Money Matters in DSMT and MNT: Increase Your Insurance Reimbursement NOW!

Mary Ann Hodorowicz
RDN, MBA, CDE, CEC
(Certified Endocrinology Coder)
Owner, Mary Ann Hodorowicz Consulting, LLC
Palos Heights, IL
hodorowicz@Comcast.net
www.maryannhodorowicz.com
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:
  – Mary Ann Hodorowicz has no conflicts to report
• Non-Endorsement of Products:
  – Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity
• Off-Label Use:
  – Participants will be notified by speakers to any product used for a purpose other than for which it was approved by the Food and Drug Administration.

LEARNING OBJECTIVES
1. Describe the beneficiary eligibility criteria for Medicare DSMT and MNT.
2. State the lab values of the 3 lab tests that diagnose T1 and T2 diabetes.
3. Name the procedure codes used to bill Medicare for DSMT and MNT.
4. Describe the quality standards for Medicare DSMT and MNT.
5. Name the approved referring providers for Medicare DSMT and MNT.
6. List the 3 conditions for reimbursement of 10 initial DSMT hours as individual visits.
7. Describe 3 of the key and unique Medicare coverage guidelines for DSMT and MNT telehealth.

THE GOLDEN RULE
• He who has the gold makes the rules!
• He who wants the gold must identify all the rules…and follow the rules.
• He who doesn't follow the rules will likely have to give all the gold back…..and pay penalties and fines.
• He who has to give all the gold back…and pay penalties and fines…will likely be out of a job!

INSURER’S RULES RULE!
Medicare Reimbursement Maze:
Navigate at your own risk!

REIMBURSEMENT RULES for
MEDICARE DSMT* and MNT are all about the:

C's

* Diabetes Self-Management Training (Medicare’s term for the benefit).

COPIOUS, CONVOLUTED, CONFUSING, COMPLICATED, COMPLEX... and CONSTANTLY CHANGING
**CONSTANTLY CHANGING!**

How to be keep abreast of changes?
Sign up for free MLN Newsletter on CMS website:

The Medicare Learning Network®


**THERE ARE LOTS OF BENEFITS TO PROVIDERS WHO JOIN MEDICARE!**

M = Medicare’s benefits increase patient outcomes.

E = Engagement with CDC (e.g., grant funds to state depts. of health) to ↑ access to, and quality of DSMT, MDPP, etc.

D = Dependable transparency and timeliness with benefit coverage rules, reimbursement rates, reminders.

I = Increase in preventive benefits.

C = Captive audience of patients usually with many medical problems…and with secondary insurance.

A = Amenable to changes in coverage rules due to complaints, concerns, criticism (e.g., intensive behavior therapy for obesity benefit).

R = Regularly pays claims.

E = Enormous number of new beneficiaries in next 2–4 years.
RD OPTIONS for MEDICARE MNT -- DSMT

B: Become Medicare provider and bill for MNT; can then bill on behalf of entire DSMT program.

R: Refer beneficiary for MNT or DSMT to Medicare provider rendering MNT or to DSMT program.

O: Opt out of Medicare by filing opt out affidavit letter every 2 years; then enter into private contract with each beneficiary, using Medicare contract and language.

X: Execute ABN for DSMT when hours beyond the limit to be furnished.

MEDICARE BENEFICIARY MNT -- DSMT ENTITLEMENT

Must have Medicare Part B insurance or Medicare Advantage Plan. Suggestion: make copy of Medicare card for medical record.

MEDICARE MNT and DSMT: COMPLIMENTARY but DISTINCT

MNT
- Personalized nutrition (and related) therapy to control A-B-C's of diabetes, primarily as individual visits.
- Personalized meal plan. Adjustments in SMBG, exercise & medication plans* are often suggested, due to pt's lifestyle and diabetes management changes.
- Longer-term follow-up with more extensive monitoring of labs, outcomes, behavior change, with adjustments in plans.*

DSMT
- General training on key self-care behaviors to control A-B-C's of diabetes, primarily in group format.
- Objective is to increase patients' knowledge of why and basic skill in how to: adopt healthier lifestyle behaviors; adhere to their medication and SMBG regimen.
- Shorter-term follow-up with less extensive monitoring of labs, outcomes, behavior change, etc., over time.
**COORDINATION OF MEDICARE MNT – DSMT**

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

<table>
<thead>
<tr>
<th>Initial MNT: 3 Hours* in Calendar Year</th>
<th>Initial DSMT: 10 Hours* in 12 Consecutive Months</th>
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<td>T1, T2 diabetes; GDM; non-dialysis renal disease; 36 months after kidney transplant.</td>
<td>T1, T2 diabetes; GDM. Adherence to 2017 National Standards of DSMES required.</td>
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4 Step Nutrition Care Process
1. Assessment
2. Diagnosis
3. Intervention
4. Monitoring and Evaluation

Nutrition is 1 of 10 topics taught as overview of healthy eating to control A-B-C’s of diabetes. No individualized eating plans created for pts; this is furnished in MNT benefit.

