

Diabetes Screening Tests, Supplies, Self-Management Training, Medical Nutrition Therapy, and Other Services

Overview

Millions of people have diabetes and don't know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and death related to pneumonia and flu. Diabetes is the leading cause of blindness among adults, and the leading cause of end-stage renal disease.

The good news is that scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay many of the illnesses and complications associated with diabetes. Section 613 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 expanded preventive services covered by Medicare to include preventive screening for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. This benefit will help to improve the quality of life for Medicare beneficiaries by preventing more severe conditions that can occur without proper treatment from undiagnosed or untreated diabetes.

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- ▶ A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions.
- ▶ A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions.
- ▶ A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Stand Alone Benefit

It is important to emphasize that the diabetes screening benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and **does not** have to be obtained within the first 12 months of a beneficiary's Medicare Part B coverage.

Pre-diabetes

Pre-diabetes is a condition of abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100-125 mg/dL or a 2-hour post-glucose challenge of 140-199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

The diabetes screening blood tests covered by Medicare include the following:

- ▶ A fasting blood glucose test

AND

- ▶ A post-glucose challenge test; not limited to
- ▶ An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults

OR

- ▶ A 2-hour post-glucose challenge test alone

Risk Factors

To be eligible for the diabetes screening tests, beneficiaries must have any of the following risk factors or at least two of the following characteristics:

Beneficiaries are considered at risk for diabetes if they have any of the following risk factors:

- ▶ Hypertension,
- ▶ Dyslipidemia,
- ▶ Obesity (a body mass index greater than or equal to 30kg/m²), or
- ▶ Previous identification of an elevated impaired fasting glucose or glucose tolerance.

OR

Beneficiaries who have a risk factor consisting of at least two of the following characteristics:

- ▶ Overweight (a body mass index greater than 25 but less than 30kg/m²),
- ▶ Family history of diabetes,
- ▶ Age of 65 or older, or
- ▶ A history of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds.

Coverage Information

Effective for services provided on or after January 1, 2005, Medicare provides coverage of diabetes screening tests for beneficiaries in the risk groups previously listed or those diagnosed with pre-diabetes.

Pre-diabetes is a condition of abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100-125 mg/dL or a 2-hour post-glucose challenge of 140-199 mg/dL. The term “pre-diabetes” includes impaired fasting glucose and impaired glucose tolerance.

Medicare provides coverage for diabetes screening tests with the following frequency:

Beneficiaries diagnosed with pre-diabetes

Medicare provides coverage for a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart) for beneficiaries diagnosed with pre-diabetes.

Beneficiaries previously tested but not diagnosed as pre-diabetic or who have never been tested

Medicare provides coverage for 1 diabetes screening test within a 12-month period (i.e., at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for beneficiaries who were previously tested and were not diagnosed with pre-diabetes, or who have never been tested.

Medicare provides coverage for diabetes screening as a Medicare Part B benefit after a referral from a physician or qualified non-physician practitioner for an individual at risk for diabetes. The beneficiary will pay nothing for this screening (there is no coinsurance or copayment and no deductible for this benefit).

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the diabetes screening blood tests, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Current Procedural Terminology (CPT) codes listed in Table 1 to report the diabetes screening tests:

Table 1 – CPT Codes for Diabetes Screening Tests

CPT Code	Code Descriptor
82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)

NOTE: Medicare makes payment for these procedure codes under the Clinical Laboratory Fee Schedule.

Diagnosis Requirements

Medicare providers must report the screening (“V”) diagnosis code V77.1 (Special Screening for Diabetes Mellitus). Effective April 1, 2005, when a Medicare provider submits a claim for diabetes screening where the beneficiary meets the definition of pre-diabetes, they should report the appropriate diagnosis code with modifier TS. The appropriate CPT code(s) are also required on the claim.

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at <http://www.cms.hhs.gov/NationalCorrectCodInitEd> on the CMS website.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians or qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate CPT code and the corresponding diagnosis code(s) in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code(s) in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the diabetes screening tests when submitted on the following Types of Bills (TOBs) listed in Table 2:

Table 2 – Facility Types and Types of Bills for Diabetes Screening Services

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Hospital Non-patient Laboratory Specimens including CAH	14X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
SNF Outpatient	23X
CAH Outpatient	85X

Special Billing Instructions

- ▶ Skilled Nursing Facility (SNF) - When furnished to a beneficiary in a SNF Part A covered stay, the SNF must bill the FI/AB MAC using bill type 22X.

- ▶ Generally, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) cannot bill for non-RHC/FQHC services. The diabetes screening tests are considered non-RHC/FQHC services. However, if the RHC or FQHC is provider-based, then the base provider can bill the lab tests to the FI/AB MAC, using the base provider's NPI. The FI/AB MAC will make payment to the base provider, not the RHC/FQHC. If the facility is freestanding, then the individual practitioner bills the carrier/AB MAC for the lab tests using the practitioner's ID number.

