Diabetes Self-Management Training (DSMT) Reimbursement

Sponsored by:

The Disparities National Coordinating Center

Delmarva Foundation for Medical Care

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12:30 PM Eastern Time

Money Matters in Diabetes Self-Management Training: Increase Your Insurance Reimbursement NOW!

June 2013

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LEARNING OBJECTIVES

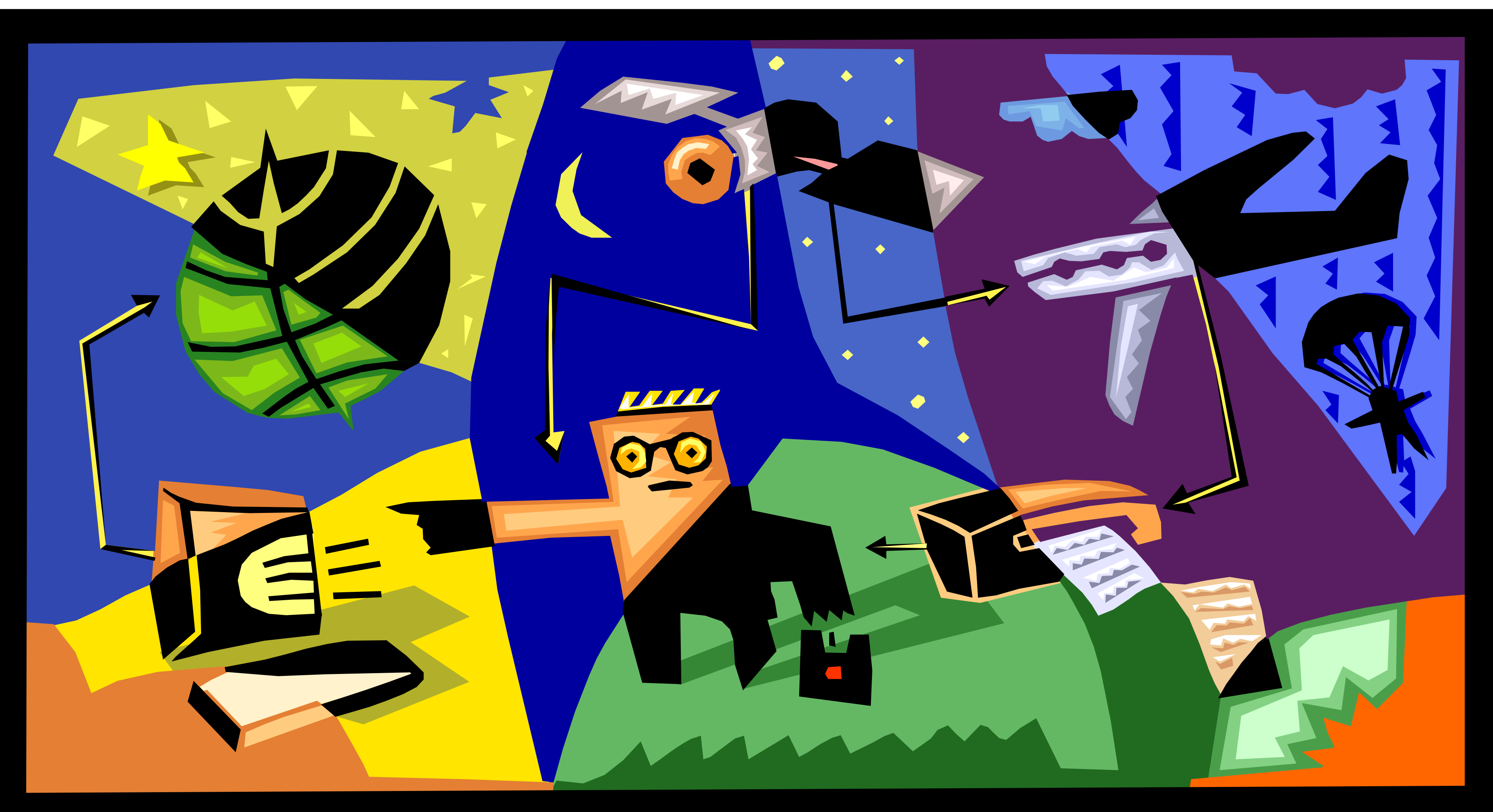
1. Describe the beneficiary eligibility criteria for Medicare DSMT

