Table of Content

Frequently Used Abbreviations /Definitions ................................................................. 1
Purpose of Toolkit ........................................................................................................... 2
Background ..................................................................................................................... 2
Prevalence of Diabetes .................................................................................................... 3
   The Impact of Diabetes .................................................................................................. 3
   Addressing the Epidemic ............................................................................................... 3
   Diabetes Self-Management Education ......................................................................... 4
Medicare DSMT Benefit Overview .................................................................................. 5
   Who Is Eligible for the DSMT Benefit? ........................................................................ 5
   Diagnostic Criteria ....................................................................................................... 6
   Medical Nutrition Therapy (MNT) ................................................................................ 7
A Comparison of DSMT and MNT ................................................................................ 7
Provider Reimbursement .................................................................................................. 8
Components of a Qualified DSMT Program .................................................................... 12
Medicare Referral Form .................................................................................................. 12
   Medicare Billing Detail ................................................................................................. 13
Sample Patient Utilization of DSMT .............................................................................. 13
   Table 1: Beneficiary exhausts 10 Hours of DSMT within 12 consecutive months of referral. ...... 13
   Table 2: Beneficiary exhausts 10 Hours of DSMT in the initial calendar year. ....................... 13
HCPCS Coding .................................................................................................................. 14
DSMT and MNT Revenue Projections ............................................................................. 16
Reimbursement Example #1 (using lowest average national reimbursement rate) ............. 17
Reimbursement Example #2 (using highest average national reimbursement rate) ............. 17
Federally Qualified Health Centers (FQHC) ................................................................... 17
   Appendix A .................................................................................................................... 20
   Appendix B .................................................................................................................... 22
Frequently Used Abbreviations

AADE..................American Association of Diabetes Educators
ADA..................American Diabetes Association
AIRR..................All-Inclusive Reimbursement Rate
CDC..................Centers for Disease Control and Prevention
CDE..................Certified Diabetes Educator
CMS..................Centers for Medicare and Medicaid Services
DSME..................Diabetes Self-Management Education
DSMT..................Diabetes Self-Management Training
FQHC..................Federally Qualified Health Centers
HCPCS..................Healthcare Common Procedure Coding System
MAC..................Medicare Administrative Contractor
MNT..................Medical Nutrition Therapy
NPI..................National Provider Identifier
QNPP..................Qualified Non-Physician Practitioner
RD..................Registered Dietitian

Definitions

Qualified Non-Physician Provider – defined by CMS as a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, clinical psychologist or clinical social worker who is managing a beneficiary’s diabetes condition.

Facility – examples provided by CMS include hospital, skilled nursing facility or ambulatory surgical center.

Non-Facility – examples provided by CMS include physician office, urgent care center or independent clinic.
PURPOSE OF TOOLKIT

The purpose of this toolkit is to provide QIOs, healthcare professionals and other key stakeholders with vital information on the implementation and reimbursement for accredited DSMT programs that meet CMS guidelines for Medicare reimbursement.

BACKGROUND

Prevalence of Diabetes

Diabetes is a serious public health concern in the United States. It was the seventh leading cause of death in the United States in 2011 (1). For people diagnosed with diabetes, their risk of death is two times that of a person of similar age who does not have the disease (2). According to the American Diabetes Association® (ADA), nearly 26 million adults and children have the disease. An additional 79 million people have pre-diabetes, many of whom do not know it, placing them at increased risk for developing Type 2 diabetes (3). The Centers for Disease Control and Prevention (CDC) reports that from 1980 through 2011, the number of Americans diagnosed with diabetes has more than tripled from 5.6 million to 20.9 million (4). Diabetes is seven times more prevalent in people aged 65 years and older compared to those in the 20-44 age group.

Additionally, people of certain races and ethnicities experience higher rates of the disease, especially Hispanic Americans, non-Hispanic Blacks, Asian Americans, Native Americans and Alaskan Natives. According to the U.S. Office of Minority Health, African Americans are two times more likely to have a diagnosis of diabetes compared to non-Hispanic Whites. As of 2010, 13.2% of the Hispanic population has diabetes. Diabetes is the fifth leading cause of death among the Asian American and Pacific Islander population (5). People within these minorities group are more likely to be diagnosed with diabetes at a younger age compared to non-Hispanic whites, resulting in the incidence of diabetes-related complications earlier in life (2).