Reimbursement Information

General Information

Reimbursement of diabetes screening tests is made under the Clinical Laboratory Fee Schedule.

Medicare will reimburse Critical Access Hospitals (CAHs) at 101 percent of their reasonable cost.

Medicare will reimburse Maryland hospitals according to the Maryland State Cost Containment Plan.

Additional information about the Clinical Laboratory Fee Schedule can be found at <http://www.cms.hhs.gov/ClinicalLabFeeSched/01overview.asp> on the CMS website.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes screening tests:

- ▶ The beneficiary is not at risk for diabetes.
- ▶ The beneficiary has already had two diabetes screenings within the past year and has not been identified as having pre-diabetes.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Providers can obtain additional information about claims from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

DIABETES SUPPLIES

Medicare provides coverage for the following diabetes supplies.

Supplies Covered

Medicare provides limited coverage, based on established medical necessity requirements, for these diabetes supplies:

- ▶ Blood glucose self-testing equipment and associated accessories
- ▶ Therapeutic Shoes
 - ▶ One pair of depth-inlay shoes and three pairs of inserts

OR

- ▶ One pair of custom-molded shoes (including inserts), if the beneficiary cannot wear depth-inlay shoes because of a foot deformity, and two additional pairs of inserts within the calendar year
- ▶ Insulin pumps and the insulin used in the pumps

NOTE: In certain cases, Medicare may also pay for separate inserts or shoe modifications.

Blood Glucose Monitors and Associated Accessories

Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent persons with diabetes based on medical necessity.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 3 to report blood glucose self-testing equipment and supplies:

Table 3 – HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

HCPCS Code	Code Descriptor
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4259	Lancets, per box of 100
E0607	Home blood glucose monitor

Coverage Information

Medicare provides coverage for diabetes-related durable medical equipment (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DME MAC. Visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website for the name, address, and telephone number of the local DME MAC.

For Medicare to cover a blood glucose monitor and associated accessories, the provider must provide the beneficiary with a prescription that includes the following information:

- ▶ A diagnosis of diabetes,
- ▶ The number of test strips and lancets required for one month's supply,
- ▶ The type of meter required (i.e., if a special meter for vision problems is required, the physician should state the medical reason for the required meter),
- ▶ A statement that the beneficiary requires insulin or does not require insulin, and
- ▶ How often the beneficiary should test the level of blood sugar.

Insulin-Dependent

For beneficiaries who are insulin-dependent, Medicare provides coverage for the following:

- ▶ Up to 100 test strips and lancets every month
- ▶ One lancet device every 6 months

Non-Insulin Dependent

For beneficiaries who are non-insulin dependent, Medicare provides coverage for the following:

- ▶ Up to 100 test strips and lancets every 3 months
- ▶ One lancet device every 6 months

NOTE: Medicare allows additional test strips and lancets if deemed medically necessary. However, Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers. This includes lancets, test strips, and blood glucose monitors.

Therapeutic Shoes

Medicare requires that the physician who is managing a patient's diabetic condition document and certify the beneficiary's need for therapeutic shoes. Coverage for therapeutic shoes under Medicare Part B requires that the following conditions are met:

- ▶ The shoes are prescribed by a podiatrist or other qualified physician.
- ▶ The shoes must be furnished and fitted by a podiatrist or other qualified individual, such as a pedorthist, prosthetist, or orthotist.

Coverage Information

Medicare provides coverage for depth-inlay shoes, custom-molded shoes, and shoe inserts for beneficiaries with diabetes as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the Medicare provider does not accept assignment, the amount the beneficiary pays may be higher, and the beneficiary may be required to pay the full amount at the time of service. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

The physician must certify that the beneficiary meets the following criteria:

- ▶ The beneficiary must have diabetes
- ▶ The beneficiary must have at least one of the following conditions:
 - ▶ Partial or complete amputation of a foot,
 - ▶ Foot ulcers,

- ▶ Calluses that could lead to foot ulcers,
- ▶ Nerve damage from diabetes and signs of calluses,
- ▶ Poor circulation, or
- ▶ A deformed foot.

The beneficiary must also be treated under a comprehensive plan of care to receive coverage.

For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year:

- ▶ No more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes)
- ▶ No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 4 to report therapeutic shoes:

Table 4 – HCPCS Codes for Therapeutic Shoes

HCPCS Code	Code Descriptor
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

Insulin Pumps

Insulin pumps that are worn outside the body and the insulin used with the pump may be covered for some beneficiaries who have diabetes and who meet certain conditions. Insulin pumps are available through a prescription. Beneficiaries must meet either of the criteria listed in Table 5 to receive coverage for an external infusion pump for insulin and related drugs and supplies:

Table 5 – External Infusion Pump for Insulin and Related Drugs and Supplies Coverage Criterion

Criteria A	Criteria B
<p>The beneficiary has completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to the initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen:</p> <ul style="list-style-type: none"> ▶ Glycosylated hemoglobin level (HbA1c) > 7.0 percent; ▶ History of recurring hypoglycemia; ▶ Wide fluctuations in blood glucose before mealtime; ▶ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; or ▶ History of severe glycemic excursions. 	<p>The patient with diabetes has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.</p>

In addition to meeting Criterion A or B above, the beneficiary must meet the following general requirements:

The patient with diabetes must be Insulinopenic per the updated fasting C-peptide testing requirement, or, as an alternative, must be beta cell autoantibody positive.

