Diabetes Self-Management Training (DSMT) Reimbursement

Sponsored by:
The Disparities National Coordinating Center
Delmarva Foundation for Medical Care

June 25, 2013
12:30 PM Eastern Time
Money Matters in Diabetes Self-Management Training: Increase Your Insurance Reimbursement NOW!

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June 2013
LEARNING OBJECTIVES

1. Describe the beneficiary eligibility criteria for Medicare DSMT

2. List three of the Medicare coverage guidelines for telehealth DSMT

3. Name the procedure codes used to bill Medicare for DSMT
Medicare DSMT Reimbursement Rules: COPIOUS, CONVOLUTED, CONFUSING, COMPLICATED, CONSTANTLY CHANGING!
MEDICARE BENEFICIARY DSMT ENTITLEMENT

- Must have Medicare Part B insurance
- Suggestion: Make copy of Medicare card for MR
MNT--DSMT: COMPLIMENTARY but DISTINCT

**MNT**

- **Individualized** nutrition (and related) therapy to aid control of “A-B-C’s” of diabetes
- **Personalized** behavior change plans: eating, SMBG, exercise, stress control plans*
- **Long-term** follow-up with extensive monitoring of labs, outcomes, behavior Δ, etc. with required adjustments in plans*

**DSMT**

- **General** and basic training on AADE7™ behaviors in primarily group format
- **↑ pt’s knowledge of why and skill in how** to change key behaviors
- **Shorter-term** follow-up with limited monitoring of labs, outcomes, etc.*
COORDINATION OF MEDICARE MNT--DSMT

Medicare covers MNT and DSMT...but NOT on same day!

**MNT: First Calendar Year, 3 Hrs**
- Individual or group*.
- **Individualized** assessment, nutrition dx, intervention (personalized plans) and outcomes monitoring and evaluation.

**DSMT: 12 Consecutive Months, 10 Hrs***
- **Group** classes*^ in 10 topic areas (as needed by pt) on basic diabetes self-care outlined in *National Standards of DSME*.

**MEDICAL CONDITIONS**
- Diabetes: Type 1, Type 2, GDM, Non-Dialysis Renal Disease, and
- for period of 36 months after successful kidney transplant.
  - *Group = 2 or more pts; need not all be Medicare.*

Nutrition is 1 of 10 topics presented as overview of healthy eating to control A-B-C's of diabetes; **no** individualized plans created for pt.

*^9 hrs of 10 to be **group**; 1 may be **individual**.
- 10 hrs may be all **individual** if: special needs documented on referral or no program scheduled in 2 months of referral or additional insulin training Rx'd.
MEDICARE DSMT BILLING PROVIDER ELIGIBILITY

Select individual and entity Medicare providers can bill. Must be billing for other Medicare services and reimbursed.

Individual Medicare providers who can bill on behalf of entire DSMT program: MD, DO, RD, NP, PA, CNS, LCSW, clinical psychologists.

Cannot join Medicare just to furnish DSMT.

Above can all be instructors in program, but program must have RD or RN or RPh per National Standards of DSME, 2007.

Separate Part B DSMT billing is allowed in:

- hospital OP depts, skilled nursing home, FQHC, DME, pharmacy, clinic, physician or physician extender practice, RD private practice, home health.

Separate Part B DSMT billing NOT allowed in:

- hospital inpt, nursing home, ESRD facility, hospice care, ER dept., rural health clinic.
My mother taught me about the science of Osmosis…

“Shut your mouth and eat your supper!”
MEDICARE PAYMENT RULE: ORDERING PROVIDERS MUST BE ENROLLED IN MEDICARE*

• Benefits must be ordered by physician or eligible professional enrolled in Medicare or in opt out status
  – Must also be enrolled with specialty type eligible to order and refer those specific items/services….example:
    • Only MDs and DOs can order MNT
    • MDs, DOs and qualified non-physician practitioner (NPPs) can order DSMT
      – NPPs = NPs, PAs, CNSs
  – Provider’s NPI # must be on claim as “referring provider”
    • Organizational NPI # cannot be used as “referring provider”
Chiropractors not eligible to order services or supplies for Medicare beneficiaries

Home Health Agency (HHA) services may only be ordered by:

- MD
- DO
- DPM (Doctor of Podiatric Medicine)

