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## **Diabetes Self-Management Training (DSMT) Reimbursement Webinar**

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Ladies and gentlemen, thank you for standing by. Welcome to the Diabetes Self-Management Training Reimbursement webinar. During the presentation all participants will be in a listen-only mode. Afterwards we will conduct a question and answer session. At that time if you have a question, please press one followed by the four on your on your telephone. If you need to reach an operator, please press star zero. As a reminder this conference is being recorded Tuesday, June 25, 2013. I would now like to turn the conference over to Ms. Laura Benzel, Quality Improvement Consultant.

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Welcome, everyone to our reimbursement webinar describing how you can be reimbursed for Diabetes Self-Management Training. My name again is Laura Benzel and I'm with the Disparities National Coordinating Center, the sponsors for our webinar today. So again thank you for joining us. Just to let you know, our presenter has a little bit of a glitch in that she does not have Internet access. So I will be advancing the slides. She does have her presentation in front of her, but unfortunately, she can't control it so we want to let you know that I will be advancing the slides. However, she can still hear everyone and can still see everything that we're seeing. So we wanted to mention that. Additionally, during the presentation we will have three separate opportunities for you to ask questions. And we will actually present a slide that lets you know it is time for questions and answers -- we encourage you to jot down your questions as they come up for you so that when we do open up the phones for the Q&A, you'll have your questions ready. Our operator will explain to you how you can queue up to ask those questions, but again you'll see a slide indicating when we're going to take the questions. And then he will explain how you can queue up to do that. So it will be two times during the presentation and then at the end. So I'd like to take this opportunity to introduce our presenter, Mary Ann Hodorowicz is a registered dietitian and a certified diabetes educator. Mary Ann has a consulting firm offering support for nutrition, diabetes and reimbursement for healthcare providers and the food service industry. At this time I'd like to turn over the webinar to Mary Ann-- Mary Ann.

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Hello, everyone and good afternoon to some of you, good morning to everyone else. Thank you, Laura, for introducing me and thank you from the webinar company. I am also a certified endocrinology coder and I had to get that credential to teach at the diabetes Institute in San Jose, California. And we do cover this extensively. So I'm really happy to be here today with you. And I hope that you learn a lot. This is a very confusing and convoluted topic. That's why we are taking Q&A session for a total of three times. I want to let you know too that if we don't get to all your questions, that you can e-mail me privately after the webinar. My e-mail information is

on one of your PowerPoint slides. It is simply my last name at Comcast.net. Let me spell that now for you. It is hodorowicz@comcast.net. Please feel free if we don't get to all your questions. Also I'll be referring to some of my own forums that support the provision of DSMT, Diabetes Self-Management Training that I've created that could help you. And I'm willing to share those forms with you too if you want to e-mail me afterwards. That would be great. Again, perfect timing last night at the very end of the final hockey game for the Stanley Cup. I'm from Chicago and the Blackhawks won, when my Comcast cable, phone and TV went out and we still haven't got it back yet. We are into plan B. Laura is going to push my slides. So on the next slide, with the learning objectives, for the sake of time I'm not going to go through these objectives, because you're going to learn about 1000 times more things than this. On the picture slide on the next slide, you see the very weird kind of picture that to me represents, ladies and gentlemen, what Medicare DSMT reimbursement rules really are all about. I mean, I think if any negative word you can think of, that's what we're going to be talking about today. Copious, convoluted, complicated, and typical Medicare fashion, they are constantly changing. Just when you think you've got a handle on what you need to do, something changes. And so with that said, this is [Indiscernible] moment, what I mean, is that I'm going to say something that's not written your slides, and this would be a good opportunity if you wanted to jot it down on your notepad. How do you keep up with the changes that are always happening with the Medicare reimbursement benefit rules? You can go to the CMS website, which is [www.CMS.gov](http://www.CMS.gov). And you can sign up to get instant e-mail messages into whatever e-mail you input to get updates and changes on all of the benefits. You do not have to be a Medicare provider in order to sign up for the instant update. I am on two different platforms for the updates from the CMS website. So when you get once a week and open your e-mail and if you see a benefit that relates to what you do, it's a hot leg. Click on it and it will take you right to change. Then you can keep going and going with information if you want to. That's a really good tip. On the next slide, let's start with Medicare -- I'll read the title of the slide, because Laura is kind enough to move the slides for me. Medicare beneficiary entitlement. Martha Stewart is going to be our beneficiary today. With Martha, people love her or hate her. Maybe I should be using Paula Deen right now because she's in the news but we will use Martha Stewart. To be entitled, for Martha to be entitled to this benefit, she has to have part B insurance because the reimbursement money for this benefit is coming out of part B, not part A. A little-known fact, this is probably another moment, when we all turn 65, we automatically eligible for part A Medicare which is your inpatient hospitalization, that's the main area, we have to opt into part B. It's optional. Part B is optional and in enrolling in part B -- B happens once a year and there's an annual premium you have to pay but you don't write out a check to pay the premium. It comes directly out of your Social Security payment at the beginning of the year. And there are also deductibles to be met. And this DSMT benefit does have a patient co-pay. You'll see that on another slide. Unlike the Medicare MMT, medical nutrition therapy benefit which does not have a co-pay. So my best practice suggestion is when the patient cold calls because she has a prescription for this -- or you are calling because you have faxed a prescription or a referral, that you ask Martha to pull out her Medicare card, ask her if she has part B and when she comes in for the visit to make a copy of the card, for your paper charts or stay -- scan it into your EMR. On the next slide, where it says MMT and DSMT complementary but distinct. I know we're not talking about mentee today but it's very important to show the distinct differences between these two benefits. It's been my experience, a lot of patient education and MNT and DSMT and my career now I just work with healthcare providers and end TDs -- I find that what we do is we crisscross these benefits in terms of what is furnished

in the benefit. Let's start in the DSMT box. When we're doing DSMT, how it is meant to be, ladies and gentlemen, is a very general, basic training on key self-care behaviors in a group format. And those self-care behaviors are called the AADE7, seven key behaviors like nutrition, being active, monitoring, problem solving, taking medication, so it's one-size-fits-all training or education. We do not individualize. We do not individualized those self-care behaviors for the patient -- I call IVs, issues and variables. So if I have a group class I'm talking about healthy eating, I'm not individualize them for each in the class how many grams of carbohydrates or ounces of protein or grams of fiber, grams of saturated fat -- if I'm talking about exercise, I'm not individualizing and exercise plan for the patient. I'm talking in general about the healthy behaviors. So I'm looking to increase their knowledge of why they have to do these behaviors, and I'm helping them develop the skills and how in a general non-individualized way -- we don't typically do long-term follow-up. It's very short-term follow-up, limit heard -- limited monitoring allows because we're not supposed to be individualizing any of these healthy self-care behaviors. On the other side, medical nutrition therapy, the reason Medicare give us that benefit and it is paying very well, that one is a moneymaker, you never thought you would hear me say Medicare moneymaker but this one is. This is where, ladies and gentlemen, we do that individualization. To control what we call the ABCs of diabetes, A1c, blood pressure and all the cholesterol factors. So a lot of people think of the second bullet point that it's just about and individualized eating plan, but it's really not. In MNT we doing individualized personalized eating plan for the patient again, IVs, issues and variables, medical, clinical, psychosocial but we also work into that in individualized self-monitoring of blood glucose plan and individualized Xers -- exercise plan. We do address stress and stress management and the reason we do all these individual plans is because they are all connected. If I make a change in the eating plan, chances are the patient's going to have to change exercise or monitoring plan. We do much longer term follow-up. Do we monitor labs and behavioral outcomes and clinical outcomes? Because when the labs are not going in the right direction, we have to change one of the personalized plans, eating, exercise, medication monitoring. With meds, we don't have the authority to do that as RD CDE's but we work closely with the referring physicians. So really, Medicare beneficiaries optimally should receive both of these in the initial episode of care, which is 10 hours on the DSMC -- DSMT side, and three hours of MNT in the initial first year. And then Medicare pays for follow-up for both of these benefits which would be two hours and two hours every year until the patient dies, which is a really good deal. Medicare pays for both because patients optimally do better, they get better outcomes when both are furnished. On the next slide, we're going to show the coordination of Medicare MNT and DSMT. The way I set this up, we're going to focus on DSMT of course, I set it up in this boxed type of format. A lot of the slides will be this way. So you can clearly think of what's going on in your brain, adult brains like things chunked up and not just rambling on with sentences. So if you look over at the blue on the right-hand side, DSMT, we get 12 consecutive months to furnish the 10 initial hours. So we call those 12 consecutive months a rolling year. Not a calendar year, but a rolling year. The other side on the left-hand side, it shows about MNT, how that is totally different in terms of the calendar year and the number of hours. I'm not going to focus on that right now. But you have it to look at off-line. Back to the DSMT, you get a 12 rolling months to get the initial 10 hours furnished. If they are not furnished in those initial rolling 12 months, June to 2013 -- to June 2014, so those initial 10 hours are lost forever. So this is a once-in-a-lifetime benefit when we talk about the initial episode of care, which is the 10 hours. Okay? The clock starts ticking with those 12 rolling months, not with the date on the referral, from the PCP, the clock starts ticking with the date of