*3 hours can be individual and/or group. Special condition not required for individual.

**9 hours of 10 must be in GROUP.**
10 hours can be INDIVIDUAL but ONLY if 1 of 3 special conditions documented.
**2 or more pts, need not be all Medicare.

Initial MNT: 3 Hours* in Calendar Year
T1, T2 diabetes; GDM; non-dialysis renal disease; 36 months after kidney transplant.

Initial DSMT: 10 Hours* in 12 Consecutive Months
T1, T2 diabetes; GDM. Adherence to 2017 National Standards of DSMES required.

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1 hour of 10 may be INDIVIDUAL on any topic.
9 hours of 10 to be furnished in GROUP.
BUT: All 10 hours can be INDIVIDUAL if 1 of 3 conditions exist:

1. No group class scheduled within 2 months of referral date.
2. Provider orders "additional insulin training" on DSMT referral.
3. Provider documents on referral a beneficiary need that limits group learning.

Examples of special needs: Hearing; vision; language; cognitive; non-ambulatory.

**DSMT FORMAT of INITIAL 10 HOURS in FIRST 12 CONSECUTIVE MONTHS**

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**MEDICARE DSMT BILLING PROVIDER ELIGIBILITY**

Select **individual** and **entity** providers can bill. Must be billing for other Medicare services first. Cannot join Medicare just to bill for DSMT.

**Individual** providers who can bill for all DSMT furnished, if part of program:

Physician (MD, DO); NP, PA, CNS; RD; nutrition professional; CLSW; dentist certified nurse midwife; clinical licensed psychologist.
No Medicare payment allowed in:
Nursing home; inpatient hospital; ESRD facility; hospice care.

Entity providers paid via Physician Fee Schedule under Part B:
Hospital OP dept.; home health agency; clinic;
private practice of RD, nutrition professional, physician, NP, PA, CNS,
pharmacy; skilled nursing facility; DME company.

MEDICARE DSMT BILLING PROVIDER ELIGIBILITY, CONT

Entity providers paid via other Medicare payment models

FQHC: Payment is 80% of lesser of OP Prospective Payment System (PPS) rate
(fixed and bundled rate) or actual charge for DSMT visit.
ONLY INDIVIDUAL DSMT IS PAYABLE.

Rural Health Clinic: Cost-based payment via annual cost report.
ONLY COST OF INDIVIDUAL DSMT CAN BE PUT ON ANNUAL COST REPORT.

MEDICARE DSMT RENDERING PROVIDER ELIGIBILITY, CONT

Rural Health Clinic:
If single/solo instructor, must be RD-CDE.
CMS gives designation of “RHC” to a clinic.
MEDICARE MNT BILLING PROVIDER ELIGIBILITY

Only RDs and Nutrition Professionals can furnish MNT and only they can bill. Must enroll in Medicare Part B by completing CMS 855I form.

If employed by entity, must reassign reimbursement to employer who bills on their behalf, by completing CMS 855R form.

Must be licensed or certified in state where furnishing MNT. CDE not required.

MEDICARE MNT BILLING PROVIDER ELIGIBILITY, CON’T

No Medicare MNT payment allowed in:
Skilled nursing home; inpatient hospital; hospice care.

MEDICARE MNT BILLING PROVIDER ELIGIBILITY, CON’T

Entities who direct bill Part B for MNT on behalf of RD or Nutrition Professional, and paid via Medicare Physician Fee Schedule:
Hospital, nursing home, home health agency, clinic, ESRD facility, DME company, private practice of physician, NP, PA, CNS.

MEDICARE MNT BILLING PROVIDER ELIGIBILITY, CON’T

Entity MNT providers paid via other Medicare payment models:
FQHC: Payment is 80% of lesser of OP Prospective Payment System rate (fixed and bundled rate) or: actual charge for MNT visit. ONLY INDIVIDUAL MNT IS PAYABLE.
Rural Health Clinic: Cost-based payment via annual cost report. ONLY COST OF INDIVIDUAL MNT CAN BE PUT ON ANNUAL COST REPORT
REVIEW: MEDICARE REQUIREMENTS FOR RDs and NUTRITION PROFESSIONALS WHO FURNISH MNT

RD or nutrition professional is required by Medicare to:
1. Obtain NPI number (https://nppes.cms.hhs.gov/NPPES/Welcome.do)
2. Enroll in Medicare Part B as individual provider (via CMS 855B application).
3. Will receive Medicare provider transaction access number (PTAN).
4. If employee, must reassign MNT reimbursement back to employer via submission of CMS 855R form (re-assignment of reimbursement).

Reassignment allows employer to bill Medicare on RD’s behalf and receive MNT reimbursement. Prevents RD from double dipping: receiving Medicare reimbursement and employee salary for MNT.

My mother taught me about the science of Osmosis…

“Shut your mouth and eat your supper!”