*Reference:
MEDICARE PAYMENT RULE: ORDERING PROVIDERS MUST BE ENROLLED IN MEDICARE*

- DSMT providers can check if referring provider enrolled in Medicare (or opted out) via enrollment record in web-based

  PECOS =
  Provider Enrollment, Chain and Ownership System

  https://pecos.CMS.hhs.gov
MEDIicare payment rule: ordering providers must be enrolled in medicare*

- Can also be used in lieu of Medicare enrollment application (i.e., paper CMS-855I) to:
  - Submit/track initial Medicare enrollment application
  - View/change enrollment info
  - Add/change reassignment of benefits
  - Submit changes to Medicare enrollment info
  - Reactivate existing enrollment record
  - Withdraw from Medicare Program
RD’s OPTIONS: MEDICARE MNT--DSMT

B: Become Medicare provider and Bill for MNT; can then bill for AADE-accredited DSMT program

R: Refer beneficiary for MNT or DSMT to Medicare RD provider who is furnishing, or to AADE-accredited DSMT program

O: Opt out of Medicare by filing opt out affidavit letter every 2 yrs; enter into private contract with each beneficiary, using Medicare contract language

X: Exclude Medicare involvement and rules for MNT excluded in Medicare Part B
MEDICARE DSMT QUALITY STANDARDS

DSMT

Required: recognition of program by ADba or accreditation by AADE. Send copy of certificate to Medicare carrier or regional MAC, return receipt.

Both require adherence to National Standards of DSME. Standard 5: RD or RN or pharmacist can be solo instructor, but multi-disciplinary team recommended.

DSMT program in Rural Health Clinic:
If solo instructor, must be RD-CDE.
CMS defines rural area (www.cms.gov)

Pts in DSMT class must sign attendance sheet.
Help me to always give 100% at work...

12% on Monday
23% on Tuesday
40% on Wednesday
20% on Thursday
5% on Fridays
Diabetes can be dx'd prior to Part B entry. Pt on renal dialysis only eligible for non-nutrition content areas.

Best Practice Suggestion
Use *DSME/T and MNT Services Order Form* (revised 8/2011) Access at: www.aadenet.org
Best Practice Suggestions
Educators may wish to obtain documentation of diagnostic lab.
Can use revised DSME/T--MNT Services Order Form.
Download at: aadenet.org or www.eatright.org

T1 and T2 Diabetes
Per Medicare: T1, T2 diabetes diagnosed using 1 of 3 lab tests (next slide)*.
Above statement now on revised DSMT and MNT Services Order Form (revised 8/20/11).

Documentation of T1 or T2 diabetes dx is DSMT coverage rule.
But language of benefits do NOT state WHO must have documentation.

MNT: Only physicians can refer.
DSMT: physicians and qualified non-physician practitioners (NPPs) can refer:
NPP = NP, PA, CNS

Best Practice Suggestions
Educators may wish to obtain documentation of diagnostic lab.
Can use revised DSME/T--MNT Services Order Form.
Download at: aadenet.org or www.eatright.org
MEDICARE DIAGNOSTIC LAB CRITERIA for DSMT

FPG \( \geq \) 126 mg on 2 tests, or
2 hr OGTT \( \geq \) 200 mg on 2 tests, or
Random BG \( \geq \) 200 mg + uncontrolled DM symptom(s).
HbA1c not added as of conference date in 2013

Symptoms of uncontrolled diabetes:
Excessive thirst, hunger, urination, fatigue, blurred vision; unintentional wt loss; tingling, numbness in extremities; non-healing cuts, wound, etc.

Gestational Diabetes
Provider to provide documentation of gestational diabetes dx code.

Best Practice Suggestions
May wish to obtain documentation of diagnostic lab.
Use revised DSME/T--MNT Services Order Form.
Download: aadenet.org or eatright.org (revised 8/20/11)

\(^\text{HbA1c} \geq 6.5\%\) diagnostic for T1, T2 DM per ADbA, *Standards of Medical Care*, 2013

*Federal Register, Vol. 68, #216, 11-7-03, p.63261
**MEDICARE DSMT REFERRAL REQUIREMENTS**

**DSMT**

Written Rx by treating physician or qualified non-physician practitioner (NPP): NP, PA, CNS. To include: Rx date + beneficiary's name.

