August 8, 2017*		
P	Places of service for in-person benefit Place of service facility fee billing for in-person benefit	Places of services for in-person benefit (not telehealth DSMT): 1. Hospital outpatient (OP) department; critical access hospital; private physician practice; registered dietician (RD) practice; independent clinic; federally qualified health centers (FQHC); rural health clinic (RHC); home health agency; skilled nursing home; pharmacy; durable medical equipment (DME) company. o Hospital: ▪ DSMT must be furnished in hospital OP department or in hospital-owned provider-based clinic or group. ▪ Not payable IF furnished at alternate non-hospital, off-site locations. o FQHC: Only individual DSMT payable. If there is solo diabetes instructor, must be RD or CDE. o RHC: Only individual DSMT payable. o Home health agency: DSMT payable when furnished outside of Medicare Part A home health benefit. o Skilled nursing facility (SNF): SNF Part A benefit and DSMT Part B benefit can be received at same time. 2. Excluded places of services: Hospital inpatient, nursing home, renal dialysis facility. Place of service facility fee billing for in-person benefit: 1. Facility fee not payable. Exception: payable if billed by originating site after DSMT telehealth visit.
A	Approved type of claim forms Accepting assigned, adjusted reimbursement rate	Approved types of claim forms: 1. 837P professional claim: e-format of CMS-1500 paper claim used by non-institutional professional providers and suppliers to bill Medicare Administrative Contractors (MACs). 2. CMS-1500 professional paper claim: used by non-institutional professional providers and suppliers to bill MACs when paper allowed. 3. CMS-1450 paper claim: used by institutional providers (e.g., hospitals) and FQHCs when paper allowed. 4. UB-04 claim: e-format of CMS-1450 paper claim. Must enter 3 digit "type of bill" (TOB) code on line 4 that describes TOB provider is submitting to payer: a. 1st digit refers to type of facility. b. 2nd digit definition depends on 1st digit; has different meanings for clinics and special facilities. c. 3rd digit refers to frequency. Accepting assigned, adjusted reimbursement rate: 1. Participating Medicare providers must accept Medicare's assigned, geographically adjusted reimbursement rate; providers are paid 80% of DSMT assigned rate. Beneficiary required to pay 20% of assigned rate (also known as (aka) co-payment). Can access geographically adjusted rates at: https://www.cms.gov/

