Navigating the DSMT Reimbursement Maze in Today’s Changing Environment

Disclosure to Participants
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Presenter:
Patty Telgener, RN, MBA
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Outline
- Review of DSMT reimbursement and FAQ
- Ways to improve profitability of AADE program
- Impact of Accountable Care Organizations, ICD-10 and Competitive Bidding on diabetes management
- Healthcare reform initiatives potential impact on DSMT
- Q&A session

REVIEW AND FREQUENTLY ASKED QUESTIONS (FAQ)
Medicare’s Definition of Diabetes

- Medicare diagnosis of diabetes is by any of the following criteria:
  - A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions
  - A two-hour post glucose challenge greater than or equal to 200 mg/dL on two different occasions
  - Random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes
- Criteria does not include A1C level
- Medicare does not currently cover pre-diabetes, but expansion of coverage is important initiative for AADE

When are DSMT Services Covered by Medicare?

- Referral from physician or non-physician practitioner
- The training must be ordered by the physician or qualified non-physician provider treating the beneficiary’s diabetes

DSMT Recognized Providers

- Recognized Providers
  - RDs
  - Pharmacies
  - Physicians (MDs and DOs)
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
- Legislation under way to recognize CDEs as providers

DSMT Accreditation

- CMS has stated that only recognized programs can bill Medicare for DSMT services
  - ADA or AADE
- The NPI is attached to the clinician but the accreditation is to the Program
- Can not bill Medicare until program is accredited

Medicare’s Coverage for DSMT

- Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes
- Medicare will typically pay one hour of individual training and the other nine hours as group training
  - Groups do not need to be all Medicare patients
  - Groups can be two to twenty individuals
  - No requirement to do individual training. All ten hours can be done as all group

Conditions that may allow additional individual training:

- Referral documents patient barriers that hinder group learning
- Insulin training
- Program not starting in 2 months of referral date
DSMT Initial Training Criteria

- Furnished to a beneficiary who has not previously received initial training
- Furnished within a continuous 12 month period
  - Can be provided in any combination of one-half hour increments over the 12 month period
- Does not exceed a total of 10 hours for the initial training
  - Patient or provider may be liable if exceeds

Criteria for Follow-up Training

- After receiving the initial training, Medicare covers follow-up training under the following conditions:
  - Consists of no more than two hours of training each year
  - May be provided in either group or 1:1
  - Furnished any time in a calendar year after a year in which the beneficiary completes the initial training

Example of DSMT Training

- Patient starts initial DSMT in April 2015
  - Completes initial 10 hours DSMT in June 2015
- Eligible for follow-up DSMT in January 2016
  - Completes follow-up DSMT in May 2016
  - Eligible for next year DSMT in January 2017

Example of DSMT Training

- Patient starts initial DSMT in December 2014
  - Completes initial 10 hours DSMT in May 2015
- Eligible for follow-up DSMT in June 2015
  - Completes follow-up DSMT in November 2015
  - Eligible for next year DSMT in January 2016

2015 DSMT Medicare Reimbursement

- G0108 Diabetes outpatient self-management training services (DSMT); individual session, face-to-face with the pt, each 30 minutes of training (approximately $50 depending on CF factor)
- G0109 Diabetes outpatient self-management training services (DSMT); group session (2 or more), face-to-face with the pt, each 30 minutes (approximately $14 depending on CF factor)

2016 Medicare Proposed Payment Rates

- No change in payment level for G0108 and G0109 in 2016 Proposed Medicare Rule
- Sustainable Growth Rate issue finally resolved (no threat of 25% reduction like last 5 years)
Medicare Medically Unlikely Edits (MUE)

- Medicare has added edits on number of hours that can be billed on same day/same patient
- Medically Unlikely Edits (MUE)
- Limit is 3 hours of G0108 and 6 hours of G0109 provided on same day

Can Patients Receive both DSMT and MNT?

- Yes, a beneficiary can receive the full 10 hours of initial DSMT and the full three hours of MNT
- But DSMT and MNT cannot be billed on the same date of service
- In subsequent years the beneficiary can receive two hours of DSMT (with a referral) and two hours of MNT (with a referral)

Hospital Review of DSMT Financials

- Make sure program metrics and objectives are aligned
  - Increased revenue is only one metric
  - Venue to increase revenue of other hospital services (Lab, inpatient, ER)
  - Helps physician and/or hospital achieve Pay for Performance metrics
  - Increased referrals
  - Better diabetes control may result in less unscheduled visits or ER encounters

Hospital Review of DSMT Financials

- Offer both DSMT and MNT services
  - Are patients using allowed hours?
- Consider off-site locations for DSME/T
- Increase efficiency
  - Group versus individual; Shared medical visits
- Other CPT codes and Services
  - Education codes such as 98960-98962
  - Continuous glucose monitoring (CGM)
  - Weight loss programs

CDC National Diabetes Prevention Program (DPP)

- The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes
- The year-long program helps participants make real lifestyle changes such as eating healthier, including physical activity into their daily lives, and improving problem-solving and coping skills.