ICD-9 dx or code (5-digits for T1, T2 DM). Physician's/NPP's NPI + signature. Separate Rx for: initial and f/up DSMT. For **initial**: topics + hrs to be taught (10 total each).

For **initial**: whether group or individual DSMT. If **individual**: special needs that warrant. Physician/NPP to maintain pt's plan of care in chart maintained in provider's office.

Revised **DSME/T and MNT Order Form** lists diagnostic lab criteria + asks provider to send labs for pt eligibility and outcomes monitoring. Original to be in pt's chart in provider's office.
Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information

Patient's Last Name
First Name
Middle

Date of Birth: ______/_____/______
Gender: Male □ Female □

Address: ____________ City: ____________ State: ______ Zip Code: ______

Home Phone: ______ Other Phone: ______ E-mail Address: ______

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and additional services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested:
- Initial group DSME/T: ______ hours or ______ mo. hrs. requested
- Follow-up DSME/T: ______ hours or ______ mo. hrs. requested
- Telehealth: ______

Please check any special needs that apply:
- Vision
- Hearing
- Physical
- Cognitive impairment
- Language limitations
- Additional training: ____________________________
- Telehealth: ____________________________

DSME/T Content

- Monitoring diabetes
- Psychological adjustment
- Physical activity
- Nutritional management
- Goal setting, problem solving
- Medications
- Prevent, detect, and treat acute complications
- Preconception/pregnancy management, or DSM
- Prevent, detect, and treat chronic complications

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Diagnosis

Type 1 □ Type 2 □
Diabetes code: ____________

Complications/Co-morbidities

Check all that apply:
- Hypertension
- Dyslipidemia
- Stroke
- Hypoglycemia
- PVD
- Kidney disease
- Renal failure
- Retinopathy
- ESRD
- Macular degeneration
- Nausea
- Sleep disorder
- Other

Definition of Diabetes (Medicare)

Medicare coverage of MNT: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Other payers may have other coverage requirements.

Signature and HPI: ____________________________
Date: ______/_____/______

Group practice name, address and phone: ____________________________

Revised August 2011

Revised 2011 by the American Association of Family Physicians and the American Diabetes Association.
Added Definition of Diabetes (Medicare):

“Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following”:

- FPG $\geq 126$ mg/dl on 2 different occasions;
- 2 hr PPG $\geq 200$ mg/dl on 2 different occasions; or
- Random BG $\geq 200$ mg/dl with symptoms of uncontrolled DM

Source: Volume 68, #216, Nov.7, 2003, page 63261/Federal Register
Other payors may have other coverage requirements.
WHAT’S DIFFERENT ON REVISED FORM

**Added** MNT Telehealth and DSMT Telehealth

**Added** in DIAGNOSIS section:

“Please send recent labs for patient eligibility & outcomes monitoring.”

**Omitted** these words in DIAGNOSIS section:

“Uncontrolled” and “Controlled” for Type 1, Type 2
WHAT’S DIFFERENT ON REVISED FORM

Omitted these sections:

• Current Diabetes Medications
• Patient Behavior Goals/Plan of Care
Are we confused yet?
MEDICARE DSMT LIMITS in FIRST YEAR and STRUCTURE OF

Medicare MNT and DSMT in initial year may NOT be provided on same day!

**DSMT**: 10 hrs in 12 consecutive months. Cannot extend into next yr.
9 hrs group + 1 hr may be individual
Visit is \( \geq 30 \) min. (1 billing unit; no rounding).

1 hr may be for individual assessment, insulin instruction or training on ANY topic.
10 hrs may be used for only 1 topic (new!).

**Additional Hrs Not Cited by CMS as Payable.**
9 hrs can be individual IF referring provider documents in medical record and on Rx:
Pt's special needs precluding group (vision, language, hearing, physical, cognitive, etc.)
OR no program starting within 2 months of Rx date,
OR physician orders additional insulin training.
MEDICARE DSMT LIMITS in FOLLOW-UP YEARS and STRUCTURE OF

F/Up DSMT After First 12 Consecutive Months

2 hrs each 12 months after initial DSMT completed. Cannot extend hrs into next 12 months. Individual, group or combination.

