

**Money Matters in DSMT, MNT
and
Shared Medical Appointments:
Increase Your Insurance
Reimbursement **NOW!****



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Mary Ann Hodorowicz Consulting, LLC MAY 2015**



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PRESENTER DISCLOSURE INFORMATION

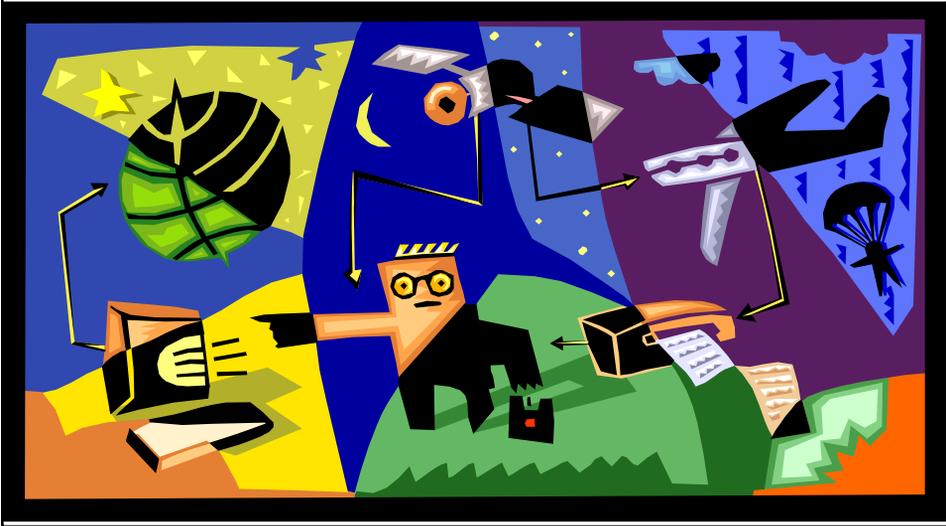
MARY ANN HODOROWICZ, RD, MBA, CDE, CERTIFIED ENDOCRINOLOGY CODER

- Board Member: American Association of Diabetes Educators
- Consultant:
 - Panasonic, Inc.
 - Johnson and Johnson Diabetes Institute
 - Metagenics, Inc.
 - Healthways, Inc.
 - Konsyl Fiber, Inc.
 - Indiana State Dept. of Public Health
 - Mississippi State Dept. of Public Health
 - Health Promotion Council, Inc.
 - dLife (website)
 - Today's Dietitian magazine

LEARNING OBJECTIVES

1. Describe the beneficiary eligibility criteria for Medicare MNT and DSMT.
2. List 3 of the Medicare coverage guidelines for telehealth MNT and DSMT.
3. Name the procedure codes used to bill Medicare for MNT and for DSMT.
4. Describe 3 of the key and unique Medicare coverage guidelines for MNT and DSMT telehealth.
5. Name whose NPI# must be used on claims for billing each of the 2 parts of a shared medical appointment (provider visit and educator visit).

**Medicare MNT--DSMT Reimbursement Rules:
COPIOUS, CONVOLUTED, CONFUSING,
COMPLICATED, CONSTANTLY CHANGING!**



**There's Lots of Benefits to
Providers Who Join Medicare!**



- M = MNT** and other benefits are *money makers*
- E = Engagement** with CDC (grant \$ to state depts. of PH) to ↑ access to, and quality of, DSME programs
- D = Dependable** transparency & timeliness with benefit coverage rules, reimbursement, rates, reminders
- I = Increase** in *preventive* benefits, esp. due to ACA
- C = Captive** audience of patients usually with many medical problems...and secondary insurance
- A = Amenable** to changes in coverage rules due to complaints, concerns, criticism (eg, obesity benefit)
- R = Regularly** pays clean claims
- E = Enormous** # of new beneficiaries in 2 - 4 years

MEDICARE BENEFICIARY MNT--DSMT ENTITLEMENT

- Must have Medicare Part B insurance
- Suggestion: Make copy of Medicare card for MR

MEDICARE HEALTH INSURANCE	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JOHN D. DOE	
MEDICARE CLAIM NUMBER 123-45-6789A	SEX MALE
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE (PART A)	1/1/95
MEDICAL INSURANCE (PART B)	1/1/95
SIGN HERE	<i>John D. Doe</i>

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™ self-care 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 Hours

Individual or group*. Individual assessment; nutrition dx; intervention and personalized meal plan; outcomes monitoring and evaluation.

DSMT: 12 Consecutive Months, 10 Hours*

Group classes*^A 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** personalized plans created for pt.

for period of 36 months after successful kidney transplant.