Updated fasting C-peptide testing requirement:

- ▶ Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method.
- ▶ For patients with renal insufficiency and creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) ≤ 50 ml/minute, Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method.
- ▶ Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose ≤ 225 mg/dL.
- ▶ Levels only need to be documented once in the medical records.

Continued coverage of the insulin pump would require that the beneficiary has been seen and evaluated by the treating physician at least every three months. A physician who manages multiple patients with Continuous Subcutaneous Insulin Infusion (CSII) pumps and who works closely with a team including nurses, diabetes educators, and dietitians who are knowledgeable in the use of CSII must order the pump.

Coverage Information

The Medicare Part B deductible and coinsurance or copayment applies. When covered, Medicare will pay for the insulin pump, as well as the insulin used with the insulin pump.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 6 to report insulin pumps and supplies:

Table 6 – HCPCS Codes for Insulin Pumps and Supplies

HCPCS Code	Code Descriptor
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units

Billing Requirements

Billing and Coding Requirements Specific to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

Beneficiaries can no longer file their Medicare claim forms for diabetes supplies. The Medicare provider must file the form on behalf of the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DME MAC. Visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website for the name, address, and telephone number of the local DME MAC.

Reimbursement Information

General Information

Reimbursement of diabetes supplies is made by the four DME MACs based on the DME Fee Schedule. Medicare Part B deductible and coinsurance apply. Medicare pays 80 percent of the approved Fee Schedule.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes supplies:

- ▶ The beneficiary does not have a prescription for the supplies.
- ▶ The beneficiary exceeds the allowed quantity of the supplies.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Additional information about claims can be obtained from the DME MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

DIABETES SELF-MANAGEMENT TRAINING (DSMT) SERVICES

Medicare provides coverage of diabetes self-management training (DSMT) services for beneficiaries who have been recently diagnosed with diabetes, determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage under the Medicare Program.

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT services when a certified provider who meets certain quality standards furnishes these services. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes the following services:

- ▶ Instructions in self-monitoring of blood glucose,
- ▶ Education about diet and exercise,
- ▶ An insulin treatment plan developed specifically for insulin dependent patients, and
- ▶ Motivation for patients to use the skills for self-management.

DSMT services are aimed toward individuals with Medicare who have recently been impacted in any of the following situations by diabetes:

- ▶ Problems controlling blood sugar,
- ▶ Beginning diabetes medication, or switching from oral diabetes medication to insulin,
- ▶ Diagnosed with eye disease related to diabetes,
- ▶ Lack of feeling in feet or other foot problems such as ulcers or deformities, or an amputation has been performed,
- ▶ Treated in an emergency room or have stayed overnight in a hospital because of diabetes, or
- ▶ Diagnosed with kidney disease related to diabetes.

The DSMT program should educate beneficiaries in the successful self-management of diabetes as well as be capable of meeting the needs of its patients on the following subjects:

- ▶ Information about diabetes and treatment options,
- ▶ Diabetes overview/pathophysiology of diabetes,
- ▶ Nutrition,
- ▶ Exercise and activity,
- ▶ Managing high and low blood sugar,
- ▶ Diabetes medications, including skills related to the self-administration of injectable drugs,
- ▶ Self-monitoring and use of the results,
- ▶ Prevention, detection, and treatment of chronic complications,
- ▶ Prevention, detection, and treatment of acute complications,
- ▶ Foot, skin, and dental care,
- ▶ Behavioral change strategies, goal setting, risk factor reduction, and problem solving,
- ▶ Preconception care, pregnancy, and gestational diabetes,
- ▶ Relationships among nutrition, exercise, medication, and blood glucose levels,
- ▶ Stress and psychological adjustment,
- ▶ Family involvement and social support,

- ▶ Benefits, risks, and management options for improving glucose control, and
- ▶ Use of health care systems and community resources.

For coverage by Medicare, DSMT programs must incorporate the following:

- ▶ Be accredited as meeting quality standards by a CMS-approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the Indian Health Service (IHS) as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered.
- ▶ Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes.
- ▶ Submit an accreditation certificate from the ADA, AADE, or IHS to the local Medicare Contractor's provider enrollment department.

For additional information on DSMT enrollment, see the Internet-Only Manual, Pub. 100-08, Chapter 10.

Coverage Information

Medicare provides coverage of DSMT services only if the treating physician or treating qualified non-physician practitioner managing the beneficiary's diabetic condition certifies that DSMT services are needed. The referring physician or qualified non-physician practitioner must maintain a plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if ordered. The order must also include a statement signed by the physician or qualified non-physician practitioner that the service is needed as well as the following information:

- ▶ The number of initial or follow-up hours ordered (the physician can order less than 10 hours, but cannot exceed 10 hours of training),
- ▶ The topics to be covered in training (initial training hours can be used to pay for the full initial training program or specific areas, such as nutrition or insulin training), and
- ▶ A determination if the beneficiary should receive individual or group training.

