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Contractor's Policy Number

02-02-R1

Contractor's Name

CareFirst of Maryland Inc., Medicare Part A

Contractor Number

00190

Contractor Type

Fiscal Intermediary

LMRP Title

Diabetes Outpatient Self-Management Training

AMA CPT Copyright Statement

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CMS National Coverage Policy

- Establishment of national policy supersedes all previous contractor policy

statements, including Local Medical Policy coverage guidelines

- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Primary Geographic Jurisdiction

Maryland

Washington, DC

Secondary Geographic Jurisdiction

Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Washington state, and Wyoming

CMS Region

Region III

CMS Consortium

Northeast

Original Policy Effective Date

11/27/2002

Original Policy Ending Date

05/31/2004

Revision Effective Date

10/01/2003

Revision Ending Date

LMRP Description

A diabetes outpatient self-management and training service is a program, which educates beneficiaries in the successful self-management of diabetes. Medicare coverage of this service is furnished by a certified provider who meets certain quality standards. 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 or insulin requiring, and motivation for patients to use the skills for self-management.

Indications and Limitations of Coverage and/or Medical Necessity

- Coverage of this service is allowed under Section 4105 of the Balanced Budget Act of 1997.
- Medicare may cover diabetes outpatient self-management training services only if the physician or qualified non-physician practitioner who is managing the diabetic condition certifies that such services are needed.
- The program providing the Diabetes Self-Management Training must be certified by the American Diabetes Association.
- The services are furnished by a certified provider who meets the following quality standards:
 - 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.

I. STRUCTURAL STANDARDS

A. Organizational support by sponsoring organization

Standard 1: Maintain a written policy affirming education as an integral component of diabetes care.

Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget, and instructional materials.

Standard 3: Clearly define and document organizational relationships, lines of authority, staffing, job descriptions, and operational policies.

B. Community needs assessment

Standard 4: Assess the service area to define target population and determine allocation of personnel and resources.

C. Program management

Standard 5: Establish a standing advisory

committee including at least a physician, nurse educator, dietitian, behavioral science expert, consumer, and community representative to oversee the program.

Standard 6: The advisory committee should participate in annual planning to determine target population, program objectives, participant access, and follow-up mechanisms.

Standard 7: Professional program staff should have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow-up.

Standard 8: Assess community resources periodically.

D. Program staff

Standard 9: Designate a coordinator responsible for program planning, implementation, and evaluation.

Standard 10: Program instructors should include at least a nurse educator and dietitian with recent didactic and experimental training in diabetes clinical and educational issues. Certification as diabetes educator by the National Certification Board of Diabetes Educators is recommended.

Standard 11: Professional program staff should obtain continuing education about diabetes, educational principles, and behavioral change strategies.

E. Curriculum

Standard 12: The program must be capable of offering, based on target population needs, instruction in the following 15 content areas:

- Diabetes overview
- Stress and psychosocial adjustment
- Family involvement and social support
- Nutrition
- Exercise and activity
- Medications
- Monitoring and use of results
- Relationships among nutrition, exercise, medication, and glucose levels
- Prevention, detection, and treatment of acute complications
- Prevention, detection, and treatment of chronic complications
- Foot, skin, and dental care
- Behavior change strategies, goal setting, risk factor reduction, and problem solving
- Benefits, risks, and management options for improving glucose control

- Preconception care, pregnancy, and gestational diabetes
- Use of health care systems and community resources

Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program

Standard 15: The program must be conveniently and regularly available.

Standard 16: The program must be responsive to requests for information and referrals from consumers, health

II. Process Standards

A. Assessment

Standard 17: Develop and update an individualized assessment for each participant, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes,

behavior and goals; support systems; barrier to learning; and socioeconomic factors.

B. Plan and Implementation

Standard 18: Develop an individualized education plan, based on the individualized assessment, in collaboration with each participant.

Standard 19: Document the assessment, intervention, evaluation, and follow-up for each participant, and collaboration and coordination among program staff and other providers, in a permanent record.