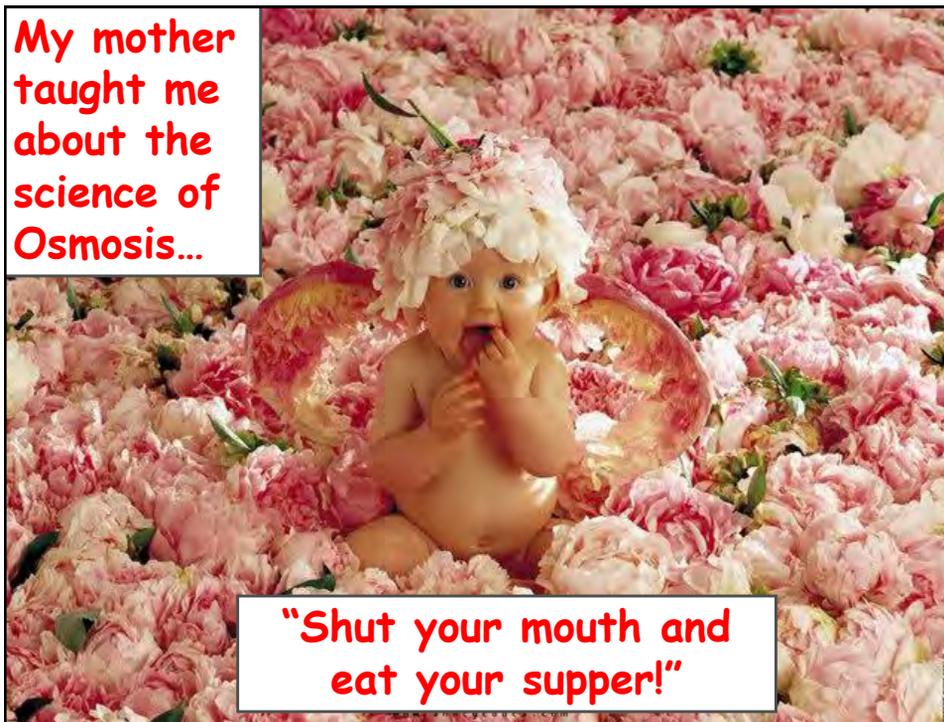
*Group = 2 or more pts; need not all be Medicare.

*^A9 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 MNT—DSMT BILLING PROVIDER ELIGIBILITY

MNT	DSME
RD or Nutrition Professional (NP) who is Medicare provider and has met below criteria:	Select individual + entity Medicare providers can bill. Must provide and bill for other Medicare services and be directly reimbursed. Cannot join Medicare just to provide and bill for DSMT.
BS in nutrition/dietetics from accredited school. Minimum 900 hrs of practical experience.	Individual Medicare providers who can bill on behalf of entire program: physician, PA, RD, NP, CNS, clinical psychologist, LCSW. Can also teach but program must have RD or RN or RPh.
Licensed or certified in state where furnishing MNT, if state has law regarding. CDE status not required.	Entity Medicare providers: DME, pharmacy, hospital OP dept, clinic, skilled nursing facility, MD/RD practice, Federally Qualified Health Center, Home Health Agency
Separate billing allowed: hosp.OP, nursing home, ESRD facility, FQHC, clinic, MD/RD practice, home health. NOT allowed: inpt hospital, rural health clinic, skilled nursing facility	Separate DSME billing NOT allowed: hospital inpt, hospice care, nursing home, rural health center, ESRD facility



RD's OPTIONS for MEDICARE MNT--DSMT

- B:** Become Medicare provider and **B**ill 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 years; enter into private contract with each beneficiary, using Medicare contract language
- X:** e**X**ecute Medicare ABN for diseases e**X**cluded in in **MNT** benefit

MEDICARE MNT--DSMT QUALITY STANDARDS

MNT

Must use nationally recognized protocols such as current evidence-based Nutrition Practice Guidelines for disease state

published by Academy of Nutrition and Dietetics (A.N.D.) and published in A.N.D.'s online Nutrition Care Manual

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, 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 MNT--DSMT

Diabetes MNT

Documentation of diabetes dx using 1 of 3 labs.
Treating physician to have documentation.*
Physician referral for initial, f/up, extra hrs.

DSMT

Documentation of diabetes dx using 1 of 3 labs.
Medicare doesn't say **who** must have documentation.
Physician/qualified NPP referral for initial and f/up.

Pre-Dialysis Renal MNT

Dx documentation of 1 of renal disease stages
that supports diagnostic criteria:
Stage III, IV and V CKD

Diabetes can be dx'd prior to Part B entry.
Initial not rec'd ever before; once in lifetime benefit.
Pt on renal dialysis only eligible
for non-nutrition content areas.

Kidney Transplant MNT

Successful kidney transplant.
MNT is in 36 months following transplant.

**Beneficiaries in class
to sign attendance sheet.**

* Per statutory language of benefit.

MEDICARE DIAGNOSTIC LAB CRITERIA for MNT--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*.
 A1c not added as of 5-1-15[^]

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.

Pre-Dialysis Renal Disease

GFR on 1 lab test of: 13–50 ml/min.1.73m²
 Stage III = 30–50, Stage IV = 15–29
 Stage V = <15

[^]A1c \geq 6.5% is diagnostic for T1, T2 DM
 per ADA, Standards of Medical Care, 2015

*Federal Register, Vol. 68, #216, 11-7-03, p.63261

MEDICARE DIAGNOSTIC LAB CRITERIA for MNT--DSMT

T1 and T2 Diabetes

MNT benefit states treating physician must have documentation.
DSMT benefit does NOT state WHO must have documentation.*

MNT: Only MDs and DOs can Rx.

DSMT: MDs, DOs + qualified NPPs can Rx (NPP = NP, PA, CNS).

Suggestion Regarding Diagnostic Lab:

*Consult with your practice's **Medicare Compliance Officer** and Medicare
 Administrative Contractor to determine WHO must maintain documentation of
 DSMT diagnostic lab: provider who Rx's DSMT OR practice who furnishes benefit.