the first DSMT visit. So if the date on the referral was June 1, but the date of the first visit was today, June 25, Martha has from today, June 25 '13 to June 25, 2014, to have received these 10 hours. Now, in the first blue box, Medicare has set this up saying that we primarily have to do it in groups. The last box says that nine hours of the 10 have to be in group. I'll give you those exceptions. Back to the first box, in 10 topic areas. Medicare actually in the statutory language of the benefit actually lists the 10 topic areas. And we have the AADE7 self-care behavior. Medicare has 10 topic areas. And they are a little more robust. But that's not saying we have to teach all 10. It's as required by the patient. That is determined when we do the initial assessment at the very first visit. That initial individualized assessment determines which topics we teach in the program. Now, again on basic self-care, and we have to follow the national standard of DSME. The 10 national standards are published by an independent body, not by CMS, not by a ADE, not by the American diabetes Association, it's an independent body. Those of the quality standards that we have to adhere to and prove adherence to in order to bill Medicare. That's why we need accreditation of our program from AADE or recognition of the program from the American diabetes Association, either one, -- I personally like a ADE, it's simpler, shorter and less expensive -- but accreditation or recognition is based on 99%, based on proving that you're going with paperwork that you're going to adhere toe to the 10 national standards of DSME. And just to let you know, part of my consulting business, I offered AADE accreditation support. I have all the supporting materials, the manuals, things like that. In the second blue box on the r ight, nutrition is just one of the 10 topics that the patient may need. Usually they do need nutrition. Again it's presented in a non--- in a non-individualized basis. You can see that Medicare requires nine of the 10 hours must be furnished in groups. And pens-out moment, they define group as two or more patients. Now, if it's just two patients, they both do not need to be Medicare. You can have Martha as our Medicare patients, and Tom Cruise as the Blue Cross Blue Shield patient. That's fine. But it is to registered patients. What would not be a group is Martha Stewart and her caregiver. There has to be to registered patients or more is what they consider a group. Now, the only way you can do all 10 hours on an individual basis is if you have documentation by the referring PCP meaning the primary care provider -- I just use that as kind of an easy way to say the physician or the mid-level -- nurse practitioner, physician assistants or clinical nurse specialist -- we call those mid-level or physician extenders -- I'm generically saying PCP, primary care provider, if the primary care provider documents on the referral form -- you will need a referral -- that Martha has special needs, then we can do special needs that limit group learning -- special needs that would make it difficult for her to learn in a group like vision, hearing, cognitive issues, languages use. Or Martha is non-ambulatory. That's a special need. She cannot leave her home. And we have to go to her in her home. And so on my customized referral form -- I'm more than happy to e-mail you that -- I make every attempt to be Medicare compliance -- I have those special needs, little checkboxes so the PCP can easily check one of the special needs. So the special needs is one way to get it individual -- another is if you have no DSMT program scheduled within two months of the date on the referral. So I just got done consulting at a diabetes program in Kansas City where they were doing their DSMT helter-skelter like dropping, walk-in appointments and so we got them on the program schedule where each program is eight visits or six to eight visits depending on how they want to do that. That was a program. And they are going to schedule four programs a year. And actually schedule it for the entire year. So when you get that referral in an update on the referral is your next program for the year is more than two months away and you can show that on a calendar schedule, you can then do it all individually for Martha. The third way you can do it all individually is if the

PCP on the referral checks one of your boxes -- I hope you have that type of referral -- it makes it very easy for Martha requires -- additional insulin training. Then believe it or not, you can do all these 10 topics if the patient needs it individually. Okay. So on the next slide, where it says willing provider eligibility, billing provider, talking about the type of provider that can furnish it in a minute -- on billing provider, who can build? On the left-hand side, I've got my slides in the yellow boxes, any individual Medicare provider or entity Medicare provider can bill. So an individual Medicare provider like a physician, registered dietitian, a nurse practitioner, a physician assistant, all individual Medicare providers -- remember, accreditation or recognition of the program is also required. Also, entity Medicare providers can bill, but certain ones -- we'll get more granular as we move along. Entity Medicare provider, what is that? A pharmacy, a hospital, outpatient department, a freestanding clinic, a physician practice. A registered dietitian's private practice. Where they are enrolled in Medicare as an entity provider, not as an individual but an entity. Now, the caveats on this to bill for DSMT, you need to be billing whether you are an individual like I am an RD or a pharmacy, you have to be billing Medicare for other services first. And successfully being reimbursed -- an individual or an entity Medicare provider cannot join Medicare just to bill for DSMT. Now, why they did this, I have no idea. And Iowa's joke when I'm live at a podium, don't kill the messenger. Believe it or not, the last box on the left, when we say about entity providers, we said select entity providers are allowed to bill. What entity providers are not allowed to bill, part B? For DSMT? You can see on the last box on the left, hospital inpatient, nursing home, ESRD facilities, end-stage renal disease facilities, hospice, ER departments, and rural health clinics. Now, it's interesting you see their nursing -- nursing homes. On another slide you're going to see that you are allowed to bill -- to skilled nursing facilities. As an entity provider, they are allowed to bill skilled nursing but not nursing homes. Go figure. This is typical Medicare. On the right-hand side, let's give a little more granular -- on those individual Medicare providers who can bill and be -- on behalf of the entire program. You see them listed there, MD, DR, RD's, the ones who are actually listed in the text -- statutory language. Let's say that me as an RD, I'm already billing Medicare for medical nutrition therapy and I've got a successful reimbursement track record. Now I can bill on behalf of the whole DSMT program. So even though I have a pharmacist teaching in the program, and an are in teaching the program, and a psychologist teaching in the program, teaching the different classes, I'm going to -- I will be the billing provider, I will be billing under my NPI number on behalf of all of these classes that are taught. So again, any of these people can be instructors in the program. But in the middle box on the right, what's really critical here -- get back to the national standards of DSME -- we are following the 2007 ones right now. The revised ones are ready, but they're not really utilized yet. By the diabetes Association or AADE. But the national standards say, in terms of your instructors, you have to have at least an RD or an RN or a pharmacist as an instructor in your program. These national standards say that you can have a solo instructor. So if you just had an RD teaching all of your classes, let's say you are on a six visit program, and the RD is teaching all six visits, that's fine because she is an RD. If you have an RN teaching all six visits, that's okay too, per the national standards. Or a pharmacist teaching all 10 -- all six visits, all topics. That's fine too. But let's say for example you have a clinical psychologist teaching all the topics. That would not be consistent with the statutory language. Now, the standards still say that a multidisciplinary team is still recommended. So I always say, get the right people on the bus and get the right people off the bus. A dietitian teaching nutrition, pharmacist teaching -- a clinical psychologist teaching coping skills. That is ideal, but a solo instructor is allowed -- it has to be one of those three disciplines. Okay? So on the right, last box,