Figure 1: Annual Number of U.S. Adults Aged 18-79 Years with Diagnosed Diabetes, 1980-2010
The Impact of Diabetes

Diabetes is a complex disease that, if not managed effectively, can result in several comorbidities:

- Cardiovascular disease is the leading cause of death among people with diabetes. In fact, people with diabetes are up to four times more likely to die from cardiovascular disease or have a stroke than people without the disease (6).
- Sixty-seven percent of adults with diabetes also have hypertension (2).
- People with diabetes have average medical expenses that are twice as high as a person without diabetes. According to a study commissioned by the American Diabetes Association, the total cost of diabetes in 2012 was $245 billion, a 41% increase over the same data analyzed in 2007, the last year this information was calculated. This number represents $176 billion in direct medical costs and $69 billion on lost productivity (3).
- In a study funded by the National Institutes of Health, people with diabetes under the age of 65 have 12 times the risk of stroke compared to people without diabetes in the same age group. Those over the age of 65 with diabetes are three times more likely to have a stroke compared with non-diabetic people in the same age group (7).
- Diabetes is the leading cause of renal failure, non-traumatic amputation and blindness in the United States. (8). Additional complications include nervous system disease, periodontal disease and increased incidence of depression.

Addressing the Epidemic

People with diabetes can live well by being thoughtful about the lifestyle choices they make and learning effective techniques for managing the disease. Controlling diabetes significantly reduces the risk of complications, slows the progression of the disease and improves health outcomes. This is accomplished through a combination of disease self-management and clinical preventive services, as well as collaboration between the person with diabetes and his or her healthcare provider.

Effectively managing diabetes can be a complex and time consuming endeavor that falls mainly upon the patient. The person with diabetes must learn about the disease, treatment options and the skills
necessary for self-care. It is estimated that 80% of patients’ diabetes care is accomplished through clinical collaboration with a primary care provider versus other healthcare providers (9). Thus, the primary care setting plays a crucial role in guiding patients with diabetes to the interventions that are most beneficial. According to the CDC, the average length of a primary care visit was 18.7 minutes in 2004 (10). Due to these system and time constraints inherent in the primary care setting, it is difficult for the primary care provider to deliver the comprehensive diabetes education that patients need to effectively manage the disease. The challenge, therefore, is to expand the delivery of diabetes knowledge beyond the primary care provider and in a way that is meaningful to the patient.

**Diabetes Self-Management Education**

Diabetes Self-Management Education (DSME) is an evidence-based intervention that facilitates the knowledge and skills of people with diabetes to optimize their ability to self-manage the disease. According to the American Association of Diabetes Educators (AADE), DSME is defined as “a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions.” (11) Certified diabetes educators utilize DSME curricula that engage participants in informed decision-making, and reinforces self-care, problem-solving behaviors and a collaborative approach with their healthcare providers to improve clinical outcomes (12).

AADE developed seven self-care behaviors known as the AADE7™ that are widely recognized as the guiding principles for participants in a DSME program:

- Healthy eating
- Being active
- Monitoring
- Taking medication
- Problem solving
- Healthy coping
- Reducing risks (13)

A systematic review with meta-analysis of 21 studies comparing group-based DSME with standard diabetes treatment, participants with Type 2 diabetes randomized to the group-based intervention showed improvement in clinical, lifestyle and psychosocial outcomes (14). In a three year retrospective claims analysis of 4 million covered lives, which included 250,000 Medicare beneficiaries, there was a reported Medicare average costs savings of $135 per month among those beneficiaries who completed a DSME program (15).

In 1997, Section 4105 of the federal Balanced Budget Act expanded Medicare coverage for outpatient diabetes education if furnished by a certified diabetes educator who meets certain quality standards recognized by the U.S. Health Care Finance Administration – now called the Centers for Medicare and Medicaid Services (CMS).
Despite coverage for this benefit, Medicare beneficiary and provider use of DSME services remains low, and CMS is working to expand access to DSME for Medicare beneficiaries. Quality Improvement Organizations (QIOs) in each state can play an integral role in expanding the availability of DSME among underserved populations.

**Medicare DSMT Benefit Overview**

The Centers for Medicare and Medicaid (CMS) provides Medicare reimbursement for Diabetes Self-Management Training (DSMT) to beneficiaries under certain conditions. *(Note: The terms DSME and DSMT are often used interchangeably. Although DSME is the preferred term, CMS requires the use of DSMT in reimbursement documentation. Therefore, “DMST” will primarily be used throughout the remainder of this guide).* This benefit provides the following:

- Up to 10 hours of diabetes-related training within a consecutive 12-month period following the submission of the first claim for the benefit which includes:
  - One hour for either a group or individual assessment;
  - Nine hours for group-only diabetes education;
- Up to 2 hours of follow-up training each year after the initial 12-month period;
- The training can be performed in any combination of 30 minute increments. See the chart of HCPCS coding on page 15.

Medicare will cover additional hours of individual training based on the following criteria:

- No group session is available within two months of the date the training is ordered.
- The beneficiary’s physician or qualified non-physician provider (defined by CMS as a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, clinical psychologist or clinical social worker who is managing a beneficiary’s diabetes condition) documents in the beneficiary’s medical record that the beneficiary has special needs resulting from conditions that will hinder effective participation in a group training session.
- It is deemed necessary for the beneficiary to receive additional insulin administration training.