CDC National Diabetes Prevention Program

- Participants meet with a trained lifestyle coach and a small group of people who are making lifestyle changes to prevent diabetes. Sessions are weekly for 6 months and then monthly for 6 months.
- Can help people with prediabetes and/or at risk for type 2 diabetes make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes by 58 percent.
New CPT Code for Pre-Diabetes Education

- 0403T: Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
  - Released July 1, 2015
  - Implemented January 1, 2016

Accountable Care Organizations (ACOs)

- Network of providers such as primary care doctors, physician specialists, hospitals, and/or home care agencies that share responsibility for care of patients
- Unlike the current healthcare system, in which providers make money only when treating sick people, ACOs would reward providers with a share of the cost savings achieved by retaining or improving patient health. Conversely, providers may see financial losses if they don’t meet benchmarks in patient outcomes and care coordination

Diabetes Educators and other non-physician personnel will be key to the success of these new ACOs which emphasize prevention, care coordination, wellness, teamwork and health education

Diabetes educators will have a unique opportunity to help patients navigate barriers to care and to educate patients about how to manage their chronic disease such as diabetes

Chronic Care Management

- Effective January 2015, Medicare began paying for chronic care management (CCM)
- Chronic care management (CCM) payments will reimburse providers for non-face-to-face services to qualified beneficiaries over a calendar month.

What can be counted toward the 20-minute requirement:
- Medication reconciliation and overseeing the beneficiary’s self-management of medications
- Ensuring receipt of all recommended preventive services
- Monitoring the beneficiary’s condition (physical, mental, social)
- Education with patient, family, guardian, and/or caregiver
- Identify and arrange for needed community resources; and
- Communicate with home health agencies and other community service providers utilized by the beneficiary.

Chronic Care Management

- Time spent on different days or by different clinical staff members in the same month may be aggregated to total 20 minutes
- However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted
- Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month
- Providers must be using Electronic Medical Records
CPT Codes for Chronic Care Management

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<th>CPT Code</th>
<th>Description</th>
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<td>99490</td>
<td>Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.</td>
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2015 Medicare Non-Facility Payment

$42.91

Change in Co-Payments for Preventive Services

- CMS and Commercial Payers trying to remove barriers to "Preventive Services"
- Diabetes screening and MNT have had no co-pays
- DSME/T not listed for removal of co-pay, but AADE working with CMS and US Preventive Screening Task Force (USPSTF)

Diabetes Supplies Competitive Bidding

- A rational mail-order competitive bidding program for diabetic testing suppliers in effect
- The term “mail-order” means items shipped or delivered to the beneficiary’s residence regardless of the method of delivery
- Only contract suppliers are reimbursed by Medicare for diabetic testing supplies delivered to beneficiaries’ residences
- Contract suppliers are required to use the KL modifier on each claim for diabetic testing supplies furnished on a mail-order basis

Diabetes Supplies Competitive Bidding

- Beneficiaries with fee for service Medicare will have two options to purchase their diabetic testing supplies:
  - Beneficiaries can have their diabetic testing supplies delivered directly to their home by a national mail-order contract supplier (mail-order), or
  - Beneficiaries can pick up their supplies in person from any Medicare-enrolled supplier of diabetic testing supplies (non-mail-order)
- Medicare-approved amount for diabetic testing supplies will be the same regardless of where the supplies are furnished

Competitive Bidding Impact on Patients

- Before competitive bidding, Medicare beneficiaries paid an average of $15.58 a month for testing supplies
- Now, average out of pocket is $4.50
- But most likely to have less options!

ICD-10 and 5010

- Reasons for Moving to ICD-10
  - Many categories of ICD-9 are full
  - Need better descriptions of diagnoses and procedures
  - Rest of world is using ICD-10
- Implementation date is now October 2015
  - ICD-10 diagnoses will be used by ALL providers in all settings
  - ICD-10 procedure codes will only be inpatient
Examples of ICD-10 Diagnosis Codes

- E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
- E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
- E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
- E11.41, Type 2 diabetes mellitus with diabetic mononeuropathy

Summary

- Diabetes is recognized as a significant healthcare issue
- AADE continues to make progress with increasing access to DSMT (both pre-diabetes and diabetes)
- Diabetes programs can be profitable and provides value-add to payers, physicians and hospitals
- Healthcare Reform incentives are aligned with diabetes education