MEDICARE MNT--DSMT REFERRAL REQUIREMENTS

<p align="center">MNT</p> <p>Written Rx by treating physician. To include: Rx date + beneficiary's name.</p>	<p align="center">DSMT</p> <p>Written Rx by treating physician or qualified non-physician practitioner (NPP): NP, PA, CNS. To include: Rx date + beneficiary's name.</p>
<p>ICD-9 dx or code (5 digits for T1, T2 DM). Physician's NPI + signature (stamped not allowed). Faxed + e-referral allowed. Separate Rx for: initial, f/up MNT and extra hours.</p>	<p>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).</p>
<p>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.</p>	<p>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.</p>

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 the type of training services and number of hours requested

Initial group DSME/T: 10 hours or _____ mo. hrs. requested

Follow-up DSME/T: 7 hours or _____ mo. hrs. requested

Individual

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

Identifying diabetes Diabetes as chronic process

Psychological adjustment Physical activity

Individual management Food eating, problem solving

Medication Personal, diet and local acute complications

Preconception/pregnancy management or DSM

Personal, diet and local chronic complications

Insurance 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 Diagnostic code: _____

Comorbidities/Contraindications

Check all that apply:

Hypertension Hypertension Stroke

Anemia CKD

Kidney disease Retinopathy CVD

Heart failure/MI Pregnancy Obesity

Mental/behavioral disorder Other _____

Medical Nutrition Therapy (MNT)

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

Initial MNT 3 hours or _____ mo. hrs. requested

Renewal/follow-up MNT 2 hours or _____ mo. hrs. requested

Telehealth Additional MNT services in the same calendar year per 100

Additional hrs. requested _____

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

Insurance 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)

Insurance 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 level over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: 50 Linc. no. 2410, November 7, 2003 (page 3000) Federal Register.

Other payers may have other coverage requirements.

Revised Aug. 2011

Signature and NPI #: _____ Date: _____

Group practice name, address and phone: _____

Revised 08/2011 by the American Association of Diabetes Educators and the American Dietetic Association.



DIETITIAN LICENSURE/CREDENTIALING STATE LAWS for FURNISHING MNT

Laws in states below specifically outline mandates¹ re:

- Written physician referral for nutrition services/MNT, or
- Dietitian's activities based on physician's order, or
- Physician involvement when treatment/condition is medical
- Provisions for dietitian conduct when physicians involved

Alabama	Indiana	Connecticut	Tennessee	California
Illinois	Florida	Massachusetts	Maine	South Carolina

1. www.eatright.org/HealthProfessionals/content.aspx?id=6863 Accessed 3-26-12

MEDICARE MNT--DSMT LIMITS in **FIRST YEAR** and STRUCTURE OF

Medicare will not pay for MNT and DSMT provided on same day!

<p>MNT: 3 hrs in calendar yr. Cannot extend into next yr. Individual, group or combination. Group visit is >= 30 min. (1 billing unit; no rounding).</p>	<p>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).</p>
<p>Individual visit is >= 15 min. Can round: >= to 8 min. to <= to 23 min. does equal 1, 15 min. billing unit.</p>	<p>1 hr may be for individual assessment, insulin instruction or training on ANY topic. 10 hrs may be used for only 1 topic (new!).</p>
<p>Additional Hrs > 3 Reimbursable IF: RD obtains NEW Rx from treating physician which documents # extra hrs to be furnished and medical necessity for.</p>	<p>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,</p>
<p>Examples of medical necessity: Change in medical condition, diagnosis and/or treatment regimen requiring additional MNT.</p>	<p>(language, hearing, physical, cognitive, etc.) OR no program starting within 2 months of Rx date, OR physician orders additional insulin training.</p>

CHANGES THAT MAY JUSTIFY EXTRA HOURS of MEDICARE MNT

DIABETES MNT

- Oral meds to insulin
- Lack of understanding of diabetes diet
- GDM pt requires frequent diet changes
- Diabetes complication requiring tighter diet control

NON-DIALYSIS RENAL MNT

- Significant decrease in renal sufficiency
- Lack of understanding of renal diet
- Onset of malnutrition
- Completes DSMT and develops renal condition

MEDICARE MNT--DSMT LIMITS in FOLLOW-UP YEARS and STRUCTURE OF

F/Up MNT After First Calendar Year	F/Up DSMT After First 12 Consecutive Months
2 hrs in each calendar yr after first. Cannot extend hrs to next yr. Individual, group or combination. Group visit: >= 30 min. (1 billing unit)	2 hrs each 12 months after initial DSMT completed. Cannot extend hrs into next 12 months. Individual, group or combination.
Individual visit: >= 15 min. = 1 billing unit. Can round: >= to 8 min to <= to 23 min.= 1 unit. New Rx for follow-up.	Individual or group visit: >= 30 min = 1 billing unit (1 billing unit). No rounding. New Rx for follow-up.
After 3 Yrs from Original Initial MNT Visit Beneficiary MAY be eligible for INITIAL MNT again as may be considered NEW pt after 3 years. Check with your MAC.	Special needs do not need to be documented for individual follow-up DSMT. Can obtain even if INITIAL DSMT not received.
ALWAYS DOCUMENT "START" TIME and "END" TIME FOR EVERY VISIT!	

MEDICARE TIME FRAME CHANGES for FOLLOW-UP DSMT: EXAMPLE

Pt Completes Initial 10 Hrs That Spans 2 Yrs: 2014 and 2015:

- Starts initial 10 hours in August 2014
- Completes initial 10 hours in August 2015
- Eligible for...and starts...2 hr follow-up in September, 2015
- Completes 2 hour follow-up in Dec., 2015
- Eligible for next 2 hour follow-up in Jan., 2016

Pt Completes Initial 10 Hrs in Same Calendar Year:

- Starts initial 10 hours in August 2014
- Completes initial 10 hours in Dec., 2014
- Eligible for...and starts...2 hours follow-up in Jan., 2015
- Completes 2 hour follow-up in July 2015
- Eligible for next 2 hour follow-up in Jan. 2016

DIAGNOSES for MEDICARE MNT--DSMT

Diagnosis is Required Documentation
In MR maintained by physician/NFP.

