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

Mary Ann Hodorowicz, RD, MBA, CDE
Certified Endocrinology Coder
Mary Ann Hodorowicz Consulting, LLC

Mary Ann Hodorowicz, RD, LDN, MBA, CDE, CEC, is a licensed registered dietitian and certified diabetes educator and earned her MBA with a focus on marketing. She is also a certified endocrinology coder and owns a private practice specializing in corporate clients in Palos Heights, IL. She is a consultant, professional speaker, trainer, and author for the health, food, and pharmaceutical industries in nutrition, wellness, diabetes, and Medicare and private insurance reimbursement. Her clients include healthcare entities, professional membership associations, pharmacies, medical CEU education/training firms, government agencies, food and pharmaceutical companies, academia, and employer groups. She serves on the Board of Directors of the American Association of Diabetes Educators.

Mary Ann Hodorowicz Consulting, LLC
hodorowicz@comcast.net  708-359-3864
www.maryannhodorowicz.com
Twitter: @mahodorowicz
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!
**MEDICARE BENEFICIARY**

**MNT--DSMT ENTITLEMENT**

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

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**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

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**MEDICARE HEALTH INSURANCE**

**SOCIAL SECURITY ACT**

<table>
<thead>
<tr>
<th>NAME OF BENEFICIARY</th>
<th></th>
<th>SEX</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHN D. DOE</td>
<td></td>
<td>MALE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICARE CLAIM NUMBER</th>
<th>IS ENTITLED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>123-45-6789A</td>
<td>HOSPITAL INSURANCE (PART A) 1/1/95</td>
</tr>
<tr>
<td></td>
<td>MEDICAL INSURANCE (PART B) 1/1/95</td>
</tr>
</tbody>
</table>

**SIGN HERE**

John D. Doe
### 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 extensive** follow-up with monitoring of labs, outcomes, behavior $\Delta$, etc. with required adjustments in plans

**DSMT**
- **General** and basic training on AADE7$^\text{™}$ self-care behaviors in primarily group format
- Pt's knowledge of why and skill in how to change key behaviors
- **Shorter-term limited** follow-up with monitoring of labs, outcomes, etc.

### COORDINATION OF MEDICARE MNT--DSMT

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

<table>
<thead>
<tr>
<th>MNT: First Calendar Year, 3 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual or group*. Individual assessment; nutrition dx; intervention and personalized meal plan; outcomes monitoring and evaluation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSMT: 12 Consecutive Months, 10 Hours*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group classes** in 10 topic areas (as needed by pt) on basic diabetes self-care outlined in National Standards of DSME.</td>
</tr>
</tbody>
</table>

**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.

**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 MNT—DSMT
BILLING PROVIDER ELIGIBILITY

<table>
<thead>
<tr>
<th>MNT</th>
<th>DSME</th>
</tr>
</thead>
<tbody>
<tr>
<td>RD or Nutrition Professional (NP) who is Medicare provider and has met below criteria:</td>
<td>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.</td>
</tr>
<tr>
<td>BS in nutrition/dietetics from accredited school. Minimum 900 hrs of practical experience.</td>
<td>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.</td>
</tr>
<tr>
<td>Licensed or certified in state where furnishing MNT, if state has law regarding. CDE status not required.</td>
<td>Entity Medicare providers: DME, pharmacy, hospital OP dept, clinic, skilled nursing facility, MD/RD practice, Federally Qualified Health Center, Home Health Agency</td>
</tr>
<tr>
<td>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</td>
<td>Separate DSME billing NOT allowed: hospital inpt, hospice care, nursing home, rural health center, ESRD facility</td>
</tr>
</tbody>
</table>

My mother taught me about the science of Osmosis...

"Shut your mouth and eat your supper!"
RD’s OPTIONS for 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 years; enter into private contract with each beneficiary, using Medicare contract language

X: Execute Medicare ABN for diseases excluded 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 ADA 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.

**Pre-Dialysis Renal MNT**
- Dx documentation of 1 of renal disease stages that supports diagnostic criteria: Stage III, IV and V CKD

**Kidney Transplant MNT**
- Successful kidney transplant.
- MNT is in 36 months following transplant.

**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.

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

* Per statutory language of benefit.

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.
**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.*

**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

**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.

*^A1c >/= 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*

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**MEDICARE DIAGNOSTIC LAB CRITERIA for MNT--DSMT**

- FPG >/= 126 mg on 2 tests, or 2 hr OGTT >/= 200 mg on 2 tests, or Random BG >/=200 mg + uncontrolled DM symptom*.
- A1c not added as of 5-1-15^
**MNT**
Written Rx by treating physician.
To include: Rx date + beneficiary’s name.

**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 NPI + signature (stamped not allowed).
Faxed + e-referral allowed.
Separate Rx for: initial, flup MNT and extra hours.

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.

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.
Are we confused yet?

DIETITIAN LICENSURE/CREDENTIALING
STATE LAWS for FURNISHING MNT

Laws in states below specifically outline mandates 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

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Indiana</th>
<th>Connecticut</th>
<th>Tennessee</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Florida</td>
<td>Massachusetts</td>
<td>Maine</td>
<td>South Carolina</td>
</tr>
</tbody>
</table>

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!