<table>
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<td>R</td>
<td>Reimbursement methodology type and requirements in various places of service</td>
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1. Type in approved places of service, other than FQHCs and RHCs:
a. DSMT reimbursement paid via Medicare Physicians' Fee Schedule under Part B.
2. FQHCs:
a. Individual DSMT is core FQHC service. Group DSMT not payable under OP PPS.
b. FQHC visits may take place in these locations when requirements met:
i. FQHC; beneficiary's home; assisted living facility; Medicare-covered Part A skilled nursing facility.
c. Medicare Part B pays 80% of the lesser of: FQHC OP Prospective Payment System (PPS) rate (bundled payment for all approved FQHC services furnished to beneficiary/day) OR the total of the amounts charged on claim's qualifying visit procedure code(s); beneficiary pays 20%.
d. Part B deductible does not apply to FQHC services.
e. Exception: separate payment made for visits to same beneficiary on same day when beneficiary has qualified medical visit and mental health visit on same day. DSMT is considered a medical visit. But when DSMT furnished with another medical visit on same day for same beneficiary, DSMT not separately payable.
f. List approved "qualifying visit" code on claim:
i. G0466: FQHC visit, new patient.
ii. G0467: FQHC visit, established patient.
g. Also list procedure code G0108 on claim that corresponds to qualifying visit code.
h. Use appropriate revenue code on claim:
<table>
<tr><th>Revenue Code</th><th>Definition</th></tr>
<tr><td>0521</td><td>Clinic visit by member to RHC/FQHC</td></tr>
<tr><td>0522</td><td>Home visit by RHC/FQHC practitioner</td></tr>
<tr><td>0524</td><td>Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)</td></tr>
<tr><td>0525</td><td>Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility</td></tr>
<tr><td>0527</td><td>RHC/FQHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area</td></tr>
<tr><td>0528</td><td>Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)</td></tr>
</table>
i. Must use TOB 77x in locator field 4 on UB-04 claim form.
j. Regarding group DSMT:
i. May be able to furnish as "incident to FQHC practitioner services", but:
1. Cannot separately bill for group DSMT for additional Part B payment.
2. May be able to include cost of group classes on annual FQHC cost report.
3. RHCs:
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		a. Cost-basis reimbursement. Cost of DSMT is calculated for code G0108 under OP Prospective Payment System rate and included on annual cost report for reimbursement. b. Beneficiary 20% copay and Part B deductible do apply. c. List procedure code G0108 on claim as additional service line (Line 2) on TOB 71x. d. Use appropriate revenue code on claim (see above under FQHC).
T	Time frame, utilization limits and format of DSMT in *initial* and *follow-up* episodes of care	Initial DSMT: 1. Time frame: 12 consecutive months, starting with date of first visit. Is once-in-a-lifetime benefit. 2. Utilization limit: 10 hours. Unused hours not payable if extended into next 12 months. The 10 hours to be furnished in increments of no less than 0.5 hour (30 minutes, face-to-face), as procedure code is a 30-minute time-based code; rounding of time furnished is not allowed. 3. Format: 9 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 criterion for individualized DSMT is met. a. Treating provider orders "additional insulin training" on DSMT referral. b. Treating provider documents a condition/conditions on DSMT referral that limit beneficiary's group learning (e.g., language, vision, hearing, cognitive, non-ambulatory). c. No group class is scheduled within 2 months of the date on the DSMT referral. Follow-up DSMT: 1. Time frame: 12 months after initial DSMT completed. 2. Utilization limit: 2 hours. Unused hours not payable if extended into next 12 months. The 2 hours to be furnished in increments of no less than 0.5 hour (30 minutes, face-to-face), as procedure code is a 30-minute time-based code; rounding of time furnished is not allowed. 3. Example of eligible follow-up time frames: • Completes Initial 10 Hours Spanning 2 Years: 2016, 2017: o Starts initial 10 hours in August 2016 o Completes initial 10 hours in August 2017 o Eligible for…and starts…2 hours of follow-up in September 2017 o Completes 2 hours of follow-up in December, 2017 o Eligible for next 2 hours of follow-up in January, 2018 • Completes Initial 10 Hours in Same Calendar Year: o Starts initial 10 hours in August 2016 o Completes initial 10 hours in December, 2016 o Eligible for…and starts…2 hours of follow-up in January, 2017 o Completes 2 hours of follow-up in July 2017 o Eligible for next 2 hours of follow-up in January, 2018 4. Format: May be group or individual. Criteria not required for furnishing follow-up DSMT on individual basis. DSMT not payable if furnished on same day as the medical nutrition therapy (MNT) benefit.

<table>
<tr><td>I</td><td>Incident to physician services billing method</td><td>This specific billing method is not permitted for DSMT.</td></tr>
<tr><td>C</td><td>Codes required on claim form: procedure, revenue and diagnosis</td><td>1. Procedure codes:
<table><tr><th>Visit must be at least 1 unit of code. Enter code 1 time on claim, and number of units furnished.</th><th>1 Unit</th></tr><tr><td>DSMT, individual, initial or follow-up, 30 minutes</td><td>30 min</td></tr><tr><td>DSMT, group, initial or follow-up, 30 minutes</td><td>30 min</td></tr></table>
2. Revenue codes:
a. See “R” section above for FQHCs and RHCs.
b. All other places of services using UB-04 claim form: revenue code 0942.
3. Diagnosis codes:
a. Billable, valid ICD-10 diagnosis codes for Type 1 and Type 2 diabetes must have minimum of 5 characters.
b. CMS Transmittal CR9861 made adjustments to CMS National Coverage Determination (NCD) 40.1 for DSMT:
o NCD40.1: Diabetes Outpatient Self-Management Training: Contractors shall END-DATE invalid ICD-10 dx codes effective 9/30/16. Contractors shall ADD new 2017 ICD-10 dx codes effective 10/1/16. Contractors shall REMOVE ICD-10 unspecified codes effective 1/1/17.
o See NCD40.1 spreadsheet for specific coding changes at:
• https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1755OTN.pdf
• https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9861.zip</td></tr>
<tr><td>I</td><td>Imperative initial DSMT referral documentation requirements