**Who Is Eligible for the DSMT Benefit?**

Medicare covers outpatient DSMT for beneficiaries who meet the following criteria:

- Recently diagnosed with Type 1 and Type 2 diabetes **AND**
- Determined to be at risk for complications from diabetes by a physician or qualified non-physician provider. **OR**
- Were previously diagnosed with diabetes before meeting Medicare eligibility requirements and are now eligible for coverage.
Diagnostic Criteria

According to Medicare guidelines, diabetes is defined as a condition of abnormal blood glucose metabolism using the following diagnostic criteria:

- Fasting glucose > 126 mg/dL on two separate occasions OR
- Two-hour post glucose challenge > 200 mg/dL on two separate occasions OR
- A random glucose test > 200 mg/dL for a person with symptoms of uncontrolled diabetes (16).

Medicare covers diabetes screening tests for those at risk for diabetes or those with a pre-diabetes diagnosis. The diagnostic tests covered by Medicare include:

- A fasting blood glucose test
- A post-glucose challenge test
  - An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults OR
  - A 2-hour post-glucose challenge test alone.

The HCPCS codes for these tests are:

- 82947 Glucose: quantitative, blood (not reagent strip)
- 82950 Glucose: post glucose dose (includes glucose)
- 82951 Glucose: tolerance test (GTT), three specimens (includes glucose)

To be eligible for the diabetes screening tests, beneficiaries must have ONE of the following risk factors:

- Hypertension
- Dyslipidemia
- Obesity (a body mass index greater than or equal to 30kg/m2)
- Previous identification of an elevated impaired fasting glucose or glucose tolerance

OR at least two of the following characteristics:

- Overweight (a body mass index greater than 25 but less than 30 kg/m2)
- A family history of diabetes
- Age 65 or older
- A history of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds (16).

Medicare currently does not recognize the HbA1c test as a valid diagnostic criterion for eligibility for the DSMT benefit. Additionally, although DSMT has been shown to reduce the incidence of diabetes in those at risk for the disease (17), Medicare currently does not offer DSMT as a benefit to those with a primary diagnosis of pre-diabetes.
Medical Nutrition Therapy (MNT)

While DSMT covers a variety of topics utilizing a structured curriculum that reinforces self-management and engagement, MNT focuses specifically on nutritional therapy. MNT is a complementary service to DSMT for those beneficiaries diagnosed with diabetes or kidney disease. It is provided by a registered dietician or nutrition professional and is covered under Medicare Part B. Beneficiaries are eligible for 3 hours of MNT in the 12-month period following the initiation of services and 2 hours for every year thereafter. Medicare will consider additional hours of MNT if the treating physician or qualified non-physician provider determines there is a medical necessity such as change in medical condition, diagnosis or treatment plan. A referral for MNT is required and can only be written by the treating physician. Unlike DSMT, non-physician providers are not eligible to provide a referral for this service.

Because DSMT and MNT are complementary services, they can be provided to beneficiaries concurrently. However, DSMT and MNT cannot be billed on the same service date.

After the initial 3 hours of MNT during the initial 12-month period, the beneficiary is eligible for 2 hours of training in subsequent years. The training can be conducted in either an individual or group setting. The chart below provides a comparison of the training offered by DSMT and MNT.

### A Comparison of DSMT and MNT (18)

<table>
<thead>
<tr>
<th></th>
<th>DSMT</th>
<th>MNT</th>
</tr>
</thead>
</table>
| **Initial Training** | • Provided to beneficiary who has not previously received initial or follow-up training.  
                      | • Provided in a consecutive 12-month period or less.  
                      | • Initial training cannot exceed 10 hours and is conducted in any combination of a minimum of 30 minute increments.  
                      | • The treating physician or qualified non-physician provider must provide a written referral indicating a diagnosis of diabetes or kidney disease.  
                      | • Allows for one hour of individual training, with the remaining conducted in a group setting of 2 to 20 participants, not all of whom must be Medicare beneficiaries.  
                      | • The one hour of individual training can cover any DSMT topic, including insulin administration. | • A registered dietician or nutrition professional must provide the MNT services.  
                      | | • The benefit includes 3 hours of therapy in the first year with additional hours available if deemed medically necessary.  
                      | | • The therapy is conducted in increments of no less than 15 minutes.  
                      | | • Education may be provided either individually or in a group setting without restrictions.  
                      | | • The treating physician must provide a written referral and indicate a diagnosis of diabetes or kidney disease.  
                      | | • Group training consists of 2 to 20 individuals, not all of whom must be Medicare beneficiaries.  
                      |
Follow-Up Training

- The benefit allows for no more than 2 hours of individual or group training each calendar year.
- Group training consists of 2 to 20 individuals, not all of whom must be Medicare beneficiaries.
- The training is furnished any time in the calendar year following the year in which the beneficiary completes the initial training.
- The training is conducted in increments of no less than 30 minutes.

