INDIAN HEALTH SERVICE
Medicare Part A & B Coverage and Billing Requirements
Medical Nutrition Therapy (MNT) and Diabetic Self-Management Training (DSMT)

The following table is provided to assist Indian Health Service Hospital Outpatient and Free-standing Clinics with identifying the differences for billing for MNT and DSMT services.

Medicare Benefits and CMS Coverage Guidelines	**MNT Medical Nutrition Therapy**	**DSMT Diabetes Self-Management Training**
Statute	Section 105 of the Benefits Improvement and Protection (BIPA) Act of 2000 permits Medicare coverage of MNT services when furnished by a registered dietitian or nutrition professional meeting certain requirements, effective January 1, 2002.	Section 4105 of the Balanced Budget Act (BBA) of 1997 permits Medicare coverage of the diabetes outpatient self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards, effective July 1, 1998
Provider Qualifications and Requirements	Registered dietitian or nutrition professional who meet the following criteria: • BS degree in nutrition or dietetics • Completion of 900 hours of supervised dietetics practice • Licensed or certified as a dietitian or nutrition professional by state in which services are performed (federal employees can be licensed or certified in any state). • "Registered Dietitian" credential with the Commission on Dietetic Registration (CDR) is proof that education and experience requirements are met. • Grandfathered dietitian, nutritional professionals licensed or certified as of 12/21/00.	Program must be accredited as meeting approved quality standards, i.e*. National Standards for Diabetes Self-Management Education Programs*. CMS-approved national accreditation organizations include American Diabetes Association and the Indian Health Service. **NOTE: A Diabetes Education Program Cannot Seek Reimbursement From Medicare Until The Program Has Been Accredited.**
Qualifying Diagnoses	Diabetes: • Type 1 • Type 2 • Gestational Renal: • Non-Dialysis Kidney Disease • Post-Kidney Transplants	• New onset diabetes • Inadequate blood sugar control (HgA1c 8.5 mg/dl or more) • Change in treatment regimen • High risk for complications based on inadequate blood sugar control • High risk based on at least one of the following: Lack of feeling in the foot or foot complication; pre-proliferative or proliferative retinopathy or prior laser treatment of the eye; kidney complications related to diabetes. **NOTE**: beneficiaries with diabetes, becoming newly eligible for Medicare, can receive DSMT.
Limitations of Coverage	• No coverage for maintenance dialysis • If beneficiary has diabetes and renal disease, the number of hours allowed is for diabetes or renal disease. • Only face-to-face time with patient DSMT and MNT services cannot be provided on the same date.	• No payment will be made for group sessions unattended (class attendance sheet) • Only Face-to-face time with patient • DSMT and MNT services cannot be provided on the same date.

Medicare Benefits and CMS Coverage Guidelines	**MNT** **Medical Nutrition Therapy**	**DSMT** **Diabetes Self-Management Training**

Other Conditions of Coverage	• The number of hours covered in a 12-month period (episode of care) cannot be exceeded.
	• Services can be provided on an individual or group basis
		The training must meet the following conditions:
		• Following an evaluation of the beneficiary's need for training, the treating provider must order DSMT.
		• Included in a comprehensive plan of care (POC).
		• It is reasonable and necessary for treating or monitoring the beneficiary's condition (signed statement of need).
		• When training under a POC is changed, the provider must sign it.
		• In the initial DSMT benefit, 9 of the 10 hours must be provided in a group setting (2-20 individuals) unless special conditions exist:
		  o No group class is available within 2 months of the date the training is ordered; or,
		  o The beneficiary has special needs resulting in problems with hearing, vision or language limitations.
		  o Additional insulin instruction is needed.

Practice Settings	Included: Hospital outpatient department, FQHC, RHC and free-standing clinics, and Home Health Excluded: Inpatient stay in hospital or skilled nursing facility	Included: Hospital outpatient department and free-standing clinic Excluded: Inpatient hospital, skilled nursing facility, nursing home, hospice, FQHC and RHC
Basic Coverage Second Physician Referral	Initial MNT: 3 hours per year in the first year. Follow-up MNT: 2 hours per year in subsequent years. Hours can be spread over any number of visits during the year (1 visit = 15 min.) The number of hours can be increased if the treating physician determines there is a change in medical condition, diagnosis and/or treatment plan. **Effective January 2003,** two new codes have been added. The codes would be used for reassessment and subsequent intervention following a second physician referral in the same calendar year.	Initial DSMT: 10 hours per year in the first year (1 hour individual assessment or specialized training plus 9 hours group classes). Continuous 12-month period-need not be on calendar-year basis. Follow-up DSMT: 2 hours per calendar year in subsequent years (individual or group training). Hours can be spread over any number of visits during the year (1 visit = 30 min.)
Diabetes Self-Management Training Benefit and MNT Benefit	CMS considers DSMT and MNT complimentary services. This means Medicare will cover both DSMT and MNT without decreasing either benefit as long as the referring physician determines that both are medically necessary.	SAME