## MNT: 3 hrs in calendar yr.
- Cannot extend into next yr.
- Individual, group or combination.
- Group visit is \( \geq 30 \) min. (1 billing unit; no rounding).

## 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).

### Individual visit is \( \geq 15 \) min.
- Can round: \( \geq 8 \) min. to \( < \) 23 min. does equal 1, 15 min. billing unit.

### Additional Hrs > 3 Reimbursable IF:
- RD obtains NEW Rx from treating physician which documents # extra hrs to be furnished and medical necessity for.

### 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.

### Examples of medical necessity:
- Change in medical condition, diagnosis and/or treatment regimen requiring additional MNT.

### 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

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Medicare will not pay for MNT and DSMT provided on same day!
MEDICARE MNT--DSMT LIMITS in FOLLOW-UP YEARS and STRUCTURE OF

**F/Up MNT After First Calendar Year**
- 2 hrs in each calendar yr after first.
  - Cannot extend hrs to next yr.
  - Individual, group or combination.
  - **Group visit:** \( \geq 30 \) min. (1 billing unit)

**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 visit:** \( \geq 15 \) min. = 1 billing unit.
- Can round: \( \geq 8 \) min to \( \leq 23 \) min. = 1 unit.
- New Rx for follow-up.

**Individual or group visit:** \( \geq 30 \) 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 \( \text{\textbf{4}} \)
- Completes initial 10 hours in August 2015 \( \text{\textbf{5}} \)
- Eligible for…and starts…2 hr follow-up in September, 2015 \( \text{\textbf{5}} \)
- Completes 2 hour follow-up in Dec., 2015 \( \text{\textbf{5}} \)
- Eligible for next 2 hour follow-up in Jan., 2016 \( \text{\textbf{6}} \)

**Pt Completes Initial 10 Hrs in Same Calendar Year:**
- Starts initial 10 hours in August 2014 \( \text{\textbf{4}} \)
- Completes initial 10 hours in Dec., 2014 \( \text{\textbf{4}} \)
- Eligible for…and starts…2 hours follow-up in Jan., 2015 \( \text{\textbf{5}} \)
- Completes 2 hour follow-up in July 2015 \( \text{\textbf{5}} \)
- Eligible for next 2 hour follow-up in Jan. 2016 \( \text{\textbf{6}} \)
**DIAGNOSES for MEDICARE MNT--DSMT**

4th digit = clinical manifestation/complication of diabetes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.0</td>
<td>Diabetes mellitus without mention of complication</td>
</tr>
<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 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.X0</td>
<td>Type 2 controlled</td>
<td>1 Unit</td>
</tr>
<tr>
<td>250.X1</td>
<td>Type 1 controlled</td>
<td>1 Unit</td>
</tr>
<tr>
<td>250.X2</td>
<td>Type 2 uncontrolled</td>
<td>1 Unit</td>
</tr>
<tr>
<td>250.X3</td>
<td>Type 1 uncontrolled</td>
<td>1 Unit</td>
</tr>
</tbody>
</table>

PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial episode of care (EOC), individual</td>
<td>15 min</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, f/up EOC, individual</td>
<td>15 min</td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or f/up EOC, group</td>
<td>30 min</td>
</tr>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, beyond 3 hours or MNT, f/up, individual, beyond 2 hours per 2nd referral in same year</td>
<td>15 min</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, beyond 3 hours or MNT, f/up, group, beyond 2 hours per 2nd referral in same year</td>
<td>30 min</td>
</tr>
<tr>
<td>G0108</td>
<td>DSMT, individual, initial or f/up, each 30 min.</td>
<td>30 min</td>
</tr>
<tr>
<td>G0109</td>
<td>DSMT, group, initial or f/up, each 30 min.</td>
<td>30 min</td>
</tr>
</tbody>
</table>
CMS’ GUIDE for 15 MIN. TIME-BASED CODES

<table>
<thead>
<tr>
<th>UNITS</th>
<th>MINUTES to MINUTES¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 8                 ≤ 23</td>
</tr>
<tr>
<td>2</td>
<td>≥ 24                ≤ 37</td>
</tr>
<tr>
<td>3</td>
<td>≥ 38                ≤ 52</td>
</tr>
<tr>
<td>4</td>
<td>≥ 53                ≤ 67</td>
</tr>
<tr>
<td>5</td>
<td>≥ 68                ≤ 82</td>
</tr>
<tr>
<td>6</td>
<td>≥ 83                ≤ 97</td>
</tr>
<tr>
<td>7</td>
<td>≥ 98                ≤ 112</td>
</tr>
<tr>
<td>8</td>
<td>≥ 113               ≤ 127</td>
</tr>
</tbody>
</table>

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.
### MEDICARE MNT--DSMT REIMBURSEMENT RATES, 2015

#### Medicare MNT Rates

Accessed 1-22-15 on CMS.gov

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-Facility</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>Individual, 30 min:</td>
<td>$53.27</td>
<td></td>
</tr>
<tr>
<td>G0109</td>
<td>Group, 30 min:</td>
<td>$14.30</td>
<td></td>
</tr>
</tbody>
</table>

Aver. Unadjusted Rates*: 97802, initial, 15 min:
- Non-Facility: $35.04
- Facility: $32.89

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

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

#### Medicare DSMT Rates

Accessed 1-22-15 on CMS.gov

Aver Unadjusted Rates*, Facility, Non-Facility:
- G0108, individual, 30 min: $53.27
- G0109, group, 30 min: $14.30

*Rates also vary per geographic region.