Focus

- General education best delivered in a group setting that is based on the ten National Standards for Diabetes Self-Management Education (see Appendix A, p.18)

Provider Reimbursement

Payment for outpatient DSMT is made under Medicare’s physician’s fee schedule. Medicare entities and healthcare providers eligible for separate payment of outpatient DSMT include:

- Private provider practices including individual physicians, mid-level providers and Registered Dietitians (Per CMS program memorandum B-02-062. For more information, please go to: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/b02062.pdf)
- Hospital outpatient departments
- Outpatient clinics
- Skilled nursing facilities
- Durable medical equipment (DME) suppliers
- Home health agencies
- Federally Qualified Health Centers
- Pharmacies
Entities or healthcare providers seeking reimbursement for DSMT or MNT must have an NPI number as well as be enrolled as a Medicare provider for services other than DSMT. Also, a notice of DMST accreditation must be submitted to the local Medicare Administrative Contractor (MAC).

- For NPI application forms, please visit: https://nppes.cms.hhs.gov or for a paper application, call 800-465-3203.
- If the entity or provider is new to Medicare, Form 855I must be submitted to enroll as a Medicare provider. The forms can be obtained from the local Medicare Administrative Contractor (MAC).
- A notice of DMST accreditation must be submitted to the local Medicare Administrative Contractor (MAC). See next section.
- Confirm that the HCPCS codes for billing DSMT and MNT are loaded in the billing system.
- If the entity or provider is interested in obtaining reimbursement from commercial payers, there should be verification that DSMT and MNT are included in the contract. Please note that commercial payers require accreditation as well. (20)

A healthcare provider or entity interested in obtaining Medicare reimbursement for DSMT must become an accredited program provider. There are two accrediting organizations recognized by CMS: the American Diabetes Association’s Education Recognition Program (ERP) and the American Association of Diabetes Educators’ Diabetes Education Accreditation Program (DEAP). Both programs meet the ten guiding principles of the National Standards for Diabetes Self-Management Education (NSDSME). These standards were established to ensure quality diabetes self-management education that is evidence-based. The standards are reviewed every five years to ensure they incorporate the latest research related to diabetes (21). A brief discussion of the ten standards is listed in Appendix A.

The process for obtaining accreditation from ADA or AADE is similar, but there are a few noticeable differences. The following chart provides a detailed comparison of each organization’s requirements.

<table>
<thead>
<tr>
<th>American Association of Diabetes Educators Accreditation and American Diabetes Association Recognition Requirements</th>
<th>AADE</th>
<th>ADA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Diabetes Education Accreditation Program (DEAP)</td>
<td>Education Recognition Program (ERP) 8th Edition</td>
</tr>
<tr>
<td><strong>Guiding Standards</strong></td>
<td>Both are based on the National Standards for Diabetes Self-Management Education 2012</td>
<td></td>
</tr>
</tbody>
</table>
| **Cost** | • 1 – 10 sites: $800  
  • 11-20 sites: $1,200  
  • >20 sites: Contact AADE  
  • Same fee structure for reaccreditation | • First site: $1,100  
  • Additional sites: $100 each  
  • Same fee structure for renewal |
### American Association of Diabetes Educators Accreditation and American Diabetes Association Recognition Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>AADE</th>
<th>ADA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Application</strong></td>
<td>• On-line application with start/stop option; paper application also available&lt;br&gt;• Supporting documentation must be submitted within 2 weeks&lt;br&gt;• Complete a telephone interview or on-site audit with AADE DEAP staff or auditors after fee, application &amp; supporting documentation has been submitted</td>
<td>• On-line application for all application types&lt;br&gt;• Supporting documentation must be submitted within 2 weeks</td>
</tr>
<tr>
<td><strong>Initial Application Process</strong></td>
<td>Three steps:&lt;br&gt;• Complete on-line or paper-based application&lt;br&gt;• Gather supporting documentation &amp; submit within 2 weeks&lt;br&gt;• Complete telephone interview or randomly selected site audit</td>
<td>Three steps:&lt;br&gt;• Contact ADA to be added into application system&lt;br&gt;• Complete on-line application&lt;br&gt;• Gather supporting documentation &amp; audit items and submit within 2 weeks of application submission</td>
</tr>
<tr>
<td><strong>Renewal Application</strong></td>
<td>• Complete same three steps as initial application&lt;br&gt;• Submit reaccreditation application&lt;br&gt;• Submit supporting documentation&lt;br&gt;  ○ One de-identified patient chart&lt;br&gt;  ○ Copy of most recent Advisory Group meeting minutes&lt;br&gt;• Complete on-site audit if one of the 10% of sites randomly selected</td>
<td>• Complete same two steps as initial application&lt;br&gt;• Submit supporting documentation:&lt;br&gt;  ○ Licenses &amp; certifications of instructors&lt;br&gt;  ○ Proof of CE credits for non-certified staff&lt;br&gt;  ○ Complete audit of one of the five items sent with initial application if randomly selected</td>
</tr>
<tr>
<td><strong>Timeline for Accreditation Process Completion</strong></td>
<td>• At least one patient has completed program through follow-up &amp; documentation for that patient is submitted&lt;br&gt;• No outcomes data required&lt;br&gt;• Documentation of education process&lt;br&gt;• Application process: 2-8 weeks&lt;br&gt;• Eligible to submit Medicare claims starting on date of approval&lt;br&gt;• Must complete status updates and annual reports&lt;br&gt;• Accreditation valid for 4 years</td>
<td>• Reporting period up to 6 months prior to application submission&lt;br&gt;• Application must be submitted no more than 3 months after reporting period ends&lt;br&gt;• At least one patient seen during reporting period&lt;br&gt;• Applications review first-come first-serve and can take up to 30 days&lt;br&gt;• At least two outcomes must be tracked for program effectiveness&lt;br&gt;  ○ Patient-defined goals &amp; measure of goal attainment</td>
</tr>
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# American Association of Diabetes Educators Accreditation and American Diabetes Association Recognition Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>AADE</th>
<th>ADA</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>o Other outcome such as metabolic, clinical, quality of life, process with measure of attainment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Annual status report required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognition valid for 4 years</td>
</tr>
</tbody>
</table>