Required on REFERRAL
Diagnosis can be
narrative description OR ICD9 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
ICD9 dx codes for narrative diagnoses
**PHYSICIANS, QUALIFIED NFPs and
LICENSED MEDICAL RECORD CODERS**

DIAGNOSES for MEDICARE MNT--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 MNT--DSMT

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

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

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

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 hours or MNT, f/up, individual, beyond 2 hours per 2 nd referral in same year	15 min
G0271	MNT, initial, group, beyond 3 hours or MNT, f/up, group, beyond 2 hours per 2 nd referral in same year	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

CMS' GUIDE for 15 MIN. TIME-BASED CODES

UNITS	MINUTES to MINUTES¹	
1	≥ 8	≤ 23
2	≥ 24	≤ 37
3	≥ 38	≤ 52
4	≥ 53	≤ 67
5	≥ 68	≤ 82
6	≥ 83	≤ 97
7	≥ 98	≤ 112
8	≥ 113	≤ 127

1. www.cms.gov/manuals/downloads/clm104c05.pdf Accessed 3-26-12

UPDATED PAYABLE PLACES of SERVICES (POS) with NUMERIC CODES for MEDICARE MNT for CLAIMS SUBMITTED to PART B MAC*

***References:**

1. CMS Publication 100-03, Medicare National Coverage Determinations Manual, Part 1:180.1 Medical Nutrition Therapy
2. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4:300 Medical Nutrition Therapy (MNT) Services
3. CMS Transmittal No. AB-02-059, Program Memorandum Intermediaries/Carriers, Change Request #2142, May 1, 2002, provides additional clarification for medical nutrition therapy (MNT) services.

97802*, 97803*, G0270

- School (3)
- Homeless shelter (4)
- Office (11)
- Home (12)
- Assisted living facility (13)
- Group home (14)
- Temporary lodging (16)
- Outpatient hospital (22)
- Nursing facility (32)
- Custodial care facility (33)
- Independent clinic (49)
- Intermediate care facility/MHMR (54)
- Residential substance abuse treatment (55)
- Nonresidential substance abuse treatment facility (57)
- State, local public health clinic (71)

97804*, G0271

- School (3)
- Homeless shelter (4)
- Office (11)
- Assisted living facility (13)
- Group home (14)
- Outpatient hospital (22)
- Nursing facility (32)
- Custodial care facility (33)
- Independent clinic (49)
- Intermediate care facility/MHMR (54)
- Residential substance abuse treatment (55)
- Nonresidential substance abuse treatment facility (57)
- State, local public health clinic (71)

***For codes 97802, 97803, 97804: POS 99 (Other Unlisted Facility) may be used only if there is not more appropriate POS code to describe place of service.**

MEDICARE MNT--DSMT REIMBURSEMENT RATES, 2015

Medicare MNT Rates Accessed 1-22-15 on CMS.gov	Medicare DSMT Rates Accessed 1-22-15 on CMS.gov
100% of Medicare Physician Fee Schedule (MPFS). Medicare pays 100% of adjusted rate. 20% pt co-payment waived, BUT paid by Medicare.	100% of condensed MPFS for par providers, but only 95% for non-par providers. Medicare pays 80% of adjusted rate, pt pays 20%
Aver. Unadjusted Rates*: 97802, initial, 15 min: Non-Facility: \$35.04 Facility: \$32.89	Aver Unadjusted Rates*, Facility, Non-Facility: G0108, individual, 30 min: \$53.27 G0109, group, 30 min: \$14.30 <i>*Rates also vary per geographic region.</i>
97803, follow-up, 15 min: Non-Facility: \$30.03 Facility: \$27.53	
97804, group, initial or f/up, 30 min: Non-Facility: \$16.09 Facility: \$15.37	

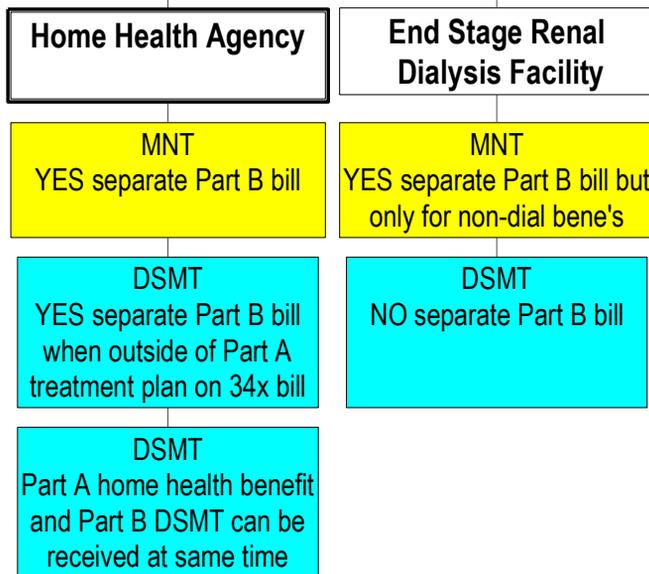
**My mother
taught
me
about
contortionism**