100% of condensed MPFS for par providers, but only 95% for non-par providers. Medicare pays 80% of adjusted rate, pt pays 20%.
My mother taught me about contortionism.

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

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

- **Home Health Agency**
  - **MNT** YES separate Part B bill
  - **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**
  - **MNT** YES separate Part B bill but only for non-dial bene's
  - **DSMT** NO separate Part B bill
### SKILLED NURSING FACILITY and NURSING HOME MEDICARE MNT--DSMT BILLING

<table>
<thead>
<tr>
<th>Skilled Nursing Facility</th>
<th>Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MNT</strong></td>
<td></td>
</tr>
<tr>
<td>NO separate Part B bill</td>
<td></td>
</tr>
<tr>
<td><strong>DSMT</strong></td>
<td></td>
</tr>
<tr>
<td>YES separate Part B bill. Part A SNF benefit and Part B DSMT can be received at same time</td>
<td>NO separate Part B bill</td>
</tr>
</tbody>
</table>

Uee 22x, 23x type of bill

Revenue code 0942

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

<table>
<thead>
<tr>
<th>FQHC</th>
<th>Rural Health Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MNT</strong>*: Type of Bill (TOB) 73x/77x; revenue code 0521. 1:1 only is separately billable with MNT codes but paid at all-inclusive FOHC rate. No co-insurance. RD may be able to bill incident to to physician services.</td>
<td><strong>MNT</strong>: 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.</td>
</tr>
<tr>
<td><strong>DSMT</strong>*: Type of bill 73x/77x; revenue code 0521. 1:1 only is separately billable with G0108 but paid at all-inclusive FOHC rate. Co-insurance applies.</td>
<td><strong>DSMT</strong>: 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.</td>
</tr>
</tbody>
</table>

*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.
MNT--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 = UB04 claim
    - or HIPAA 837
    - 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 Part A
    - Intermediary being replaced by Medicare Administrative Contractors

- **Private Practice:**
  - RD is provider:
    - CMS 1500 = UB04 claim
    - or HIPAA 837
    - Prof ECF**
  - To Private Insurance

^ 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

**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.
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)

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetes management program, f/up visit to non-MD provider</td>
</tr>
<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>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**
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 TELEHEALH BASICS**

<table>
<thead>
<tr>
<th><strong>INDIVIDUAL + GROUP MNT and DSMT</strong></th>
<th>can be delivered via telehealth(^1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REIMBURSEMENT:</strong></td>
<td>Same as for original MNT and DSMT benefits.</td>
</tr>
<tr>
<td><strong>CPT code modifier GT</strong></td>
<td>to be added to MNT/DSMT code on claim: “interactive audio and video telecommunications system”</td>
</tr>
<tr>
<td><strong>DSMT:</strong></td>
<td>&gt;1 hour of 10 in <em>initial</em> year and &gt;1 hour in <em>follow-up</em> years to be furnished <em>in-person</em> for training on injectable medications (individual or group).</td>
</tr>
<tr>
<td><strong>WHAT IT IS:</strong></td>
<td>HIPAA-compliant, interactive audio and video telecommunication permitting <em>real time</em> communication and visualization.</td>
</tr>
</tbody>
</table>


**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

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**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.

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**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
  
o  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:
  
o  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**

<table>
<thead>
<tr>
<th>Aver. # pts</th>
<th>10</th>
<th>10</th>
</tr>
</thead>
<tbody>
<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># individ. visits by physician</td>
<td>10 x approx. $100/pt = $1000</td>
<td>10 x approx. $100/pt = $1000</td>
</tr>
</tbody>
</table>
| 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**

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### 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

- 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
For RDs to avoid 2015 and 2016 payment decrease:

- Satisfactorily report and earn 2014 PQRS incentive

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

## 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
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
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<table>
<thead>
<tr>
<th>Resources by Mary Ann Hodorowicz</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Turn Key Materials for AADE DSME Program Accreditation</strong></td>
</tr>
<tr>
<td>DSME Program Policy &amp; Procedure Manual Consistent with NSDSME (72 pages)</td>
</tr>
<tr>
<td>Medicare, Medicaid and Private Payer Reimbursement</td>
</tr>
<tr>
<td>Electronic and Copy-Ready/Modifiable Forms &amp; Handouts</td>
</tr>
<tr>
<td>Fun 3D Teaching Aids for AADE7 Self-Care Topics</td>
</tr>
<tr>
<td>Complete Business Plan</td>
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</table>

| 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 |


| 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 |