Diabetes Outpatient Self-Management Training (NCD 40.1)

Guideline Number: MPG074.04

Approval Date: February 13, 2019

Table of Contents

<table>
<thead>
<tr>
<th>POLICY SUMMARY</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLICABLE CODES</td>
<td>1</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>3</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>3</td>
</tr>
<tr>
<td>GUIDELINE HISTORY/REVISION INFORMATION</td>
<td>4</td>
</tr>
<tr>
<td>TERMS AND CONDITIONS</td>
<td>4</td>
</tr>
</tbody>
</table>

Related Medicare Advantage Policy Guideline(s)

- Closed-Loop Blood Glucose Control Device (CBGD) (NCD 40.3)
- Home Blood Glucos Monitors (NCD 40.2)
- Insulin Syringe (NCD 40.4)
- Outpatient Intravenous Insulin Treatment (OIVIT) (NCD 40.7)

Related Medicare Advantage Coverage Summary(ies)

- Diabetes Management, Equipment and Supplies
- Telemedicine/Telehealth Services

POLICY SUMMARY

Overview

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.

All DSMT programs must be accredited as meeting quality standards by a CMS approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association, American Association of Diabetes Educators and the Indian Health Service as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered.
Beneficiaries Eligible for Coverage and Definition of Diabetes
Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes.

Diabetes is 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.

Documentation that the beneficiary is diabetic is maintained in the beneficiary’s medical record.

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they have been certified as requiring initial training or they may receive follow-up training when ordered even if Medicare does not have documentation that initial training has been received. In that instance, contractors shall not deny the follow-up service even though there is no initial training recorded.

Certified Providers
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 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. 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, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement. Certified providers may be asked to submit updated accreditation documents at any time or to submit outcome data to an organization designated by CMS.

Frequency of 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:
- Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS codes G0108 or G0109;
- Is furnished within a continuous 12-month period;
- Does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of 1/2 hour increments);
- 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;
- One hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training
Medicare covers follow-up training under the following conditions:
- No more than 2 hours individual or group training per beneficiary per year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;
- Follow-up training is furnished in increments of no less than one-half hour; and
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Coverage Requirements for Individual Training
Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions:
- No group session is available within 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 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
- The physician orders additional insulin training.
- The need for individual training must be identified by the physician or non-physician practitioner in the referral.
Telehealth

Individual and group DSMT services may be paid as a Medicare telehealth service. Before 03-11-2016, this manual provision required that 1 hour of the 10 hour DSMT benefit’s initial training must be furnished in-person to allow for effective injection training. Because injection training is not always clinically indicated, we are revising this provision to permit all 10 hours of the initial training and the two (2) hours of annual follow-up training to be furnished via telehealth in those cases when injection training is not applicable. The in-person injection training, when provided, may be furnished through either individual or group DSMT services. By reporting place of service (POS) 02 or the –GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year following the initial DSMT service or any calendar year’s 2 hours of follow-up training.

As specified in the Medicare Benefit Policy Manual, chapter 15, section 300.2, individual DSMT services may be furnished by a physician, individual, and group DMST services may be furnished by a physician, other individual, or entity that furnishes other items or services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, a national accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 190.6 of this chapter, Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a licensed PA, NP, CNS, CNM, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable.

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

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 the appropriate completed form, 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 National Provider Identification (NPI) number, the supplier can begin receiving reimbursement for this service.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes</td>
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<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes</td>
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<tr>
<th>Modifier</th>
<th>Description</th>
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<tr>
<td>GQ</td>
<td>Via asynchronous telecommunications system</td>
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<tr>
<th>Place of Service</th>
<th>Description</th>
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<tr>
<td>02</td>
<td>Telehealth: The location where health services and health related services are provided or received, through a telecommunication system</td>
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PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
• Medicare coding or billing requirements, and/or
• Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 40.1 Diabetes Outpatient Self-Management Training

CMS Benefit Policy Manual
Chapter 15; § 300 Diabetes Self-Management Training Services (DSMT)

CMS Claims Processing Manual
Chapter 9; § 70.5 - Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)
Chapter 12; § 190 Medicare Payment for Telehealth Services
Chapter 18; § 1.2 Table of Preventive and Screening Services; § 120 Diabetes Self-Management Training (DSMT) Services

CMS Transmittals
Transmittal 109, Change Request 6510, Dated 08/07/2009 (Diabetes Self-Management Training (DSMT) Certified Diabetic Educator)
Transmittal 365, Change Request 7236, Dated 01/28/2011 (Diabetes Self-Management Training (DSMT))
Transmittal 2005, Change Request 10318, Dated 01/18/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 3938, Change Request 10393, Dated 12/22/2017 (Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List)

MLN Matters
Article MM9428, Telehealth Services
Article MM9844, Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List
Article MM10152, Elimination of the GT Modifier for Telehealth Services
Article SE0905, Training Medicare Patients on Use of Home Glucose Monitors and Related Billing Information

Others
CMS Covered Telehealth Services, CMS Website
Medicare Learning Network Telehealth Services
Medicare Preventive Services, CMS Website

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<tr>
<th>Date</th>
<th>Action/Description</th>
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</thead>
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<tr>
<td>04/01/2019</td>
<td>• Reorganized policy template; relocated Terms and Conditions and Purpose section</td>
</tr>
<tr>
<td>02/13/2019</td>
<td>• Annual review</td>
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TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.
Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.