Medicare Coverage Guidelines	**Individual and Group Medical Nutrition Therapy, Initial and Follow-Up Episodes of Care: 2012 (Part B Benefit)** **LATEST REVISION DATE: 4-22-12** **Developed by: Mary Ann Hodorowicz, RD, MBA, CDE, CEC**	**Individual and Group Diabetes Self-Management Training Initial and Follow-Up Episodes of Care: 2012 (Part B Benefit)** **LATEST REVISION DATE: 4-22-12** **Developed by: Mary Ann Hodorowicz, RD, MBA, CDE, CEC**
	Diabetes type 1, type 2, gestational diabetes, pre-dialysis renal disease and for the period of 36 months following a successful kidney transplant.	Ten self-care topics included; nutrition is 1 of 10 presented as broad overview of basic concepts.
Allowed Settings	Outpatient settings that include hospital outpatient dept.'s, private practices, federally qualified health centers, home health agencies, nursing homes, pharmacies, renal dialysis facilities, rural health clinic.	Outpatient settings that include hospital outpatient dept.'s, private practices, federally qualified health centers, home health agencies, skilled nursing homes pharmacies, durable medical equipment co's.
Excluded Settings	Hospital inpatient, skilled nursing homes.	Hospital inpatient, nursing homes, renal dialysis facilities, rural health clinics.
Utilization Limits and Format	Initial: 3 hrs in first calendar year; can be repeated every 3 years. Follow-up: 2 hours in each subsequent calendar year. Cannot extend unused initial or follow-up hrs into next calendar year. Format of Initial and Follow-up: Group or individual. Individualized meal & exercise plans with extensive monitoring of outcomes in order to adjust plans & meds to meet targets. Individual visit to be minimum of 15 minutes, as CPT code 97802 and 97803 is 15-minute time-based code. Group visit to be minimum of 30 minutes as CPT code 97804 is 30-minute time-based code. Additional hrs may be reimbursed if RD obtains documentation of medical necessity on another referral from treating physician and specific number of extra units of time are Rx'd. Cannot be provided on same day as DSMT.	Initial: 10 hours in 12 consecutive months, starting with date of first visit; once-in-a-lifetime benefit. Format of Initial: 9 of 10 hrs must be provided in group, unless beneficiary meets criteria for individualized DSMT. One hour may be used for individual visit. Group consists of 2 – 20 pts, not all of which have to be Medicare beneficiaries. Follow-Up: 2 hours in each year following year in which DSMT completed. Format of Follow-Up: Group or individual; learning barriers not required for individual follow-up DSMT. Cannot be provided on same day as MNT.
Billing Providers	*Individual* providers: Medicare provider RDs and nutrition professionals (latter has met same educational requirements as RD but has not taken national registration exam given by Commission on Dietetic Registration of American Academy of Nutrition (formerly known as American Dietetic Association). Non-RD Medicare individual providers (e.g., physician) and entity Medicare providers (e.g., clinics, physician offices) may bill Medicare *on behalf* of Medicare provider RD, who has reassigned her/his reimbursement to practice entity.	*Individual* providers: RDs; qualified nutrition professionals; physicians; physician assistants; nurse practitioners; clinical nurse specialists; nurse midwives; clinical social workers and clinical psychologists. *Entity* providers: Outpatient hospital, private healthcare practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes; durable medical equipment companies. Must be billing for other Medicare services and receiving payment. Only one individual or entity Medicare provider can bill for entire hours of training; benefit may not be subdivided for purposes of billing. Cannot be billed as "incident to"