in terms of entity billing providers, what Medicare entity providers can bill, hospital outpatient, skilled nursing homes, federal qualified health centers, a durable medical equipment company, a pharmacy, a clinic, a physician or physician extender practice like NT practice, or RD private practice and home health agencies, these are all approved Medicare entity providers who can bill on behalf of all the visits that are being furnished. So on the next slide, this is for a little fun, my mother taught me about the science of osmosis, shut your mouth and eat your supper. A little comic relief. On the next slide, I'm not going to read through this. I'm just going to highlight what's really important. I call it really focusing on what I call the key core message. And when I trained on motivational interviewing, in the area of doing DSMT and medical nutrition therapy, in motivational interviewing with patients, we're supposed to get laser focused and focus on the key core message when we're talking -- educating them on something very complicated and convoluted. So the key core message here is that your PCP who refer to you for this benefit, physicians and physician extenders, they have to be enrolled in Medicare. They have to be active Medicare providers status. So everybody goes like, oh, my gosh. I didn't know that. What does this mean? Dr. Miller refers to you, but he's not a Medicare provider. He's not in the Medicare system. Technically, if you furnish that benefit with that order, you are not consistent with these coverage guidelines. Now, how do you know if -- I just moved my slides -- I'm on the second slide where the first will at point says chiropractors not eligible to order services or supplies. How do you know if your PCP is in the Medicare system? How do you know that? On the slide I -- I moved my site again, it says Medicare payment will, ordering providers must be enrolled in Medicare. Then in an orange color, it says -- how do you know if Dr. Miller -- a new physician referring to you is a Medicare provider? You can go into this website called PECOS. And there's the URL at the bottom. And all Medicare providers who are Medicare providers, listed in this system. And this is open access to get into this system to look up your PCP, to see if they are enrolled in Medicare. If you don't want to ask them because you are embarrassed. Okay. On the next slide, we still talk about ordering providers must be enrolled in Medicare. Medicare enrollment -- the first bullet point is talking about Medicare enrollment using the paper CMS 855 R form. So what is the purpose of this slide? If somebody is on this webinar and they are thinking, I want to do this and I want to be enrolled in Medicare, you do have to -- if you want to be an individual Medicare provider, this is the form you have to fill out. The CMS 855 I, stands for individual. And you could either download the paper application on the CMS website, or you can do it online to fill out the application. And you can do it through the CMS website or through the PECOS website, to do your application as an individual Medicare provider. So on the next slide, this is about RD options with regard to Medicare MNT and DSMT. There probably -- RD on call here -- I'm the queen of acronyms -- the RD we have to become a Medicare provider, first bill for MNT, be billing for something else first, whether you are an entity or individual provider of Medicare. And then bill for an accredited DSMT program. If you're not doing that, you have to refer the beneficiary to an RD who is doing it or to some other entity who's doing it. Or you have to opt out of Medicare. And that is a tricky thing here. For those of you thinking, well, I've been thinking of opting out of Medicare, okay, that is a way to do this, but then with the opt out period is for two years -- we get Martha Stewart coming with her referral, before you can furnish one minute of DSMT, you have to give her a contract -- you can't just use your own, you have to use the language that Medicare requires in the contract -- it basically tells Martha that you, David Smith, pharmacist, have opted out of Medicare. And therefore, you, Martha Stewart, is going to be responsible for the entire bill because I won't be billing Medicare even though this is a covered benefit. I've opted out of the system, therefore you have to pay out-of-pocket, the full

bill, which is dollar amount. So you have to do that with every single patient who comes to see you for the DSMT. So it gets a little sticky on a political or arena -- and from a relationship issue and you have to let them know that it's a covered benefit, but you're not in the system and you cannot bill. So it gets a little tricky if you want to do it that way. Last is for MNT, if you're doing MNT in any other disease State that's not covered by Medicare, you can exclude all the rules. Let's go on the next slide where it says Medicare DSMT quality standards. Quality standards. Again, we've talked about this but we're getting a little more granular now and a little more robust. We have started kind of broad, now were getting to get -- going to get more detailed. For DSMT, the program again, your program to prove quality has to have recognition by the American diabetes Association or accreditation by AADE. And again, don't reinvent that we'll. If you're going to go for accreditation, I strongly suggest you contact me because I've got all the materials you could ever want, rather than you starting from scratch. When you get that actual certificate, okay, let's use AADE, when you get that actual certificate that you have achieved accreditation and is a paper certificate, you also get it electronically -- AADE is going to send that to your Medicare carrier, which is the insurance company in your locality that processes all of the part B claims. AADE is going to let them know that you achieved accreditation but it suggests that you also make a copy of that certificate with a cover letter, okay, and send it special postage where you're going to get a signed receipt that your carrier has actually received it. They have to know that you've achieved this. Because when you start billing, they're going to connect that to this certificate. Now, in the first box, it says carrier or regional MAC. Let me explain the difference here. Part B, they're called carriers, local insurance companies that process part B claims and Medicare applications in your region. CMS, the governing body for Medicare said, look, we don't want all these individual carriers in the United States and all these individual fiscal intermediaries -- the insurance companies that process part A claims. We don't want them all separate. We want to bring them together under one roof and call them MAC, Medicare administrative contractor. Medicare administrative contractor. So basically it's a larger insurance company that houses all the part B stuff and all the part A stuff together. And every region of the country was given a timeline to convert to a MAC. I know here in Illinois, we still have not converted to a MAC so we are still using a part B carrier. So you can look up your region of the US, wherever you're at to see if you are still with a carrier or converted to a MAC on the CMS website, which is [CMS.gov](http://CMS.gov). So again the quality standard adhering to the national standard of DSME, and there's 10 of them, there's 10 of them. And again, working right now, 2007 -- the new ones coming out -- they have been written and approved. AADE is not using them yet. The revised ones for accreditation -- because they have not written yet what they call the interpretive guidance. Leslie cold is the director of the accreditation program. I spoke to her about this because I helped so many cards get this and she said, until we write the interpretive guidance, for each standard, we're still using the 2007 -- not much has changed. I can tell you that. Standard five clearly says an RD or an RN or a pharmacist can be the one solo in structure -- solo instructor. If your program -- if we have anybody on the call that is from a rural health clinic, a rural health clinic, and that's the kind of Medicare entity that you work in and -- if you are in that entity, and you have a solo instructor, it has to be an RD CDE in that particular Medicare provider entity. Now, what is a rural health clinic? Is actually -- that name is a designation given to a clinic in a rural area that exists to provide medical services to individuals, Medicare individuals who live in these rural nonmetropolitan areas. When they did this special designation for Medicare, they funding -- they do get Medicare funding more than the rest of us, to run that rural health clinic. And Medicare decides what is a rural area? Not us. The very last box on this