The provider of the service must maintain documentation that includes the original order from the physician and any special conditions noted by the physician. The plan of care must be reasonable and necessary and must be incorporated into the beneficiary's medical record.

When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

Initial DSMT Training

The initial year for DSMT is the 12-month period following the initial date.

Medicare will cover **initial** training that meets the following conditions:

- ▶ Is furnished to a beneficiary who has not previously received initial or follow-up training billed under HCPCS codes G0108 or G0109,
- ▶ Is furnished within a continuous 12-month period,
- ▶ Does not exceed a total of 10 hours for the initial training (the 10 hours of training can be done in any combination of ½ hour increments and can spread over the 12-month period or less),

- ▶ With the exception of 1 hour of individual training, training is usually furnished in a group setting, which can contain patients other than Medicare beneficiaries, and
- ▶ The 1 hour of individual training may be used for any part of the training including insulin training.

Follow-Up DSMT Training

After receiving the initial training, Medicare covers **follow-up** training that meets the following conditions:

- ▶ Consists of no more than 2 hours of individual or group training for a beneficiary each year,
- ▶ Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries,
- ▶ Follow-up training is furnished in increments of no less than ½ hour,
- ▶ The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic, and
- ▶ Follow-up training for subsequent years is based on a 12-month calendar year after the completion of the full 10 hours of initial training. However, if the beneficiary exhausts 10 hours in the initial year then the beneficiary would be eligible for follow-up training in the next calendar year. If the beneficiary does not exhaust 10 hours of initial training, he/she has 12 continuous months to exhaust initial training before the 2 hours of follow-up training are available.

Examples

Example #1: Beneficiary Exhausts 10 hours in the Initial Year (12 continuous months)

Beneficiary receives first service: **April 2007**

Beneficiary completes initial 10 hours DSMT training: **April 2008**

Beneficiary is eligible for follow-up training: **May 2008** (13th month begins the subsequent year)

Beneficiary completes follow-up training: **December 2008**

Beneficiary is eligible for next year follow-up training: **January 2009**

Example #2: Beneficiary Exhausts 10 hours Within the Initial Calendar Year

Beneficiary receives first service: **April 2007**

Beneficiary completes initial 10 hours of DSMT training: **December 2007**

Beneficiary is eligible for follow-up training: **January 2008**

Beneficiary completes follow-up training: **July 2008**

Beneficiary is eligible for next year follow-up training: **January 2009**

Individual DSMT Training

Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:

- ▶ No group session is available within two months of the date the training is ordered,
- ▶ The beneficiary's physician or qualified non-physician practitioner documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations, or other such special conditions as identified by the treating physician or qualified non-physician practitioner, that will hinder effective participation in a group training session,

- ▶ The physician orders additional insulin training, or
- ▶ The need for individual training must be identified by the physician or qualified non-physician practitioner in the referral.

Coverage for DSMT services is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment apply.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 7 are used to report DSMT services:

Table 7 – HCPCS Codes for DSMT Services

HCPCS Code	Code Descriptor
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes Note: For FQHCs, codes representing group sessions do not constitute a separate billable visit.

Diagnosis Requirements

There are no specific diagnosis requirements for DSMT services. For further guidance, contact your Medicare Contractor.

Billing Requirements

General Information

All Medicare 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.

Medicare providers cannot submit claims for DSMT services as “incident to” services. However, a physician advisor for a DSMT program is eligible to bill for the DSMT service for that program.

Medicare providers must bill for services for DSMT with the appropriate HCPCS code in 30-minute increments.

Also, the following conditions apply:

- ▶ A cover letter and National Provider Identifier (NPI) must be included with the accreditation certificate.
- ▶ The Medicare provider must have a provider and/or supplier number and the ability to bill Medicare for other services.

- ▶ Registered dietitians are eligible to bill on behalf of an entire DSMT program as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

DME suppliers are reimbursed through local carriers/AB MACs.

Claims from physicians, qualified non-physician practitioners, or suppliers who did not accept assignment are subject to Medicare's limiting charge. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS code and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS code, revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for DSMT services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 8:

Table 8 – Facility Types, Types of Bills, and Revenue Codes for DSMT Services

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	0942
Skilled Nursing Facility (SNF)*	22X, 23X	0942
Indian Health Service (IHS) provider billing hospital outpatient Part B	13X	0942
IHS provider billing hospital inpatient Part B	12X	0942
IHS Critical Access Hospital (CAH) billing outpatient Part B	85X	0942
IHS CAH billing inpatient Part B	12X	0942
Method I or Method II CAH (technical services)	12X, 85X	0942
Home Health Agency (HHA)	34X	0942
Federally Qualified Health Center (FQHC)**	73X	052X, 0900
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	0942

***NOTE:** 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:** Effective January 1, 2006, payment for DSMT provided in an FQHC that meets all of 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 codes G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

NOTE: An End-Stage Renal Disease (ESRD) facility is a reasonable site for this service; however, because it is required to provide dietitian 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. Likewise, an RHC is a reasonable site for this service; however, it must be provided in an RHC with other qualifying services and paid at the all-inclusive encounter rate.

