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.

Medicare MNT–DSMT Reimbursement Rules: COPIOUS, CONVOLUTED, CONFUSING, COMPLICATED, CONSTANTLY CHANGING!
M = MNT and other benefits are money makers
E = Engagement with CDC (grant to state depts. of PH) to t 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 (e.g., 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 (MEDICARE BENEFIT)
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
JOHN D. DOE
MEDICARE CLAIM NUMBER
123-46-5789
SEX
M
ENROLLED TO
07/01/2015
DATE ISSUE
07/01/2015
MEDICAL INSURANCE (PART A)
1/1/95
DEATH
HOME ADE15

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 with adjustments in plans

DSMT
- General and basic training on AADE™ 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.

MEDICARE MNT—DSMT BILLING PROVIDER ELIGIBILITY
MNT
- RD or Nutrition Professional (NP) who is Medicare provider and has met below criteria:
  - BS in nutrition/dietet if accredited school
  - Minimum 800 hrs of practical experience
  - Licensed or certified in state where furnishing MNT, if state has law regarding, CDE status not required.
  - Separate billing allowed: home CP, nursing home, ESRD facility, hosp, rural health

DSME
- 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
- Individual Medicare providers who can bill on behalf of entire program: MD, PA, RD, NP
  - DME, clinical psychologist, LCSR
  - Can also teach but program must have RD or RN or RPh.
  - Separate DSME billing NOT allowed: hosp, hosp care, rural health, NOT allowed: hosp

MEDICAL CONDITIONS
Diabetes: Type 1, Type 2, GDM, Non-Dialysis Renal Disease, etc.
- 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.
- DSMT: 12 Consecutive Months, 10 Hrs*
- For period of 36 months after successful kidney transplant. *Group = 2 or more pts; need not all be Medicare.

My mother taught me about the science of Osmosis...
"Shut your mouth and eat your supper!"
**RD 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 furnishing **MNT**, 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 ABN for diagnoses excluded in MNT benefit

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**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 ADFA 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

---

**MEDICARE BENEFICIARY ELIGIBILITY 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***

*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**

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

**Pre-Dialysis Renal MNT**
- Documentation of 1 of renal disease stages that supports diagnostic criteria:
  - Stage III = 30--50 ml/min.1.73m²
  - Stage IV = 15--29
  - Stage V = <15

**Gestational Diabetes**
- Provider to provide documentation of gestational diabetes dx code.

**Documentation of diabetes dx is MNT, DSMT coverage rule.**
- Treating physician must have documentation.
- DSMT benefit does NOT state WHO must have documentation.

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

**T1 and T2 Diabetes**
- 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 diabetes dx lab is MNT, DSMT coverage rule.
- MNT benefit states treating physician must have documentation.
- DSMT benefit does NOT state WHO must have documentation.

**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

**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, f/up MNT and extra hours.

- Revised DSMT 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.

- ICD-9 dx or code (5 digits for T1, T2 DM).
- Physician’s NPI + signature.
- Separate Rx for: initial and f/up DSMT.
- For initial: topics + hrs to be taught (10 total each).

Are we confused yet?

NEW! MEDICARE MEDICAL UNLIKELY EDITS (MUEs) for DSMT, EFFECTIVE 7/1/15

Aka: Limits on number of units of code payable/visit

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>OP Hospital Services MUE Values</th>
<th>Practitioner Services MUE Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>8 units = 4 hours</td>
<td>6 units = 3 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0109</td>
<td>12 units = 6 hours</td>
<td>12 units = 6 hours</td>
</tr>
</tbody>
</table>

**Examples of medical necessity:**
- Change in medical condition, diagnosis and/or treatment regimen requiring additional MNT.
- 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 (year).
  - Additional Hrs Not Cited by CMS as Payable.

**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.

<table>
<thead>
<tr>
<th>Visit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>10 hours within 2 years of initial MNT</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2 hours each 12 months after initial MNT</td>
</tr>
</tbody>
</table>

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.

Individual visit: ≥ 15 min. = 1 billing unit.
Can round: ≥ 8 min to ≤ 23 min. = 1 unit.

New Rx for follow-up.

2 hrs in each calendar yr after first.
Cannot extend hrs into next 12 months.
Individual, group or combination.

Group visit: ≥ 30 min. (1 billing unit)

F/U MNT After First Calendar Year
Special needs do not need to be documented for individual follow-up DSMT.
Can obtain even if INITIAL DSMT not received.