## Support Services

- Email, toll-free telephone support
- AADE7 on-line patient education system
- DEAP e-community
- Free webcasts & podcasts
- On-line tools and sample documents
- Conferences
- Accreditation programs information listed on website
- Career network
- Journals & newsletters

- Email, toll-free telephone number
- On-line tools, sample templates & documents
- ADA publications
- Publication discounts
- KRAMES on-line patient education system
- Scientific sessions, conferences
- Free webcasts & podcasts
- Recognition programs listed on website

## Audits

- 5% of initial applications annually
- 10% of sites currently accredited
- 10% of sites seeking re-accreditation
- Volunteer auditors
- 2 weeks’ notice

- 5% annually of currently recognized sites
- Volunteer auditors
- 2 weeks’ notice

For further information about each of these organizations, please contact AADE or ADA directly at:

**Association of Diabetes Educators (AADE)**
http://www.diabeteseducator.org
(800) 338-3633

**American Diabetes Association (ADA)**
http://www.diabetes.org
1-800-DIABETES

Once a provider or entity achieves accreditation or recognition, the accreditation/recognition certificate from ADA or AADE must be submitted to the local Medicare Contractor’s provider enrollment department before claims will be considered for reimbursement. The accreditation/recognition certificate should be submitted along with the Medicare provider status and National Provider Identification Number (NPI). Once this information is received, the provider or entity will be officially recognized by Medicare to conduct a DSMT program.
Components of a Qualified DSMT Program

Qualified DSMT programs must include training that covers the following components:

- Diabetes and treatment options
- Diabetes overview/pathophysiology of diabetes
- Nutrition
- Exercise and activity
- Managing high and low blood sugar
- Diabetes medications, including skills related to the self-administration of injectable drugs
- Self-monitoring and the use of results
- Prevention, detection, and treatment of chronic complications
- Prevention, detection, and treatment of acute complications
- Foot, skin, and dental care
- Behavioral change strategies, goal setting, risk-factor reduction, and problem solving
- Preconception care, pregnancy, and gestational diabetes
- Relationships among nutrition, exercise, medication, and blood glucose levels
- Stress and psychological adjustment
- Family involvement and social support
- Benefits, risks, and management options for improving glucose control
- Use of health care systems and community resources (22).

Medicare Referral Form

Medicare stipulates that certain information be part of the beneficiary referral for DSMT and kept in the beneficiary’s medical record. The referral must be generated by the treating physician or qualified non-physician provider. The referral must include the following information:

- Statement of the need for DSMT services
- Plan of care
- The length of time that DSMT services are required
- The expected health outcomes
- Any identified barriers that would require individualized beneficiary education
- Signature of the treating physician or qualified non-physician provider

A sample referral form is available from the American Association of Diabetes Educators at http://www.diabeteseducator.org/ProfessionalResources/Library/ServicesForm.html. A PDF copy of the sample form is also available in Appendix B, p.22. While this referral form is not required by Medicare, it contains all the information required to meet Medicare requirements for DSMT or MNT referrals and can be utilized by any entity or healthcare provider to streamline the referral process.
Medicare Billing Detail

Initial education must be provided in a continuous 12-month period starting with the first date the DSMT benefit is provided and is reflected on the claim. It is available to beneficiaries who have not previously received any services billed under HCPCS codes G0108 or G0109. In the initial year, the total number of hours billed cannot exceed 10 hours and must be delivered in no less than 30 minute increments. The beneficiary is eligible for one hour of individual training and nine hours in a group setting. The only exception would be if the beneficiary’s provider can justify otherwise. All DMST must be documented in the beneficiary’s medical record, as well as the diagnosis of diabetes.