C. Follow-up

Standard 20: Offer appropriate and timely educational intervention based on periodic reassessments of health status, knowledge, skills, attitude, goals, and self-care behaviors.

III. OUTCOME STANDARDS

A. Program

Standard 21: The advisory committee should review program performance annually, and use the results in subsequent planning and program modification.

B. Participant

Standard 22: The advisory committee should annually review and evaluate predetermined outcomes for program participants.

- Medicare will cover initial training that meets the following conditions:
 - Is furnished to a beneficiary who has not previously received initial training under the G0108 or G0109 code.
 - Is furnished within a continuous 12-month period.
 - Does not exceed a total of 10 hours. The 10 hours training can be done in any combination of one-half hour increments. They can be spread over a 12-month period or less.
 - With the exception of one (1) hour, training is furnished in a group setting who need not be all Medicare beneficiaries.
 - Is furnished in increments of no less than one-half hour.
 - May include one (1) hour of individual training. One half of this hour could be used to assess the beneficiary and the remaining one-half hour could be used for insulin training.

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

- No group session is available within two (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, that will hinder effective participation in a group training session.
- The physician orders additional insulin training.

- After receiving the initial training, Medicare covers follow-up training that meets the following conditions:
 - Consists of no more than two (2) hours of individual or group training each year.
 - Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries.

Note: If individual training has been provided to a Medicare beneficiary and subsequently it is determined through review, that training should have been provided in a group, the service will be downcoded to HCPCS G0109 for a group session.

- Is furnished any time in a calendar year following a year in which the initial training is completed.
 - Is furnished in increments of no less than one-half hour at a time.
 - The physician or qualified non-physician practitioner treating the beneficiary must document in the referral for training and the beneficiary's medical record, the specific medical condition that the follow-up training must address.

- Medicare Part B covers one course of initial training for a beneficiary who has one or more of the following medical conditions present within the 12-month period before the physician's order for the training:
 - New onset diabetes.
 - Inadequate glycemic control as evidenced by a glycosylated hemoglobin (HbA1C) level of 8.5 percent or more on two (2) consecutive HbA1C determinations three

(3) or more months apart in the year before the beneficiary begins receiving training.

- A change in the treatment regime from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.
- High risk for complications based on inadequate glycemic control (documented acute episodes of severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization).
- High risk based on at least one of the following documented complications:
 - Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation.
 - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye.
 - Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

Note: Beneficiaries with diabetes, becoming newly eligible for Medicare, can receive diabetes outpatient self-management training in this program.

- For a beneficiary with a diagnosis of diabetes, Diabetes Self-management Training (DSMT) and Medical Nutrition Therapy (MNT) services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. They may not be provided on the same day to the same beneficiary.

CPT/HCPCS Section & Benefit Category

Level II HCPCS codes

Type of Bill Code

13X, 72X, 74X, 75X, 83X

Revenue Codes

942

CPT/HCPCS Codes

G0108	Diabetes outpatient self-management training services, <i>individual</i> session, per 30 minutes of training
G0109	Diabetes outpatient self-management training services, <i>group</i> session (2 or more), per individual, per 30 minutes of training

Not Otherwise Classified (NOC)

N/A

ICD-9 Codes that Support Medical Necessity

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

Covered for:

250.00- 250.93	Diabetes mellitus, with or without complications or manifestations (NOTE: Please specify the applicable 5-digit ICD-9-CM code)
790.21	Impaired fasting glucose
790.22	Impaired glucose tolerance test (oral)
790.29	Other abnormal glucose

Diagnoses that Support Medical Necessity

As listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Diagnoses that DO NOT Support Medical Necessity

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Reasons for Denial

- Services will not be reimbursed when rendered in the following facilities:
 - An inpatient in a hospital,
 - An inpatient in a skilled nursing facility (SNF),
 - In hospice care,
 - A resident in a nursing home, and;
 - An outpatient in a rural health clinic (RHC) or federally qualified health center (FQHC).
- A beneficiary may not receive Diabetes Self-management Training and Medical Nutrition Therapy on the same day.