Individual or group visit: ≥ 30 min = 1 billing unit (1 billing unit). No rounding.

New Rx for follow-up.

F/U DSMT After First 12 Consecutive Months
ALWAYS DOCUMENT ‘START TIME’ and ‘END TIME’ FOR EVERY VISIT!

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

Completes Initial 10 Hours 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 for MNT--DSMT is required documentation:
- in medical record maintained by physician/NPP
- on MNT--DSMT referral
- on claims

Diagnosis can be narrative description OR ICD-9 dx code

Use 5 digit code whenever 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 DIABETES 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>

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>
</tr>
</thead>
<tbody>
<tr>
<td>250.X0</td>
<td>Type 2 controlled</td>
</tr>
<tr>
<td>250.X1</td>
<td>Type 1 controlled</td>
</tr>
<tr>
<td>250.X2</td>
<td>Type 2 uncontrolled</td>
</tr>
<tr>
<td>250.X3</td>
<td>Type 1 uncontrolled</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>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial episode or care (EOC), individual</td>
<td>15 min</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, follow-up EOC, individual</td>
<td>15 min</td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or follow-up EOC, group</td>
<td>30 min</td>
</tr>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, ≥3 hrs or follow-up, individual, ≥2 hrs per 2nd referral, same year</td>
<td>15 min</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, ≥3 hrs or f/up, group, ≥2 hrs per 2nd referral, same year</td>
<td>30 min</td>
</tr>
<tr>
<td>G0108</td>
<td>DSMT, individual, initial or follow-up, 30 min.</td>
<td>30 min</td>
</tr>
<tr>
<td>G0109</td>
<td>DSMT, group, initial or follow-up, 30 min.</td>
<td>30 min</td>
</tr>
</tbody>
</table>
**CMS’ GUIDE for 15 MINUTE TIME-BASED CODES**

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

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. AS-02-003, Program Memorandum Intermediaries/Criers, Change Revised #174, 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 (23)
- Custodial care facility (33)
- Independent clinic (46)
- 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 (23)
- Custodial care facility (33)
- Independent clinic (46)
- 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.

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

**Medicare MNT Rates**
Accessed 1-22-15 on CMS.gov

<table>
<thead>
<tr>
<th>Average Unadjusted Rates</th>
<th>Facility, Non-Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802, Initial, 15 min</td>
<td>$35.04, $30.89</td>
</tr>
<tr>
<td>97803, Follow-up, 15 min</td>
<td>$20.03, $18.09</td>
</tr>
</tbody>
</table>

**Medicare DSMT Rates**
Accessed 1-22-15 on CMS.gov

<table>
<thead>
<tr>
<th>Average Unadjusted Rates</th>
<th>Facility, Non-Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0107, Group, Initial or Follow-Up, 30 min</td>
<td>$15.61, $14.30</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Time</th>
<th>Non-Facility</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 min</td>
<td>$35.04</td>
<td>$30.89</td>
</tr>
<tr>
<td>15 min</td>
<td>$20.03</td>
<td>$18.09</td>
</tr>
</tbody>
</table>

100% of Medicare Physician Fee Schedule (MPFS) for par providers, but only 95% for non-par providers.

Medicare pays 100% of adjusted rate, pt pays 20%.

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

- **End Stage Renal Dialysis Facility**
  - MNT: YES separate Part B bill but only for non-dial bene's
  - DSMT: NO separate Part B bill

Medicare pays 100% of condensed MPFS for par providers, but only 95% for non-par providers.

Medicare pays 80% of adjusted rate, pt pays 20%.

Medicare pays 100% of adjusted rate, pt pays 20%.

Medicare MNT Rates

Accessed 1-22-15 on CMS.gov

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.
**SKILLED NURSING FACILITY and NURSING HOME MEDICARE MNT–DSMT BILLING**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>MNT</td>
<td>NO separate Part B bill</td>
</tr>
<tr>
<td>DSMT</td>
<td>YES separate Part B bill</td>
</tr>
</tbody>
</table>

Use 22x, 23x type of bill
Revenue code 0342

**RURAL HEALTH CLINIC MEDICARE MNT–DSMT BILLING**

MNT: Revenue code 0521. NOT separately billable for additional payment. INDIVIDUAL may be included on COST REPORT with 97802, 97803 as ‘incident to’ physician services.