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

3. Name the procedure codes used to bill Medicare for DSMT

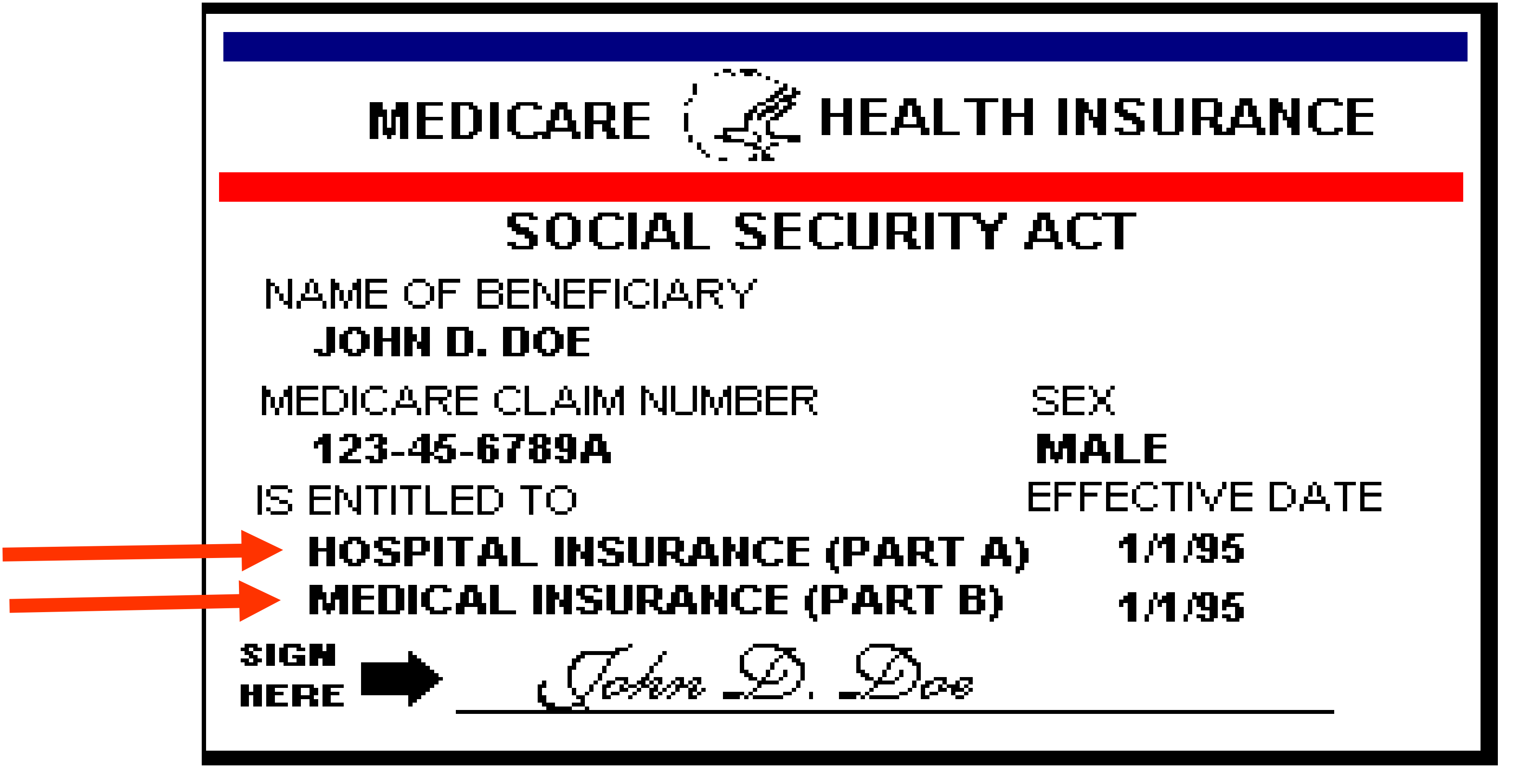
Medicare DSMT Reimbursement Rules:

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 △, 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	DSMT
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	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.
for period of 36 months after successful kidney transplant. *Group = 2 or more pts; need not all be Medicare.	*^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.

