Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUESTS 199, 606 and 1455

This instruction manualizes Transmittals AB-00-66 (CR 199), AB-00-67 (CR 606), and B-01-40 (CR 1455))

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-4.1 - 4-4.2 (2 pp.)	4-4.1 - 4-4.2 (2 pp.)
4280-4280.8	4-68.4Q - 4-68.4T (4 pp.)	------

MANULIZATION--*EFFECTIVE DATE: Non-applicable*

Section 4280, Diabetes Outpatient Self-Management Training Services, explains conditions for coverage of Diabetes outpatient self-management training services.

Section 4280.1, General Conditions of Coverage and Diabetes Training Hours, describes the practitioners and non-practitioners that may provide diabetes outpatient self-management training services and the number of hours covered by Medicare.

Section 4280.2, Beneficiaries Eligible for Coverage, explains the medical conditions that must be present in the 12 months prior to the physician's or non-practitioner's order for the training.

Section 4280.3, Provider/Supplier Eligibility to Provide the Training, explains that provider/supplier billing for the service must be eligible to provide and bill for other individual Medicare services.

Section 4280.4, Quality Standards, describes how the diabetes outpatient self-management training program must be accredited.

Section 4280.5, Enrollment of DMEPOS Suppliers, explains how DMEPOS suppliers must enroll through the local Medicare carrier.

Section 4280.6, Enrollment of Entities Other Than DMEPOS, explains what any qualified provider that is currently enrolled must provide before they can be reimbursed for this service.

Section 4280.7, HCPCS Coding, lists the two HCPCS codes that must be used when billing diabetes outpatient self-management training services.

Section 4280.8, General Payment Conditions, explains conditions that providers/suppliers must meet to receive reimbursement for diabetes training services.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Section

Stem Cell Transplantation....................4183
General....................4183.1
HCPCS and Diagnostic Coding....................4183.2
Non-Covered Conditions....................4183.3
Edits....................4183.4
Suggested MSN/EOMB and RA Messages....................4183.5
Glaucoma Screening....................4184
Conditions of Coverage....................4184.1
Claims Submissions Requirements and Applicable HCPCS Codes....................4184.2
Calculating the Frequency....................4184.3
Common Working File (CWF) Edits....................4184.4
Claims Editing....................4184.5
Diagnosis Coding Requirements....................4184.6
Payment Methodology....................4184.7
Remittance Advice Notices....................4184.8
Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Messages....................4184.9

Provider-Based Physician Billing

Billing for Provider-Based Physician Services....................4200

Other Billings

Billing by Carrier-Dealing Group Practice Prepayment Plans....................4255
Billing by Direct Dealing Group Practice Prepayment Plan....................4260
Billing By Organizations on HCFA-1500 or HCFA-1490U....................4265
Health Maintenance Organization (HMO) - Claims For Physician/Supplier Services Furnished to HMO Member....................4267
Claims Processing Procedures for Physician/Supplier Services to HMO Member....................4267.1
Procedures for Handling Claims Transferred by the HMO....................4267.2
ESRD Bill Processing Procedures....................4270
Home Dialysis Supplies and Equipment....................4270.1
Bill Review of Laboratory Services....................4270.2
Home Dialysis Patients' Option for Billing....................4271
Payment for Dialysis Furnished to Patients Who are Traveling....................4271.1
Payment for Method II Home Dialysis Supplies when the Beneficiary is an Inpatient....................4271.2
Monthly Capitation Payments for Physician's Services to Maintenance Dialysis Patients....................4272
Billing Requirements for the Monthly Capitation Payment....................4272.1
Data Elements Required for Claims for Payment under the Monthly Capitation Payment Method....................4272.2
Controlling Claims Paid Under the Monthly Capitation Payment Method....................4272.3
Physician's Services Furnished to a Dialysis Patient Away from Home or Usual Facility....................4272.4
Claims for Payment for Epoetin Alfa (EPO)....................4273
Completion of Initial Claims for EPO....................4273.1
Completion of Subsequent Claims for EPO....................4273.2
Initial Method Payment for Physician's Services to Maintenance Dialysis Patients....................4275
Billing Requirements for the Initial Method (IM)....................4275.1
Definitions....................4275.2
Abortion Services....................4276
Conditions of Coverage....................4276.1
Billing Instructions....................4276.2
Common Working File (CWF) Edits....................4276.3
Medicare Summary Notice (MSN) Explanation of Your Medicare Benefits (EOMB) Remittance Advice Message....................4276.4
External Counterpulsation (ECP) 4277