**Individual** or **group** visit:

$\geq 30$ min. (1 billing unit). No rounding. New Rx for follow-up.

Special needs do not need to be documented for individual follow-up DSMT. Can obtain even if INITIAL DSMT not received.
MEDICARE TIME FRAME CHANGES for FOLLOW-UP DSMT: EXAMPLE

Pt Completes Initial 10 Hrs That Spans 2 Yrs: 2013 and 2014:

• Starts initial 10 hrs in August 2013
• Completes initial 10 hrs in August 2014
• Eligible for…and starts…2 hr follow-up in September, 2014
• Completes 2 hr follow-up in Dec., 2014
• Eligible for next 2 hr follow-up in Jan., 2015

Pt Completes Initial 10 Hrs in Same Calendar Year:

• Starts initial 10 hrs in August 2013
• Completes initial 10 hrs in Dec., 2013
• Eligible for…and starts…2 hrs follow-up in Jan., 2014
• Completes 2 hr follow-up in July 2014
• Eligible for next 2 hr follow-up in Jan. 2015
Only certain professionals authorized to select ICD-9 dx codes for narrative diagnoses: PHYSICIANS, QUALIFIED NPPs and LICENSED MEDICAL RECORD CODERS.

Diagnosis is Required Documentation:
In MR maintained by physician/NPP.
Educator/RD may wish to also obtain documentation before furnishing MNT or DSMT.

Required on REFERRAL.
Diagnosis can be narrative description OR ICD-9 dx code.

Required on CLAIMS. Use 5 digit code when possible:
250.02 = Type 2 uncontrolled diabetes vs. 250 = diabetes mellitus.
Claim may be denied if 5th digit not used!

Educator/RD may wish to also obtain documentation before furnishing MNT or DSMT.
DIAGNOSES for MEDICARE DSMT

4th digit = clinical manifestation/complication of diabetes

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>250.0</td>
<td>Diabetes mellitus without mention of complication</td>
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<tr>
<td>250.1</td>
<td>with ketoacidosis</td>
</tr>
<tr>
<td>250.2</td>
<td>with hyperosmolarity</td>
</tr>
<tr>
<td>250.3</td>
<td>with other coma</td>
</tr>
<tr>
<td>250.4</td>
<td>with renal manifestations</td>
</tr>
<tr>
<td>250.5</td>
<td>with ophthalmic manifestations</td>
</tr>
<tr>
<td>250.6</td>
<td>with neurological manifestations</td>
</tr>
<tr>
<td>250.7</td>
<td>with peripheral circulatory disorders</td>
</tr>
<tr>
<td>250.8</td>
<td>with other specified manifestations</td>
</tr>
<tr>
<td>250.9</td>
<td>with unspecified complications</td>
</tr>
</tbody>
</table>
DIAGNOSES for MEDICARE DSMT

- 5th digit identifies:
  - T1 or T2 diabetes
  - Controlled or uncontrolled diabetes

  To be coded as “uncontrolled”, treating provider must document “uncontrolled” in MR

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.X0</td>
<td>Type 2 controlled</td>
</tr>
<tr>
<td>250.X1</td>
<td>Type 1 controlled</td>
</tr>
<tr>
<td>250.X2</td>
<td>Type 2 uncontrolled</td>
</tr>
<tr>
<td>250.X3</td>
<td>Type 1 uncontrolled</td>
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</table>
PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

HCPCS* Codes for Initial + Follow-Up Visits:
- Individual: G0108 (1 unit = 30 min)
- Group: G0109 (1 unit = 30 min)

Private payers may require other codes or their own unique codes identified in payer-provider contract.

HCPCS = Healthcare Common Procedure Coding System
# MEDICARE REQUIRED MNT, DSMT CODES

Visit can be any # of units but must be > 1 | 1 Unit
--- | ---
97802 | MNT, initial episode of care (EOC), individual | 15 min
97803 | MNT, f/up EOC, individual | 15 min
97804 | MNT, initial or f/up EOC, group | 30 min
G0270 | MNT, initial, individual, beyond 3 hrs or MNT, f/up, individual, beyond 2 hrs per 2\(^{nd}\) referral in same yr | 15 min
G0271 | MNT, initial, group, beyond 3 hrs or MNT, f/up, group, beyond 2 hrs per 2\(^{nd}\) referral in same yr | 30 min
G0108 | DSMT, individual, initial or f/up, each 30 min. | 30 min
G0109 | DSMT, group, initial or f/up, each 30 min. | 30 min
REVENUE CODE DESCRIPTIONS for BILLING MEDICARE DSMT

