

§ 410.134

record. Referrals must be made for each episode of care and any additional assessments or interventions required by a change of diagnosis, medical condition, or treatment regimen during an episode of care.

§ 410.134 Provider qualifications.

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means an individual who, on or after December 22, 2000:

(a) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

(b) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(c) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a) and (b) of this section.

(d) *Exceptions.* (i) A dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements of (a) and (b) of this section.

(ii) A "registered dietitian" in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of (a) and (b) of this section.

[66 55331, Nov. 1, 2001; 67 FR 20684, Apr. 26, 2002]

42 CFR Ch. IV (10-1-06 Edition)

Subpart H—Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements

SOURCE: 65 FR 83148, Dec. 29, 2000, unless otherwise noted.

§ 410.140 Definitions.

For purposes of this subpart, the following definitions apply:

ADA stands for the American Diabetes Association.

Approved entity means an individual, physician, or entity accredited by an approved organization as meeting one of the sets of quality standards described in § 410.144 and approved by CMS under § 410.141(e) to furnish training.

Deemed entity means an individual, physician, or entity accredited by an approved organization, but that has not yet been approved by CMS to furnish and receive Medicare payment for the training. Upon being approved by CMS under § 410.141(e) to furnish training, CMS refers to this entity as an "approved entity".

Diabetes means 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.

NSDSMEP stands for the National Standards for Diabetes Self Management Education Programs.

Organization means a national accreditation organization.

Rural means an area that meets one of the following conditions:

(1) Is not urbanized (as defined by the Bureau of the Census) and that is designated by the chief executive officer of the State, and certified by the Secretary, as an area with a shortage of personal health services.

(2) Is designated by the Secretary either as an area with a shortage of personal health services or as a health professional shortage area.

(3) Is designated by the Indian Health Service as a health service delivery area as defined in § 36.15 of this title.

Training means outpatient diabetes self-management training.

[65 FR 83148, Dec. 29, 2000, as amended at 68 FR 63261, Nov. 7, 2003]

§ 410.141 Outpatient diabetes self-management training.

(a) *General rule.* Medicare Part B covers training defined in § 410.140 if all of the conditions and requirements of this subpart are met.

(b) *Conditions for coverage.* The training must meet the following conditions:

(1) *Training orders.* Following an evaluation of the beneficiary's need for the training, it is ordered by the physician (or qualified nonphysician practitioner) (as defined in § 410.32(a)) treating the beneficiary's diabetes.

(2) *Plan of care.* It is included in a comprehensive plan of care established by the physician (or qualified nonphysician practitioner) treating the beneficiary for diabetes that meets the following requirements:

(i) Describes the content, number of sessions, frequency, and duration of the training as written by the physician (or qualified nonphysician practitioner) treating the beneficiary.

(ii) Contains a statement specified by CMS and signed by the physician (or qualified nonphysician practitioner) managing the beneficiary's diabetic condition. By signing this statement, the physician (or qualified nonphysician practitioner) certifies that he or she is managing the beneficiary's diabetic condition and the training described in the plan of care is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage the beneficiary's diabetes. The physician's (or qualified nonphysician practitioner's) statement must identify the beneficiary's specific medical conditions (described in paragraph (d) of this section) that the training will address.

(iii) Provides that any changes to the plan of care are signed by the physician (or qualified nonphysician practitioner) treating the beneficiary.

(iv) Is incorporated into the approved entity's medical record for the bene-

fiary and is made available, upon request, to CMS.

(3) *Reasonable and necessary.* It is reasonable and necessary for treating or monitoring the condition of a beneficiary who meets the conditions described in paragraph (d) of this section.

(c) Types and frequency of training—(1) Initial training—

General rule. (i) Medicare Part B covers initial training that meets the following conditions:

(A) Is furnished to a beneficiary who has not previously received initial training under this benefit.

(B) Is furnished within a continuous 12-month period.

(C) Does not exceed a total of 10 hours.

(D) Except as permitted under paragraph (c)(1)(ii) of this section, 9 hours of the training are furnished in a group setting consisting of 2 to 20 individuals who need not all be Medicare beneficiaries.

(E) Is furnished in increments of no less than one-half hour.

(F) May include 1 hour of individual training for an assessment of the beneficiary's training needs.

(ii) *Exception.* Medicare covers training on an individual basis for a Medicare beneficiary who meets any of the following conditions:

(A) No group session is available within 2 months of the date the training is ordered.

(B) The beneficiary's physician (or qualified nonphysician practitioner) documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations that will hinder effective participation in a group training session.

(2) *Follow-up training.* After receiving the initial training described in paragraph (c)(1) of this section, Medicare covers follow-up training that meets the following conditions:

(i) Consists of no more than 2 hours individual or group training for a beneficiary each year.

(ii) Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries.

(iii) Is furnished any time in a calendar year following the year in which