CHAPTER IV

Section

Diabetes Outpatient Self-Management Training Services....................4280
General Conditions of Coverage and Diabetes Training Hours....................4280.1
Beneficiaries Eligible for Coverage....................4280.2
Provider/Supplier Eligibility to Provide the Training....................4280.3
Quality Standards....................4280.4
Enrollment of DMEPOS Suppliers....................4280.5
Enrollment of Entities Other Than DMEPOS....................4280.6
HCPCS Coding....................4280.7
General Payment Conditions....................4280.8

Medicare as Secondary Payer

Intermediary Notification of Other Insurance Involvement....................4300
Reviewing Claims for the Working Aged....................4301
Processing Claims for Primary Medicare Benefits Where Working Aged Provisions May Apply....................4301.1
Reviewing Claims Involving Automobile Medical, Automobile No Fault, and Any Liability Insurance....................4302
Paying Secondary Benefits Where EGHP has Paid Primary Benefits for ESRD Beneficiary....................4303
Reviewing Medicare Claims Where VA Liability May Be Involved....................4304
Payment Safeguards....................4304.1
Performance Indicators....................4304.2
Selected Trauma Related Codes for MSP Development....................4305
Medicare Secondary Payment (MSP) Modules (MSPPAY)....................4306
Payment Calculation for Physician/Supplier Claims (MSPPAYB Module)....................4306.1
Payment Calculation for Physician/Supplier Claims (MSPPAYBL)....................4306.2
Medicare Secondary Payer (MSP) Claims Processing Under Common Working File (CWF)....................4307
Definition of MSP/CWF Terms....................4307.1
MSP Maintenance Transaction Record Processing....................4307.2
MSP Claim Processing....................4307.3
MSP Cost Avoided Claims....................4307.4
First Claim Development....................4307.5
First Claim Development Audit Trail for CPEP Purposes....................4307.6
CWF MSP On-Line Inquiry....................4307.7
MSP Purge Process....................4307.8
Exhibit 1 - CWF MSP Assistance Request....................
Exhibit 2 - MSP Utilization Edits and Correct Resolution....................

Request for Information From the Public

Request for Information Required in the Development of MSP Claims....................4308
Model Development Letter Questions....................4308.1
Example 1 - Model Working Age Questionnaire
Example 2 - Model ESRD Questionnaire....................
Example 3 - Model Disability Questionnaire....................
Example 4 - Model Questionnaire for Disabled Adult Child....................
Example 5 - Model Questionnaire for Disabled Widow/Widower Nonparticipating Physicians to Provide Notices For Elective Surgery....................4360
Provide Notice of Requirement....................4360.1
New Physicians....................4360.2
Handling Beneficiary Complaints....................4360.3

4280. DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES (DSMT)

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT when these services are furnished by a certified provider who meets certain quality standards. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in the self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management of their diabetes. Medicare coverage of DSMT is effective for dates of service (DOS) on or after July 1, 1998.

DSMT may be covered by Medicare only if the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed by sending an original referral form to the diabetes education program. The referral for education must be done under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's conditions. The specific coverage requirements are addressed below and can be found at 42 CFR 410.140 – 146. (The Final Rule became effective February 27, 2001.)

All certified providers that provide other individual items or services on a fee for service basis and that meet quality standards can receive reimbursement for diabetes training. (As with all fee for-service benefits, M+COs may only be reimbursed for DSMT if they meet all the requirements and are billing for services provided to beneficiaries not enrolled in a Medicare+Choice plan.) Certified providers must be currently receiving payment for other Medicare services.

