

National Coverage Determination

Nutrition Training Benefits

Contractor's Determination Number

PHYS-041

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402, 52280

Contractor Type

Carrier B
Fiscal Intermediary A
MAC A
MAC B

Primary Geographic Jurisdiction

Carrier B: Wisconsin, Illinois, Michigan, Minnesota

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, Connecticut, Florida, Georgia, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, U.S. Virgin Islands

MAC A/B: Iowa, Missouri, Nebraska, Kansas

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CMS National Coverage Policy

42 CFR 410.140 – 410.146
§1861 (r) (l) of the Social Security Act

Federal Register: December 29, 2000 (Volume 65, Number 251
42 CFR Parts 410, 414, 424, 480, and 498
Medicare Program; Expanded Coverage for Outpatient Diabetes Self-
Management Training and Diabetes Outcome Measurements; Final Rule and
Notice

Coverage Issues Manual (CIM) 80-2, 80.3

Medicare Claims Processing Manual Chapter 4 - 300-300.6- Medical Nutrition Therapy (MNT) Services
Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services DMST
Table of Contents (Rev. 72.1, 05-25-07) 300.3 - *Frequency of Training*; 300.4 - *Coverage Requirements for Individual Training* ; 300.5 - *Payment for DSMT*; Effective Date: July 1, 2007;
Implementation Date: July 2, 2007
Medicare Claims Processing Pub 100-04; Transmittal 1255; Date: MAY 25, 2007; Change Request 5433
Guidelines for Payment of Diabetes Self-Management Training (DSMT); Effective Date: July 1, 2007;
Implementation Date: July 2, 2007
*Medicare Claims Processing Pub 100-04, Transmittal 2127, Date: DECEMBER 29, 2010
Change Request 7262, SUBJECT: Medical Nutrition Therapy (MNT) Manual Correction
Effective Date: January 1, 2002, Implementation Date: March 29, 2011

Formerly

Medicare Carriers Manual (MCM) 4280-4280.8

Program Memorandums (PM(s): AB-98-36, B-01-40, B-01-48, AB-02-059, B01-109, B-02-010; AB-02-151; B03-043

Description:

Medicare offers two nutrition benefits. They are described below.

A. Diabetes Outpatient Self-Management Training Services

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards.

A diabetes outpatient self-management and training service is a program which educates beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for self-management.

B. Medical Nutrition Services

Section 1861(s)(2)(V) of the Social Security Act authorizes Medicare part B coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease, effective for services furnished on or after January 1, 2002. Regulations for medical nutrition therapy (MNT) were established at 42 CFR §§410.130 - 410.134. This national coverage determination establishes the duration and frequency limits for the MNT benefit and coordinates MNT and diabetes outpatient self-management training (DSMT) as a national coverage determination.

Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR §410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease or diabetes is 2 hours. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in this NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception at 42 CFR §410.132(b)(5), additional hours are considered to be medically necessary and covered if the treating physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

Effective October 1, 2002, if the treating physician determines that receipt of both MNT and DSMT is medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in the NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception at 42 CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if the treating physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

HCPCS/CPT Section:
Professional Services

Procedure Codes CPT or HCPCS:

- G0108** Diabetes outpatient self-management training services, individual session, per 30 minutes of training.
- G0109** Diabetes outpatient self-management training services, group session, per individual, per 30 minutes of training.
- 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.)
- 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
- 97803** Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97804** Group (2 or more individual(s)), each 30 minutes

Indications and Limitations of Coverage:

I. Diabetes Outpatient Self-Management Training Services

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed 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.

Patient selection must ensure that those enrolled will gain a sufficient knowledge to benefit from the program. This would be based on their cognitive ability and their familiarity with their disease and treatment. A long-term stable diabetic who has not had a change in condition or treatment regimen would not be an appropriate candidate for these programs, unless there is documentation in the medical record that there are new problems, i.e., new medications.

Outpatient self-management and training programs must not be routinely substituted for the provision of the usual reasonable and necessary diabetic education which is rendered as part of

an inpatient or extended care stay, a home health visit, or a physician's services. An outpatient program can be considered medically reasonable and necessary only for those diabetic patients who are unable to benefit from the ordinary methods of instruction and whose physician believes he/she can only benefit from a more formal approach.