**Will you
look at
the dirt
on the back
of your neck!**

Steve Grotto

HOME HEALTH AGENCY and ESRD FACILITY MEDICARE MNT--DSMT BILLING



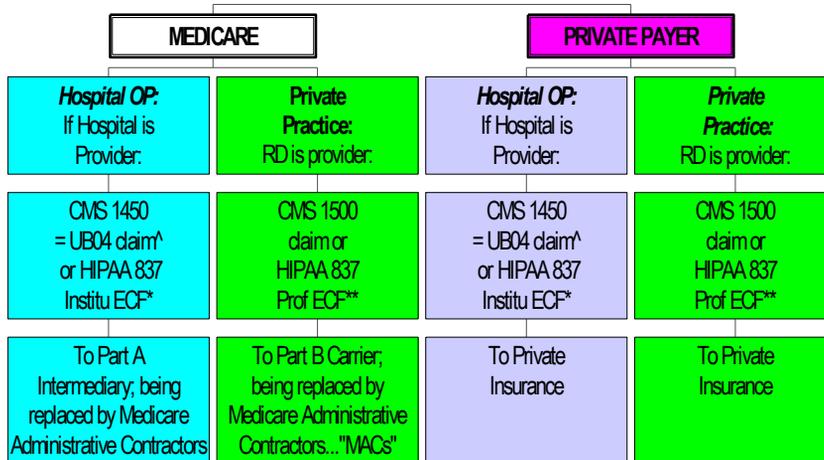
SKILLED NURSING FACILITY and NURSING HOME MEDICARE MNT--DSMT BILLING

Skilled Nursing Facility	Nursing Home
MNT NO separate Part B bill	MNT YES separate Part B bill
DSMT YES separate Part B bill. Part A SNF benefit and Part B DSMT can be received at same time	DSMT NO separate Part B bill
Use 22x, 23x type of bill Revenue code 0942	

FEDERALLY QUALIFIED HEALTH CENTER and RURAL HEALTH CLINIC MEDICARE MNT--DSMT BILLING

FQHC	Rural Health Clinic
MNT* : Type of Bill (TOB) 73x/77x; revenue code 0521. 1:1 only is separately billable with MNT codes but paid at all-inclusive FQHC rate. No co-insurance. RD may be able to bill incident to to physician services.	MNT : TOB 71x; revenue code 0521. NO separate billing with MNT codes. RD may be able to bill incident to*. Report cost on cost report; paid at all-inclusive RHC rate.
DSMT* : Type of bill 73x/77x; revenue code 0521. 1:1 only is separately billable with G0108 but paid at all-inclusive FQHC rate. Co-insurance applies.	DSMT : TOB 71x; revenue code 0521. Sole instructor to be RD-CDE. No separate billing with G codes. Report cost on cost report; paid at all-inclusive RHC rate.
*DSMT and MNT : NOT paid with additional physician/mid-level medical visit on SAME day. DSMT & MNT consider medical visit; only 1 is paid. MNT + DSMT provided on same day not paid.	*Medicare Claims Processing Manual Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers Rev. 3000, 07-25-14

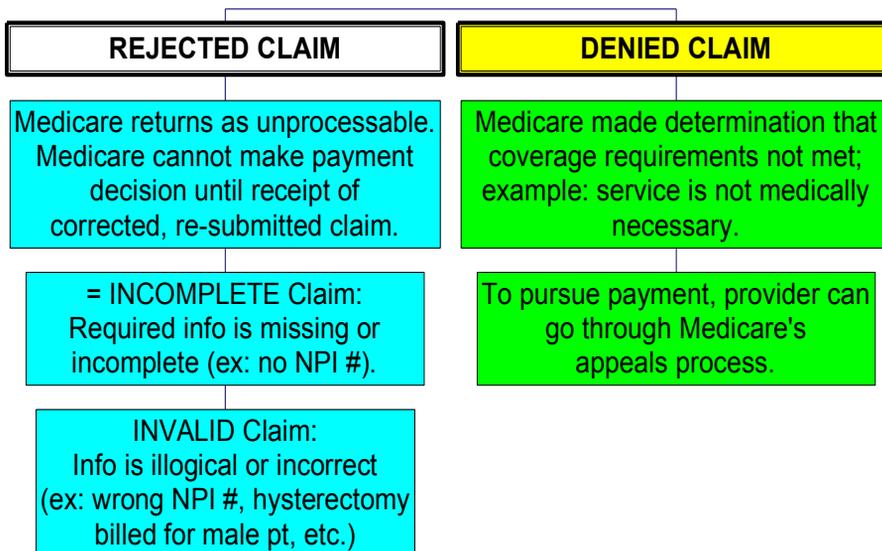
MNT--DSMT CLAIM FORMS for HOSPITAL and PRIVATE PRACTICE



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

*Institu ECF = Institutional electronic claim **Prof ECF = Professional electronic claim

REJECTED vs. DENIED CLAIMS



PRIVATE PAYER and MEDICAID COVERAGE of MNT--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

STATE INSURANCE MNT—DSMT PAYMENT MANDATES for PRIVATE PAYERS

- 46 states* and DC have **state** insurance laws that require private payer coverage for:
 - DSMT, MNT, DM-related services and supplies¹
- *** 4 states with no laws: AL, ID, ND, OH**
- Laws override any coverage limitations in health plan
- Exclusions 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 1-22-15

YOUR PRIVATE PAYER HOMEWORK

1. Identify **if** DSME-MNT covered by private health plans
2. If **yes**, identify coverage **guidelines**, such as:
 - Referring provider eligibility
 - Who can bill
 - Pt eligibility and entitlement
 - Benefit structure, utilization limits, place of service
 - Billing codes, claim types, etc.
 - Reimbursement rates



YOUR PRIVATE PAYER HOMEWORK

- How to identify coverage....**6 possible ways:**
 1. Review all of your providers' **in-network provider contracts**
 2. Contact insurer's **Provider Relations Dept.** by phone, citing in-network providers' contract numbers, and ask about coverage using:
 - Names of benefits in this slide deck, and/or
 - Procedure codes of benefits

YOUR PRIVATE PAYER HOMEWORK

3. Contact insurer's **Subscriber/Patient Coverage Dept.** by phone....cite subscriber's number....and ask about coverage, citing:
 - Specific names of benefits in this slide deck, and/or
 - Procedure codes of benefits

YOUR PRIVATE PAYER HOMEWORK

4. Access **insurer's website** to determine if insurer has secure **subscriber coverage portal** that can be accessed by in-network and out-of-network providers
5. Access subscriber's coverage via **electronic claims submission software** that may be provided by insurer

YOUR PRIVATE PAYER HOMEWORK

6. Insert patient's "swipe/scan healthcare ID card" in special card reader provided by insurer

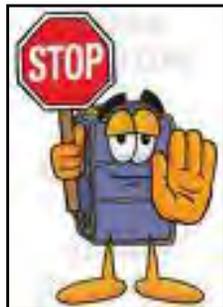
Picture of Magnetic Swipe Insurance Card Reader:



Keep database of results, and update regularly!