Imperative follow-up DSMT referral documentation requirements</td><td>Imperative initial DSMT referral documentation requirements:
1. Must establish medical necessity for initial DSMT services via written or e-referral for DSMT by treating provider for both initial and again for follow-up DSMT. The treating provider is the physician or qualified non-physician practitioner (nurse practitioner, physician assistant, clinical nurse specialist) who is managing the beneficiary’s diabetes. The provider must maintain a plan of diabetes care in the beneficiary’s medical record and submit a referral documenting:
a. That DSMT is needed.
b. If DSMT is to be group or individual.
1. If individual, documents ≥1 of following special condition(s) that warrant need for individual DSMT*:
• Additional insulin training
• Barrier(s) that would limit group learning: e.g., vision, hearing and/or cognitive impairment; language barrier; non-ambulatory).
i. Note: All 10 initial DSMT hours may also be furnished individually if there is no group class scheduled within 2 months of the date of the initial DSMT referral.</td></tr>
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		c. Number of initial hours to be furnished (10 hours, or fewer than 10 hours). d. Topics to be taught; i.e., all 10 topics or only specific topic(s), such as nutrition. e. Diagnosis or valid, ICD-10 diagnosis code (for Type 1 and Type 2 diabetes, 5-character primary diagnosis code of diabetes required). f. Signature of referring provider (stamped signature not allowed, but e-signature in EMR is allowed). g. NPI number of referring provider. h. Beneficiary's name. i. Date. *Note: Documentation not needed for FQHCs or RHCs as only individual DSMT is payable. Imperative follow-up DSMT referral documentation requirements: 1. Treating provider must maintain a plan of diabetes care in the beneficiary's medical record and submit a referral documenting: a. That follow-up DSMT is needed. b. Diagnosis or valid, ICD-10 diagnosis code (for Type 1 and Type 2 diabetes, 5-character primary diagnosis code of diabetes required). c. Signature of referring provider (stamped signature not allowed, but e-signature in EMR is allowed). d. NPI number of referring provider. e. Beneficiary's name. f. Date.
P	Providers types: referring, billing and rendering Payment of other benefits on same day	Providers types: 1. Referring providers authorized by statute: 2. Billing providers authorized by statute: a. Individual Medicare Part B providers (in active or official opt out status): o Registered dietitians (RDs); qualified nutrition professionals; physicians; physician assistants; nurse practitioners; clinical nurse specialists; nurse midwives; clinical licensed social workers and clinical psychologists. b. Entity Medicare Part B providers authorized by statute: o Hospitals; clinics; practices of RDs, qualified nutrition professionals, nurse practitioners, physician assistants and clinical nurse specialists; federally qualified health centers (FQHCs); rural health clinics; home health agencies, pharmacies, skilled nursing homes; durable medical equipment (DME) companies. • Must be billing for other Medicare services and receiving payment; cannot enroll in Medicare just to bill for DSMT. • Only one individual or entity Medicare Part B provider can bill for all hours of training in initial DSMT benefit and in follow-up benefit; benefit may not be subdivided among different providers for billing purposes. 3. Rendering providers: a. UB-04 (e-format of CMS-1450 paper claim form): does not have data field for rendering provider. b. 837P professional claim (e-format of CMS-1500 paper claim): used by non-institutional professional providers and suppliers to bill Medicare Administrative Contractors (MACs):

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o Does have data field for rendering provider (required data field).
o Must insert NPI number of:
• Individual Medicare Part B provider who works in DSMT service (is known as type 1 individual NPI number), OR
• DSMT service (known as type 2 organizational NPI number)
➢ Service can be considered ‘sub-part’ of sponsoring organization, and as such, a type 2 NPI number can be assigned to it.