slide for quality standards, little-known fact, very hidden in the statutory language that your patient and your DSMT class have to sign an attendance sheet. So everybody says to me, well, do I save them or what? I'm like, yeah, I would save them. In the event of a Medicare audit. My best practice suggestion is that whether you do an individual session with a patient, have them sign an attendance sheet -- you can take it -- in your group classes, pass around that attendance sheet. I have one. You can e-mail me for it. My attendance sheet also acts as a billing sheet. Have everybody sign it. And at least you have it. You know? And when you talk about a Medicare audit, just so you know, a lot of these coverage guidelines that we're talking about today are not adhered to by anyone on the phone, a lot of this is documentation in an EMR's and paper charts and Medicare doesn't really know when your billing. If you really have the appropriate documentation. But they will know if they come to do an audit. That's the thing, they will know. So I always say that following all these documentation requirements, it's for R&R. Retention of reimbursement. You can retain the reimbursement you received in the event of an audit. And just to let you know, Medicare is ramping up their audit program in spades. Hugely. Hugely. They hired independent auditors, many organizations who are going to be auditing small, medium and large entity providers. If an individual providers. To bill Medicare. Because the Medicare system is losing B as in boy, billions of dollars actually, annually in fraudulent claims, claims that documentation doesn't support the claim. And so Medicare wants to stop this big, gaping, gushing leak in the system in order to save the system. And I have to tell you, I'm actually in favor of that because I want Medicare to be there when I grow up, so to speak. Okay. On the next slide, just a little joke, so I'm going to pass that -- the little baby in the cup. And then on the next slide, Medicare beneficiary eligibility for DSMT, eligibility, what makes the beneficiary eligible? Martha Stewart cannot have received the initial benefit ever before. Remember, the initial 10 hours is a once-in-a-lifetime benefit. That's really important. So how do you know if she comes to you, how are you going to know if she has received it before? How are you going to know if in this current year, she's gotten a couple hours over at the hospital down the street, and now decided to come to your pharmacy? There's two ways to do that. You can either go to your carrier website or your MAC website and sign up with a username and a password to get into a special portal that they are required to develop by Medicare, but there's a timeline where they are required to do this. The carrier and MAC's on the website have to have patient portals which are basically a huge database that lists all of the Medicare beneficiaries that they have processed claims for. And so if I went into Wisconsin physician services, which is my carrier, and I have to be a provider in order to get you into this portal -- I have to be a Medicare provider, individual entity, I you sign up you get a username and password -- this is patient information -- then I could get in and look to see if Martha Stewart has received any DSMT in the past. So the second way to do that is put the burden on the patient. The patient can call Medicare. They -- busy Medicare helpline. Specifically for beneficiaries to ask these kind of questions. Have I received this in the past? When did I receive it? How many hours were received? Either you can assume that responsibility or have your patient assume it, depending on the administrative decision you make. Now, the follow-up benefit is two hours every year. Will talk about that later on. But the other beneficiary eligibility criteria is there has to be documentation of a diabetes diagnosis using one of three labs. Medicare wants us to prove that Martha really did have -- does have diabetes. Okay? And the lab, we're going to show you what those labs are in a minute here, you have to have documentation of one of them. But the lab does not have to be documented on the referral form. You could obtain a copy of the lab reports, that would be your documentation through your chart. Or it could be the labs or it could be in the

EMR, that would be your documentation. Or you could get it on the referral form. You can get it on the referral form. On my referral form, I have a section for labs. All right? The diabetes can be diagnosed prior to Martha coming into parts B. That's fine. She could have it diagnosed. We still have to have the lab to prove it. And in the last box, there is a DSMT and MNT order form that three of our associations have put together. I was on the original one. It's been revised now in 2011. It's for downloading the AADE site or Academy of nutrition site -- it's meant to be Medicare compliant -- I'm going to the next slide -- I'll show you a picture of that in a minute but I really do like my form better if you want to e-mail me because there's room on my form for branding and it has some little extra things that make it a little easier for the PCP to document. Now, on this slide, the diagnostic lab -- lab criteria, let me say this first because this is another confusing part, before we get into the labs, okay, actually, this slide actually does address this. If you look at the second box, okay, the red font there, documentation of type one and type two diabetes diagnosis is a DSMT coverage will. It is. But, but, the statutory language of the benefit for DSMT, the DSMT benefit does not state who must have the documentation. Does not state who must have the documentation. This is a really, really, really important point here, ladies and gentlemen. This is probably the most important point of all of what you're learning today on this webinar. I have inquired with American diabetes, AADE, Academy of nutrition, and with all the reimbursement people in threes -- these three associations and with my fellow certified endocrinology coders at the Johnson & Johnson diabetes Institute to say who really then -- what are we going to say here? Because again, the benefit does not dictate -- is it the PCP? Who has to have the documentation? And/or the DSMT program? Okay. This is the bottom line. Because it doesn't say, your entity has to make an administrative decision on this subject. Who's going to have to have the documentation? You could say no, because it doesn't say in the benefit, if we feel that if the PCP has the documentation of the lab, that's how we interpret the benefits language. However, your entity could also make another decision and say, no, our interpretation -- because we're getting the Medicare money, we have to have a copy of that lab, documentation of the lab. So for all of you on the call if you're not administrators, over your entity, you are doers, the instructors, the program coordinators, I -- if I were in your position I would not be making that decision. I would default to the Medicare compliance officer in your entity. Or you are VP or the president of your organization and explain to them what the situation is and let them make that decision. Whether you have to get the labs or it is just for the physician. Or the ordering PCP. On the next slide, let's look at what the three diagnostic labs are for DSMT. Over on the left, fasting blood glucose of 126 or more on two tests. Two, you can go back as far as you want, there's no language to that -- the timeframe in between, there's no language on that either in the benefit -- or a two our oral glucose tolerance test of 200 or more. That has to be on two tests again. Or a random blood sugar of 200 or more. Only one of those on random -- you only can have one, you only need one on a random -- but you have to have at least one symptom of uncontrolled diabetes. Again, I have those symptoms in checkbox format on my referral form. Example, excessive thirst, excessive urination, excessive hunger, unintentional weight loss, tingling in the extremities, blurry vision, impaired thinking, so on the random, we need one plus one symptom. A1c is a diagnostic lab. It does diagnosed diabetes but as of today, this webinar, Medicare has not yet added the A1c to these three labs. Medicare has not added it yet so we cannot use the A1c. Very, very, very important. Okay? On gestational diabetes on the right, there is no documentation of a lab that's required. It's just the ICD-9 diagnosis code. Now, on the next slide, let's look at the referral requirements. DSMT referral requirements. There has to be a written referral by the treating physician, keyword, treating. Treating physician or qualified

nonphysician practitioner. We also call those mid-level or physician extenders. What has to be on the referral, the date, the beneficiary name, and an ICD-9 code, diagnosis or code. Related to diabetes, type one, type two and gestational. The PCP can write type one diabetes on -- uncontrolled, type two diabetes uncontrolled, I prefer having codes, diagnosis codes on the referral. That represent these diagnoses, because -- this is really important -- Medicare is -- has a tendency not to reject claims -- anything diabetes related claims -- without a five digit ICD-9 diagnosis code. It is critical you use a five digit ICD-9 diagnosis code on these DSMT claims going to Medicare. Very important. We have a slide coming up that shows you some of those codes. All right? The referral has to have the treating physician's NPI number and their signature, electronic signatures are permitted, but not stamped. And the referral has to say whether it is for initial or follow-up D SMT. If initial or follow-up -- and for the initial, they have to have the opportunity to say what topics they want taught. You have to list the topics. I have mine in check box form. One of my checkboxes says, all topics. Then the individual ones are listed. The referral has to give the PCP an opportunity to say how many hours they want in the initial benefit. They want all 10 hours? Or less than 10 hours? Again, my referral allows for them to do that. Then again, whether in the third box down, for the initial benefit, whether the physician wants it in group or individual, by default it's going to go group. If the PCP wants individual, we have to have a special needs checked off or additional insulin training. So this is all pretty granular, what has to be on that referral. I did my best here -- again, if you e-mail me for mine, that would be great. On the next slide, this is the picture of the universal one that was done by the three associations, I was involved in the first draft. This is the second revision, 2011. Pretty hard to see, but they do have checkboxes for initial or follow-up DSMT, 10 hours or less than 10 hours. Whether all 10 topics should be taught or only individual topics. So it gets pretty granular. On this slide, what's different on the revised form? I'm actually not going to review this. Because I'm encouraging you to e-mail me for my form. And then on the next slide, again it says, what's different on the revised form? It says they added MNT telehealth and DSMT telehealth, which can be provided telehealth -- I also have that on my form. And they added in the diagnosis section, please send recent labs for patient eligibility and outcomes monitoring. Again, this is that interpretation. Who has to have the labs? On this form, they're saying please send us the labs. So their interpretation is the people getting Medicare money have to have the labs but it doesn't statutorily say that in the benefits. Okay? It does not say that. On the next slide, this is what's been omitted. I'm going to skip that. And on this slide, are we confused yet? Yeah. I mean, a little comic relief. I think you probably are at this point, probably. So now I'm going to open this up to some questions, about five minutes of questions.

