JAZZ IT UP
WITH INNOVATION
AND ENGAGEMENT

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AADE American Association of Diabetes Educators

Patty Telgener
RN, MBA, CPC

VP of Reimbursement
Emerson Consultants

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Navigating the DSMT Reimbursement Maze in Todays Changing Environment

Patty Telgener, RN, MBA, CPC
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Emerson Consultants

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Disclosure to Participants

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Presenter:
Patty Curoe 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

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REVIEW AND FREQUENTLY ASKED QUESTIONS (FAQ)

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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

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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

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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

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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

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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

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Medicare's Coverage for DSMT

- 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

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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

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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

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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

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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

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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)

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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)

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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

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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)

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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

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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

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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.

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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.

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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

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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 patient
- 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

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Accountable Care Organizations (ACOs)

- 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

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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.

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Chronic Care Management

- 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.

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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

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CPT Codes for Chronic Care Management

99490	"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."	2015 Medicare Non-Facility Payment $42.91

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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)

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Diabetes Supplies Competitive Bidding

- A national 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

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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

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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!

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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

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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

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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

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