Payment of other benefits on same day:
1. Both individual and follow-up DSMT not payable if furnished on same day.
2. Both DSMT and medical nutrition therapy (MNT) not both payable if furnished on same day.
3. To increase reimbursement success for both physician’s established evaluation and management (E/M) patient visit and DSMT visit on same day (when billing on CMS 1500 claim form):
a. Insert NPI number of physician as rendering provider of E/M visit, and
b. Insert NPI number of individual Medicare Part B provider who works in DSMT service or NPI number of DSMT service.
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<tr><td>A</td><td>Ascertaining if beneficiary had initial DSMT in past</td><td>
1. Ask beneficiary to call 1-800-MEDICARE and ask.
2. Ask beneficiary to complete Authorization to Disclose Personal Health Information; then DSMT service staff can contact Medicare Administrative Contractor (MAC) and ask.
3. Access secure portal on MAC’s website that summarizes all beneficiary’s transactions.
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<tr><td>T</td><td>Telehealth DSMT requirements</td><td>
1. Individual and group DSMT (initial and follow-up) can be provided as telehealth services. Medicare requires real-time audio-visual (A/V) telecommunication system as the substitute for in-person encounter between beneficiary and provider who are at different sites (known as “originating site” and “distant site”). Medicare’s specific telehealth coverage guidelines for billing and payment are:
a. Beneficiary must be at an originating site at time DSMT being furnished.
b. Originating sites must be located in rural health professional shortage area, or in county outside of metropolitan area.
c. Entities that participate in federal telemedicine demonstration project approved by (or receiving funding from) Secretary of Dept. of Health and Human Services as of 12-31-00, qualify as originating sites regardless of geographic location.
d. Originating sites authorized by law for ambulatory telehealth DSMT are:

<table>
<tr><td>o Physicians’/qualified non-physician practitioners’ office</td><td>o Federally qualified health center (FQHC)</td></tr>
<tr><td>o Hospital</td><td>o Hospital-based or CAH-based renal dialysis center</td></tr>
<tr><td>o Critical access hospital (CAH)</td><td>o Skilled nursing facility</td></tr>
<tr><td>o Rural health clinic (RHC)</td><td>o Community mental health center</td></tr>
<tr><td colspan="2">The provider is at ‘distant site’ at time DSMT is being furnished.</td></tr>
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e. Individual Medicare providers authorized to furnish DSMT via telehealth at the **distant site** are:
   - Physicians (MDs, DOs)
   - Physician assistants (PAs)
   - Nurse practitioners (NPs)
   - Clinical nurse specialists (CNSs)
   - Certified nurse midwives (CNMs)
   - Clinical psychologists
   - Clinical licensed social workers (CLSWs)
   - Registered dietitians (RDs) and qualified nutrition professionals

f. 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/Non-physician Practitioners (Rev. 3678, 08-12-16)

g. Excluded **distant sites**:
   - Independent renal dialysis facilities.
   - Pharmacies.
   - Beneficiary's home.

h. A/V 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 definition of an interactive telecommunications system.
   - Asynchronous "store and forward" technology permitted only in federal telehealth demonstration services conducted in Alaska or Hawaii.

i. Medicare Part B billing provider of DSMT at **distant site** bills MAC for telehealth DSMT. Reimbursement rate is same as when DSMT services delivered in-person.