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Yes, ma'am. Ladies and gentlemen, if you would like to register a question, please press the one followed by the four on your telephone. You will hear a three tone prompt direct knowledge or -- your request. If your question has been answered, please press the one followed by the three. If you're using speakerphone, please let your handset before entering your request. Again, it is 1-4 on your phone to register a question. One moment please for the first question. And we do have a question from the line of Andrea trout in there. Please.

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I'd like to know if a registered dietitian needs to cosign the docket for billing if their NPI number is associated with the ADA recognized DSME program?

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I didn't hear the first part of your question. Can you talk a little bit louder? I'm having a little bit hard time hearing you.

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Does the registered dietitian whose NPI number is associated with the DSME ADA recognized program have to go back and cosign the RN or other healthcare provider teaching the DSME group class?

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No. No. If the RD is the billing provider, the RD is the Medicare provider and the RD is going to bill on behalf of the entire program, and the RN teaches class number 1 and I think if I understand your question correctly, the RN writes the progress notes, no, the RD does not have to cosign that. Absolutely not. This is not like incident two physician services billing. That's not required.

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Okay. What about if an RN is seeing gestational diabetics for example on an individual basis? For the clinical aspect of the consultation? And then the RD follows up in a subsequent visit for the nutrition? Does the RD have to go back for that and cosign?

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No. There's no cosigning required here at all. Absolutely not. Not this benefit. No. Good question. Thank you.

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Kerry Conroy.

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You may have mentioned this earlier but I wanted to verify whether or not the billing RD can build both the DSMT codes as well as the MNT codes? I know they can't be built on the same day, but can they on separate occasions?

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Yes. Absolutely. Yes. The RD does use the DSMT codes, procedure code. We haven't talked about was yet, the two codes are G 0108 for individual and 0109 for group DSMT. She has to use those codes she's the billing provider. Because those of the codes mandated by Medicare for DSMT. So remember for the RD to be the billing provider on behalf of all the classes that are furnished, all of the hours, she has to first be a Medicare provider, billing for MNT, with the MNT codes and getting reimbursed and then she gets her DSMT program recognized or credited, and becomes the billing provider for the DSMT program using the G codes. You have to use the G codes for Medicare.

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Right.

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The next question?

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The next question comes from the line of Kay Hamilton.

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I'm fairly new. And this is for accounting -- a County health Department. Medicare provider, we do the flu roster billing only so I'm not sure what would -- if we are considered a billing Medicare provider. What I need to know that before we could try to get this or you said that you couldn't apply for this to be [Indiscernible -- multiple speakers]

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Right. Are you in a rural health clinic?

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[Indiscernible -- multiple speakers] just considered County health Department. We are  
[Indiscernible -- multiple speakers]

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You are in a rural setting? You probably are considered a rural health center or rural health clinic by Medicare. And I'm going to -- I'm not going to answer that question for you right now because I have a specific slide coming up about the nuances of roster billing. So hang on. Don't go away. That's coming up. Okay?

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That's the only thing we do with Medicare is roster billing.

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Right. I get it. We've got a slide coming up just for that.

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All right. Thank you.

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You're welcome.

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And there are no other questions at this time.

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Okay. Then I'm going to move on beyond my little vegetable question slide --

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Maryann, this is Laura. We did have one question come into the chat -- Mary Ann. It should be a quick one. This is from Deborah. I hope I said that right -- she wants to know that instead of the participant signing a sign-in sheet, can a spreadsheet be kept on the computer of participants and dates of attendance?

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Well, the actual statutory language of the DSMT benefit says that the beneficiaries have to sign an attendance sheet. So for everyone on the phone, on this webinar, thank you for participating. I try to follow the letter of the law when it comes to these statutory language -- the actual language used in the benefit. Beneficiaries have to sign an attendance sheet. So that's interpretation. I interpret that very clearly as a legitimate hand signature on an attendance sheet.

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Thank you.

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You're welcome.

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I'm going to move on them move on then because we're going to have another Q&A period coming up. Now on this slide, it says the Medicare DSMT limits in the first year. As one of our attendees said, Medicare MNT and DSMT in initial year cannot be provided on the same day. For DSMT the initial first year structure, 10 hours in 12 consecutive months, we talked about this before, if it is now furnished in that first 12 months you cannot extend these initial hours into the next year. You just cannot. They are lost forever. We talked about nine hours being in group and one hour individual. Now, a visit has to be at least 30 minutes. Because the G codes, which are procedure codes we're going to be using our 30 minute time based codes. There's no grounding of the time on the clock. And so if you provide 35 minutes to a patient, you can only bill one, --

one unit of the 30 minute code. If you only provide 25 minutes to a patient, you cannot even build one unit because you did not provide 30. So best practice suggestion, in your charting or your documentation after the visit, you should note the start time and the end time of your visit, whether it is individual or group. Note the start time and the end times is -- to support how many units of the code you are billing. The one hour can be for individual assessment. It may be for an individual assessment insulin instruction on any topic you want it to be -- okay? However, my suggestion -- this is not statutory. This is just a suggestion, okay? I prefer saving that one hour till the end of the program, that one hour individual, save it till the end of the program because now you know what your patient -- each patient needs extra help with on an individual basis, whether it is the eating plan, exercise, monitoring, ED, psychosocial, issues, whatever it is. How does that allow you to comply, then, if you're going to hold that one hour at the end to get that individual assessment? If you're very first class in your program is group, and that's what I recommend -- you ask the patients to come in earlier, just for that first class, class starts at 9:00, ask everybody to come in early for paperwork, registration, HIPAA on clip boards, put your assessment form a medical board and have them start filling out their individual assessment forms, on that clipboard as they are coming into the first class. You are saving the time in the class, saving precious time. That qualifies as an individual assessment, because they are filling out their own forms. And then you have time to look that over before the next class to get to know them a little bit better. If you want an idea of that individual assessment form -- what it should contain, you can e-mail me, because you have to really assess everything about the patient. Now, can we build for additional hours over and beyond the 10? -- can we bill? Miscarry says they have not cited additional hours as payable. And we talked about that -- you can do all nine hours individually. If you get certain documentation. On your referral form. Now, in the next slide we're showing the structure of the benefit in the follow-up years. All right? So follow-up is after the first 12 consecutive months. We'll show you the timeline on that. You get two hours every 12 months for follow-up. Again, you have to have a separate referral. And it has to say, follow-up. On the referral. You have to say initial on the referral or follow-up on the referral. Again, with the follow-up, if you don't get those in within the 12 months, you cannot extend them into the next 12 months. In the follow-up episode of care you can do individual group or combination. Your -- in follow-up, you do not have to do all group. You can do all individual. But remember, your 30 minute billing unit and documenting your start time and end time. So again, to do individual follow-up, you do not need special needs. You can do individual without getting documentation of special needs. Now, on the next slide, we have an example of Medicare timeframe changes for follow-up. This is a little confusing, but we'll get through it. This is a Medicare example, not mine. I just put in current year, 2013 and '14. The very top one, if a patient complete the initial 10 hours over the span of two years, follow-up kicks in a little differently -- stay with me here at the top -- Martha starts her initial 10 hours in August '13. She completes it in the next year, August '14, that's 12 rolling months. Third bullet point, she is not eligible for follow-up in September '14. Okay? September '14. She has hit the clicker, she's rendered -- ready for follow-up. Let's go down to the second example. The patient starts the initial 10 hours in August 13 -- '13. Complete it in '13. So it start -- it is started and completed in the same year, third bullet point, second example, now Martha is eligible for follow-up in January of 2014. So if you are looking at this and saying, oh, my God, I thought the rest this was confusing, this is even muddier than the rest of the stuff, and I've been in this a long time, I had to review this probably 30 times before I understood it. So pour yourself a big cup of whatever caffeine beverage is of your choice, look this over, mull it over, you will understand it. If you

