PROGRAM MEMORANDUM INTERMEDIARIES/CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. AB-00-66 **Date JULY 20, 2000**

This Program Memorandum re-issues Program Memorandum AB-99-46, Change Request 199 dated June 1999. The only change is the discard date; all other material remains the same.

This Program Memorandum re-issues Program Memorandum AB-98-36, Change Request 199 dated July 1998. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 199

SUBJECT: Coverage of Diabetes Outpatient Self-Management Training Services, Effective: July 1, 1998.

The Balanced Budget Act of 1997

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. This program memorandum will partially implement this provision effective July 1, 1998.

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.

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.

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) as subsequently revised. These standards are listed in detail in the following section.

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. These services may be provided in two ways. First, the services performed by nonphysician practitioners may be incident-to a physician's professional services, must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's direct personal supervision. Second, a nonphysician 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's 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).

The Rules for Billing and Payment to Non-Physician Practitioners Providing Diabetes Outpatient Self-Management and Training.

Employers of PAs must bill Part B of the Medicare program for professional services furnished by the PA, as well as services furnished as an incident-to the professional services of a PA. The PA's physician supervision (or a physician designated by the supervision physician or employer as provided under State law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the Balanced Budget Act Medicare payment for PA services is made only to the PA's employer regardless of whether the PA is employed as a W-2 employee or whether the PA is acting as an independent contractor. Also, while a PA has an option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in case of an emergency. However, any services furnished incident-to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any services furnished incident to the professional service of a PA must comply with all of the "incident-to" requirements mentioned above.

Clinical nurse specialist and NPs may bill the Medicare Part B program directly for services that are performed in collaboration with a physician. They may also bill the program directly for services furnished as an incident to their professional services in which case the direct supervision requirement in particular and all the incident-to requirements apply.

We are requiring that CNs, NPs and the employers of the PAs must submit claims to the Part B carrier under their own respective billing numbers for their professional services furnished in facilities or other provider settings except in the case where the services of these nonphysician practitioners are furnished to patients in rural health clinics (RHCs) and federally qualified health centers (FQHCs). Payment for these services of these nonphysician practitioners in the RHC/FQHC setting is bundled under the facility cost payment that is made by the intermediary under the all inclusive rate.

Coding and Payment: When a provider bills for diabetes self-management training services they should use the following CPT codes:

G0108 - Diabetes outpatient self-management training services, individual session, per 60 minutes of training.

G0109 - Diabetes outpatient self-management training services, group session, per individual, per 60 minutes of training.

We will allow $55.41 (practice expense relative value unit (RVU) of 1.51) per hour for an individual session and $32.62 (RVU of .89) per beneficiary per hour in a group session. Like other services paid under the physician fee schedule, the actual payment amounts will vary among geographic areas to reflect differences in costs of practice as measured by the Geographic Practice Cost Indexes.

Sandards: A certified provider must meet all of the following NDAB standards and be recognized by the American Diabetes Association.

NDAB Standards as Subsequently Revised
(Diabetes Care, Volume 18, Number 1, January 1995)

I. STRUCTURAL STANDARDS:

A. Organizational support by sponsoring organization

Standard 1: Maintain written policy affirming education as 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 service area to define target population and determine appropriate allocation of personnel and resources.

C. Program management

Standard 5: Establish 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, instructional methods, resource requirements, and program evaluation.

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 experiential 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:

- o diabetes overview
- o stress and psychosocial adjustment
- o family involvement and social support
- o nutrition
- o exercise and activity
- o medications
- o monitoring and use of results
- o relationships among nutrition, exercise, medication, and glucose levels
- o prevention, detection and treatment of acute complications
- o prevention, detection and treatment of chronic complications
- o foot, skin, and dental care
- o behavior change strategies, goal setting, risk factor reduction, and problem solving
- o benefits, risks and management options for improving glucose control
- o preconception care, pregnancy, and gestational diabetes
- o 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 professionals, and health agencies.

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.

Carrier Billing Requirements

Providers should bill for their professional services using CPT code G0108 and G0109 on the form HCFA - 1500. When billing for these codes the certified provider must on the first claim, provide you with a copy of it's "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized provider. For the initial office visit the provider should bill an evaluation and management code. Thereafter, one of the new diabetes self-management education codes should be used. The statute requires that physicians and other indidividuals must provide other items and services for which payment may be made under title XVIII, however, this does not prevent new physicians or entities who did not previously possess a billing number from simultaneously obtaining a billing number and becoming a certified provider.

Apply the deductible and coinsurance.

Billing Requirements for Intermediaries

The provider bills for the diabetes self-management training services on the HCFA-1450 or its electronic equivalent. The cost of the service is billed under revenue code 51X in FL 42 "Revenue Code". The provider will report CPT codes G0108 or G0109 in FL 44 "HCPCS/Rates". The definition of the CPT code used should be entered in FL 43 "Description". As mentioned above, when a provider bills for these codes, they must on the first claim, provide you with a copy of it's "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized provider.

Apply the deductible and coinsurance..

Applicable Bill Types

The appropriate bill types are 11X, 12X, 13X, 71X, (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X.

Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages

Intermediaries and carriers that have not yet converted to MSN should utilize the following EOMB messages. Intermediaries who have converted to MSN should utilize the following MSN messages.

If the claim is being denied because the procedure code or revenue code is invalid, use the following message:

"This item or service was denied because information required to make payment was incorrect." (MSN message 9.4) or "Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. (EOMB message 9.21)

These instructions should be implemented within your current operating budget.

Contact person for this PM is Betty Burrier (410)-786-4649. Any questions regarding Part B carrier claims processing contact Mel Page (410)-786-4727; for fiscal intermediary claims contact Doris Barham (410) 786-6146.

This Program Memorandum may be discarded June 1, 2001.