The statute states that a 'certified provider' is a physician or other individual or entity designated by the Secretary that, in addition to providing diabetes outpatient self-management services, provides other items or services for which payment may be made under title XVIII such as medical services or durable medical equipment, and meets certain quality standards. CMS is designating all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, and durable medical equipment suppliers as eligible providers.

4280.1 General Conditions of Coverage and Diabetes Training Hours.--Training must be ordered by the physician or qualified nonphysician practitioner treating the beneficiary's diabetes. The order must be part of a comprehensive plan of care established by the physician or qualified non-physician practitioner and describe the training that the referring physician or qualified non-physician practitioner is ordering and/or any special concerns such as the need for general training, or insulin-dependence. The referring physician or qualified non-physician practitioner must maintain the 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. The plan of care may be maintained as a separate document or integrated into the beneficiary's medical record. The order must also include a statement signed by the physician that the service is needed. The provider of the service must maintain documentation in file that includes the original order from the physician and any special conditions noted by the physician or non-physician practitioner.

When the training under the order is changed, the change must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file at the provider of the training.

Outpatient diabetes self-management training is classified as initial or follow-up training. When a beneficiary has not yet received initial training meeting the quality standards of this section, he/she is eligible to receive 10 hours of initial training within a continuous 12-month period. The 12-month period does not need to be on a calendar-year basis. Nine hours of initial training may be provided

in a group setting consisting of 2 to 20 individuals unless the ordering physician or nonphysician practitioner certifies that a special condition or reason exists that makes it impossible for the beneficiary to attend a group training session. Those conditions include but are not limited to:

- No group session is available within 2 months of the date the training is ordered;
- The beneficiary has special needs resulting from problems with hearing, vision or language limitations, or other such special conditions as identified by the treating physician or non-physician practitioner; or
- Additional insulin instruction is needed.

The need for individual training must be identified by the physician or non-physician practitioner in the referral.

NOTE: If individual training has been provided to a Medicare beneficiary and subsequently you determine that training should have been provided in a group, downcode the reimbursement from individual to the group level and educate the provider instead of denying the service as billed.

For all beneficiaries, one hour of initial training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training. For example the 1 hour could be ½ hour of individual assessment and ½ hour of insulin instructions. The 10 hours of initial training may be provided in any combination of half-hour increments within the 12-month period and less than 10 hours of initial training may be used in the 12-month period if, for example, the beneficiary does not attend all of the sessions or the physician does not order the full training program.

4280.2 Beneficiaries Eligible for Coverage.--Medicare covers initial training for beneficiaries who have at least one of the following medical conditions present in the 12 months prior to the physician's or non-physician practitioner's order for the training.

- New onset diabetes.
- Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HBA1c) level of 8.5 percent or more on two consecutive HbA1c determinations 3 or more months apart in the year before the beneficiary begins receiving training.
- A change in treatment regimen from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- High risk for complications inadequate glycemic control (documented acute episodes of sever hypoglycemia or acute severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization).

- High risk based on at least one of the following:
  - Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation.
  - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye.
  - Kidney complications related to diabetes, when manifested by albuminuria, without other cause, or elevated creatinine.

The condition requiring training must be documented in the beneficiary's medical record maintained by the referring physician or qualified nonphysician practitioner.

Beneficiaries are eligible to receive two hours of follow-up training each calendar year following the year in which they have had their initial training.

NOTE: Beneficiaries with diabetes, who become eligible for Medicare, are deemed to be considered "new onset" for the purpose of receiving DSMT.

4280.3 Provider/Supplier Eligibility to Provide the Training.--The provider/supplier billing for the service must be eligible to provide and bill for other individual Medicare services. The types of providers/suppliers include but are not limited to, physicians, durable medical equipment suppliers, renal dialysis facilities, and hospital outpatient departments.

4280.4 Quality Standards.--The DSMT program must be accredited as meeting approved quality standards. CMS currently accepts recognition of the American Diabetes Association (ADA) as meeting the National Standards for DSMT Programs. Claims submitted by programs that are not ADA certified must be denied. If other organizations besides the ADA are recognized in the future by CMS as accreditation organizations, CMS will notify you in a program memorandum.