• 052X Freestanding Clinic
• 0521 Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC)
• 0522 RHC/FQHC - Home
• 0524 RHC/FQHC (SNF Stay Covered in Part A)
• 0525 RHC/FQHC (SNF Stay Not Covered in Part A)
• 0527 RHC/FQHC Visiting Nurse Service - Home
• 0528 RHC/FQHC Visit To Other Site
• 090X Behavioral Health Treatments/Services
• 0942 Education and Training (Hospital OP Depts)
MEDICARE DSMT REIMBURSEMENT RATES, 2013

Medicare MNT Rates: 2013
Accessed 6/1/13 on CMS.gov

85% of Medicare Physician Fee Schedule (MPFS). Medicare pays 100% of adjusted rate. 20% pt co-payment waived, BUT paid by Medicare.

Facility-Adjusted Rates*: 97802, initial, 15 min:
Non-Facility: $29.36 -- 45.15
Facility: $27.51 -- 42.24

97803, follow-up, 15 min:
Non-Facility: $25.25 -- $38.89
Facility: $23.41 – 35.98

97804, group, initial or f/up, 30 min:
Non-Facility: $14.56 - $20.24
Facility: $14.28 - $19.88

Medicare DSMT Rates: 2013
Accessed 6/1/13 on CMS.gov

100% of condensed MPFS for par providers, but only 95% for non-par providers. Medicare pays 80% of adjusted rate, pt pays 20%.

Rates*, Facility and Non-Facility:
G0108, individual, 30 min: $48.46 – $68.11
G0109, group, 30 min: $12.05 – $18.43

*Rates also vary per geographic region.
My mother taught me about contortionism.

Will you look at the dirt on the back of your neck!
MEDICARE DSMT BILLING in HOME HEALTH AGENCY and ESRD FACILITY

- **Home Health Agency**
  - **DSMT**
    - YES separate Part B bill when outside of Part A treatment plan on 34x bill
  - **DSMT**
    - Part A home health benefit and Part B DSMT can be received at same time

- **End Stage Renal Dialysis Facility**
  - **DSMT**
    - NO separate Part B bill
MEDICARE DSMT BILLING in SKILLED NURSING FACILITY and NURSING HOME

**Skilled Nursing Facility**

- **DSMT**
  - YES separate Part B bill.
  - Part A SNF benefit and Part B DSMT can be received at same time

- **Uee** 22x, 23x type of bill
- **Revenue code** 0942

**Nursing Home**

- **DSMT**
  - NO separate Part B bill
MEDICARE DSMT BILLING
In FEDERALLY QUALIFIED HEALTH CENTER
and RURAL HEALTH CLINIC

FQHC

DSMT
Same
TOB 73x, revenue code 052x

Rural Health Clinic

DSMT
NO separate Part B bill.
Paid at all-inclusive Part A rate.
Solo instructor to be RD-CDE
**MEDICARE DSMT TELEHEALTH**

**INDIVIDUAL + GROUP** DSMT can be delivered via telehealth

**REIMBURSEMENT:** Same as in original DSMT benefits

**DSMT:** ≥1 hr of 10 in **initial** yr & ≥1 hr in **follow-up** yrs to be furnished in-person for training on injectable medications (individual or group)

**WHAT IT IS:** Interactive audio & video telecommunications system permitting **real time** communication + visualization

Excluded: Telephone calls, faxes, email without visualization, stored and delayed transmissions of images of pt

DSMT Provider Eligibility:
Licensed or certified in state where provider works AND in state where patient located

If pt in 1 state and provider location in another, provider must be licensed or certified in both states

Beneficiary receiving DSMT must be present and participate in telehealth visit

CPT code modifier “GT” added to DSMT code on claim: “Interactive audio and video telecommunications system”
**Originating Site:** Location of beneficiary. To be in NON-metropolitan statistical area (see www.census.gov). Facility fee can be billed via code Q3014; deductible + coinsurance apply (2012 = $24.10)