These services would normally be provided in group sessions. However individual training sessions can be provided for a beneficiary if their physician decides that it is medically necessary, for example, because of language or physical challenges, such as severely impaired hearing and sight.

Entrance into these programs is by physician referral only (or qualified nonphysician practitioner as defined in Sec. 410.32). Self-referral is not covered.

The program must be sufficiently flexible to meet the individual needs of the patient. The individual plan of care must indicate at a minimum the goals for the individual patient and how these goals will be realized.

The duration of these programs should be sufficient to meet the goals of self-management within the timeframe indicated in the plan of treatment.

Generally, as a basic guideline, it would not be medically necessary for a beneficiary to receive more than 10 hours of services for the initial training.

It is not expected that any given patient could be eligible to reenter an education program unless new conditions warrant it.

A. Diabetes Self-Management Training Services - 300 -

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.

B. Frequency of Training 300.3 -

1. - 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:

- a. Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS codes G0108 or G0109;
- b. Is furnished within a continuous 12-month period;
- c. Does not exceed a total of 10 hours* (the 10 hours of training can be done in any combination of 1/2 hour increments);
- d. 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;
- e. 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.

2. - Follow-Up Training

Medicare covers follow-up training under the following conditions:

- a. No more than 2 hours individual or group training per beneficiary per year;
- b. Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- c. Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;
- d. Follow-up training is furnished in increments of no less than one-half hour*; and
- e. 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.

C. Coverage Requirements for Individual Training 300.4 -

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

- a. No group session is available within 2 months of the date the training is ordered;*
- b. 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*
- c. The physician orders additional insulin training.*
- d. 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.*

D. Payment for DSMT

Payment to non-physician practitioners billing on behalf of a DSMT program (G0108 or G0109) should be made at the full fee schedule rate and should not be paid at 85 percent of the fee schedule like other non-physician practitioner services. This is because the payment is for the DSMT program and is not being made for the services of a single practitioner.

Non-physician practitioners that bill on behalf of a DSMT program are subject to mandatory assignment.

Billers for DSMT services should note that any income from codes G0108 or G0109 will be accrued under their provider number and reported to the Internal Revenue Service.

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. 300.5

E. Certified Providers:

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. For initial implementation of this benefit we are designating as a certified provider those physicians, individuals or entities that are paid under the physician-fee schedule. These certified providers must meet the National Diabetes Advisory Board Standards (NDAB).

Along with physicians we will designate as certified providers other nonphysician practitioners who meet the NDAB standards and whose services are paid for under the physician fee schedule.

A non-physician practitioner, such as a physician assistant or nurse practitioner, may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without physician supervision and have the services separately covered and paid for directly by Medicare as physician assistant or nurse practitioner services. Medicare only covers procedures and services that are performed in accordance with State license.

In keeping with the requirements of the legislation, services provided by individuals other than physicians will be covered when they are provided within the current coverage requirements. These include: Physician assistants (PAs), Nurse Practitioners (NPs), Nurse Midwives (NMs), clinical Psychologists (CPs) and clinical social workers (CSWs).

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 part of a multi-disciplinary team that provides DSMT services for the DSMT program. A dietitian may not be the sole provider of the DSMT service unless they are performing the service in a rural area as defined in 42 CFR 410.144. The accreditation organizations, the American Diabetes Association (ADA) or the Indian Health Service (IHS), will determine if the program can qualify to have a single-member team. The program may also include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. The benefit provided by the program may not be subdivided for the purposes of billing Medicare.

A hospital that has a DSMT program (accredited by the ADA or IHS) can be the biller without any reassignment. If a dietitian or certified diabetic educator has a DSMT program accredited under their name and they work for a hospital, then they would need to reassign their benefits to the hospital. If a physician is part of the DSMT program, (i.e., a physician advisor), he or she can be the certified provider and bill Medicare using the physician's Medicare provider number. A registered dietitian, who has a Medicare provider number and is part of the DSMT program, can bill on behalf of the DSMT program.

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

***Certified Provider Requirements - Section - 300.2**

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 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.

II. MEDICAL NUTRITION THERAPY

A. Background

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(l) of the Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment (“episode of care”) to assure compliance with the dietary plan. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.