PROCEDURE CODES for MNT--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**

MEDICARE MNT--DSMT TELEHEALTH BASICS

INDIVIDUAL + GROUP MNT and DSMT can be delivered via telehealth¹.

REIMBURSEMENT: Same as for original MNT and DSMT benefits.

CPT code modifier **GT** to be added to MNT/DSMT code on claim:
“interactive audio and video telecommunications system”

DSMT: ≥ 1 hour of 10 in **initial** year and ≥ 1 hour in **follow-up** years to be
Furnished **in-person** for training on injectable medications (individual or group).

WHAT IT IS: HIPAA-compliant, interactive audio and video
telecommunication permitting *real time* communication and visualization.

1. www.cms.gov/transmittals/downloads/R140BP.pdf Accessed 3-26-12. As of 5-12-14, no change.

Excluded: Telephone calls, faxes, email w/o audio and visualization
In real time, texts, and stored and delayed transmissions of images
of beneficiary.

Individual Billing Provider Requirement:

Licensed or certified in state where provider furnishes benefit
AND in state where beneficiary receives benefit.

If beneficiary in 1 state (originating site) and provider in another,
(distant site), provider must be licensed or certified in **both** states.

Beneficiary must be **present and participate** in telehealth visit.

Approved Distant Sites (where PROVIDER is during MNT - DSMT visit):

- Physician or qualified non-physician practitioner office*
- Hospital
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital and CAH-based renal dialysis center
- Skilled nursing facility (SNF)
- Community mental health center

Distant Sites (where PROVIDER is during MNT-DSMT visit)

Excluded:

- Home health
- Independent renal dialysis facilities
- Pharmacies

Medicare pays same for telehealth services under Medicare Physician Fee Schedule (MPFS) as for original benefits, including MNT and DSMT.*

***Exception:** For physicians/practitioners in CAH who have reassigned their billing rights to CAH that has elected Optional Payment Method II, CAH bills Part A for telehealth services with revenue codes 096x, 097x or 098x. Payment amount is 80% of MPFS.

**Approved Rendering and Billing Providers of Medicare Telehealth
MNT--DSMT (subject to State law):**

- Physicians (MDs, DOs)
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists (CNSs)
- Certified nurse midwives (CNMs)
- Clinical psychologists
- Clinical licensed social worker (CLSWs)
- Registered dietitians (RDs) and nutrition professionals

Originating Sites: where BENEFICIARY is at time of MNT--DSMT visit:

Geographic criteria:

Health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by Office of Rural Health Policy or a county outside of metropolitan statistical area.

See: www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Originating Sites eligible to receive **FACILITY FEE** for each visit.

To claim **facility fee**, originating site must bill **HCPCS code Q3014**,
“telehealth originating site facility fee” in addition to procedure code.

Type of service is **"9"** on claim form (“other items and services”).

Deductible and coinsurance rules apply to **facility fee code Q3014**.

2015 Medicare facility fee = \$28.22

More About Facility Fee Billing:

Hospital OP Dept.: Fee payment is as described on previous slide and not under outpatient prospective payment system (OPPS). Part A is billed.

CAH: Fee payment is separate from cost-based reimbursement methodology and is 80% of originating site facility fee. Part A is billed.

Physicians' and practitioners' offices: Fee payment amount is lesser of 80% of actual charge or 80% of originating site facility fee, regardless of geographic location. Part B contractor does not apply geographic practice cost index to fee; fee is statutorily set and not subject to geographic payment adjustments authorized under Physician Fee Schedule. Part B is billed.

Renal dialysis center (or its satellite) that is based in hospital or CAH:
Fee covered in addition to any composite rate or MCP amount. Bills Part A and must use revenue code 78x.

More About Facility Fee Billing:

Skilled nursing facility (SNF): Fee is outside SNF prospective payment system bundle and not subject to SNF consolidated billing; is separately billable Part B payment. Bills Part A and must use revenue code 78x.

Community Mental Health Center (CMHC): Fee is not partial hospitalization service; does not count towards number of services used to determine payment for partial hospitalization services. Fee not bundled in per diem payment for partial hospitalization; is separately billable Part B payment. Bills Part A and must use revenue code 78x.

Independent and provider-based RHCs and FQHCs: Fee is billed to Part A using RHC or FQHC bill type and billing number. Code Q3014 is only non-RHC/FQHC service that is billed using the clinic/center bill type and provider number. Must use revenue code 078x.