j. Claims for DSMT telehealth services submitted using appropriate procedure G0108 or G0109 code along with telehealth procedure code modifier GT, "via interactive audio and video telecommunications system" (e.g., G0108 GT).
   - By using GT modifier, **distant site** billing provider certifies that beneficiary was present at eligible **originating site** when telehealth DSMT furnished.
   - In the case of federal telemedicine demonstration services conducted in Alaska or Hawaii, providers use the telehealth modifier GQ, "via asynchronous telecommunications system" (e.g., G0108 GQ).

k. For DSMT telehealth, minimum of 1 hour of in-person instruction (individual or group) in self-administration of injectable drug training must be furnished during the year following initial DSMT service, if beneficiary is prescribed this type of drug therapy.

l. **Originating site** that owns specialized A/V equipment can bill MAC a facility fee as described by procedure code Q3014 (telehealth originating site facility fee).

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Facility fee separately billable as Part B payment. To claim facility fee, originating site must bill code Q3014 “telehealth originating site facility fee“ in addition to DSMT procedure code. Beneficiary pays unmet deductible and coinsurance on facility fee.
The 2017 Medicare facility fee is 80% of the lesser of the actual charge, or $25.40.
Type of service is "9" on claim form (“other items and services”).
Originating site facility fee is Part B payment. Medicare pays it outside of current fee schedule or other payment methodologies.
Place of service (POS) code on claim is “02” (location where health services and health related services are provided or received, through telecommunication technology).

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<tr><td>I</td><td>Initial and follow-up DSMT beneficiary entitlement and eligibility</td><td>
Initial DSMT entitlement: Has Medicare Part B insurance or Medicare Advantage Plan.

Initial DSMT eligibility:
1. Has type 1 or type 2 diabetes defined as a condition of abnormal glucose metabolism diagnosed using 1 of the following criteria:
a. Fasting blood sugar greater than or equal to 126 mg/dL on 2 different occasions*.
b. Two-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions*.
c. Random glucose test over 200 mg/d with symptom(s) of uncontrolled diabetes.
o Note: HbA1C is not accepted by Medicare as diagnostic laboratory value for type 1 and type 2 diabetes.
d. Has gestational diabetes mellitus.
e. Beneficiary on renal dialysis is only eligible for non-nutrition topics in DSMT service.
2. Follow-up DSMT entitlement: Has Medicare Part B insurance or Medicare Advantage Plan
3. Follow-up DSMT eligibility: Meets time frame for follow-up DSMT. Follow-up DSMT payable even if beneficiary has not received initial DSMT or has not completed all 10 hours of initial DSMT.
*Note: time frame between tests not specified in statute. Diabetes can be diagnosed prior to Medicare Part B entry.
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<tr><td>N</td><td>National procedure code medical unlikely edit (MUE) values</td><td>
National procedure code medical unlikely edits (MUEs):
<table>
<tr><th>HCPCS Procedure Code</th><th>OP Hospital Services MUE Values</th><th>Practitioner Services MUE Values</th></tr>
<tr><td>G0108
Individual DSMT, 30 min. = 1 unit</td><td>8 units
= 4 hours</td><td>6 units
= 3 hours</td></tr>
<tr><td>G0109
Group DSMT, 30 min. = 1 unit</td><td>12 units
= 6 hours</td><td>12 units
= 6 hours</td></tr>
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<tr><td>G</td><td>General standards of quality required

Grantors of quality certification</td><td>
General standards of quality required:
1. Evidence of quality is a coverage requirement for Medicare DSMT reimbursement. Quality must be proven by DSMT provider via obtaining a certificate from:
a. AADE for a Diabetes Education Accreditation Service (DEAP), OR
b. ADA for an “Education Recognition Service” (ERP).

Grantors of quality certification:
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		1. Grantors of certificate that have been vetted and approved by Centers of Medicare and Medicaid Services (CMS) are: a. American Association of Diabetes Educators (AADE). Quality designation referred to as "Diabetes Education Accreditation Service (DEAP)". b. American Diabetes Association (ADA). Quality designation referred to as "Education Recognition Service (ERP)".

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