DRIVING CHANGE & INNOVATION

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Mary Ann Hodorowicz, RDN, 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. She served on the Board of Directors of the American Association of Diabetes Educators from 2013 – 2015, and was the Chair of the Advanced Practice Community of Interest in 2016.

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DISCLOSURE TO PARTICIPANTS

- **Notice of Requirements For Successful Completion**
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
- **Conflict of Interest (COI) and Financial Relationship Disclosures:**
  - Presenter: Mary Ann Hodorowicz, RDN, MBA, CDE, CEC
  - I have no conflict-of-interest or financial disclosures to declare
- **Off-Label Use**
  - Presenter: Mary Ann Hodorowicz, RDN, MBA, CDE, CEC
  - I will not be discussing off-label use of any medications or technologies.

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Rejected DSMT Claims

- First need to understand the basics of DSMT reimbursement to understand why claim rejected
- Partner with your Business Office
- Request summary of claims submitted versus paid!

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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 or 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 advance practice provider
- The training must be ordered by the physician or advance practice provider *treating* the beneficiary's diabetes

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DSMT Certified Providers

- Certified Providers
  - RDs
  - Pharmacies
  - Physicians (MDs and DOs)
  - Advanced Practitioners (i.e. Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist)
- Legislation under way to recognize CDEs as providers

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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
  - 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: Training Over One Year

- Patient starts initial DSMT in April 2016
  - Completes initial 10 hours DSMT in June 2016
- Eligible for follow-up DSMT in January 2017
  - Completes follow-up DSMT in December 2017
  - Eligible for next year DSMT in January 2018

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Example: Training Over Two Years

- Patient starts initial DSMT in April 2016
  - Completes initial 10 hours DSMT in June 2016
- Eligible for follow-up DSMT in January 2017
  - Completes follow-up DSMT in December 2017
  - Eligible for next year DSMT in January 2018

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Medicare limits on number of units of code payable/visit; referred to as "medical unlikely edits"

HCPCS Code	OP Hospital Services Limits	Practitioner Services Limits
G0108 Individ DSMT	8 units = 4 hours	6 units = 3 hours
G0109 Group DSMT	12 units = 6 hours	12 units = 6 hours

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2017 DSMT Medicare Reimbursement

Facility (i.e., Hospital) and Non-Facility (No Difference)

G0108	Diabetes outpatient self-management training services (DSMT); individual session, face-to-face with the patient, each 30 minutes of training National Average: $54.19 – increased from $52.99 Range, Based on Geographical Adjustment: $46.38 - 71.01
G0109	Diabetes outpatient self-management training services (DSMT); group session (2 or more), face-to-face with the patient, each 30 minutes National Average: $14.71 - increased from $14.33 Range, Based on Geographical Adjustment: $12.59 - 16.78

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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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Potential Reasons for DSMT Denials

- Denial of initial 10 hour benefit:
  - Patient already used 10 hour initial benefit
  - More than 1 hour of 1:1 billed
  - Not furnished within 12 month continuous period
- Denial for 2 hour follow-up DSMT:
  - Time when beneficiary is eligible not adhered to
  - Can be provided either 1:1 or group, but several Medicare Contractors are denying 1:1 training without additional documentation

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Potential Reasons for DSMT Denials, Cont.

- RN's or pharmacist's NPI used as rendering provider on CMS 1500 professional claim
  - RNs and pharmacists can furnish DSMT, but cannot be Medicare providers, and thus cannot bill Medicare
  - DSMT billed as "incident - to" by multiple Medicare providers within same 10 hour program
    - Cannot sub-divide billing among multiple providers; only 1 provider can bill on behalf of entire program, even if the individual billing provider does not teach

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Potential Reasons for DSMT Denials, Cont.

- Referral not from "physician treating the patient's diabetes"
- DSMT and MNT are provided on same day
- Both individual + group DSMT are furnished on same day
- Medicare Administrative Contractor does not know that DSMT program is AADE accredited or ADA recognized
- When legitimate claims for >1 hour of 1:1 visits are denied, billers do not initiate claims appeals process and submit documentation of special needs

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Potential Denials for DSMT

- Billing for RN time
  - RNs can provide DSMT, but billing done under NPI of accredited DSMT program
  - DSMT not considered "incident - to"
- Referral must come from "physician treating the patient's diabetes"
- DSMT and MNT can't be provided on same day

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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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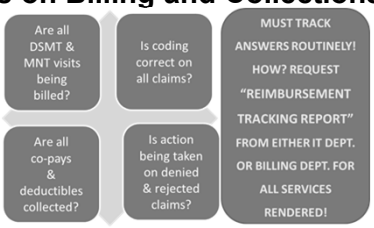
Focus on Billing and Collections



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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 DSMT
- 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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Medicare Coverage of Personal Use "Dexcom G5®" CGM Mobile System

- Payment for G5® device/supplies Medicare approved in 2017
- Eligibility criteria for Medicare beneficiary:
  - Has Part B insurance + Type 1 or Type 2 diabetes
  - Has been using home BG monitor and performing frequent (≥4 times/day) BG testing
  - Be on multiple daily insulin injections or insulin pump
  - Insulin regimen requires frequent adjustment by beneficiary on basis of **"therapeutic" *** CGM results

***Defined as CGM used as replacement for fingerstick BG testing for diabetes treatment decisions i.e., non-adjunctive use.**

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Medicare Coverage of Personal Use "Dexcom G5®" CGM Mobile System, Cont.