SHARED MEDICAL APPOINTMENT: SMA

Typically **2** distinct 'shared' services in **group** visit at **same** encounter, targeted to a **common** problem:

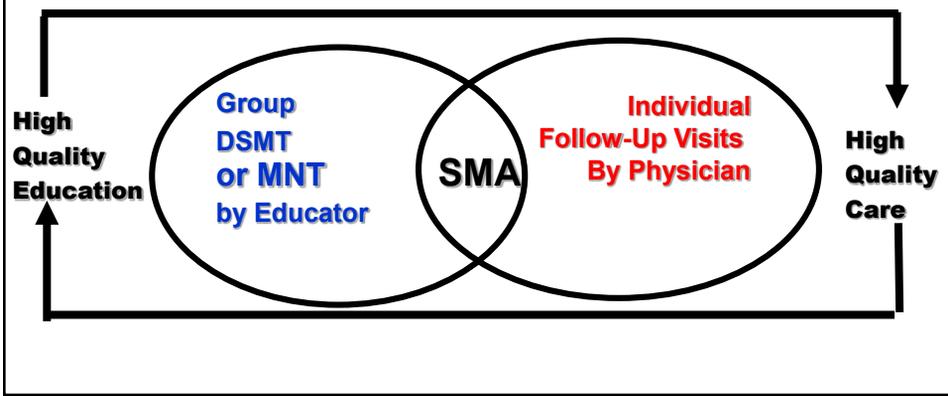
1. Individual, follow-up medical patient care via evaluation and management (E&M) by provider (physician or mid-level)

and

2. **MNT, DSMT** 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 is **NOT** to be used as criteria for provider's 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: <i>Only 1 hr for physician</i>	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		

MNT--DSMT BILLING IN SMA

- **MNT:** Medicare and private payers are billed under RD's NPI#
 - RD may be required to reassign reimbursement if retained by employer to furnish Medicare MNT
- **DSMT:** Medicare and private payers billed under NPI# of sponsoring organization (e.g., physician practice) or sponsoring individual provider (e.g., RD)
 - RD's NPI# to be different than provider's NPI# who furnished E&M services

Cannot bill Medicare for both DSMT and MNT on same day!

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**

CMS PQRS:

PHYSICIAN

QUALITY

REPORTING

SYSTEM

PHYSICIAN QUALITY REPORTING SYSTEM

- **PQRS** is voluntary Medicare program for eligible professionals (EPs) to report data on **quality measures** for Physician Fee Schedule (PFS) services furnished to Part B Fee-for-Service beneficiaries
- Goals:
 - Promote reporting of quality data on pt care to:
 - Improve quality of care
 - Maximize provider efficiency
 - Why? CMS moving toward Part B provider payment that rewards **value (quality)** rather than **volume**

PHYSICIAN QUALITY REPORTING SYSTEM

- **PQRS** program allows EPs to:
 - Assess quality of care already provided, thus helping to ensure that pts get right care at right time
 - Quantify how often they meet each quality measure
 - Use CMS' feedback report to compare their performance on specific measure with their peers

PHYSICIAN QUALITY REPORTING SYSTEM

- To prompt EP participation, program applies:
 - Payment adjustment (↓) in for EPs who do **NOT** report data on quality measures beginning in **2015**:
 - EPs receiving payment adjustment in **2015** will be paid **1.5% less** than the MPFS amount for that service
 - For **2016** and subsequent years, payment adjustment is **2% less**

PHYSICIAN QUALITY REPORTING SYSTEM

- Eligible professionals are:
 - Individual Medicare Part B providers who furnish Part B Physician Fee Schedule services and bill Medicare
 - Includes RDs and nutritional professionals
 - Can participate as **individual provider** or as part of **group practice**
 - Group practices that bill Medicare Part B and participating in Group Practice Reporting Option (GPRO)

PHYSICIAN QUALITY REPORTING SYSTEM

- Report methods for individual EPs:
 - Claims
 - Qualified registry
 - Directly from EHR using CEHRT (Certified Electronic Health Record Technology)
 - CEHRT using data submission vendor
 - Qualified Clinical Data Registry

PHYSICIAN QUALITY REPORTING SYSTEM

- Types of measures reported change from year to year
- About measures:
 - Generally vary by specialty
 - Focus on areas such as:
 - Care coordination
 - Patient safety and engagement
 - Clinical process/effectiveness
 - Population/public health

PHYSICIAN QUALITY REPORTING SYSTEM

- For RDs to **avoid 2015** and **2016** payment decrease:
 - Satisfactorily report and earn **2014** PQRS incentive

OR

- Report at least **3** measures covering 1 National Quality Strategy (NQS) domain for at least **50%** of their Medicare Part B FFS patients satisfactorily

PHYSICIAN QUALITY REPORTING SYSTEM

2015 PQRS Measures Applicable to RDs

- Diabetes: Hemoglobin A1c Poor Control
 - % of patients 18-75 years of age with diabetes with A1c > 9.0% during measurement period
- Diabetes: LDL-C Control (<100 mg/dL)
 - % of patients 18-75 years of age with diabetes whose LDL-C adequately controlled (<100 mg/dL) during measurement period

PHYSICIAN QUALITY REPORTING SYSTEM

- Preventive Care and Screening: BMI Screening and Follow-Up
 - % of patients aged ≥ 18 years with documented BMI during current encounter or during past 6 months
 - AND
 - When BMI outside of normal parameters, follow-up plan documented during encounter or during previous 6 months of encounter
 - Normal Parameters: ≥ 65 yrs old with BMI ≥ 23 and < 30 ; 18-64 yrs with BMI ≥ 18.5 and < 25

PHYSICIAN QUALITY REPORTING SYSTEM

- Documentation of Current Medications in MR
 - % of visits for patients ≥ 18 years for which EP attests to documenting list of current meds using all immediate resources available on date of encounter
 - List **must** include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements
 - AND
 - **Must** contain medications' name, dosage, frequency and route of administration

PHYSICIAN QUALITY REPORTING SYSTEM

- Elder Maltreatment Screen and Follow-Up Plan
 - % of patients aged ≥ 65 years with documented elder maltreatment screen using Elder Maltreatment Screening Tool on date of encounter