	Only RD provider (or individual or entity Medicare provider billing on behalf of RD) can bill; benefit may not be subdivided for purposes of billing. Cannot be billed as "incident to" physician's services.	physician's services.
Reimburse-ment	RDs must "accept assignment"; means RD: 1. Must accept current geographically-adjusted assigned reimbursement rate set by Medicare as payment in full. 2. Cannot bill beneficiary, nor secondary insurance for difference between RD's fee and Medicare payment. Text box below this table provides example.	*Non-participating* Medicare providers need not accept assignment: can bill beneficiary or his/her secondary insurance for difference between fee and Medicare's assigned reimbursement rate. However, fee is subject to Medicare's limiting charge. *Participating* providers however, are required to accept assignment.
Payment/Co-Payment	Effective 1-1-11, beneficiaries no longer required to pay MNT co-payment of 20%. Medicare pays 100% of adjusted allowed rate. **(4/22/12)**	Beneficiaries are required to pay the 20% co-payment. Medicare payment based on the Physician Fee Schedule.. **(4/22/12)**
Facility Fee	No Medicare facility fee allowed, except if furnished as telehealth.	No Medicare facility fee allowed, except if furnished as telehealth.
Quality Standards	Regulations state: *"RDs and nutritionists must use nationally recognized protocols, such as those developed by the ADA"*. Also known as evidence-based nutrition practice guidelines, and available at: www.nutritioncaremanual.org	Program must have accreditation from AADE or recognition from American Diabetes Association; status based on program meeting the ten National Standards for Diabetes Self-Management Education, and meeting application requirements.
Beneficiary Entitlement	*Initial MNT:* Has Medicare Part B insurance, and has not received initial MNT in previous 3 yrs. Medicare carriers now in process of meeting new requirement to allow provider access to hx of beneficiary's claims. Beneficiary can call Medicare to obtain own hx (1-800-MEDICARE). *Follow-Up MNT:* Has Part B insurance.	*Initial DSMT:* Has Medicare Part B insurance, and has not received initial DSMT ever. *Follow-Up DSMT:* Has Medicare Part B insurance.
Allowed Referring Providers	Treating physicians who are MDs and DOs only. Qualified non-physician practitioners cannot refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).	Treating physician (MDs and DOs) and qualified non-physician practitioners can refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).
Beneficiary Eligibility: Referral	Must establish medical necessity by RD obtaining written referral for MNT by treating physician for initial and again for follow-up MNT. Referral must include: dx of diabetes or 5-digit diab ICD-9 dx code; pt name; date; provider signature & NPI#; order for initial or f/up MNT.	To establish medical necessity of DSMT via written referral for DSMT by for initial and again for f/up DSMT. Referral must include: dx of diabetes or 5-digit diab ICD-9 dx code; pt name; date; provider signature & NPI#; order for initial or f/up DSMT; if initial, no. of hrs of 10 total to be furnished, which topic(s) of 10 to be taught & if to be individual or in group; if individual, reason(s) for/barriers to group learning.
Beneficiary Eligibility: Diagnostic Lab Criteria	Documentation of 1 of 3 in chart maintained by RD for T1/T2 DM: 1) Fasting BG $\geq$126 mg on 2 different occasions.* 2) Two hr post-glucose challenge test $\geq$200 mg on 2 different occasions. 3) Random BG test $\geq$200 mg for person with symptoms of uncontrolled diabetes.* Documentation in chart maintained by RD for pre-dialysis renal MNT: estimated GFR 13- 50 mL/min/1.73m^2	Same. * Cannot be obtained from home-based or inpatient (bedside) BG meter

Coverage: Telehealth (4)	Individual and group MNT and DSMT (initial and follow-up) can be provided as telehealth services. Telehealth services use a real-time audio-visual telecommunication system as a substitute for an in-person encounter between the Medicare beneficiary and the provider who are at different sites. Medicare's specific telehealth coverage guidelines for billing and payment are: 1) The beneficiary must be at an 'originating site' at the time the service being furnished. 2) Originating sites must be located in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. a. However, entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. 3) The originating sites authorized by law are: a. Offices of physicians or qualified non-physician practitioners b. Hospitals c. Critical Access Hospitals (CAHs) d. Rural Health Clinics e. Federally Qualified Health Centers f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites) g. Skilled Nursing Facilities h. Community Mental Health Centers 4) The provider is a 'distant site" at the time the service being furnished 5) An interactive audio and video telecommunications system must be used that permits real-time communication between the provider at the distant site and the beneficiary at the originating site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. a. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii. 6) Claims for telehealth services are submitted using the appropriate CPT or HCPCS code along with the telehealth modifier GT, "via interactive audio and video telecommunications system" (e.g., 97802 GT). By using the GT modifier, the distant site provider certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. a. In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, providers use the telehealth modifier GQ, "via asynchronous telecommunications system" (e.g., 97802 GQ) 7) For DSMT telehealth services, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs training must be furnished in-person during the year following the initial DSMT service, if the beneficiary is prescribed this type of drug therapy. The injection training may be furnished through either individual or group DSMT services. 8) Providers at the distant site can bill either the Medicare Carrier or the Part A/Part B Medicare Administrative Contractor (MAC) for telehealth MNT and DSMT. Reimbursement rates are the same as when MNT and DSMT services are delivered face to face. 9) In addition, the originating site that owns the specialized A/V equipment can bill the Medicare Carrier or A/B MAC a facility fee as described by HCPCS code Q3014 (telehealth originating site facility fee). Facility fee is separately billable Part B payment. Providers paid according to applicable payment methodology for facility or location; usual Medicare deductible and coinsurance policies apply to this code. In 2010 – 2011, the average facility fee was $24.00.
References	1. Medicare Coverage Policy Decision: Duration and Frequency of the Medical Nutrition Therapy (MNT) Benefit (#CAG-00097N); www.cms.gov/coverage/8b3-ggg.asp; accessed 1-10-12 2. Final MNT Regulations. CMS-1169-FC. Federal Register, November 1, 2001. Department of Health and Human Services. 42 CFR Parts: 405, 410, 411, 414, and 415; www.eatright.org/cmsfinal110101.html; accessed 1-10-12 3. CMS Program Memorandum, Additional Clarification for MNT Services for Beneficiaries with Diabetes or Renal Disease. Published May 1, 2001; www.cms.hhs.gov/manuals/pm_trans/AB02059.pdf; accessed 11-15-11 4. CMS Medicare Claims Processing Manual, Chapter 12, Section 190, Rev. 2282, 08-26-11 (Medicare telehealth services and regulations for providing MNT or DSMT via telehealth). 5. National Standards for Diabetes Self-Management Education, Mensing C, et al., Diabetes Care. 25 (Supp 1): S140-S147, 2002 6. Expanded Coverage of Diabetes Out-Patient Self-Management Training, June 15, 2001. PM B-01-40; www.cms.hhs.gov/manuals/pm_trans/B0140.pdf; accessed