After the initial 12-month period, a maximum of 2 hours of follow-up education are available as either individual or group education.

Beneficiaries are eligible for 3 hours of MNT education in the initial year - in either an individual or group session - and are billable in no less than 15-minute increments. In all subsequent years, beneficiaries are eligible for 2 hours of MNT education. Additional hours may be covered if medically necessary.

Sample Patient Utilization of DSMT

Table 1: Beneficiary exhausts 10 Hours of DSMT within 12 consecutive months of referral. (23)

<table>
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</thead>
<tbody>
<tr>
<td>Beneficiary obtains referral for DSMT from physician or qualified non-physician provider.</td>
<td>Beneficiary receives 1 hour of individual DSMT service.</td>
<td>Beneficiary completes 9 hours of DSMT in a group setting.</td>
<td>Beneficiary is eligible for 2 hours of follow-up DSMT in either individual or group sessions.</td>
<td>Beneficiary completes 2 hours of follow-up DSMT.</td>
<td>Beneficiary is eligible for an additional 2 hours of follow-up DSMT</td>
</tr>
</tbody>
</table>

Table 2: Beneficiary exhausts 10 Hours of DSMT in the initial calendar year. (23)

<table>
<thead>
<tr>
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<tbody>
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<td>Beneficiary obtains referral for DSMT from physician or qualified non-physician provider.</td>
<td>Beneficiary receives 1 hour of individual DSMT service.</td>
<td>Beneficiary completes 9 hours of DSMT in a group setting.</td>
<td>Beneficiary is eligible for 2 hours of follow-up DSMT in either individual or group sessions.</td>
<td>Beneficiary completes 2 hours of follow-up DSMT.</td>
<td>Beneficiary is eligible for an additional 2 hours of follow-up DSMT</td>
</tr>
</tbody>
</table>
The following chart provides the HCPCS codes for DSMT and MNT:

**HCPCS Coding**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Allowable Units</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Year of DSMT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G0108</strong></td>
<td>Individual outpatient DSMT</td>
<td>2 units = 1 hour</td>
</tr>
<tr>
<td></td>
<td>Medicare allows for 1 hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billable in 30 minute increments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 unit = 30 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>G0109</strong></td>
<td>Group outpatient DSMT</td>
<td>18 units = 9 hours</td>
</tr>
<tr>
<td></td>
<td>2 or more participants in the group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare allows for 9 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billable in 30 minute increments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 unit = 30 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>Initial Year of MNT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>97802 or 97803</strong></td>
<td>Individual MNT</td>
<td>12 units = 3 hours</td>
</tr>
<tr>
<td></td>
<td>Medicare allows for 3 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billable in 15 minute increments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 unit = 15 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97802 is for initial visit and 97803 is for follow-up visits</td>
<td></td>
</tr>
<tr>
<td><strong>97804</strong></td>
<td>Group MNT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 unit = 30 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>DSMT - Each Year After Initial Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G0108 and/or G0109</strong></td>
<td>Individual and/or group outpatient DSMT</td>
<td>4 units = 2 hours</td>
</tr>
<tr>
<td></td>
<td>Medicare allows for any combination of 2 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Billable in 30 minute increments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 unit = 30 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>MNT - Each Year After Initial Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>97803 or 97804</strong></td>
<td>Individual and/or group MNT</td>
<td>8 units = 2 hours or 4 units = 2 hours</td>
</tr>
<tr>
<td></td>
<td>Medicare allows for any combination of 2 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97803 billable in 15 minute increments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97804 billable in 30 minute increments</td>
<td></td>
</tr>
<tr>
<td><strong>MNT – Medically Necessary Additional Hours</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G0270</strong></td>
<td>Individual MNT beyond initial 3 hours or MNT beyond 2 hours in subsequent years</td>
<td>Depends on referral</td>
</tr>
<tr>
<td></td>
<td>Billable in 15 minute increments</td>
<td></td>
</tr>
<tr>
<td><strong>G0271</strong></td>
<td>Group MNT beyond initial 3 hours or MNT beyond 2 hours in subsequent years</td>
<td>Depends on referral</td>
</tr>
<tr>
<td></td>
<td>Billable in 30 minute increments</td>
<td></td>
</tr>
</tbody>
</table>
Reimbursement

To bill the Medicare Part B program for DSMT, a number of key elements must be in place. The beneficiary must have:

- A diabetes diagnosis
- A written referral for DSMT, provided by a physician provider or qualified non-physician provider;
- Part B benefits under “original Medicare” (for the definition of original Medicare, please refer to: http://www.medicare.gov/glossary/o.html)
- Met their annual deductible, have Medicaid or other health insurance coverage (i.e. Medigap policy) that pays the deductible.