read through it a few times. With a little caffeine under your belt. On the next slide about diagnosis, we do need a diagnosis as required. Condition. So we have to have a diagnosis from the referring physician or qualified nonphysician practitioner. All right? We have to have that diagnosis before we furnish the benefit. So it has to be on the referral. We want a five digit ICD-9 diagnosis code for type one or type two. Gestational doesn't come with a five digit. For type one and type two we need a five digit if Medicare is going to pay the claim. Now, on the last box, if you get narrative diagnoses and you have to convert it to a code, the only professional authorized to select a code from a narrative diagnoses or a long hand written diagnosis, our physicians -- and physician extenders and licensed medical record coders -- RDs, RNs, pharmacists cannot look at a narrative hand written diagnosis and say, that is code 250.02, because that is coding. That's not in your scope of practice. On the next slide, it shows you the diagnoses for Medicare DSMT. This is for type one and type two. It shows you what the fourth digit means. It means the manifestation if the patient has a certain manifestation or complication of their diabetes. So that's what that fourth digit is. A zero means there is no complication. On the next slide, it says diagnoses for Medicare DSMT -- I'm only saying the name of the slides -- because Laura is advancing these slides for me. The fifth digit on that five digit code represents type one or type two and represents controlled or uncontrolled. Now, this is it pans out moment. - this is a pens-out moment. In order to be coded as uncontrolled, uncontrolled, the referring PCP has to write the words uncontrolled -- that gives us a narrative diagnoses. Okay? If he doesn't use the word uncontrolled, we cannot code it as uncontrolled. Very, very, very important point. Okay. On the next slide, now we're going to talk about the procedure codes. Required by Medicare, and commonly accepted by private payers, what we call the G codes. Medicare requires the G codes. Many private payers are also requiring the G codes. But on the private payer's side, private payers can require any codes they want. Out of the coding system. They're not obliged to use the G codes. They can require any codes they want. So the key is -- they can also make their own codes, believe it or not, the key is you have to contact them -- I really mean this sincerely -- you have to contact them and find out what codes each of them want. You don't do this hit or miss. Try billing the G codes to Aetna and see what happens. I will try to Linda G codes to UnitedHealthcare in Massachusetts and see what happens. That's hit or miss and that's a waste of precious time and energy. Contacting them, inquiring is the key. Again, these G codes are time based. We have one for initial, we have one for follow-up and there are 30 minutes -- you cannot round the codes. On the next slide, this is just a grid of the codes for MNT and DSMT. On the G codes at the bottom -- the ones we're using for DSMT. Okay? So on the next slide, these are revenue code descriptions. What our revenue codes? Revenue codes are special codes only for certain types of healthcare entities. Hospitals, rural health clinics, FQHC's, if you're in a pharmacy, you don't need a revenue code. If you are in a RD private practice physician private practice, you don't need a revenue code. Only in certain entities. At the very bottom here, you see 0942. If you are a hospital outpatient apartment, you have to use that revenue code. Hospitals do in put a revenue on their claim forms. On the next slide, you can see here the current reimbursement rates for DSMT, 2013 on the right-hand side. Right-hand side. In the third box going down, facility and non-facility, non-facility, that's like physician private practice, RD private practice, all right? A facility is a clinic, a hospital, a rural health center, and FQHC, that's different from non-facility. So you see here the ranges of the reimbursement rates. The reason you have the range is because Medicare geographically adjusts your payment rate for your region based on your cost of living. And you can look up your specific rate for your specific region on the CMS website. And you do not need to be a provider to get into those rates

for your specific region like Joliet, Illinois or Boston, Massachusetts. Okay. This is just a joke. I'm going to pass on that. So now this slide, Medicare DSMT and home health agencies and ESRD facilities, this is all very complicate stuff. If you feel like you're swimming in mud right now, I understand. On home health agencies, separate DSMT part B billing is allowed as long as you are finishing the DSMT outside of the part A treatment plan. So your documentation has to clearly say that you are finishing the DSMT outside of the part A treatment plan. You can furnish it on the same day that the patient is getting part A treatment but your documentation has to say that. Okay? Very, very, very important. In stage -- end-stage renal dialysis facilities, no separate part B bill. You can furnish the DSMT within the ESRD facility, but you cannot bill for it separately. The cost of doing that is going to be bundled in the all-inclusive payment rate paid by Medicare to the facility for everything that went on with that patient that day. So the cost of doing the DSMT is going to be part of your part A all-inclusive payment rate. You can't pull it out and bill for it separately. On the next slide, the Skilled Nursing Facility, yes, you can submit a separate part B bill. A separate part B bill. Again, you're going to want to document that the DSMT was provided outside of the part A benefit and treatment on that day. Okay? And in nursing homes, no separate part B bill. It can be furnished come up but you cannot bill for it separately. On the next slide, FQHC's, FQHC's. Okay? In and FQHC, the DSMT -- the slide -- I should have a little more robust information. The DSMT can be provided in FQHC and separate part B billing is -- is allowed -- maybe want to add that to your slides -- I apologize -- in FQHC's, it all has to be done on an individual basis. Isn't that weird? They do not allow group DSMT in and FQHC. If you could please write that on your slide, that would be great. FQHC's, it all has to be individual. And separate part B billing is allowed. In rural health clinics, the lady on the slide to ask a question about this, I don't know if she's a rural health clinic, she's a community clinic in a rural area. If she's doing last billing, that tells me there billing part A. And that tells me that no separate part B billing is going to be allowed. That the cost of doing the DSMT is going to be added to the all-inclusive part A rate. But that if she is -- has a designation of a rural health clinic. If not, if this questionnaire did not have that designation, then would have to look at that separately. And she can e-mail me. On the telehealth, can we provide this telehealth? The answer is yes. The answer is yes. Medicare allows DSMT -- DSMT, same as DSME education to be provided telehealth, both individual and group. The reimbursement is the same. Okay? The reimbursement is the same. Now, there's a couple other little goofy rules about telehealth. We have to dedicate at least one hour of the 10, one hour of the 10 in the initial year in at least one hour of the two in the follow-up year for in person training on injectable medication. So if you're patient is on any meds that is injected, pump or needle, with a pump or a needle, one hour of the 10 in the initial -- one hour of two in the follow-up has to be not telehealth, but in person to train on the meds. But the last box, it has to be interactive audio and video telecommunication. What does that mean? What we're doing right now, ladies and gentlemen, doesn't meet the requirements because you cannot see me and I cannot see you. We are doing it audio in real-time, yes we are. But there's no video. So this would not count. It has to be audio and visual. On the next slide, this corroborates what I'm saying. Excluded our telephone calls and faxes, and e-mails without the visual. So that's basically then farmer Joe -- the patient has to be in a rural area. And Medicare determines what is rural. The beneficiary has to be in a rural area. So the beneficiary, farmer Joe in the rural area comes to farmer Dr. Miller into Dr. Miller's office sits down at a special computer, signs in, to see the instructor in another area, audio and visual to do either class, group or individual. The group or the class, DSMT. And the physician who supplies that computer and the software can bill a facility fee for that. I have that coming up on a slide