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15. **Medicare Coverage Policy Decision: Duration and Frequency of the Medical Nutrition Therapy (MNT) Benefit** (#CAG-00097N), www.cms.hhs.gov/coverage/8b3-ggg.asp; accessed 11-15-11

16. **National Standards for Diabetes Self-Management Education**, Mensing C, et al., Diabetes Care. 25(Supp 1): S140-S147, 2002

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    - American Dietetic Association: www.eatright.org/mnt
    - American Diabetes Association: www.diabetes.org
    - American Association of Diabetes Educators: www.aadenet.org
    - Centers for Medicare and Medicaid Services (formerly HCFA): www.cms.gov
20. **Step-by-Step Guide to Medicare Medical Nutrition Therapy (MNT) Reimbursement 2nd Edition,** April 2010, Indian Health Service, Division of Diabetes Treatment and Prevention, Albuquerque, New Mexico, www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/CKDNutrition/MNT_Reimburse_Guide_508c.pdf; accessed 11-15-11
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RD's usual and customary fee: $60 for one, 30 min. unit of group MNT (CPT code 97804). Medicare's geographically adjusted reimbursement rate: $15 per 1 unit. RD must accept $15 as payment in full; cannot bill beneficiary directly, nor beneficiary's supplemental insurance, for difference between $60 fee and Medicare's payment rate of $15. Does not mean, however, that RD should make usual and customary fee same as Medicare reimbursement rate. Fees determined by compiling and analyzing several factors, incl. Medicare reimbursement rate, but not solely on rate.

TABLE 2 (* reference #20, 21)

HCPCS or CPT Code *	Description	Utilization Limits in Initial Episode of Care and Provision of Hours	Utilization Limits in Follow-Up Episode of Care and Provision of Hours
G0108	Diabetes outpatient self-management training services (DSMT); individual visit, face-to-face with the patient, each 30 minutes of training. DSMT program must be accredited as meeting ten National Standards of DSME by either ADbA or AADE	10 hrs in first consecutive 12 months upon written referral by physician (MD or DO) or qualified non-physician practitioner; 9 hrs to be in group, unless: • Barriers that hinder group learning documented by referring provider. • No DSMT program scheduled within 2 months of referral date. • Referring provider orders additional insulin training.	2 hrs in subsequent calendar years, starting with calendar year following year in which beneficiary completed initial 10 hrs of DSMT, upon another written referral by physician (MD or DO) or qualified non-physician practitioner. Two hours may be individual or group; documentation of learning barriers not required in order to provide individual follow-up DSMT.
G0109	DSMT; group session (2 – 20 individuals*), face-to-face with patients, each 30 minutes. *Note: 2 - 20 individuals must be patients; not all patients need be Medicare beneficiaries.		
97802	Medical nutrition therapy; individual, initial assessment and intervention, face-to-face, each 15 min. Used for 1st initial	3 hrs in initial episode of care (initial assessment and intervention) in first calendar yr upon referral from treating	2 hrs in follow-up episode of care (re-assessment and intervention) in subsequent calendar yrs upon another

	visit only in initial episode of care.	physician (MD or DO).	written referral by treating physician.
97803	MNT; individual re-assessment and intervention, face-to-face, each 15 min.		
97804	MNT; group initial assessment and intervention, and re-assessment and intervention, face-to-face, group (≥2 individuals), each 30 min.		
G0270	MNT; reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, individual, face-to-face, each 13 min.	No limit* for additional hrs >3 initial hrs and >2 follow-up hrs if RD obtains: • Documentation of medical necessity for specific number of additional hrs. • Another physician's referral for specific number of additional hrs plus documentation of medical necessity. * To date, no specific limit specified by Medicare for additional hrs.	
G0271	MNT; reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, group (≥2 individuals), each 30 min.		

***Legend:**	
HCPCS: Healthcare Common Procedure Coding System CPT: Current Procedural Terminology, copyright American Medical Association AADE: American Association of Diabetes Educators ICD-9-CM: International Classification of Diseases, 9th Ed, Clinical Modifications	DSMT: Diabetes Self-Management Education/Training EMR: Electronic Medical Record ADA: American Dietetic Association ADbA: American Diabetes Association NPI: National Provider Identification number