NOTE: The Medicare provider's certification must be submitted along with the initial claim.

DSMT Coding Tips

The following tips are designed to facilitate proper billing when submitting claims for DSMT services:

- ▶ For an hour session, a "2" must be placed in the "Units" column, representing two 30-minute increments.
- ▶ Billing an Evaluation and Management (E/M) code is not mandatory before billing the DSMT procedure codes. Do not use E/M codes in lieu of HCPCS codes G0108 and G0109.
- ▶ The nutrition portion of the DSMT program must be billed using HCPCS codes G0108 and G0109. Do not use the Medical Nutrition Therapy CPT codes for the nutrition portion of a DSMT program.
- ▶ The DSMT and Medical Nutrition Therapy benefits can be provided to the same beneficiary in the same year. However, they are different benefits and require separate referrals from physicians or qualified non-physician practitioners. The medical evidence reviewed by CMS suggests that the Medical Nutrition Therapy benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.
- ▶ Medicare pays for up to 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Certified Providers

DSMT is not a separately recognized provider type like a physician or nurse practitioner. A person or entity cannot enroll in Medicare for the sole purpose of performing DSMT. DSMT is an extra service that a currently-enrolled Medicare provider can bill for, assuming the provider meets all the necessary DSMT requirements.

The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient DSMT services, provides other items and services for which payment may be made under Title XVIII of the Social Security Act, and meets certain quality standards. CMS designates all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians, and durable medical equipment suppliers as certified. A designated certified provider must bill for DSMT services provided by an accredited DSMT program.

Reimbursement Information

General Information

Reimbursement for DSMT services may be made to any certified provider or supplier that provides and bills Medicare for other individual items and services and may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.

Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of DSMT services, if they meet all requirements of an accredited DSMT service provider.

The Medicare Part B deductible and coinsurance or copayment apply. Claims from physicians, qualified non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge. However, the following non-physician practitioners must accept assignment for all of their services: physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

- ▶ The beneficiary must meet the following condition if the provider is billing for initial training:
 - ▶ The beneficiary has not previously received initial or follow-up training for which Medicare payment was made under this benefit.

FQHCs and RHCs

- ▶ Previously, DSMT-type services rendered by qualified registered dietitians or nutrition professionals were considered "incident to" services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of DSMT services. Effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these one-on-one, face-to-face encounter services provided they meet all program requirements. See Pub. 100-04, Chapter 18, Section 120. Medicare makes payment to FQHCs at the all-inclusive encounter rate. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying DSMT services. To receive payment for DSMT services in addition to a separate payment for an otherwise qualifying FQHC visit when the other services are provided on the same date, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and one of the following revenue codes: 0520, 0521, 0522, 0524, 0525, 0527, or 0528 as appropriate. (Note: For FQHCs, codes representing group sessions do not constitute a separate billable visit. Therefore, although services billed under G0109 can be provided, they cannot be separately paid outside of the single daily encounter rate.)
- ▶ FQHCs that are certified providers of DSMT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals. These services are included under the FQHC benefit as billable visits.
- ▶ While Medicare does not make separate payment for this service to RHCs, the service is covered but is considered included in the all-inclusive encounter rate. RHCs are permitted to become certified providers of DSMT services and report the cost of DSMT services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note: The provision of these services by registered dietitians or nutrition professionals might be considered "incident to" services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for DSMT services is paid under the Medicare Physician Fee Schedule (MPFS), when billed to the carrier/AB MAC.

Additional information about MPFS can be found at <http://www.cms.hhs.gov/PhysicianFeeSched> on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for DSMT services depends on the type of facility providing the service. Table 9 lists the type of payment that facilities receive for DSMT services:

Table 9 – Facility Payment Methodology for DSMT Services

If the Facility is a...	Then Payment Is Based On...
Method I or Method II Critical Access Hospital (CAH)	Reasonable Cost Basis (for technical services) (Paid at 101% of their reasonable cost)
Hospital subject to Outpatient Prospective Payment System (OPPS)	Medicare Physician Fee Schedule (MPFS)
Indian Health Service (IHS) provider billing hospital outpatient Part B	OMB-approved outpatient per visit all inclusive rate
IHS provider billing inpatient Part B	All-inclusive inpatient ancillary per diem rate
IHS CAH billing outpatient Part B	101% of the all-inclusive facility specific per visit rate
IHS CAH billing inpatient Part B	101% of the all-inclusive facility specific per diem rate
Skilled Nursing Facility (SNF)	MPFS non-facility rate
Federally Qualified Health Center (FQHC)*	All-Inclusive Encounter Rate (with other qualified services) Separate visit payment available with HCPCS Code G0108*
Maryland Hospital under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges in accordance with the terms of the Maryland Waiver
Home Health Agency (HHA) (can be billed only if the service is provided outside of the treatment plan)	MPFS non-facility rate

