CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1255	**Date: MAY 25, 2007**
	Change Request 5433

This transmittal rescinds and replaces Transmittal 1158, dated January 19, 2007. Business Requirement 5433.2 has been removed. Additionally, in section 120.1 of chapter 18, the Payment Method for Hospitals subject to OPPS has been changed from OPPS to MPFS. 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.

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	9/Table of Contents
N	9/181/Diabetes Self-Management Training (DSMT) Services Provided by RHCs and FQHCs
R	18/Table of Contents
N	18/120/Diabetes Self-Management Training (DSMT) Services
N	18/120/120.1/Coding and Payment of DSMT Services
N	18/120/120.2/Bill Processing Requirements
N	18/120/120.2.1/Special Processing Instructions for Billing Frequency Requirements
N	18/120/120.2.2/Advance Beneficiary Notice (ABN) Requirements

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. 100-04	Transmittal: 1255	Date: May 25, 2007	Change Request: 5433

This transmittal rescinds and replaces Transmittal 1158, dated January 19, 2007. Business Requirement 5433.2 has been removed. Additionally, in section 120.1 of chapter 18, the Payment Method for Hospitals subject to OPPS has been changed from OPPS to MPFS. 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	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	
	for Indian Health Service (IHS) providers, TOB 13X, revenue 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	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	
	qualifying visit is billed on TOB 73X, with HCPCS G0108 or G0109, and revenue 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 Claims Processing Manual

Chapter 9 - Rural Health Clinics / Federally Qualified Health Centers

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(Rev. 1255, 05-25-07)

181 - Diabetes Self-Management Training (DSMT) Services Provided by RHCs and FQHCs

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

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. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. See Pub. 100-04, chapter 18, section 120. Payment is made at the all-inclusive encounter rate to the FQHC. 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 codes G0108 or G0109, as appropriate, and with one of the following revenue codes, 0520, 0521, 0522, 0524, 0525, 0527, 0528 or 0900 as appropriate.

Separate payment to RHCs for these practitioners/services continues to be precluded as set forth in regulations at §414.63 and 64 as well as in Medicare Internet Only Manuals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals, are considered incident to services and do not constitute an RHC visit, in and of themselves.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

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(Rev. 1255, 05-25-07)

120 - Diabetes Self-Management Training (DSMT) Services

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage requirements, certified providers and enrollment.

120.1 - Coding and Payment of DSMT Services

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The following HCPCS codes are used to report DSMT:

- *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.*

The type of service for these codes is 1.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility	***Payment Method***	***Type of Bill***
Physician (billed to the carrier)	*MPFS*	*NA*
Hospitals subject to OPPS	*MPFS*	*12X, 13X*
Method I and Method II Critical Access Hospitals (CAHs) (technical services)	*101% of reasonable cost*	*12X and 85X*
Indian Health Service (IHS) providers billing hospital outpatient Part B	*OMB-approved outpatient per visit all inclusive rate (AIR)*	*13X*
IHS providers billing inpatient Part B	*All-inclusive inpatient ancillary per diem rate*	*12X*
IHS CAHs billing outpatient Part B	*101% of the all-inclusive facility specific per visit rate*	*85X*
IHS CAHs billing inpatient Part B	*101% of the all-inclusive facility specific per diem rate*	*12X*

*FQHCs**	*All-inclusive encounter rate with other qualified services. Separate visit payment available with HCPCS.*	*73X*
*Skilled Nursing Facilities ***	*MPFS non-facility rate*	*22X, 23X*
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	*94% of provider submitted charges in accordance with the terms of the Maryland Waiver*	*12X, 13X*
Home Health Agencies (can be billed only if the service is provided outside of the treatment plan)	*MPFS non-facility rate*	*34X*

** 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 codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.*

*** 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 22 bill type. Training services provided by other provider types must be reimbursed by X the SNF.*

***NOTE:** An ESRD facility is a reasonable site for this service, however, because it is required to provide dietician 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.*

Deductible and co-insurance apply.

120.2 - Bill Processing Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

See Pub. 100-04, chapter 25 for instructions for intermediaries.

See Pub. 100-04, chapter 26 for instructions for carriers.

Billing is to the "certified provider's" regular intermediary or carrier, i.e., there are no specialty contractors for this service. (See Pub 100-02, chapter 15, section 300.2 for the definition of "certified provider" in this instance.)

120.2.1 - Special Processing Instructions for Billing Frequency Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The frequency editing for DSMT is performed in CWF as follows:

A - Initial Training

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

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage for initial training.

B - Follow-Up Training

Follow-up training for subsequent years are based on a 12 month calendar year after the initial year. 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. 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.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, section 300 for information on coverage for follow-up training.

C - Examples

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

Bene receives first service: April, 2006
Bene completes initial 10 hours DSMT training: April, 2007
Bene is eligible for follow-up training: May 2007 (13th month begins the subsequent year)
Bene completes follow-up training: December, 2007
Bene is eligible for next year follow-up training: January, 2008

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

Bene receives first service: April 2006
Bene completes initial 10 hours of DSMT training, December 2006
Bene is eligible for follow-up training: January, 2007
Bene completes follow-up training: July 2007

Bene is eligible for next year follow-up training: January 2008

120.2.2 - Advance Beneficiary Notice (ABN) Requirements

(Rev. 1255, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

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 absence of evidence of a valid ABN, the provider will be held liable.

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.