The DSMT program must have:

- Accreditation from either AADE or ADA, both of which are the only recognized accrediting organizations by CMS;
- A partnership with a Medicare provider that is able to bill the Medicare program, or be a Medicare provider who is able to bill;
- Recognition by CMS of the accredited Medicare Provider location where the DSMT will be provided;
- A program for maintaining documentation of the beneficiary’s diabetes diagnosis in his or her medical record;
- The ability to verify a beneficiary’s Part B coverage for DSMT;
- The ability to verify the beneficiary has already met the annual deductible;
- The ability to determine whether the beneficiary has Medicare supplemental coverage through Medicaid or a private insurance policy;
- The ability to collect the 20% coinsurance from the beneficiary or supplemental coverage, as applicable.

Under the Medicare Fee for Service (FFS) payment system, the cost of DSMT is reimbursed at 80%, with beneficiaries responsible for a coinsurance payment of 20% of the Medicare approved rate for the benefit.
DSMT and MNT Revenue Projections

The Medicare reimbursement rates vary by region. The reimbursement amounts listed in the following chart are national averages. Please refer to the CMS Provider Fee Schedule for current reimbursement rates specific to your region. Medicare reimbursement rates are updated annually and vary by region. This information is published in the annual CMS Physician Fee Schedule, which can be found using this link: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

### Initial and Follow-Up Year of DSMT (Fee Schedule for 2013)

<table>
<thead>
<tr>
<th>Code</th>
<th>Base Reimbursement</th>
<th>Unit Price</th>
<th>Allowable Units Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>$48.46 - $68.11</td>
<td>Individual training in 30 minute increments</td>
<td>2 Units (1 hour)</td>
</tr>
<tr>
<td>G0109</td>
<td>$12.05 - $18.43</td>
<td>Group training in 30 minute increments</td>
<td>18 units (9 hours)</td>
</tr>
</tbody>
</table>

### Initial and Follow-Up Year of MNT (Fee Schedule for 2013)

<table>
<thead>
<tr>
<th>Code</th>
<th>Base Reimbursement</th>
<th>Unit Price</th>
<th>Allowable Units Per Year</th>
</tr>
</thead>
</table>
| 97802 | Non-facility: $29.36 - $45.15  
Facility: $27.51 - $42.24 | Individual initial MNT in 15 minute increments | 4 Units (1 hour) |
| 97803 | Non-facility: $25.25 - $38.89  
Facility: $23.41 - $35.98 | Individual follow-up MNT in 15 minute increments | 8 units (2 hours) |
| 97804 | Non-facility: $14.56 - $20.24  
Facility: $14.28 - $19.88 | Group follow-up MNT in 30 minute increments | 4 units (2 hours) |

A note about facility versus non-facility reimbursement:

To account for the increased practice expense that physicians generally incur by performing services in their offices and other non-facility locations, Medicare reimburses physicians at a higher rate for services performed in these locations rather than a facility such as a hospital. The correct place-of-service code must be used. For more information, please refer to the MLN Matters update at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7631.pdf.
### Reimbursement Example #1 (using lowest average national reimbursement rate): (24)

- **G0108 – 1:1**: $48.46 per patient $\times$ ½ hour (1 unit)
  
  $48.46 \times 2 \text{ units} \times 10 \text{ patients} = $969.20

- **G0109 – Group**: $12.05 per patient $\times$ ½ hour (1 unit)
  
  $12.05 \times 18 \text{ units} \times 10 \text{ patients} = $2,169.00

**TOTAL**: $969.20 + $2,169.00 = $3,138.20

### Reimbursement Example #2 (using highest average national reimbursement rate): (24)

- **G0108 – 1:1**: $68.11 per patient $\times$ ½ hour (1 unit)
  
  $68.11 \times 2 \text{ units} \times 10 \text{ patients} = $1,362.20

- **G0109 – Group**: $18.43 per patient $\times$ ½ hour (1 unit)
  
  $18.43 \times 18 \text{ units} \times 10 \text{ patients} = $3,317.40

**TOTAL**: $1,362.20 + $3,317.40 = $4,679.60

### Federally Qualified Health Centers (FQHC)

According to Health Resources and Services Administration (HRSA) “Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement.” (25)
FQHCs and DSMT

- Federally Qualified Health Centers are eligible for Medicare reimbursement for DSMT under the following guidelines: Section 5114 of the Deficit Reduction Act amended Section 1861(aa)(3) of the Social Security Act to add DSMT and MNT services to the list of Medicare Part B services covered and reimbursed services under the FQHC benefit.

- DSMT and MNT are considered core FQHC services and are reimbursable as a separate visit under the FQHC all-inclusive reimbursement rate (AIRR) when delivered by qualified practitioners and when the services meet all relevant program requirements. This means that these services are included under the FQHC benefit as billable visits.

- DSMT and MNT services can only be provided as one-on-one, face-to-face encounters. These services can be provided in a group setting, but they will not meet the criteria for a separate qualifying encounter:
  - If HCPCS code G0109 is submitted for group DSMT, the claim will be denied;
  - If HCPCS codes 97804 or G0271 are submitted for group MNT, the claim will be denied;
  - The cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate (26).

