CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 72	**Date: MAY 25, 2007**
	Change Request 5433

This transmittal rescinds and replaces Transmittal 64, dated January 19, 2007. Business Requirement 5433.2 has been removed. All other information remains the same.

Subject: Guidelines for Payment of Diabetes Self-Management Training (DSMT)

I. SUMMARY OF CHANGES: This instruction corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. No new codes are being established. Information and the manual sections shown below has been reorganized with obsolete material deleted and some information moved to Pub. 100-04, section 120.

New / Revised Material
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/Table of Contents
R	15/300/Diabetes Self-Management Training Services
R	15/300/300.2/Certified Providers
R	15/300/300.3/Frequency of Training
R	15/300/300.4/Coverage Requirements for Individual Training
R	15/300/300.5/Payment for DSMT

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 72	Date: May 25, 2007	Change Request: 5433

This transmittal rescinds and replaces Transmittal 64, dated January 19, 2007. Business Requirement 5433.2 has been removed. All other information remains the same.

SUBJECT: Guidelines for Payment of Diabetes Self-Management Training (DSMT)

Effective Date: **July 1, 2007**

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: This instruction corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. No new codes are being established but an existing CWF error code is being modified.

B. Policy: Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards. Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes. DSMT must be ordered by the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition. Beneficiaries are eligible to receive 2 hours of follow-up training each calendar year following the year in which they have been certified as requiring initial training.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5433.1	Contractors shall pay for DSMT only when the services are submitted on one of the following type bills: 12X, 13X, 22X, 23X, 34X, 71X, 73X, and 85X.	X		X			X	X				
5433.2	This requirement has been removed. This is intentionally left blank.											
5433.3	Contractors shall pay for DSMT for all Critical Access Hospitals (CAHs) for TOBs 12X and 85X, at 101% of reasonable cost.	X		X				X				
5433.4	Contractors shall pay for DSMT for Indian Health Service (IHS) providers, TOB 13X, revenue	X		X				X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	code 051X under the Office of Management and Budget-approved outpatient per visit all inclusive rate.											
5433.5	Contractors shall pay for DSMT for IHS providers, TOB 12X, revenue code 024X under the all-inclusive inpatient ancillary per diem rate.	X		X				X				
5433.6	Contractors shall pay for DSMT in IHS CAHs, TOB 85X, revenue code 051X at 101% of the all-inclusive facility specific per visit rate.	X		X				X				
5433.7	Contractors shall pay for DSMT in IHS CAHs, TOB 12X, revenue code 024X at 101% of the all-inclusive facility specific per diem rate.	X		X				X				
5433.8	Contractors shall pay for DSMT for Skilled Nursing Facilities, TOBs 22X or 23X, and Home Health Agencies, TOB 34X, according to the MPFS non-facility rate.	X		X			X	X				
5433.9	Contractors shall pay for DSMT provided in an RHC or FQHC with other qualifying services, TOBs 71X and 73X, respectively, with revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900, at the all-inclusive encounter rate. **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 G0108 or G0109, and revenue	X		X				X				

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.											
5433.10	Contractors shall pay for DSMT for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC), TOBs 12X or 13X, on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland Waiver.	X		X				X				
5433.11	Contractors shall be in compliance with the manual instructions in Pub. 100-04, Chapter 18, Sections 120-120.2.2.	X		X	X		X					
5433.12	Effective for claims with dates of service on and after July 1, 2007, if 10 hours have been met within the initial calendar year of the first DSMT service, CWF shall allow follow-up training to begin in the next calendar year.										X	
5433.13	Effective for claims with dates of service on and after July 1, 2007, CWF shall modify Trailer 39 for the Part B records so that the reject error code applies to the line level. **NOTE:** Currently CWF is rejecting at the claim level.										X	
5433.14	Effective for claims with dates of service on and after July 1, 2007, CWF shall modify Trailer 08 to return the detail for Part A records so that the reject applies to the line level. **NOTE**: Currently CWF is rejecting at the claim level.										X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5433.15	A provider education article related to this instruction will be available at ww.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Bill Ruiz 410-786-9283 william.ruiz@cms.hhs.gov and Maria Durham 410-786-6978 maria.durham@cms.hhs.gov for FIs' claim issues

Yvette Cousar 410-786-2160 yvette.cousar@cms.hhs.gov for carriers' claim issues

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. ***For TITLE XVIII Contractors*****, use only one of the following statements:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev. 72, 05-25-07)

300 - Diabetes Self-Management Training Services

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes self-management training (DSMT) services 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 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.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. 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, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);

- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and

- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in *a* file that includes the original order from the physician and any special conditions noted by the physician.