Cannot join Medicare just to furnish DSMT.

Separate Part B DSMT billing **NOT** allowed in: hospital inpt, nursing home, ESRD facility, hospice care, ER dept., rural health clinic.

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

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.

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"

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

- 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:

http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf

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

MEDICARE 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: **B**ecome Medicare provider and **B**ill for MNT; can then bill for AADE-accredited **DSMT** program

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

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

X: e**X**clude Medicare involvement and rules for **MNT** e**X**cluded 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

MEDICARE BENEFICIARY ELIGIBILITY for DSMT

DSMT

Initial not rec'd ever before (1/lifetime benefit).
Documentation of diabetes dx using 1 of 3 labs.
Physician/qualified NPP referral for initial and f/up.

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

MEDICARE DIAGNOSTIC LAB CRITERIA for DSMT

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

Gestational Diabetes

Provider to provide documentation of gestational diabetes dx code.

Symptoms of uncontrolled diabetes:

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

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)

^HbA1c >/=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 complementary 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: ☐ 10 hours or ____ no. hrs. requested

☐ Follow-up DSME/T: ☐ 2 hours or ____ no. hrs. requested

☐ Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision ☐ Hearing ☐ Physical

☐ Cognitive impairment ☐ Language Limitations

☐ Additional training ☐ additional hrs requested ________

☐ Telehealth Other ____________

DSME/T Content

☐ Monitoring diabetes ☐ Diabetes as disease process

☐ Psychological adjustment ☐ Physical activity

☐ Nutritional management ☐ Goal setting, problem solving

☐ Medications ☐ Prevent, detect and treat acute complications

☐ Preconception/pregnancy management or GDM

☐ Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

☐ Type 1 ☐ Type 2

☐ Gestational Diagnosis code ____________

Complications/Comorbidities

Check all that apply:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke

☐ Neuropathy ☐ PVD

☐ Kidney disease ☐ Retinopathy ☐ CHD

☐ Non-healing wound ☐ Pregnancy ☐ Obesity

☐ Mental/affective disorder Other ____________

Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested

☐ Initial MNT ☐ 3 hours or ____ no. hrs. requested

☐ Annual follow-up MNT ☐ 2 hours or ____ no. hrs. requested

☐ Telehealth ☐ Additional MNT services in the same calendar year, per RD

Additional hrs. requested ________

Please specify change in medical condition, treatment and/or diagnosis:

____

____

____

____

____

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.

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:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: Volume 68, #216, November 7, 2003 page 63261 Federal Register.

Other payors may have other coverage requirements.

Signature and NPI # ______________________ Date ____/____/____

Group/practice name, address and phone: ______________________

Revised 2011 by the American Association of Diabetes Educators and the American Dietetic Association.

Revised Aug. 2011

WHAT'S DIFFERENT ON REVISED FORM

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 >/= 126 mg/dl on 2 different occasions;
- 2 hr PPG >/= 200 mg/dl on 2 different occasions; or
- Random BG >/= 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 >/= 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:
>/= 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 201**3**
- Completes initial 10 hrs in August 201**4**
- Eligible for…and starts…2 hr follow-up in September, 201**4**
- Completes 2 hr follow-up in Dec., 201**4**
- Eligible for next 2 hr follow-up in Jan., 201**5**

Pt Completes Initial 10 Hrs in Same Calendar Year:

- Starts initial 10 hrs in August 201**3**
- Completes initial 10 hrs in Dec., 201**3**
- Eligible for…and starts…2 hrs follow-up in Jan., 201**4**
- Completes 2 hr follow-up in July 201**4**
- Eligible for next 2 hr follow-up in Jan. 201**5**

DIAGNOSES for MEDICARE DSMT

Diagnosis is Required Documentation:
In MR maintained by physician/NPP.
Educator/RD may wish to also obtain documentation before furnsihing 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!