For the purposes 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). Effective January 1, 2004, CMS updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar 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 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

B. General Conditions of Coverage (300.1)

The following are the general conditions of coverage

- 1. The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. As described above, a treating physician means the primary care physician or specialist coordinating care for beneficiary with diabetes or renal disease.*
- 2. The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;*
- 3. Services may be provided either on an individual or group basis without restrictions and;*
- 4. For a beneficiary with a diagnosis of diabetes, Diabetes Self Management Training (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 a 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 as stated in 42 CFR 410.132(b)(5).*

C. Limitations on Coverage

- 1. MNT services are not covered for beneficiaries receiving maintenance dialysis.*
- 2. A beneficiary may not receive MNT and DSMT on the same day.*

D. Referrals (300.2)

Medicare covers 3 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 3 hours of MNT but a beneficiary only uses 2 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 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours. Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

Documentation must be maintained by the referring physician 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 UPIN number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The Carrier or FI shall return claims that do not contain the referring UPIN of the referring physician.

E. Professional Standards for Dietitians and Nutritionists (300.3)

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. “Registered dietitian or nutrition professional” means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, 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. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;*
- 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.*

Covered ICD-9 Codes:

HCPCS Codes:

G0108, G0109 (DSMT)

- 249.00 – 249.91 Secondary diabetes mellitus
- 250.00-250.93 Diabetes mellitus with or without various complications and manifestations

CPT Codes:

97802, 97803, 97804, G0270, G0271 (MNT)

- 249.00 – 249.91 Secondary diabetes mellitus
- 250.00 - 250.93 Diabetes mellitus with or without various complications and manifestations
- 648.80 - 648.84 Gestational Diabetes
- 585.1 – 585.9 Chronic renal failure
- V42.0 Organ replaced by transplant - kidney

Coding Guidelines:

I. Diabetes Outpatient Self-Management Training Services

- A. A copy of the providers Education Recognition Program (ERP) certificate from the American Diabetes Association must be submitted to the carrier prior to submitting claims for diabetes self-management training services. The certificate should be mailed to:*

| Wisconsin Providers: | Illinois/Michigan Providers: | Minnesota Providers |
|-----------------------------|-------------------------------------|-----------------------------|
| MPCU | Provider Enrollment | Provider Maintenance |
| WPS-Medicare | WPS-Medicare | WPS-Medicare |
| P.O. Box 1787 | P.O. Box 8248 | 8120 Penn Avenue South #200 |
| Madison, WI 53701- | Madison, WI 53708-8248 | Bloomington, MN 55431-1394 |

Claims received before the carrier receives this certificate will be denied.

B. 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.

C. Coding and Payment of DSMT Services 120.1

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 |
|---|---|---------------------|
| <i>Physician (billed to the carrier)</i> | <i>MPFS</i> | <i>NA</i> |
| <i>Hospitals subject to OPPI</i> | <i>MPFS</i> | <i>12X, 13X</i> |
| <i>Method I and Method II Critical Access Hospitals (CAHs) (technical services)</i> | <i>101% of reasonable cost</i> | <i>12X and 85X</i> |
| <i>Indian Health Service (IHS) providers billing hospital outpatient Part B</i> | <i>OMB-approved outpatient per visit all inclusive rate (AIR)</i> | <i>13X</i> |

| | | |
|---|---|-----------------|
| <i>IHS providers billing inpatient Part B</i> | <i>All-inclusive inpatient ancillary per diem rate</i> | <i>12X</i> |
| <i>IHS CAHs billing outpatient Part B</i> | <i>101% of the all-inclusive facility specific per visit rate</i> | <i>85X</i> |
| <i>IHS CAHs billing inpatient Part B</i> | <i>101% of the all-inclusive facility specific per diem rate</i> | <i>12X</i> |
| <i>FQHCs*</i> | <i>All-inclusive encounter rate with other qualified services. Separate visit payment available with HCPCS.</i> | <i>73X</i> |
| <i>Skilled Nursing Facilities **</i> | <i>MPFS non-facility rate</i> | <i>22X, 23X</i> |
| <i>Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)</i> | <i>94% of provider submitted charges in accordance with the terms of the Maryland Waiver</i> | <i>12X, 13X</i> |
| <i>Home Health Agencies (can be billed only if the service is provided outside of the treatment plan)</i> | <i>MPFS non-facility rate</i> | <i>34X</i> |

- 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.

