CATEGORIES of HEALTHCARE INSURERS' "REIMBURSEMENT RULES" for DSMES, MNT and RELATED BENEFITS…AND THE DEFINED RULES		
INSURER NAME, INQUIRY DATE, PERSON I SPOKE TO:		
1.	**U**tilization limit (no. of initial, and no. of follow-up hours or visits)	
2.	**P**laces of service approved (OP hosp., MD practice, clinic, pharmacy, etc.)	
3.	**P**rocedure code(s) required or accepted	
4.	**P**rovider referral required from provider. If provider must be treating. Type of ordering providers approved (MD, DO, NP, PA)	
5.	**R**eimbursement rate for each procedure code approved	
6.	**T**ime period for utilization limit (calendar year or rolling year)	
7.	**B**illing providers approved (MD, DO, NP, PA, RD; entity providers)	
8.	**R**endering providers approved (MD, DO, NP, PA, RD, LCSW, etc.)	
9.	**G**roup and/or individual visits required or combination of both is OK	
10.	**I**CD-10 diagnosis codes approved and not approved	
11.	**A**DA or AADE certification required for diabetes education program	
12.	**L**ab eligibility requirement to start benefit (FBG, random BG, 2^{o}OGTT)	
13.	**I**ncident to physician billing methodology required or prohibited	
14.	**U**se of quality standards required (published nutrition guidelines)	
15.	**I**f 2 benefits are payable on same day to same patient (DSMT and MNT)	
16.	**I**f patient data must be reported to payer at scheduled intervals (DPP)	