**Eligible Originating Sites:** Physician/NPP office*, hospital, CAH, RHC, FQHC, hospital and CAH-based renal dialysis center, SNF, community mental health center. *Bills Part B; others bill Part A

**Excluded:** Home Health, independent renal dialysis facilities

**Distant Site:** Location of provider at time of service
MEDICARE DSMT TELEHEALTH GUIDELINES

- Medicare DSMT provider eligibility requirements:
  - Must be one of these provider types:
    - Physician
    - Physician assistant (PA)
    - Nurse practitioner (NP)
    - Clinical nurse specialist (CNS)
    - Certified nurse midwife (CNM)
    - Clinical psychologist
    - Clinical licensed social worker (CLSW)
    - Registered dietitian (RD) or nutrition professional
DSMT CLAIM FORMS for HOSPITAL and PRIVATE PRACTICE

**MEDICARE**

**Hospital OP:** If Hospital is Provider:
- CMS 1450 = UB04 claim^ or HIPAA 837
- Institu ECF*

To Part A Intermediary; being replaced by Medicare Administrative Contractors

**Private Practice:** RD is provider:
- CMS 1500 claim or HIPAA 837
- Institu ECF*
- Prof ECF**

To Part B Carrier; being replaced by Medicare Administrative Contractors "MACs"

**PRIVATE PAYER**

**Hospital OP:** If Hospital is Provider:
- CMS 1450 = UB04 claim^ or HIPAA 837
- Institu ECF*

To Private Insurance

**Private Practice:** RD is provider:
- CMS 1500 claim or HIPAA 837
- Institu ECF*
- Prof ECF**

To Private Insurance

*Institu ECF = Institutional electronic claim
^ If paper claim used, must use new CMS-1500 *paper* claim (08-05) and new UB-04 *paper* claim.
**Prof ECF = Professional electronic claim
REJECTED vs. DENIED CLAIMS

**REJECTED CLAIM**
Medicare returns as unprocessable. Medicare cannot make payment decision until receipt of corrected, re-submitted claim.

= INCOMPLETE Claim: Required info is missing or incomplete (ex: no NPI #).

INVALID Claim: Info is illogical or incorrect (ex: wrong NPI #, hysterectomy billed for male pt, etc.)

**DENIED CLAIM**
Medicare made determination that coverage requirements not met; example: service is not medically necessary.

To pursue payment, provider can go through Medicare's appeals process.
• Affordable Care Act mandates Medicare payments be made only via electronic funds transfer (EFT)
  – Part of CMS’ revalidation efforts
  – Providers not rec’ing EFT payments will be:
    • Identified
    • Required to submit CMS 588 EFT Form with Provider Enrollment Revalidation Application
MEDICARE ELECTRONIC PAYMENTS

- MACs and clearing houses provide electronic claims software at little/no charge at:
  
  www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage

- Support for filing paper claims at:
  
  www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp#TopOfPage
ADVANCE BENEFICIARY NOTICE (ABN)

• **ABN** (paper form CMS-R-131) can be used for cases where Medicare payment expected to be **denied**

• Notifies beneficiary **prior to** service that:
  
  – Medicare will probably deny payment for service
  
  – Reason *why* Medicare may deny payment
  
  – Beneficiary will be responsible for payment if Medicare denies payment
ADVANCE BENEFICIARY NOTICE (ABN)

• NOT required for benefits statutorily **excluded** by Medicare (e.g. MNT for HTN).

• BUT, can also used:
  – When unsure service is medically necessary, or
  – Service may exceed frequency or duration limit
  – In place of *Notice of Exclusion from Medicare Benefits* to inform beneficiary that service is **not** covered by Medicare
MODIFIERS for PROCEDURE CODES

- **GA**: Service expected to be denied as not reasonable or necessary. Waiver of liability (ABN) on file.

- **GZ**: Service expected to be denied as not reasonable or necessary. Waiver of liability **NOT** on file.