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.

NOTE: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

300.2 - Certified Providers

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to the contractor. 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 self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. The CMS is designating 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. All suppliers/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. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

The CMS will not reimburse services on a fee-for-service basis rendered to a beneficiary *under Part A.*

NOTE: *While separate payment is not made for this service to Rural Health Clinics (RHCs), the service is covered but is considered included in the all-inclusive encounter rate. Effective January 1, 2006, payment for DSMT provided in a Federally Qualified Health Clinic (FQHC) that meets all of the requirements identified in Pub. 100-04, chapter 18, section 120 may be made in addition to one other visit the beneficiary had during the same day.*

All DSMT programs must be accredited as meeting quality standards by a CMS approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association and the Indian Health Service as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered. Certified providers may be asked to submit updated accreditation documents at any time or to submit outcome data to an organization designated by CMS.

Enrollment of DMEPOS Suppliers

The DMEPOS suppliers are reimbursed for diabetes training through local carriers. In order to file claims for DSMT, a DMEPOS supplier must be enrolled in the Medicare program with the National Supplier Clearinghouse (NSC). The supplier must also meet the quality standards of a CMS-approved national accreditation organization as stated above. DMEPOS suppliers must obtain a provider number from the local carrier in order to bill for DSMT.

The carrier requires a completed Form CMS-855, along with an accreditation certificate as part of the provider application process. After it has been determined that the quality standards are met, a billing number is assigned to the supplier. Once a supplier has received a provider identification (PIN) number, the supplier can begin receiving reimbursement for this service.

Carriers should contact the National Supplier Clearinghouse (NSC) according to the instruction in Pub 100-08, the Medicare Program Integrity Manual, Chapter 10, "Healthcare Provider/Supplier Enrollment," to verify an applicant is currently enrolled and eligible to receive direct payment from the Medicare program.

The applicant is assigned specialty 87.

Any DMEPOS supplier that has its billing privileges deactivated or revoked by the NSC will also have the billing number deactivated by the carrier.

300.3 - *Frequency of Training*

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A - *Initial 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 under HCPCS codes G0108 or G0109;
- Is furnished within a continuous 12-month period;
- Does not exceed a total of 10 hours* (the 10 hours of training can be done in any combination of 1/2 hour increments);
- With the exception of 1 hour of individual training, training is usually furnished in a group setting, *which can contain other patients besides Medicare beneficiaries, and;*
- One hour of individual training may be used for any part of the training including insulin training.

** When a claim contains a DSMT HCPCS code and the associated units cause the total time for the DSMT initial year to exceed '10' hours, a CWF error will set.*

B - *Follow-Up Training*

Medicare covers follow-up training under the following conditions:

- No more than 2 hours individual or group training per beneficiary per year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;

- *Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;*

- Follow-up training is furnished in increments of no less than one-half hour*; and

- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

**When a claim contains a DSMT HCPCS code and the associated units cause the total time for any follow-up year to exceed 2 hours, a CWF error will set.*

300.4 - *Coverage Requirements for Individual Training*

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

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

- No group session is available within 2 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 non-physician practitioner, that will hinder effective participation in a group training session; or

- The physician orders additional insulin training.

- 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 the carrier or intermediary determines that training should have been provided in a group, *carriers and intermediaries* down-*code* the reimbursement from individual to the group level and provider education would be the appropriate actions instead of denying the service as billed.

300.5 - *Payment for DSMT*

(Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Payment for *DSMT* may only be made to any provider that bills Medicare for other individual Medicare services *and* may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.

See Pub. 100-04, chapter 18, section 120 for specific payment information for physicians and all provider types.