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

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.

SNF

** 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

E. Bill Processing Requirements 120.2 -

Billing is to the "certified provider's" regular intermediary or carrier, i.e., there are no specialty contractors for this service.

F. Special Processing Instructions for Billing Frequency Requirements 120.2.1 -

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

1. - 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.

2. - 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.

3. - 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

G. Advance Beneficiary Notice (ABN) Requirements 120.2.2 -

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.

H. *The billing of an evaluation and management code is not mandatory before the billing of the diabetes education codes.*

II. Medical Nutrition Services

A. Enrollment of Dietitians and Nutritionists

- *In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location.*
- *The carrier shall establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.*
- *Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.*

B. Payment for MNT

The contractor shall pay for MNT services under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self management training (DSMT) benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The contractor shall pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department.

1. Payable Codes for MNT with Applicable Instructions

| | | |
|-------|---|--|
| 97802 | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with | This code is to be used only once, for initial assessment of a new |
|-------|---|--|

| | | |
|-------|---|---|
| | <i>the patient, each 15 minutes. (NOTE: This HCPCS code must only be used for the initial visit.)</i> | <i>patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as 97803. The provider shall bill all subsequent group visits as 97804.</i> |
| 97803 | <i>– Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</i> | <i>The provider shall bill this code for all 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 (see the heading, Additional Covered Hours for Reassessments and Interventions).</i> |
| 97804 | <i>Group (2 or more individual(s)), each 30 minutes</i> | <i>The provider shall bill this code for 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.</i> |

NOTE: The above codes can be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid “incident to” physician services.

2. **HCPCS Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)**

The following HCPCS codes shall be used when there is a change in the beneficiary's condition:

| | |
|-------|---|
| G0270 | <i>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.</i> |
| G0271 | <i>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.</i> |

NOTE: These G codes should be used when additional hours of MNT services are performed

beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

C. General Claims Processing Information (300.5)

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.

1. Special Requirements for Carriers

- 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 in on the claim form.
- The specialty code for “dietitians/nutritionists” is 71

2. Medicare Summary Notices (MSNs)

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.
- If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is ‘Este servicio no estaba cubierto por Medicare cuando usted lo recibio.’
- If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is ‘Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.’

3. FI Special Billing Instructions

MNT Services can be billed to FIs when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the local Medicare carrier under their own provider number or the hospital will have to bill the local Medicare carrier.

NOTE: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13X, 14X, 23X, 32X, and 85X.

D. Common Working File (CWF) Edits (300.6)

The CWF edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen, and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

Advance Beneficiary Notice (ABN)

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. 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 professions who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Utilization Guidelines:

The MNT benefit is a completely separate benefit from the DSMT benefit. The national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same time period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, they are not allowed to bill for both DSMT and MNT on the same date of service. In subsequent years the beneficiary can receive 2 hours of DSMT (with a referral) and 2 hours of MNT in subsequent years (with a referral).

Medicare covers 3 hours of MNT in the beneficiary's initial calendar year. There will be no carrying over of initial hours to the next calendar year. For example, if a physician gives a referral to a beneficiary for 3 hours of MNT but a beneficiary only uses 2 hours in November, the calendar year ends in December and if the 3rd hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Documentation Required:

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

Reasons for Non-Coverage:

Medical Necessity and Non-covered

Comments:

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Dates and Revision History:

Effective Date: **DSMT:** 07/01/98; 06/01/99
MNT: 10/01/2002

Date Published: 10/01/2011 on website for all WPS jurisdictions
Revision Date & #: 02/01/2011, Changed post transplant time from 6 months to 36 months;
10/01/2009 removed (*or qualified nonphysician practitioner as defined in Sec. 410.32*) can order only MNT services. References not found.;

10/01/2008 (addition of ICD-9 codes); Correction that non-physician practitioners can order only MNT services 01/01/2006, Clarification that non-physician practitioners can order these services; 10/01/2005 (ICD-9 update and manual review of MNT services); 07/01/2003 (section IJ1 removed, icd-9 update), six; 03/01/2003 (section IC removed), five; 12/01/2002 (code descriptor change), four; 11/01/02 three; 02/03/99, one; 03/31/99, two