- Indicated to replace fingerstick BG monitor testing for diabetes treatment decisions, referred to by FDA as **therapeutic "non-adjunctive"** use
  - Dexcom G5® Mobile CGM System is currently only FDA-approved device with "non-adjunctive" indication
  - Non-therapeutic CGM are devices used as **adjunct** to BG testing (i.e., primary therapeutic decisions re: diabetes treatment must be made with standard home BG monitor….not the CGM)

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Medicare Proposed Coverage for DPP

- Medicare initially announced intent to expand coverage for DPP in 2016
- Recently published 2018 Physician Payment Proposed Rule. This is a PROPOSED rule – not final.
- CMS asking for feedback. Comment period open until September 11th, 2017
- Proposed effective date for DPP coverage would be April 2018
  - Would expect additional information to be published by CMS in the November final rule

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Medicare Proposed Coverage for DPP cont.

- Open to public comment until September 11, 2017
- Comments can be submitted one of two ways:
  - Electronically to www.regulations.gov. Follow the instructions for "submitting a comment."
  - By regular mail. You may mail written comments to the following address

    Centers for Medicare & Medicaid Services
    Department of Health and Human Services
    Attention: CMS-1676 - P
    Mail Stop C4-26-05
    Baltimore, MD 21244-1850

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Medicare Proposed Coverage for DPP cont.

- Propose that MDPP services available on April 1, 2018 in order to ensure that MDPP suppliers have sufficient time to enroll in Medicare
- MDPP suppliers will enroll through a new, MDPP-specific enrollment application available prior to January 1, 2018.

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Medicare Proposed Coverage for DPP cont.

- Proposing DPP to be "additional preventive service" allowing co-pays to be waived
- Diabetes diagnosis exclusion applies only at the time of the first core session

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Medicare Beneficiaries Eligible for MDPP:

- Enrolled in Medicare Part B
- Have, as of the date of attendance at the first core session, a body mass index (BMI) of at least 25 if not self-identified as Asian or a BMI of at least 23 if self-identified as Asian
- Have, within the 12 months prior to attending the first core session, a hemoglobin A1c test with a value between 5.7 and 6.4 percent, a fasting plasma glucose of 110-125 mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- No previous diagnosis of type 1 or type 2 diabetes (other than gestational
- Do not have end-stage renal disease (ESRD)

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Medicare Proposed Coverage for DPP cont.

- Each beneficiary can only receive the set of MDPP services once in their lifetime
- Medicare will over Core Services for the entire 12 months, not dependent on weight loss or attendance because they feel it is should be available to all participants. They must at least attend at least 1 core sessions though to initiate the payment
- Medicare will cover ongoing maintenance sessions after the 12-month core set of MDPP services. They are proposing to further revise the structure of MDPP services as a 3-year service period. Minimum of 12 consecutive months and a maximum of 36 consecutive months

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Virtual DPP Coverage

- Since DPP model test that met the statutory requirements for expansion did not include virtual services, Medicare does not intend to cover DPP that is furnished exclusively through remote technologies with no in-person delivery
- CMS intends to develop a separate model under CMS Innovation Center authority to test and evaluate MDPP services that are exclusively furnished virtually

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Virtual DPP Coverage cont.

- Propose to allow in-person suppliers to offer a limited number of virtual make-up sessions to beneficiaries who miss a session
- To be consistent with CDC's proposed 2018 DPRP standards, propose that the MDPP supplier may provide a maximum of one make-up session on the same day as a regularly scheduled session and may provide a maximum of one make-up session per week
- Supplier may offer no more than 4 virtual make-up sessions within the core services period to an MDPP beneficiary, of which no more than 2 virtual make-up sessions may be core maintenance sessions; and no more than 3 virtual make-up sessions that are ongoing maintenance sessions

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Proposed Payment Structure

- Performance-based payment structure, which ties payment to performance goals based on attendance and/or weight loss
- Proposed payment structure values beneficiary weight loss most significantly, as weight loss is a key indicator of success among individuals enrolled in a DPP due to the strong association between weight loss and reduction in the risk of type 2 diabetes
- Also values beneficiary attendance throughout the first year core services, because, in the DPP model test, session attendance was associated with greater weight loss
- New (HCPCS) G-codes that MDPP suppliers will be created to submit claims for payment when all the requirements for billing the codes have been met

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Medicare Proposed Payment for DPP

- Proposed coverage follows CDC approved DPP program
- CMS payment model based on number of sessions patient attends and weight loss achieved
  - Payment after one session attended- $25
  - Payment after 4 sessions attended - $30
  - Payment after 9 sessions attended - $50
  - Additional payment for weight loss of 5% - $330 (additional $25 for weight loss of 9%)
  - Payment per 3 maintenance sessions with weight loss- $50
  - If patient met total weight loss of 5% or 9% - total payment $810
  - If patient does not meet 5% weight loss – total payment is $125

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Questions…

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