here. So again, if the DSMT provider on this slide has to be licensed and certified in both states. If your patient is in one state and you are in another state, and if you have licensure or certification in both of those states, you have to have that. Very, very, very important. And the beneficiary receiving the DSMT has to be present. He cannot send his wife or mother or caregiver. And then we have the CPT code modifier GT to that DSMT code on the claim, which tells Medicare that this was provided telehealth. The reimbursement rate is the same. On the next slide, we talked about the originating site. That's where the beneficiary is located. During the telehealth session. Again, the beneficiary has to be what they call in a nonmetropolitan or rural area. Okay? Very, very important. And the physician -- or wherever that farmer Joe is going, the clinic, the hospital, the doctor's office, to sign on, into this, they can bill this facility fee for the use of that equipment. Okay? And so you can see here the eligible originating site is pretty much all the entity providers we talked about before. All the entity providers we talked about before. Including a critical access hospital renal dialysis center. And a community mental health center. Okay? Excluded, though, excluded for telehealth, home health agencies, they cannot bill for this, we cannot do this. And independent renal dialysis facilities. So what they called distance site is where the beneficiary is sitting at the time of the service. Okay. On the next slide, again, who are the individual -- the individual Medicare providers who can bill for telehealth? They are all listed here. So if you're one of these and you are also billing Medicare for something else, first, then you can bill for DSMT telehealth and DSMT non-telehealth if you're one of these individual Medicare providers. On the next slide, I'm not going to go through this at all. This is for your billing people. And these are the type of claim forms that your builder is using -- that your biller is using if you're coming out of private practice. This is the difference between rejected and denied claims. Rejected means -- it doesn't mean that they don't pay for this. It means something is wrong with your claim. You transposed the numbers, you did not have a physician signature, you didn't have an NPI number, a denied claim means Medicare doesn't pay for this. Okay? But you should not get denied claims if you're doing everything Coe pathetically -- copacetic. This is not that important. Medicare requires all reimbursement not to be done electronically. Into a bank account. Okay. Let's take some questions now.

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Ladies and gentlemen, to register a question it is 1-4 on your telephone.

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At this time, there are no questions queued up.

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We do have a question in the chat room. Can you please define nutrition professional? This is from Heidi Turpin.

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I know where this is going. Just as a backdrop to that question, so the listeners can understand, for the medical nutrition therapy benefit, who can bill for that? Only RD's and nutrition professionals. So that's into DSMT. If an RD or nutrition professional is already billing Medicare for MNT, then she or he can then bill for DSMT. And she has to meet all the other requirements. So what is a nutrition professional? The nutrition professional has to have the staying -- the same four-year bachelors degree from an accredited university that meets all of the all of -- all of the academic requirements to get a bachelors degree in nutrition or one of the required fields, just like I had to do, same thing, they have to get 900 hours after the baccalaureate degree of supervised experience -- what we call an internship -- same thing I had to do as a registered dietitian. They did not do that -- restriction exam offered by the commission

on dietetic registration. They did not take that one step further and take the registration exam. It's the same educational requirement for the bachelors degree and the internship but they did not take the exam. Any other questions in the chat room?

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A question from the audio side. From the line of Darling Jamison. Please go ahead.

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If ice -- if I saw correctly on the telehealth slide, it said that the distance location was the provider -- although I thought I heard you say the beneficiary -- can you clarify that please?

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You know what? I'm going to -- what I'll do is actually swing back to that slide. I'm swinging back to it for me but I know Laura is going to be going crazy right now. Okay? The originating site is where Martha Stewart, the beneficiary is located. And the distance site is where I would be as the RD. When we talk about that originating site, I think they know where you're going with this. Let's talk about farmer Joe -- back on the question slide with the best book -- farmer Joe lives in the farming community. And he has to go to and originating site to get his telehealth. That could be a physician's office, it could be hospital out -- outpatient department, a freestanding clinic, some type of healthcare facility or physician private practice where medical services are being provided. And this has all been prearranged for them to come and sit at a special computer to do audio and visual communication. I hope that answers the question.

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Thank you.

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Okay.

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We do have a follow-up question -- it is from the line of Kay Hamilton. Please go ahead.

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I'm just referring back to County health Department. I would ask that question -- provider for [Indiscernible] and I found I we are not a rural health clinic. There is a hospital here that's considered that, but our health Department is not. And when we bill, we do get reimbursed by part B.

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Well, it sounds to me that you would be able, then, to get an accredited or recognized DSMT program. And bill as a community health clinic as long as you are following all these other coverage guidelines. It sounds very copacetic to me.

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Okay.

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And bill directly --

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-- qualified -- [Indiscernible -- multiple speakers] we only bill for flu and pneumonia so I didn't know --

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You have to be billing Medicare, not necessarily part B. You have to be billing Medicare either part A or B for some of the Medicare benefit and getting reimbursed.

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Okay. We only bill for the flu and pneumonia. And it's part B that we bill. We don't even bill anything to part A.

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Well, that's fine. So you already have a track record of part B billing. I see no reason -- just from the very cursory conversation -- again, you can e-mail me and we can get more robust -- I don't see any reason you can't do this, honestly.

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Okay.

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So if you e-mail me, please --

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Okay. Is your e-mail going to be in parts of --

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It's one of the last slide. I will spell my name again when we get to the end.

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I've got [Indiscernible -- multiple speakers] thank you.

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Thank you. You're welcome.

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Are we good?

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There are no other questions at this time.

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Okay. Great. I hope you all appreciate my little talking vegetables here. They're cute. For a dietitian, I had to do it. Okay. So we already talked about Medicare electronic payments that you reimbursement has to come electronically now. And you actually have to fill out forms in order to get your payment electronically. It does not happen by magic. Be aware of that as you are starting in the Medicare -- we talked about advanced beneficiary notice. This is not all that important. Advanced beneficiary notice -- this is a particular see us -- CMS form -- you cannot make it up yourself -- is used when you expect Medicare payments to be denied. Meaning that it's used when primarily for covered benefits after -- used for covered benefits, DSMT has a covered benefit, but if there is some aberration or some weird situation existing in your facility right now where maybe Medicare is not going to pay for this -- say for example you did not get - - you interpreted the benefit that you need to get one of the qualifying eligible to labs -- that is how we interpreted the benefits -- you don't have one of the quality labs in your files. So you probably want to give an AVN to the patient. Let's say that you're done with the 10 hours. And the patient wants and 11 or 12 hour in the first year and you know that Medicare is probably not going to pay for the 11 or 12 hour. For the initial benefit but the patient is insistent on having it. That's probably the perfect example of giving the AVN. And the -- you have to fill it in, fill-in the blank blank and he s ays, this is a covered benefit, but in this situation, may not pay because of this reason and you fill in the reason. And then you say, if they don't p ay, you're going to be responsible for this much money. And you fill in your cost or your feet. And then the beneficiary has the opportunity to say yes or no right on the four, a checkbox yes or no, do I still want to pursue? Okay. I'm going to skip the next slide because it's not all that important right now. Then on the slide for modifiers for procedure codes, if you do use an AVN -- ABNABN -- that's not something you got to be thinking I should really know about this, this is something you should

