QIN-QIO Public Sharing Call:
The Basics for Achieving Medicare Reimbursement for DSMT
Thursday, November 8, 2018, 3:00-4:30 PM ET
Unanswered Questions

QUESTION	ANSWER
1. If the 20% is a barrier for the patient, can the 20% deductible be written off in the hospital cost report?	When a Medicare provider waives a beneficiary's deductible and/or copayment, these amounts are not considered "bad debt" and are not included as bad debt on the Medicare cost report. (Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R8P211.pdf) Below is very important information regarding the waiving of Medicare copayments and deductibles (Source: https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html): *A provider, practitioner or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is $100, but routinely waives the copayment, the actual charge is $80. Medicare should be paying 80 percent of $80 (or $64), rather than 80 percent of $100 (or $80). As a result of the supplier's misrepresentation, the Medicare program is paying $16 more than it should for this item.* *In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.* *At first glance, it may appear that routine waiver of copayments and deductibles helps Medicare beneficiaries. By waiving Medicare copayments and deductibles, the provider of services may claim that the beneficiary incurs no costs. In fact, this is not true. Studies have shown that if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed, rather than simply because they are free. Ultimately, if Medicare pays more for an item or service than it should, or if it pays for unnecessary items or services, there are less Medicare funds available to pay for truly needed services. One important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made. Otherwise, claims submitted to Medicare may violate the statutes discussed above and other provisions of the law.* It is also important to fully understand the specific nuances of these regulations and recommendations by healthcare attorneys, all of which can be found online.

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	Here are some of them below: Sources: • http://www.hcpro.com/content/42975.pdf • https://www.aafp.org/fpm/2001/0200/p13.html • http://www.cmsdocs.org/news/waiving-patient-copays-and-deductibles The financial hardship exception must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Remember, waiving copayments and deductibles is only allowed by Medicare after determining that paying them would impose a financial hardship on the beneficiary. You can reduce your risk of violating the law and not getting paid by instituting a simple policy: waiving copayments or deductibles only in cases of documented financial hardship. Setting and following such a policy helps prove to CMS that you don't waive these payments routinely. After drafting your policy, give a copy to all billing staff and post the policy in patient registration areas. Explain to your staff that the policy isn't intended to attract patients; rather, it's to be used as a way to handle requests from patients who can't afford the copayment or deductible. While there's no set definition of financial hardship, it'd prudent to base your definition on an impartial third-party standard such as the federal poverty guidelines as a starting point. For example, you may choose to waive copayments and deductibles for patients whose gross family income is at or below, say, 200 percent of the current federal poverty guidelines, or your state poverty level. It is suggested that your policy requires the patient requesting the waiver to submit reliable written proof of income. Examples of acceptable proof are: W-2 forms; pay stubs; tax returns; forms approving or denying unemployment compensation, Medicaid eligibility, or other state-funded assistance; or statements from employers or welfare agencies.
2. We have an OP hospital based Diabetes Ed program. Our medical clinic is run by the same hospital. Can I provide DSMT in the clinic as well as OP hospital based program?	Yes. This would be in accordance with the Medicare DSMT hospital rule that requires outpatient DSMT services be furnished in the hospital or in a provider-based hospital department. However, there are other Medicare reimbursement rules for successful reimbursement of DSMT services furnished in the hospital and in the hospital-owned clinic. One key rule is that your hospital-based DSMT program has to have AADE accreditation or ADA recognition. With AADE, the clinic then must be designated as either a branch site or community site. With ADA, the clinic has to be designated as either a multi-site or an expansion site. Note that AADE requires branch sites to be in the same healthcare system as the sponsoring organization (in this scenario, the hospital is the sponsoring organization).
3. Why are there so many DSME audits now?	The primary reason is the volume of Medicare fraud and abuse that occurs on an ongoing basis, which puts this federal insurance program at financial risk.

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	The Medicare Advantage improper payment rate was 10 percent in 2016, which comes to $16.2 billion. Adding in the overpayments for standard Medicare programs, the tally for 2016 approached $60 billion — which is almost twice as much as the National Institutes of Health spends on medical research each year. (Source: https://www.publicintegrity.org/2017/07/19/21011/fraud-and-billing-mistakes-cost-medicare-and-taxpayers-tens-billions-last-year) In 2018, the government has started taking a less punitive and more educational approach to correcting Medicare billing errors. CMS has been holding monthly meetings to discuss issues concerning Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs). MACs are private health insurers who review clinical documentation and process Medicare fee-for-service medical or durable medical equipment (DME) claims. RACs are private entities paid on commission to identify and correct Medicare over or underpayments. (Source: https://wire.ama-assn.org/practice-management/medicare-audits-could-take-less-punitive-approach-2018)
4. An RN, CDE cannot do telehealth? I'm curious how Medicare came to the decision of how various team members are reimbursable? How can we include RNs (especially those with years of experience and CDE certification)?	This is a great question! My answer: I really do not know the exact reason why CMS does not allow RNs to furnish DSMT telehealth at the telehealth distant sites. The list of clinicians allowed to furnish these services are: • licensed physician assistant (PA) • nurse practitioner (NP) • clinical nurse specialist (CNS) • certified nurse-midwife (CNM) • clinical psychologist • clinical social worker • registered dietitian or nutrition professional ○ Note: Medicare defines a "nutrition professional" as a person who completed an undergraduate dietetics degree and 900 hours of supervised experience, but has not taken or has not passed the registration exam for dietitians. Each of these healthcare professionals above are eligible to be Medicare Part B providers and direct bill Medicare for select services, including DSMT (if other required reimbursement rules are adhered to). Perhaps, then, the criteria for deciding who could furnish DSMT telehealth was eligibility to become a Part B provider and to direct bill for DSMT services.

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5. If a hospitalist can't order DSMT then it means that you can't use hospital referrals?	The Medicare DSMT reimbursement rules state that only the beneficiary's treating provider can order DSMT. Despite the fact that Medicare beneficiaries with diabetes may have multiple health care providers and numerous touchpoints in the health care system, the current policy states that the treating physician or treating qualified non-physician practitioner who is managing the patient's diabetes must order DSMT for the beneficiary. This policy does not recognize that other providers helping to treat the beneficiary, including hospitalists, podiatrists, optometrists, nephrologists and other specialists may identify a need for DSMT instruction but they are prohibited from ordering it for their Medicare patient. So that you are aware, the Diabetes Advocacy Alliance (DAA), and other associations and agencies have recommended to CMS to expand the list of providers eligible to refer for DSMT services. The DAA's actual recommendation is: *Broaden which providers can refer to DSMT beyond the provider managing the beneficiary's diabetes to include other providers caring for the patient.*

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