***NOTE:** Effective January 1, 2006, payment for DSMT provided in an FQHC as a one-on-one face-to-face encounter 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, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, or 0528.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of DSMT services:

- ▶ The beneficiary has exceeded the 10-hour limit of training,
- ▶ The physician or qualified non-physician practitioner did not order the training, or
- ▶ The individual furnishing the DSMT is not accredited by Medicare.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

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. In the absence of evidence of a valid ABN, the Medicare provider will be held liable. However, issuance of an ABN is not mandatory 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. If the provider desires, the ABN may be issued as a voluntary exclusion from benefits.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

MEDICAL NUTRITION THERAPY (MNT)

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). More than 13.7 million Americans, at least 60 years or older, are diagnosed with diabetes or chronic kidney disease.¹ MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

The MNT benefit was established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). It became effective January 1, 2002. This benefit allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement.

The MNT benefit is a completely separate benefit from the Diabetes Self-Management Training (DSMT) benefit.

For the purpose of disease management, covered MNT services include the following:

- ▶ An initial nutrition and lifestyle assessment,
- ▶ Nutrition counseling,
- ▶ Information regarding diet management, and
- ▶ Follow-up sessions to monitor progress.

Diabetes and Renal Disease Defined

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- ▶ A fasting blood glucose greater than or equal to 126 mg/dL on 2 different occasions.
- ▶ A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions.
- ▶ A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Renal Disease

For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m²].

Coverage Information

Medicare provides coverage of MNT services when the following general coverage conditions are met:

- ▶ The beneficiary has diabetes or renal disease.
- ▶ The treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease (non-physician practitioners cannot make referrals for this service).
- ▶ The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.

¹ Department of Health and Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at: <http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx>. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at: http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf.

- ▶ MNT services may be provided either on an individual or group basis without restrictions.
- ▶ MNT services must be provided by a registered dietitian, or nutrition professional who meets the provider qualification requirements, or a “grandfathered” dietitian or nutritionist who was licensed as of December 21, 2000. (See the Professional Standards for Dietitians and Nutrition Professionals section later in this chapter.)
- ▶ For a beneficiary with a diagnosis of diabetes, DSMT and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary.
- ▶ For the beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment.

This benefit provides three hours of one-on-one MNT services for the first year and two hours of coverage each year for subsequent years. Based on medical necessity, additional hours may be covered if the treating physician orders additional hours of MNT based on a change in medical condition, diagnosis, or treatment regimen.

Medicare provides coverage of MNT as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies.

Limitations on Coverage

The following limitations apply:

- ▶ MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Social Security Act.
- ▶ A beneficiary may not receive MNT and DSMT services on the same day.

Referrals for MNT Services

Medicare provides coverage for three hours of MNT in the beneficiary’s initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT but a beneficiary only uses two hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year, a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year, a beneficiary must have a new referral for follow-up hours.

A referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

The referring physician must maintain documentation in the beneficiary’s medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The referring physician’s provider number must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The carrier/AB Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI)/AB MAC may return claims that do not contain the provider number of the referring physician.

NOTE: Medicare may cover additional covered hours of MNT services beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within an episode of care that makes a change in diet necessary.

A physician must prescribe these services and renew the referral yearly if continuing treatment is needed into another calendar year.

Telehealth

Effective January 1, 2006, Medicare expanded the list of telehealth services to include coverage for individual MNT as described by Healthcare Common Procedure Coding System (HCPCS) codes G0207, 97802, and 97803. In addition, certified registered dietitians and nutrition professionals have been added to the list of practitioners who may furnish and receive payment for a telehealth service.

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment, or billing methodology applicable to Medicare telehealth services, as set forth in the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual. For example, originating sites must be located in either a non-Metropolitan Statistical Area (MSA) county or rural health professional shortage area, and can only include a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or federally qualified health center. Additionally, an interactive audio and video telecommunications system must be used that permits real-time communication between the distant site physician, or practitioner, and the Medicare beneficiary. As a condition of payment, the beneficiary must be present and participating in the telehealth visit. The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Tables 10 and 11 to report MNT services:

Table 10 – HCPCS/CPT Codes for MNT Services

HCPCS/CPT Code	Code Descriptor
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
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (NOTE: This CPT code must only be used for the initial visit.)

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HCPSCS/CPT Code	Code Descriptor
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

NOTE: For FQHCs, codes representing group sessions do not constitute a separate billable visit.

Table 11 – Instructions for Use of the MNT Codes

HCPSCS/CPT Code	Instructions for Use
G0270 & G0271	These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered when the treating physician determines there is a chance of diagnosis or medical condition that makes a change in diet necessary.
97802	This code is to be used once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent Group Visits are to be billed as 97804.
97803	This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient.
97804	This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

NOTE: For FQHCs, codes representing group sessions do not constitute a separate billable visit.