Only certain professionals authorized to select ICD-9 dx codes for narrative diagnoses:
PHYSICIANS, QUALIFIED NPPs and
LICENSED MEDICAL RECORD CODERS.

DIAGNOSES for MEDICARE DSMT

4th digit = clinical manifestation/complication of diabetes

250.**0**	Diabetes mellitus without **mention of complication**
250.**1**	with **ketoacidosis**
250.**2**	with **hyperosmolarity**
250.**3**	with **other coma**
250.**4**	with **renal manifestations**
250.**5**	with **ophthalmic manifestations**
250.**6**	with **neurological manifestations**
250.**7**	with **peripheral circulatory disorders**
250.**8**	with other **specified manifestations**
250.**9**	with **unspecified complications**

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

Code	Description
250.X**0**	Type 2 controlled
250.X**1**	Type 1 controlled
250.X**2**	Type 2 uncontrolled
250.X**3**	Type 1 uncontrolled

PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

DSME

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

CPT = Current Procedural Terminology.

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 2nd referral in same yr	15 min
G0271	MNT, initial, group, beyond 3 hrs or MNT, f/up, group, beyond 2 hrs per 2nd 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

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	Rural Health Clinic
DSMT Same TOB 73x, revenue code 052x	**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[1]

REIMBURSEMENT: Same as in original DSMT benefits

DSMT: $\geq$1 hr of 10 in **initial** yr & $\geq$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

1. www.cms.gov/transmittals/downloads/R140BP.pdf Accessed 3-26-12

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"

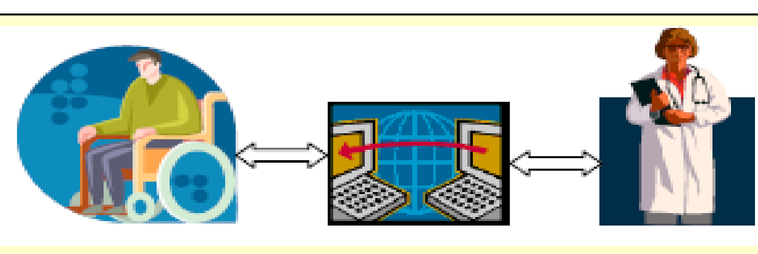
Originating Site: Location of beneficiary. To be in NON-metropolitan statistical area (see www.census.gov). Facility fee can be billed via code Q3014; deductible + coinsurance apply (2012 = $24.10)