AND

- Documented follow-up plan on date of positive screen

PHYSICIAN QUALITY REPORTING SYSTEM

Registry-Based Reporting Only

- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation
 - % of patients aged ≥ 18 years with diagnosis of diabetes mellitus who had neurological examination of their lower extremities within 12 months

PHYSICIAN QUALITY REPORTING SYSTEM

- Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear
 - % of patients aged ≥ 18 years with dx of diabetes mellitus evaluated for proper footwear and sizing
- Preventive Care and Screening: Unhealthy Alcohol Use - Screening
 - % of patients aged ≥ 18 years screened for unhealthy alcohol use at least once within 24 months using systematic screening method

The screenshot shows the CMS.gov website for the Physician Quality Reporting System (PQRS). The page includes a navigation menu with categories like Medicare, Medicaid/CHIP, and Private Insurance. The main content area is titled "Physician Quality Reporting System" and provides an overview of the program, including its purpose and how to get started. A sidebar on the left contains various links related to PQRS, such as "Spotlight", "How To Get Started", and "CMS Sponsored Calls".

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Home > Medicare > Physician Quality Reporting System > Physician Quality Reporting System

Physician Quality Reporting System

Physician Quality Reporting System (Physician Quality Reporting or PQRS) formerly known as the Physician Quality Reporting Initiative (PQRI)

About PQRS

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. This website serves as the primary and authoritative source for all publicly available information and CMS-supported educational and implementation support materials for PQRS.

Stay up to date on the latest news and updates by following us on [Twitter](#).

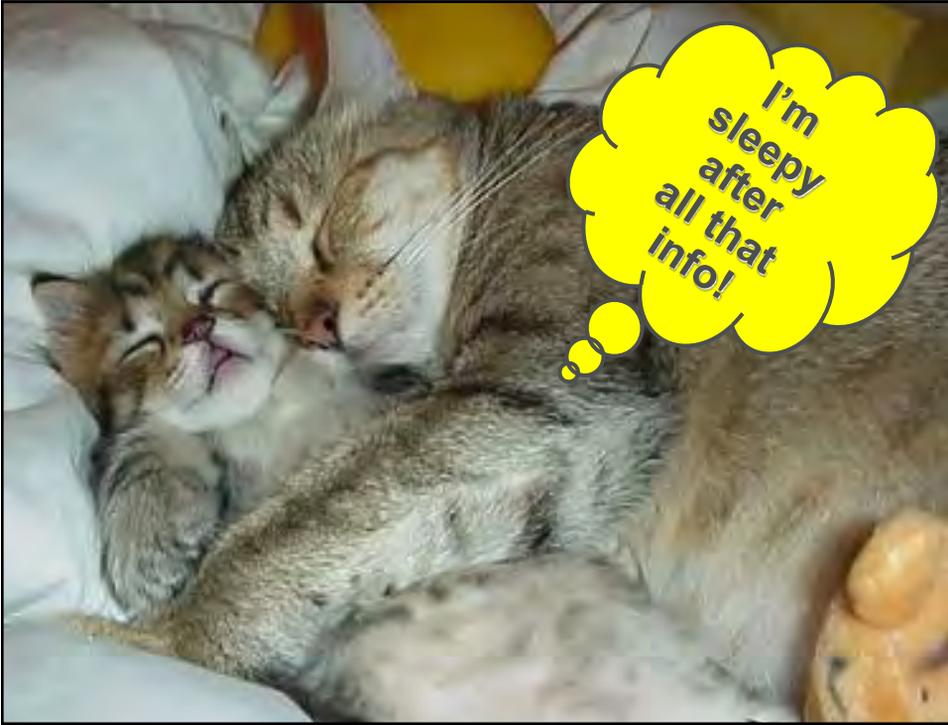
Stay informed about the latest PQRS news by subscribing to the [PQRS Listserv](#).

PQRS Quick Links

For step-by-step instructions on how to implement PQRS, view the [How to Get Started](#) page. In addition, [learn more about PQRS](#) and how to participate by visiting the following pages:

- For information on how to select measures, review the [Measures Codes](#) page.

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>



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



This information is intended for educational and reference purposes only. It does not constitute legal, financial, medical or other professional advice. The information does not necessarily reflect opinions, policies and/or official positions of the Center for Medicare and Medicaid Services, private healthcare insurance companies, or other professional associations. Information contained herein is subject to change by these and other organizations at any moment, and is subject to interpretation by its legal representatives, end users and recipients. Readers/users should seek professional counsel for legal, ethical and business concerns. The information is not a replacement for the Academy of Nutrition and Dietetics' Nutrition Practice Guidelines, the American Diabetes Association's Standards of Medical Care in Diabetes, guidelines published by the American Association of Diabetes Educators nor any other related guidelines. As always, the reader's/user's clinical judgment and expertise must be applied to any and all information in this document.

Resources by Mary Ann Hodorowicz

Turn Key Materials for AADE DSME Program Accreditation

- DSME Program Policy & Procedure Manual Consistent with NSDSME (72 pages)
- Medicare, Medicaid and Private Payer Reimbursement
- Electronic and Copy-Ready/Modifiable Forms & Handouts
- Fun 3D Teaching Aids for AADE7 Self-Care Topics
- Complete Business Plan

3-D DSME/T and Diabetes MNT Teaching Aids 'How-To-Make' Kit

- Kit of 24 monographs describing how to make Mary Ann's separate 3-D teaching aids plus fun teaching points, evidence-based guidelines and references

Money Matters in MNT and DSMT: Increasing Reimbursement Success in All Practice Settings, The Complete Guide ©, 5th. Edition, 2015

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