- If provider knows that MNT--DSMT claim will be denied, pt or provider can submit denied claim to supplemental insurance
  - Some private payers may require Medicare denial *first* before considering to pay

  - **GY** modifier added to code to obtain denial
PRIVATE PAYER and MEDICAID COVERAGE of DSMT

• Coverage policies and, if paid, coverage rules, do vary:
  – From **state to state** among major plans (BCBS of IL. vs. BCBS of CA.)
  – Among plans in payer company (HMO vs. PPO)
  – Among state Medicaid plans

• Some cover pre-diabetes (glucose intolerance, IFG)
RULES OF THUMB

Call each and every payer in local area (or check website) to inquire about payer’s MNT-DSMT:

1. Coverage **policy**
   - Does payer cover services?

2. Coverage **guidelines** re:
   - Referring provider eligibility
   - Who can bill
   - Pt eligibility and entitlement
   - Benefit structure, utilization limits, place of service
   - Billing codes, claim types, etc.
   - Reimbursement rates
46 states* and DC have state insurance laws that require private payer coverage for:
- DSMT, MNT, DM-related services and supplies

* 4 states with no laws: AL, ID, ND, OH

Laws supersede any coverage limitations in health plan

Exclusions do exist (e.g., state/federal employer health plans often exempt from state mandates)

PROCEDURE CODES for DSMT

NOT PAID by MEDICARE

BUT MAY be REQUIRED by

PRIVATE PAYERS and MEDICAID

STOP
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S9140</td>
<td>Diabetes management program, f/up visit to non-MD provider</td>
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<tr>
<td>S9141</td>
<td>Diabetes management program, f/up visit to MD provider</td>
</tr>
<tr>
<td>S9145</td>
<td>Insulin pump initiation, instruction in initial use of pump (pump not included)</td>
</tr>
<tr>
<td>S9455</td>
<td>Diabetic management program, group session</td>
</tr>
<tr>
<td>S9460</td>
<td>Diabetic management program, nurse visit</td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, dietitian visit</td>
</tr>
<tr>
<td>S9470</td>
<td>Nutritional counseling, dietitian visit</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
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<tr>
<td>98960</td>
<td>Individual, initial or f/up face-to-face education, training &amp; self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.</td>
</tr>
<tr>
<td>98961</td>
<td>Group of 2 - 4 pts, initial or f/up, each 30 min.</td>
</tr>
<tr>
<td>98962</td>
<td>Group of 5 - 8 pts, initial or f/up, each 30 min.</td>
</tr>
</tbody>
</table>

Neither AADE accreditation nor American Diabetes Association recognition of DSMT program required.
• For pts with established illnesses/diseases or to delay co-morbidities

• Physician/NPP must Rx education and training

• Non-physician's qualifications and program's contents must be consistent with guidelines or standards established or recognized by physician society, non-physician HCP society/association, or other appropriate source
WE GOT RID OF THE KIDS.....
THE CAT WAS ALLERGIC
PROCEDURE CODES

NOT PAID by MEDICARE

• Consultation codes:
  – 99241-99245, 992510–99255

• Medical Team Conference codes:
  – 99366 and 99368

• Telephone Services codes:
  – 99441 – 99443: non face-to-face services

• On-Line Medical Evaluation
  – 99444: Internet/electronic communications network; not related to evaluation & management (E&M) visit within last 7 days
SHARED MEDICAL APPOINTMENT

- Typically 2 distinct ‘shared’ services in group visit at same encounter, targeted to a common problem:

1. Individual, follow-up medical patient care via evaluation and management (E&M) by provider (physician or mid-level)

AND

2. Self-care education, MNT or other behavior change counseling by diabetes educator, RD and/or behaviorist
INDIVIDUAL Follow-Up Visit with Physician/Mid-Level in Interactive GROUP Setting AND

GROUP DSMT or MNT by Educator

Typically in 1.5 to 2 Hours with 10 – 15 Patients
SMA Results in Many Benefits for Providers and Educators, Including those that Impact Financial Bottom Line
• Improved time and resource **efficiency**:  
  – Can work smarter, not harder, to earn **MORE** revenue in **LESS** time while at same time provide high quality, patient-centered care

• Lessens huge demands for more pt visits in limited time per work week in order to barely make profit:
  – Can provide **MORE** care to **MORE** pts in **LESS** time

• 10 - 15 pts get care in time previously required for 2 – 3 in format pts WANT and NEED
• Adequate *insurance reimbursement* for time and expertise

  – Can bill *for individual*, established evaluation and management (E&M) visits for EACH patient in *group* SMA
MEDICARE REIMBURSEMENT for PROVIDER