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Referring (licensed) Providers	Physician and physician specialist	Physician or qualified non-physician practitioner: nurse practitioner, clinical nurse specialist, physician assistant, nurse midwives, clinical psychologists and clinical social workers
Provider Referral	Provider written referral containing qualifying diagnosis, physician Unique Provider Identification Number (UPIN) and signature.	Provider written and signed referral for training containing diagnosis and a written comprehensive plan of care (POC). The POC must describe the content, number of sessions, frequency, and duration of the training as written by the provider treating the beneficiary's diabetes condition.
Protocols or Standards	RDs and nutritionists should use nationally recognized protocols such as the American Dietetic Associations' MNT Evidenced-Based Guides for Practice.	**Indian Health Service** Integrated Diabetes Education and Care Standards based on IHS Diabetes Standards of Care and National Standards for Diabetes Education. Only program in nation that integrates educational, clinical and public health standards. OR **American Diabetes Association** Recognition Program based on the National Standards for Diabetes Self-Management Education.
Billable to Medicare Part A? (Facility fee)	No. The policy change below does not apply to IHS at this time. *CMS PM # A-02-115 (NOV 1, 2002) states that CMS has determined that MNT services can be billed to FIs when performed in an outpatient hospital setting.*	No
Billable to Medicare Part B? (Professional services fee)	Yes. HCFA 1500	Hospital Outpatient – Yes "Incident to". HCFA 1500 Free Standing Clinics – Yes. "Incident to" HCFA 1500 FQHC/RHC – No
Enrolling as Medicare Provider	To enroll in Medicare Part B, complete and **CMS Form 855I**, "*Medicare Federal Health Care Provider/Supplier Enrollment Application.*"	Referring provider must be enrolled as a Medicare Part B Provider. Once diabetes education program recognition is received, a copy of the ADA or IHS NDP certificate must be submitted to Medicare.
Provider Identification Number (PIN)	RD or nutrition professional must enroll in the Medicare program to become a recognized Medicare provider. Upon enrollment, the RD or nutrition professional will receive a Medicare PIN, which is used on MNT claims.	N/A
Other CMS 855 Forms for Enrollment	Complete **CMS Form 855R**, "*Medicare Federal Care Reassignment of Benefits Application,*" to reassign benefits back to employer.	N/A
Facility Application? **CMS Form 855B** "*Application for Health Care Suppliers that Bill*	Yes. If facility does not have one.	Yes. If facility does not have one. See above

Medicare Carriers"		
Medicare Benefits and CMS Coverage Guidelines	**MNT Medical Nutrition Therapy**	**DSMT Diabetes Self-Management Training**
CPT or HCPCS Codes Second Physician Referral	**97802** MNT, individual, initial visit only, each 15 minutes **97803** MNT, individual, subsequent, each 15 minutes **97804** MNT, group, each 30 minutes **G0270** MNT**,** Reassessment and subsequent intervention, second referral, same year, individual, each 15 minutes. **G0271** MNT, Reassessment and subsequent intervention, second rreferral, same year, group, each 30 minutes Multiple units of the codes can be used based on medical necessity and the complexity of the MNT decision-making.	**G0108** Diabetes outpatient self-mgmt training service, individual, per 30 minutes **G0109** Diabetes outpatient self-mgmt training services, group session, (two or more), per 30 minutes
Payment	• RD should establish a fee schedule (based on usual and customary MNT fees) for their MNT services. • Allowed payment rates have been established under the physician's fee schedule • Payment will be at 80% of the lesser of the actual charge or (80%) of 85% of the amount determined under the physician fee schedule. • CMS applies a geographical adjustment factor (GAF) to the MNT rates in regions of the country. • Deductible and coinsurance apply.	<u>Free Standing Clinics</u> - Medicare Part B fee schedule based on geographic state. Deductible and coinsurance apply. <u>Hospital Outpatient facilities</u> – Medicare Part B fee schedule based on geographic state. Deductible and coinsurance apply. **NOTE:** **1)** Non-physician practitioners, e.g. NP or RD, who are Medicare providers, are eligible to bill Medicare Part B on behalf of the DSMT program. (CMS PM B-02-062 OCT 4, 2002) **2)** **2)** Payment to non-physician practitioners billing on behalf of the DSMT program should be made at the *FULL* physician fee schedule. This is because the payment is for the DSMT program and is not being billed for the services of a single practitioner.(CMS PM AB-02-051, OCT 25, 2002).
Billing for Services Not Covered	Medicare Part B cannot be billed for non-covered MNT or for non-covered MNT services as "incident to physician's services."	Medicare Part B cannot be billed for non-covered DSMT
Medicare Part B Documentation Requirements	• Patient Name/Medical Record Number • Qualifying Medical Diagnosis • Written Provider Referral • Physician Signature • RD Name and Signature • Date of service • Time in – Time out and total time (to calculate number of units) • MNT CPT Code • Individual or group encounter*	• Patient Name/Medical Record Number • Qualifying Medical Diagnosis indicating condition requiring training • Written provider referral and signed statement of need on initial encounter • Date of original referral on all subsequent visits* • Physician Signature • Date of service • Time in – Time out and total time (to

(*recommendations to facilitate timely an accurate billing)	• Visit number with cumulative time spent with patient to date*	calculate number of units) • DSMT G- Codes • Individual or group encounter* • Visit number with cumulative time spent with patient to date*
Resources - Medicare Part B	• Medicare Part B Newsletter 9/1/2001. No 01-020. Page 27-28 • www.trailblazerhealth.com>Part B>IHS • ADA Web site: www.eatright.org	• Medicare Part B Newsletter 9/1/2001. No 01-020. Page 31-32 • www.trailblazerhealth.com>Part B>IHS • AADE Web site: www.aadenet.org
Resources - Medicare Part A	Not applicable	I H S Handbook. Pages 98-104 www.trailblazerhealth.com>Part A>IHS
Claim Follow-up	Medicare B IHS hotline: 1-866-448-5894 As for claim check status. Have available Patient Medicare # and Date of Service.	Trailblazers DDE Online System. Each facility Business Office may have access to this electronic system.