NOTE: Medicare will make payment for the above codes only if a registered dietitian or nutrition professional who meets the specified requirements under Medicare submits the claim. These services cannot be paid “incident to” physician services. The payments can be reassigned to the employer of a qualifying dietitian or nutrition professional.

NOTE: Telehealth services: Effective January 1, 2006, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and “GQ” (via synchronous telecommunications system) are valid when billed with HCPSCS codes G0270, 97802, and 97803.

Diagnosis Requirements

MNT services are available for beneficiaries with diabetes or renal disease. The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. For further guidance, contact your Medicare Contractor.

MNT and DSMT Separate Billable Services

The MNT and DSMT benefits can be provided to the same beneficiary in the same year but **may not** be provided on the same day. They are different benefits and require separate referrals from physicians.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Special Requirement Note: Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered on the claim form.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Special Requirement Note: MNT services can be billed to FIs/AB MACs when performed in an outpatient hospital setting. Hospital outpatient departments can bill for MNT services through the local FI/AB MAC if the registered dietitians or nutrition professionals reassign their benefits to the hospital. If the hospitals do not get the reassignments, the registered dietitians and nutrition professionals will have to bill the local carrier/AB MAC under their own provider number or the hospital will have to bill the local carrier/AB MAC. Registered dietitians and nutrition professionals must obtain a Medicare provider number before they can reassign their benefits.

Professional Standards for Dietitians and Nutrition Professionals

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. “Registered dietitian or nutrition professional” means an individual who, on or after December 22, 2000:

- ▶ Holds a bachelor’s or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose;
- ▶ Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
- ▶ Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

OR

- ▶ A “grandfathered” dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements above.
- ▶ A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements above.

Enrollment of Dietitians and Nutrition Professionals

The following qualifications must be met for the enrollment of dietitians and nutrition professionals:

- ▶ In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a Medicare provider and meet the requirements outlined above. MNT services can be billed with the effective date of the Medicare provider’s license and the establishment of the practice location.
- ▶ The Medicare carrier/AB MAC will enroll registered dietitians and nutritional professionals as a provider of MNT services using the NPI.
- ▶ Registered dietitians and nutrition professionals must accept assignment and the limiting charge will not apply.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for MNT services when submitted on the following Types of Bills (TOBs) and associated revenue codes listed in Table 12:

Table 12 – Facility Types, Types of Bills, and Revenue Codes for MNT Services

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	0942
Skilled Nursing Facility Outpatient (SNF)	23X	0942

Facility Type	Type of Bill	Revenue Code
Home Health Agency (HHA) (Not under an HHA plan of care)	34X	0942
Critical Access Hospital (CAH)	85X	0942

NOTE: Separate payment to RHCs (TOB 71X) is precluded as these services are not within the scope of the Medicare-covered RHC benefits. However, FQHCs (TOB 73X) may qualify for a separate visit for payment for MNT services in addition to any other qualifying visit on the same date of service as long as the services provided were individual services and billed with the appropriate site of service revenue code in the 052X series. Group services do not meet the criteria for a separate qualifying encounter.

Reimbursement Information

Reimbursement for outpatient MNT is based on rates established under the Medicare Physician Fee Schedule (MPFS) for bill types 13X, 23X, and 34X. Payment is the lesser of the actual charge or 85 percent of the MPFS. The Medicare Part B deductible and coinsurance or copayment apply. Coinsurance is based on 20 percent of the lesser charge. For Critical Access Hospitals (CAHs), bill type 85X, payment is made based on reasonable charges and is not subject to the lesser of costs or charges. For CAHs, if the distant site is a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to this CAH, the CAH should bill its regular FI/AB MAC for the professional telehealth services provided, using revenue codes 096X, 097X or 098X. In addition, all requirements for billing distant site telehealth services apply.

- ▶ Payment is made for MNT services attended by the beneficiary and documented by the Medicare provider.
- ▶ Payment is made for beneficiaries that are not inpatients of a hospital, SNF, hospice, or nursing home.

Additional information about MPFS can be found at <http://www.cms.hhs.gov/PhysicianFeeSched> on the CMS website.

Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of MNT services. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements and services must be provided by a registered dietitian or nutrition professional. In addition, the medical evidence reviewed by CMS suggests that the MNT benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.

While Medicare does not make separate payment for this service to RHCs, similar services may be covered when furnished by, or incident to, an RHC professional. Payment is included in the encounter rate when coverable.