- To receive separate payment for DSMT services, the DSMT services must be billed with HCPCS code G0108.

- To receive payment for MNT services, the MNT services must be billed with the appropriate individual MNT HCPCS codes of 97802, 97803, or G0270.

- MNT is not a qualifying visit on the same day that DSMT is provided and vice versa.

- Payment for DSMT or MNT that meets all of the program requirements may be made in addition to one other beneficiary visit during the same day if the HCPCS code G0402 is present.

- Coinsurance is applicable for DSMT.

- Current regulations only allow reimbursement for individual, face to face DSMT and MNT. A FQHC cannot be reimbursed for group DSMT or MNT. The reimbursement is limited to individual services because CMS expects the cost of group services to be included in the standard all-inclusive rate provided for the individual, face-to-face-service for FQHCs. This is a significant difference in billing procedures versus a standard Medicare provider.

The Disparities National Coordinating Center
Delmarva Foundation for Medical Care
6940 Columbia Gateway Drive
Suite 420
Columbia, MD 21046
www.cmspulse.org
Appendix A

Ten National Standards for Diabetes Self-Management Education

The two CMS-approved accrediting organizations for DSMT base their accreditation process on the national standards for diabetes education. The national standards were developed after the convening of a joint task force of the American Diabetes Association, American Association of Diabetes Educators, and other stakeholders in 2012. This task force developed a series of established standards that must be included in any structured DSMT program.

The ten DSME National Standards include the following:

Standard 1 - Internal Structure
The provider(s) of DSME will document an organizational structure, mission statement, and goals. For those providers working within a larger organization, that organization will recognize and support quality DSME as an integral component of diabetes care.

Standard 2 - External Input
The provider(s) of DSME will seek ongoing input from external stakeholders and experts to promote program quality.

Standard 3 - Access
The provider(s) of DSME will determine whom to serve, how best to deliver diabetes education to that population, and what resources can provide ongoing support for that population.

Standard 4 - Program Coordination
A coordinator will be designated to oversee the DSME program. The coordinator will have oversight responsibility for the planning, implementation, and evaluation of education services.

Standard 5 - Instructional Staff
One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be an RN, RD, or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes and with supervision and support.

Standard 6 - Curriculum
A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSME. The needs of the individual participant will determine which parts of the curriculum will be provided to that individual.
Standard 7 - Individualization
The diabetes self-management, education, and support needs of each participant will be assessed by one or more instructors. The participant and instructor(s) will then together develop an individualized education and support plan focused on behavior change.

Standard 8 - Ongoing Support
The participant and instructor(s) will together develop a personalized follow-up plan for ongoing self-management support. The participant’s outcomes and goals and the plan for ongoing self-management support will be communicated to other members of the healthcare team.

Standard 9 - Patient Progress
The provider(s) of DSME and DSMS will monitor whether participants are achieving their personal diabetes self-management goals and other outcome(s) as a way to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

Standard 10 - Quality Improvement
The provider(s) of DSME will measure the effectiveness of the education and support and look for ways to improve any identified gaps in services or service quality, using a systematic review of process and outcome data.

More detailed information on the NSDSME Standards can be found at:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3632167/
Appendix B

American Association of Diabetes Educators: Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

(Download from http://www.diabeteseducator.org/ProfessionalResources/Library/ServicesForm.html)

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Last Name</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone</td>
</tr>
</tbody>
</table>

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested:
- Initial group DSME/T: 10 hours or ___ no. hrs. requested
- Follow-up DSME/T: 2 hours or ___ no. hrs. requested
- Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:
- Vision
- Hearing
- Physical
- Cognitive Impairment
- Language Limitations
- Additional training
- Additional hrs requested
- Other

DSME/T Content

- Monitoring diabetes
- Diabetes as disease process
- Psychological adjustment
- Physical activity
- Nutritional management
- Goal setting, problem solving
- Medications
- Prevent, detect and treat acute complications
- Preconception/pregnancy management or GDM
- Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

Diagnosis

Please send recent data for patient eligibility & outcomes monitoring:
- Type 1
- Type 2
- Gestational

Complications/Comorbidities

Check all that apply:
- Hypertension
- Osteoporosis
- Stroke
- Neuropathy
- PVD
- Kidney disease
- Renal disease
- CHF
- Non-healing wound
- Pregnancy
- Obesity
- Mental/behavioral disorder
- Other

Signature and NPI #:

Group/practice name, address and phone: ____________________________


Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested:
- Initial MNT
- 3 hours or ___ no. hrs. requested
- Annual follow-up MNT
- 2 hours or ___ no. hrs. requested
- Telehealth
- Additional MNT services in the same calendar year, per RD

Please specify change in medical condition, treatment and/or diagnosis:

Additional hrs. requested

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Definition of Diabetes (Medicare)

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:
- 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.


Other payors may have other coverage requirements.
References