- All other indications not listed in the "Indications and Limitations of Coverage" section of this policy,
- The service is for screening purposes.
- The service is not medically necessary.
- The medical record does not verify that the service described by the HCPCS code was provided.
- The service does not follow the guidelines of this policy.

Non-covered ICD-9 Codes

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Non-covered Diagnoses

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Coding Guidelines

- Bill for diabetes outpatient self-management training services on the HCFA-1450 form, or its electronic equivalent.
- For billing after January 1, 2002 put the correct number in the units column, for example, 30 minutes is 1 unit, 1 hour is 2 units, 2 hours is 4 units.
- Bill in 30 minute increments.
- To report this service, use the appropriate HCPCS code.
- All of the coverage criteria must be met before this service can be reimbursed by Medicare.
- Diagnosis (es) must be present on any claim submitted, and be coded to the highest level of specificity.
- The diagnosis codes(s) must be representative of the patient's condition.

Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and available to Medicare upon request.
- The training must be ordered by the physician or qualified non-physician treating the diabetes. The referring practitioner must maintain the plan of care in the medical record.
- Documentation substantiating the need for the training on an individual basis, when group training is typically covered should also be maintained in the medical record. The order for individual service must contain a statement signed by the physician, that the service is needed.
- Services must be done under a comprehensive plan of care related to the diabetic condition, to ensure compliance with the therapy, or to provide the individual with necessary skills and knowledge in the management of the person's condition.
- The referring physician or qualified non-physician practitioner must maintain the plan of care in the medical record.
- The provider of the service must maintain documentation in the 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 change must be signed by the physician or qualified non-physician practitioner treating the individual and maintained in the file by the provider of the training.

Utilization Guidelines

- Initial training encompasses up to 10 hours of training within a continuous 12-month period. Nine of these hours must be provided in a group setting unless a special condition exists as identified in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy.
- Two hours of follow-up training is covered each year starting with the calendar year following the year in which the beneficiary completes the initial training.

Other Comments

- Payment may only be made to any provider that bills Medicare for other individual Medicare services.
- Payment may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.
- The beneficiary has not previously received initial training for which Medicare payment was made under this benefit.

Financial Responsibility:

Provider Liable

The provider of the service or the ordering physician must have notified the patient in writing, prior to the service, and obtained a signature verifying Advance Beneficiary Notice. Without prior notice, services denied as not medically necessary cannot be billed to the beneficiary. The provider is liable.

Beneficiary Liable

If there is clear evidence that the beneficiary was issued and signed an Advanced Beneficiary Notice (ABN) prior to the service, the liability rests with the beneficiary. Claims for dates of service prior to January 1, 2003 should contain the condition code 20 and occurrence code 32, with date to signify that an ABN was issued to the beneficiary. Absence of these codes will result in a provider liable determination

Claims for dates of service beginning January 1, 2003 should contain the occurrence code 32 with date to signify that an ABN was issued to the beneficiary. Absence of this code will result in a provider liable determination.

Reference: PM AB-02-168, CR 2415

Sources of Information and Basis for Decision

- Transmittals AB 02-059, CR 2142; AB 01-153, CR 1905; AB 01-109, C R

1789; B 01-48, CR 1776, Transmittal 1836, CR 1455; and AB 00-66, CR 199.

- Medicare Intermediary Manual, Part 3, (CMS Pub. 13-3) §3619.
- Program Memorandum AB 03-091, Change Request 2763.

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the appropriate specialty (ies).

Advisory Committee Meeting Date:

Start Date of Comment Period

06/24/2002

End Date of Comment Period

08/08/2002

Start Date of Notice Period

10/14/2002

Revision History

Number	Date	Change
	05/31/2004	Policy archived, so as not to override the NCD status (ie decisions are binding).
02-02-R1	10/01/2003	ICD-9 codes updated with new codes 790.21, 790.22, and 790.29. (PM AB 03-091, CR 2763)

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE FROM OUR WEBSITE AT www.marylandmedicare.com

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