work with, with your billing and operations people with these ABN's, they would know this better than you, but you do have to use the modifier, a GEA or GZ. On the next slide, private payor and Medicaid coverage of the -- DSMT. The thing is, on private payers, most private payers are paying for DSMT. Medicaid programs, I can't say that. Some are and some are not. Okay? The good news here -- the good news here is that most private payers are paying, but what you need to know is that they can make up their own coverage rules for the reimbursement coverage guidelines. They are not obliged to follow the Medicare coverage rules. They can make up any rules they want. The key is you have to find out what those rules are. And I have -- if you want to e-mail me, I have a grid I developed for another client that is actually a paper grid or a table on a Word document to keep track to all the questions you should be asking when you call the private payor. It lists the questions to ask and there is this grid for you to fill in the answers so you know about their poor billing rules. All right? So it's a private payor reimbursement grid for the particular benefit you're calling about. And the thing is, these private payers, like Blue Cross Blue Shield of Illinois could have their coverage guidelines for DSMT, meaning how many hours with a pay for in the initial year? How many hours in the follow-up year? What procedure codes to use? What diagnosis codes to use? Is a referral required or not? Are the eligibility labs required or not? All of that. Blue Cross Blue Shield could have this set in Illinois but Blue Cross Blue Shield could have a totally different set of coverage rules in California. Even though they are still Blue Cross Blue Shield. And even within Blue Cross Blue Shield of Illinois, there's HMOs, PPOs, IPOs, fee-for-service plans, every single healthcare plan within Blue Cross Blue Shield could have different coverage rules. Now, the same with Medicaid, we don't know unless we can't ask and I got this grid and the questions to ask and this grid for recording your answers. On the next slide, these are the rules -- a really brief review of some of the questions to ask. Again, I encourage you to e-mail me for my question list when you call private payers and Medicaid and the grid for documenting the answers. You don't want to be furnishing the benefit to a private payor subscriber not knowing if they covered or not, not knowing the reimbursement rules. It is so inefficient to do it that way. Kind of like doing it backwards. And the good news here on this slide, state insurance mandates for private payers, each state has a state Department of Insurance. In 46 states have state insurance laws that require private payer coverage for DSMT, MNT and diabetes related services and supplies. You can see the four states here who do not have laws. Now, these state insurance laws, they supersede, override any limitations in the health plan. So the private payer has to -- like Illinois, we have a diabetes law here. And so the trick is you've got to know what your state law mandates. How many hours of DSMT in the state of Illinois -- how many hours of MNT in the state of Illinois? How many test strips will they pay for? Will they pay for screening of the eyes or lipid test? How do you find out what your state covers for DSMT and MNT the -- the URL is at the bottom, right there. And CSL.org. Copy and paste that and you will find it -- NCLS.org. Procedure codes for DSMT not paid by Medicare, but may be required by private payers. So as I mentioned earlier in the slide deck, there are a lot of CPT procedure codes, CPT means they do not start without letters. And there are a lot of hit pick procedure codes, they start with a letter, there's tons of them out there that relate to diabetes management, diabetes training, diabetes education, nutrition counseling, you see them on this slide, and on the next slide here a 98061, 62, again, face-to-face education and training by a qualified nonphysician healthcare professional, these are not paid by Medicare, but private payers can select from these codes and say, this is the one I want you to use. Or they may require the G codes. We have to call and ask. Okay? And now we are on the joke slide. We get rid of the kids because the cat was allergic -- I had to put this in -- I have two caps. The next slide, more

procedure codes not paid by Medicare. Consultation, teen conferences, telephone services, et cetera. Shared medical appointments, that's where the physician does a medical visit in a group format, individual Medicare -- medical visits to each patient in the group. When he's done with his 10 patients in an hour, then an educator comes in and does 30 minutes of DSMT or 30 minutes of MNT. Okay? And I'm going to skip the SMA slides for right now. Actually, in don't think you have the SMA slide. I think I have those on my deck. In don't think you have those in your deck. So now I'm on the slide that says, I think you have this slide -- correct me if I'm wrong -- two cats sleeping in a bed, I'm sleepy after in -- after all that info. Laura, do you have a slide?

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We actually have a picture of a physician [Indiscernible -- audio cutting out] whiteboard -- and then [Indiscernible -- audio cutting out]

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Right. Right. I'm going to skip those slides, because that's all related to shared medical appointments. That was just information -- I put in the slide deck for our attendees. And I hope the attendees appreciate it. In a nutshell, I would love to do another webinar for you, just on SNAs, because they're wonderful, where physician or mid-level sit down with a group of homogenous patients, meaning all type one adults or all type two adults -- they all have common problems and common issues -- in a one-hour time period, doing an individual evaluation and medical management appointment in front of the other people in the group. So only spending about five or six minutes with each patient in front of the other patients. And you can bill for individual appointments even though we did it in a group and Medicare allows that. And the bottom line, the physician mid-level is making about \$17 a minute versus about \$5 a minute when he does it one on one in his office. When he's done with that one our group evaluation and medical management appointment, he leaves the room and educator comes in and does 30 minutes of DSMT or 30 minutes of MNT and you can bill for that then too. The educator can bill for that then also, for that same group of patients. That's the beauty of SNAs, it's working smarter, not harder. Earning more money and Medicare does approve medical visits, individual medical visits in a group format. So now I'm looking at a slide. I'm watching my time too, I'm looking at a slide -- if you're seeing it, Laura, it is two goats on a boat in the water.

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[Indiscernible -- audio cutting out] do you see the one with the mouse -- at the end -- the mouse lifting the weights?

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Yeah. I'm a the one where we have two cat, sleepy after all that info --here are the two goats, more Medicare -- [Indiscernible -- multiple speakers]

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We're good. Let's get the capture -- ignore Medicare and you may find yourself up a creek without a paddle. The next slide, increase your reimbursement now, all it takes is a little desire and strength on your part. The next slide, the dog and cat, your patient provider and staff will love you for it. The next slide with a little mouse in the helmet, do your homework, be prepared and take the plunge. Then the next slide with the cat inside the cage, and the Canary sitting on top of the cage, it says, otherwise, you're going to wake up one morning and realize you've made a significant boo-boo when you ignore Medicare. I really mean that sincerely, folks. Medicare age going away. I've got my next to last slide, effective information overload. Medicare age going away, as they say, and it's going to be strengthened and be made more robust with the

Affordable Care Act. And the other thing to consider -- why you should get into DSMT and MNT, is because us baby boomer -- baby boomer generation, we are the largest generation ever in terms of volume. And were all going to be hitting Medicare age in five to eight years. A lot of us are going to have diabetes, as you know. There's going to be a huge, mountainous amount of beneficiaries who are going to need DSMT and MNT. And there's not going to be enough providers going around if we don't take the plunge here, so there's enough business for all of us here. And I want to say in the end that the Medicare DSMT rates have tripled. The Medicare DSMT rates have tripled in the last year and half. And if you are operationally flipped -- slick and efficient -- I can help you with that off-line because I've developed a lot of DSMT programs from scratch -- I know how to make them slick and efficient so you can make money even on DSMT, not just breakeven but make money. It's all about marketing, marketing is huge to get your referrals and know how to do that. It's about your operational plan, your marketing plan, how you design your programs, how you teach, -- motivational interviewing, fun teaching, making the patient come out with a good feeling, all those things combined can really make your program very row -- very robust and profit driven. So anyway, thank you. Now, I'll take final questions.

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As a reminder, ladies and gentlemen, it is 1-4 on your telephone to register a question.

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At this time, there are no audio questions to -- queued up.

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Okay. If they are still here in the, that tells me one of two things. I either did a great job explaining this very convoluted complicated confusing data, or I did not do a good job and everybody is kind of swimming in the mud. I don't know which way that would go. Let me give you my e-mail address once again for help with -- if you want my assessment form. How to design a program, anything like that that I cannot be with. It is [hodorowicz@comcast.net](mailto:hodorowicz@comcast.net). And right now, my whole Comcast system is out. That's why I could not push my own site. Hopefully it's going to come back. And my cell phone number is (708)359-3864. (708)359-3864. And I have my own website, -- a lot of things -- great stuff, [www.maryannhodorowicz.com](http://www.maryannhodorowicz.com). You may want to poke around. A lot of fun stuff.

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I had a slide up with all your information for about the last couple minutes, but thank you very much. I know it was a lot of information but it was a really well run webinar. You did make it fairly clear, considering the content, so thank you very much. We appreciate it. Thank you, everyone, for your participation today. We're going to conclude the webinar at this time. Thank you.

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Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your line.

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[event concluded]