FQHCs that are certified providers of MNT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals. These services are included under the FQHC benefit as billable visits.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of MNT services:

- ▶ The beneficiary is not qualified to receive this benefit.
- ▶ The individual provider of the MNT services did not meet the provider qualification requirements.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARC)s that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements for MNT

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. 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.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

OTHER DIABETES SERVICES

Medicare provides coverage of the following services for beneficiaries with diabetes:

- ▶ Foot Care;
- ▶ Hemoglobin A1c tests;
- ▶ Glaucoma Screening;
- ▶ Influenza and pneumococcal immunizations;
- ▶ Routine costs, including immunosuppressive drugs, cell transplantation, and related items and services for pancreatic islet cell transplant clinical trials; and
- ▶ Retinal eye exams for diabetic retinopathy.*

NOTE:

- ▶ Details regarding Medicare's coverage of glaucoma screening services and influenza and pneumococcal vaccinations are described in this Guide. For specific information regarding other diabetes services, refer to relevant CMS documentation.
- ▶ *Retinal eye exams for diabetic retinopathy may be covered as a medically necessary diagnostic exam furnished to beneficiaries diagnosed with diabetes.

Diabetes Supplies and Services Not Covered by Medicare

Medicare Part B may not cover all supplies and equipment for beneficiaries with diabetes. The following may be excluded:

- ▶ Insulin pens
- ▶ Insulin (unless used with an insulin pump)
- ▶ Syringes
- ▶ Alcohol swabs
- ▶ Gauze
- ▶ Orthopedic shoes (shoes for individuals whose feet are impaired, but intact)
- ▶ Eye exams for glasses (refraction)
- ▶ Weight loss programs
- ▶ Injection devices (jet injectors)

Note: Insulin not used with an external insulin pump and certain medical supplies used to inject insulin are covered under Medicare prescription drug coverage.

For more information on coverage exclusions, contact your local Medicare Contractor.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Special Rules for Medicare Competitive Bidding Areas

If a competitively bid item is provided by a non-contract supplier in a competitive bidding area (CBA), Medicare will not pay for the item unless the non-contract supplier meets the definition of a grandfathered supplier. Grandfathered supplier means a non-contract supplier that chooses to continue to furnish competitively bid items for which payment is made on a rental basis to beneficiaries who maintain a permanent residence in the CBA. If the non-contract supplier furnishes the item to a beneficiary and does not meet the grandfathering provision, the beneficiary is not liable for payment.

If the non-contract supplier obtains a signed Advance Beneficiary Notice of Noncoverage (ABN) indicating that the beneficiary was informed in writing prior to receiving the item or service that there would be no coverage due to the supplier's non-contract status, and the beneficiary understands that he/she will be liable for all costs because of the decision to use a non-contract supplier, the non-contract supplier may charge the beneficiary for the item or service. In this instance, non-contract suppliers cannot bill Medicare and receive payment for the item or service.

For further information on the competitive bidding program, contact the Competitive Bidding Program helpline at 877-577-5331 or visit <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home> or <http://www.cms.hhs.gov/dmeposcompetitivebid> on the Web.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

Diabetes Screening Tests, Supplies, Self-Management Training, Medical Nutrition Therapy, and Other Services

Resource Materials

American Diabetes Association

Information on diabetes prevention, nutrition, research, etc. is available in both English and Spanish.

<http://www.diabetes.org>

American Diabetes Association's Diabetes Pro Professional Resources Online Website

<http://professional.diabetes.org/>

American Dietetic Association

Website provides food and nutrition information and a national referral service to locate registered nutrition practitioners.

<http://www.eatright.org>

Beneficiary Notices Initiative Website

<http://www.cms.hhs.gov/BNI>

Carrier/AB MAC and FI/AB MAC Contact Information

<http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>

Clinical Laboratory Fee Schedule Information

http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 C.F.R. Parts 409, 410, et al.; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer generated Facsimile Transmissions

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10>

Form CMS-1450 Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information

http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Indian Health Services Division of Diabetes Treatment and Prevention

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.asp>

Medicare Fee-For-Service Providers Website

This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.

<http://www.cms.hhs.gov/center/provider.asp>

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

Medicare Physician Fee Schedule Information

<http://www.cms.hhs.gov/PhysicianFeeSched>

Medicare Preventive Services General Information

<http://www.cms.hhs.gov/PrevntionGenInfo>

MLN Preventive Services Educational Resource Website

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website

<http://www.cms.hhs.gov/NationalCorrectCodInitEd>

National Diabetes Information Clearinghouse – NDIC

Information on diabetes treatment and statistics is available in both English and Spanish.

<http://diabetes.niddk.nih.gov>

National Diabetes Statistics

<http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm>

National Provider Identifier Information

<http://www.cms.hhs.gov/NationalProvIdentStand>

Physician Information Resource for Medicare Website

This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.

<http://www.cms.hhs.gov/center/physician.asp>

Remittance Advice Information

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Washington Publishing Company (WPC) Code Lists

WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.

<http://www.wpc-edi.com/Codes>

Diabetes Screening

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 90

<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

DSMT

MLN Matters Article 5433, Guidelines for Payment of Diabetes Self-Management Training (DSMT)

<http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5433.pdf>

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 300

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Beneficiary-related resources can be found in Reference F of this Guide.

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 120

<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

MNT

Medicare Claims Processing Manual – Pub. 100-04, Chapter 4, Section 300

<http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>

Beneficiary-related resources can be found in Reference F of this Guide.