DSMT: Revenue code 0521. NOT separately billable for additional payment. INDIVIDUAL may be included on COST REPORT with G0108 as ‘incident to’ physician services.

If solo instructor of DSMT, must be RD-CDE

Medicare Claims Processing Manual Chap. 9, FQHCs/RHCs (Rev. 3000, 07-25-14)

Paid either under All Inclusive Rate or Prospective Payment System Rate.

**FEDERALLY QUALIFIED HEALTH CENTER MEDICARE MNT–DSMT BILLING**

MNT: Revenue code 0521. IS separately billable with 1:1 codes 97802, 97803 for additional encounter payment but paid at PPS or AIR FQHC rate*. Co-insurance waived. Billed to FI or A/B MAC.

DSMT: Revenue code 0521. IS separately billable with 1:1 code G0108 for additional encounter payment but paid at PPS or AIR FQHC rate*. Co-insurance NOT waived. Billed to FI or A/B MAC.

*Under Prospective Payment System (PPS): DSMT or MNT NOT payable on same day as medical visit. Under All-Inclusive Rate (AIR) System: DSMT or MNT is payable on same day as medical visit.

**FQHC and RHC Medicare Billing of GROUP MNT–DSMT**

Group MNT and DSMT:
May be able to furnish and include as ‘incident to’ physician services on annual COST REPORT.

When on COST REPORT, item calculated for inclusion in All-Inclusive Rate (AIR) or Prospective Payment System Rate (PPS).
Check with Medicare Administrative Contractor (MAC) if allowable.
FQHCs converting from AIR to PPS in 2014–2016.

**MNT–DSMT CLAIM FORMS for HOSPITAL and PRIVATE PRACTICE**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital OP</td>
<td>Private Practice</td>
</tr>
<tr>
<td>CMS 1450</td>
<td>CMS 1450</td>
</tr>
<tr>
<td>+ UB04 claim* or UB04 claim*</td>
<td>+ UB04 claim* or UB04 claim*</td>
</tr>
<tr>
<td>Intermediary: being replaced by Medicare Administrative Contractor, ‘MAC’</td>
<td>Intermediary: being replaced by Medicare Administrative Contractor, ‘MAC’</td>
</tr>
</tbody>
</table>

* In paper claim used, must use new CMS 1450 paper claim (03-07); will no UB04 paper claim
**Inst 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.

**DENIED CLAIM**
Medicare made determination that coverage requirements not met; example: service is not medically necessary.

**INVALID Claim**
Info is illogical or incorrect (ex: wrong NPI #, hysterectomy billed for male pt. etc.)
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 health 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 some degree of coverage for:
  - DSMT, MNT, DM-related services and supplies
  - 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

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

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

AADE15
6. Insert patient’s “swipe/scan healthcare ID card” in special card reader provided by insurer.

**Keep database of results, and update regularly!**

Picture of Magnetic Swipe Insurance Card Reader:

---

**YOUR PRIVATE PAYER HOMEWORK**

**PROCEDURE CODES for MNT--DSMT**

**NOT PAID by MEDICARE**

**BUT MAY BE REQUIRED by PRIVATE PAYERS and MEDICAID**

<table>
<thead>
<tr>
<th>Procedure 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>
</tbody>
</table>

**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

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**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

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**WE GOT RID OF THE KIDS….. THE CAT WAS ALLERGIC**
**MEDICARE MNT--DSMT TELEHEALTH BASICS**

**INDIVIDUAL + GROUP MNT and DSMT** can be delivered via telehealth.

**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.


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**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.

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**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.

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**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
- County outside of metropolitan statistical area.

See: [www.cms.gov/Medicare/Medicare-General-Information/Telehealth](http://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 OP 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 is lesser of 80% of actual charge or 80% of originating site facility fee, regardless of location. Part B contractor does not apply geographic practice cost index to fee; fee statutorily set; not subject to geographic payment adjustments authorized under Physician Fee Schedule. Part B is billed.

Renal dialysis center (or satellite) 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 outside SNF prospective payment system bundle and not subject to SNF consolidated billing; separately billable Part B payment. Bills Part A and must use revenue code 78x.

Community Mental Health Center (CMHC): Fee not partial hospital 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; separately billable Part B payment. Bills Part A and must use revenue code 78x.

Independent and provider-based RHCs and FQHCs: Fee 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 clinic/center bill type and provider number. Must use revenue code 078x.

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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