• Provider bills **individual established pt E&M code** for each pt in group SMA:
  
  – Select E&M code for each pt based on level of care provided **and** documented for each pt:
    
    • 99212, 99213, 99214 or 99215
  
• Private payers (not Medicare) may require **modifier TT**: individualized service for >1 pt with multiple pts present

• Time NOT used as criteria for E&M level in SMA
<table>
<thead>
<tr>
<th></th>
<th>SMA: 1:1 Patient Visits in Group plus Group DSMT or MNT</th>
<th>Traditional Pt Visit with Physician or Mid-Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aver. # pts</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total time</td>
<td>2 hrs: <em>Only 1 hr for physician</em></td>
<td>3.3 hrs (~20 min/pt)</td>
</tr>
<tr>
<td>1, 30 min. unit group DSMT</td>
<td>10 pts x approx $14/pt = $140</td>
<td>None</td>
</tr>
<tr>
<td># indiv. visits by physician</td>
<td>10 x approx $100/pt = $1000</td>
<td>10 x approx $100/pt = $1000</td>
</tr>
<tr>
<td>Combined insurance reimbursement</td>
<td>DSMT: $140</td>
<td>DSMT: $0</td>
</tr>
<tr>
<td></td>
<td>Physician: $1000 in <strong>1 hr</strong></td>
<td>Physician: $1000 in <strong>3.3 hrs</strong></td>
</tr>
<tr>
<td>Reimbursement to physician</td>
<td>Physician: $1000 in only <strong>1 hour = $17/minute</strong></td>
<td>Physician: $1000 in <strong>3.3 hours = $5/minute</strong></td>
</tr>
</tbody>
</table>

**DO THE MATH! WIN-WIN FOR PHYSICIANS and EDUCATORS**
• **DSMT:** Medicare billed under NPI# of sponsoring organization (e.g., physician practice) or sponsoring individual provider (e.g., RD)

  – NPI# to be **different** than provider’s NPI# who furnished E&M services
Key TakeAway Points

• SMA is newer and highly effective alternative model of chronic care delivery….especially diabetes care

• Patients and providers work in synergistic harmony to get M.O.R.E. results:
  
  **Maximization of**
  
  **Outcomes, Revenue, and**
  
  **Empowerment of Patients**
I'm sleepy after all that info!
IGNORE MEDICARE AND YOU MAY FIND YOURSELF UP A CREEK WITHOUT A PADDLE
INCREASE REIMBURSEMENT NOW!

ALL IT TAKES IS A LITTLE DESIRE AND STRENGTH ON YOUR PART!
YOUR PATIENTS, PROVIDERS & STAFF WILL LOVE YOU FOR IT!
DO YOUR HOMEWORK, BE PREPARED AND TAKE THE PLUNGE!
OTHERWISE, YOU’RE GOING TO WAKE UP ONE MORNING, AND REALIZE YOU’VE MADE A SIGNIFICANT BOO-BOO!
EFFECT OF INFORMATION OVERLOAD
MARY ANN WILL NOW ENTERTAIN YOUR QUESTIONS
Thank you for participating in today’s webinar.

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ADDITIONAL RESOURCES

Information on Mary Ann’s products below at: www.maryannhodoroowicz.com

• Turn Key Policy & Procedure Manual, Forms, Training and Support for AADE DSME Program Accreditation and Reimbursement
  ▪ DSME Policy & Procedure Manual & All Forms Consistent with Requirements for:
    ▪ AADE Accreditation of DSME Program
    ▪ Adherence to NSDSME
    ▪ Medicare/Private Payer Reimbursement
  ▪ Plus Business Planning Support; Copy-Ready/Modifiable Forms & Handouts; Fun 3D Teaching Aids for all Self-Care Topics


• Establishing a Successful MNT Clinic in Any Practice Setting ©”

• EZ Forms for the Busy RD™: 107 total, on CD-r; Modifiable; MS Word
  ▪ Package A: Diabetes and Hyperlipidemia MNT Intervention Forms, 18 Forms
  ▪ Package B: Diabetes and Hyperlipidemia MNT Chart Audit Worksheets: 5 Forms
  ▪ Package C: MNT Surveys, Referrals, Flyer, Screening, Intake, Analysis and Other Business/Office and Record Keeping Forms: 84 Forms