4280.5 Enrollment of DMEPOS Suppliers.--CMS has directed Durable Medical Equipment, Prosthetics, Orthotics or Supplies (DMEPOS) Suppliers to send claims for DSMT to the local Medicare carrier for processing. In order to file claims for diabetes education, a DMEPOS supplier must be enrolled in the Medicare program with the National Supplier Clearinghouse (NSC). The supplier must meet the ADA quality standards. Organizations may meet these quality standards by submitting documentation of recognition by the ADA as having met the National Standards for Diabetes Self-Management Education Programs as published in Diabetes Care, Volume 23 Number 5.

When you receive an application from a DMEPOS supplier, you must contact the NSC to verify that the applicant is currently enrolled and eligible to receive direct payment from the Medicare program. Contact the NSC via e-mail over secured lines at Medicare.nsc@palmettogba.com. In your request for this information, provide your E-mail address, the carrier identification, supplier's name, NSC number of the applicant, its tax identification number, and all owners listed on the Form CMS-855. The NSC will confirm the information within 3 working days of receiving the request. The entity or organization that enrolls with you must be the same as the one that is enrolled as a DMEPOS Supplier. The owners have to be the same and the tax ID has to be the same. If they are not, reject the application giving the reason for your disapproval and record it as a denial. Once you verify that it is an approved supplier, enrolled with the NSC, and has the same identification information, process the application in accordance with Chapter 10 of the Program Integrity Manual (PIM). When you notify the applicant of its PIN, you must also provide the PIN to NSC via e-mail over secured lines along with the NSC number of the applicant. Enroll the applicant using specialty code 87.

If a DMEPOS supplier has its billing privileges deactivated or revoked by the NSC, the billing number of the DMEPOS supplier at the carriers must also be deactivated. The NSC will notify you of any DMEPOS supplier with an approved diabetes education program if its billing privileges are deactivated or revoked by the NSC.

4280.6 Enrollment of Entities Other Than DMEPOS.--Any qualified provider (other than DMEPOS) currently enrolled with you that wishes to be reimbursed for this new service, must provide you with the ADA recognition certificate. However, the provider/supplier need not submit a new Form CMS-855B. A new Form CMS-855B is required only if the applicant is not enrolled with you (e.g., is enrolled with another carrier, or with a fiscal intermediary). For those providers/suppliers who are already receiving Medicare reimbursement from you for this service, and have submitted their ADA recognition certificate, continue to process claims. Use the supplier's existing specialty code. (Code 87 should be used only for DMEPOS suppliers.)

NOTE: All providers and suppliers including DMEPOS suppliers are eligible to receive retro- active payment for this service back to the later of February 27, 2001, or the date of recognition by the ADA.

4280.7 HCPCS Coding.--The following codes must be used by providers when billing DSMT. Deductible and coinsurance apply.

- 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: Local Medical Review Policy cannot change the number of hours covered under National Coverage Policy.

4280.8 General Payment Conditions.--To receive payment, providers/suppliers must meet the following conditions:

- Payment may only be made for diabetes training services actually attended by the beneficiary and documented on attendance sheets, and a referral from the treating physician or non-physician practitioner must be part of the patient's file maintained by the provider of the DSMT. Periodic post-payment review is appropriate for determining that these requirements are met.
- Bills for payment for diabetes training from DMEPOS suppliers must be submitted to and processed by the local Medicare carrier.
- If billing for initial diabetes training, the beneficiary must not have already received initial training from an ADA recognized program.
- For initial or follow-up diabetes training, the beneficiary must not be receiving services as an inpatient in a hospital, skilled nursing facility, under a hospice or home health benefit, or be a resident of a nursing home.
- For initial or follow-up diabetes training, payment must not be made in addition to payments made to rural health clinics and federally qualified health centers under their payment systems.

NOTE: Providers/suppliers may not use the medical nutrition therapy CPT codes for the nutrition portion of the DSMT benefit.