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

Originating Site

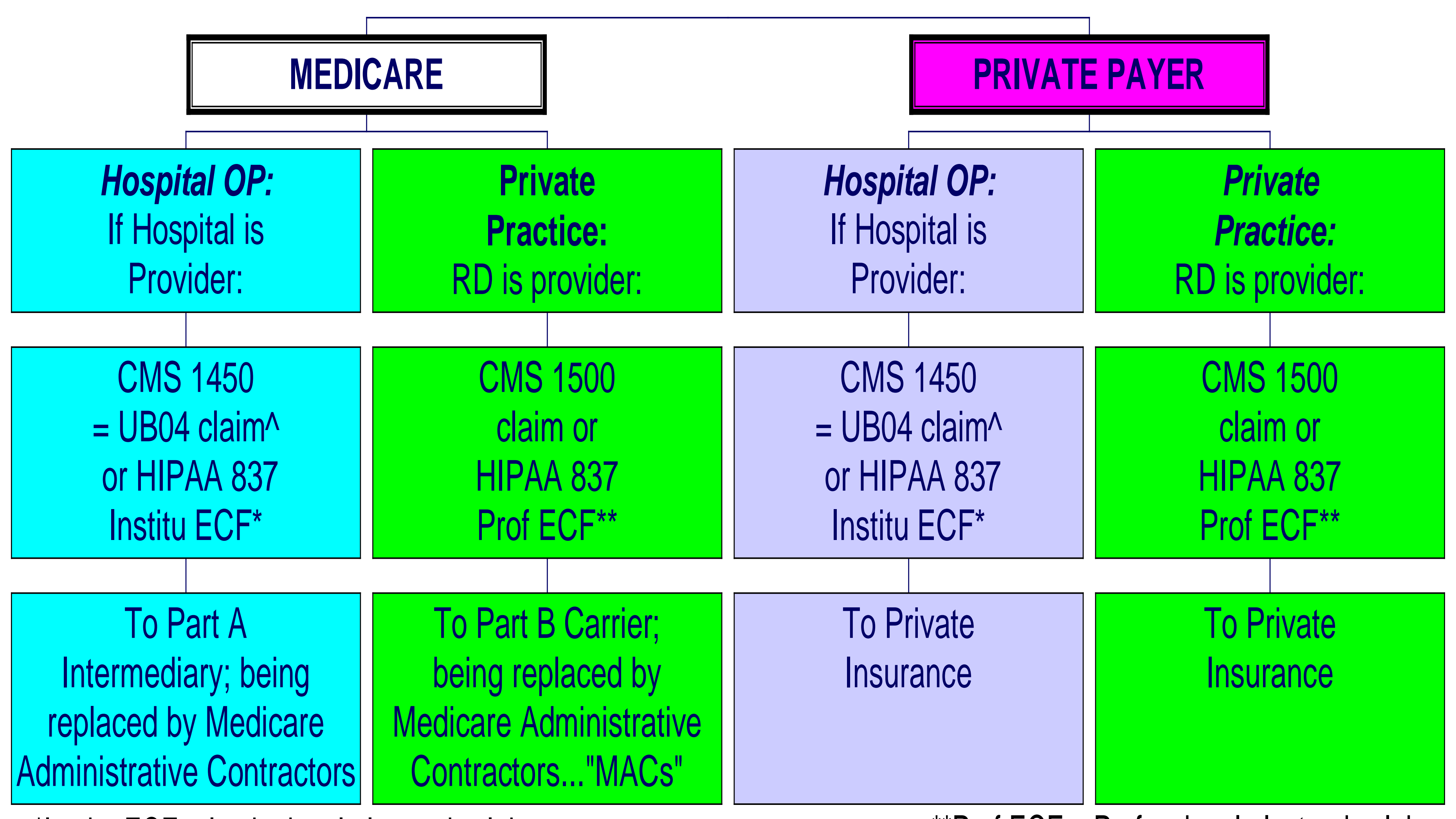


Distant Site

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



*Institu ECF = Institutional electronic claim

**Prof ECF = Professional electronic claim

^ If paper claim used, must use new CMS-1500 ***paper*** claim (08-05) and new UB-04 ***paper*** 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.

MEDICARE ELECTRONIC PAYMENTS

- 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

STATE INSURANCE MANDATES for PRIVATE PAYERS

- 46 states* and DC have state insurance laws that require private payer coverage for:
  - DSMT, MNT, DM-related services and supplies[1]

*** 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)

1. www.ncsl.org/programs/health/diabetes.htm (National Conference of State Legislatures) Accessed 6-1-13

PROCEDURE CODES for DSMT NOT PAID by MEDICARE BUT MAY be REQUIRED by PRIVATE PAYERS and MEDICAID

S9140	Diabetes management program, f/up visit to **non-MD provider**
S9141	Diabetes management program, f/up visit to **MD provider**
S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)
S9455	Diabetic management program, **group** session
S9460	Diabetic management program, **nurse** visit
S9465	Diabetic management program, **dietitian** visit
S9470	Nutritional counseling, **dietitian** visit

98960	Individual, initial or f/up face-to-face education, training & self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.
98961	Group of 2 - 4 pts, initial or f/up, each 30 min.
98962	Group of 5 - 8 pts, initial or f/up, each 30 min.
Neither AADE accreditation nor American Diabetes Association recognition of DSMT program required	

98960, 98961, 98962:

- 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

Name
H.R.
Andrew
ERIC
Richard
MARK
Grafton
Francis
James
FRANK
Ben

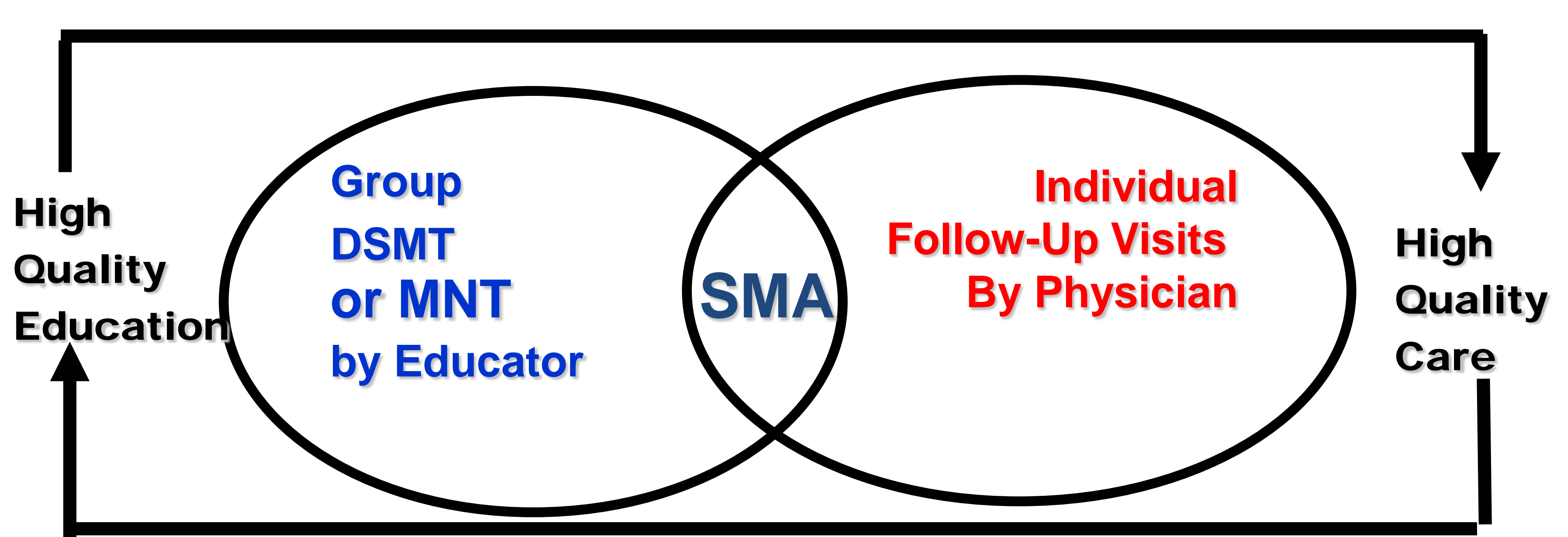
INDIVIDUAL Follow-Up Visit with Physician/Mid-Level

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

	SMA: 1:1 Patient Visits in Group plus Group DSMT or MNT	Traditional Pt Visit with Physician or Mid-Level
Aver. # pts	10	10
Total time	2 hrs: ***Only 1 hr for physician***	3.3 hrs (~ 20 min/pt)
1, 30 min. unit group DSMT	10 pts x approx $14/pt = $140	None
# individ. visits by physician	10 x approx $100/pt = $1000	10 x approx $100/pt = $1000
Combined insurance reimbursement	DSMT: $140 Physician: **$1000 in 1 hr**	DSMT: $0 Physician: **$1000 in 3.3 hrs**
Reimbursement to physician	**Physician: $1000 in only 1 hour = $17/minute**	**Physician: $1000 in 3.3 hours = $5/minute**

DO THE MATH! WIN-WIN FOR PHYSICIANS and EDUCATORS

DSMT BILLING IN SMA

- **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.maryannhodorowicz.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*
- *Money Matters in MNT and DSMT: Increasing Reimbursement Success in All Practice Settings, The Complete Guide ©", 5th. Edition*
- *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*

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