MEDICARE DSMT QUALITY STANDARDS

DSMT program "certification" required from ADA (recognition) or AADE (accreditation). Mail copy of certificate to your Medicare Administrative Contractor (MAC). Suggest using registered mail, return receipt.

Both organizations require proof of adherence to 2017 National Standards of DSME via written policies and procedures.

Standard 5:
RD, RN or pharmacist must be on team; can have single/solo instructor, but multi-disciplinary team is recommended.
MEDICARE MNT QUALITY STANDARDS


- Annual subscription required for access.
- Discount for AND members.

- Medical entity can get subscription for all its employees.
- Manual is PREMIER, GOLD STANDARD source for evidence-based nutrition guidelines.

MEDICARE DSMT LITTLE KNOWN RULES + ADVICE

- Diabetes can be diagnosed prior to Medicare Part B entry.

- Initial DSMT: continuous 12 month period starts with date of 1st. visit.

- Initial DSMT not received ever before (is once in lifetime benefit).
  - Once started, must be completed and billed within 12 consecutive months from date of 1st. visit.

- Beneficiary on renal dialysis only eligible for non-nutrition topics for DSMT.
Medicare DSMT Little Known Rules + Advice, Con’t

Beneficiaries in every visit...group or individual...to sign attendance sheet.

6 ways to determine if beneficiary had any initial DSMT in past

1. Ask bere to call 1-800-MEDICARE and ask
2. Ask bere to complete Authorization to Disclose Personal Health Information then you ask
3. Access secure portal of Medicare beneficiary transactions on your MAC’s website
4. Access your MAC’s provider call center Interactive Voice Response (IVR) unit
5. Access CMS HIPAA Eligibility Transaction System (HETS) directly or thru eligibility services vendor
6. Access your Network Service Vendor (NSV) if you have contracted with vendor

Medicare DSMT Little Known Rules + Advice, Con’t

• About Network Service Vendors (NSVs)
  o Information technology companies that help providers and payers simplify administrative and clinical tasks via data-driven improvements in healthcare
  o Goal: optimize reimbursement, care quality and staffing
  o Offer Web Portals for providers to perform Medicare Eligibility Verification
    ▪ Providers’ personnel use secure connection to NSV system to enter in basic pt information and get back an eligibility response in seconds
About HIPAA Eligibility Transaction System (HETS 270/271)

- Intended to allow the release of eligibility data to Medicare Providers, Suppliers, or their authorized billing agents for the purpose of preparing accurate Medicare claims, determining beneficiary liability or determining eligibility for specific services in real-time.

- **HETS Desktop User Guide** can be downloaded at:

- For more information, visit **HETS Help** website at:

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**WHO IS ALLOWED TO ORDER MEDICARE MNT – DSMT**

- **MNT:** Only treating* MDs and DOs can Rx.
- **DSMT:** Treating* MDs, DOs and qualified NPPs (NP, PA, CNS) can Rx.

*Treating means provider who is treating beneficiary’s diabetes or pre-dialysis renal disease,... not just eyes, feet, etc.
Best Practice Suggestion: Ask practice’s Medicare Compliance Officer and/or your regional Medicare Administrative Contractor if YOUR PROGRAM needs lab documentation.

MNT benefit states referring physician is to maintain documentation of pt’s dx of DM or CKD. Suggestion of AND: “In RD’s best interest to obtain copy of diagnostic eligibility labs”

DSMT benefit states physician or qualified non-physician practitioner treating the beneficiary must document in medical record that “beneficiary is a diabetic”

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Kidney Transplant

Period of 36 months after successful kidney transplant.

Pre-Dialysis Renal Disease
GFR on 1 lab test of:
13 -- 50 ml/min.1.73m²:
Stage IV = 15 -- 29
Stage III = 30 -- 50
Stage V = <15

Kidney Transplant
Period of 36 months after successful kidney transplant.

MEDICARE DIAGNOSTIC LAB ELIGIBILITY for RENAL MNT

Pre-Dialysis Renal Disease
GFR on 1 lab test of:
13 -- 50 ml/min.1.73m²:
Stage IV = 15 -- 29
Stage III = 30 -- 50
Stage V = <15

MEDICARE DSMT REFERRAL REQUIREMENTS

Written or e-referral by treating physician (MD, DO) or qualified non-physician practitioner (NPP): NP, PA, CNS.

For initial DSMT:
whether group or individual.
If individual: documentation on referral of special needs/conditions that warrants individual.

Physician (MD, DO) or NPP to maintain beneficiary's plan of care in chart maintained in his/her office.

*For follow-up DSMT:
can be group or individual.
Special needs/conditions NOT required for individual follow-up DSMT.

MEDICARE DSMT REFERRAL REQUIREMENTS, CONT

Rx date + beneficiary's name.

Narrative dx or ICD-10 code.
Medicare prefers 5 character code for T1, T2 diabetes. See APPENDIX for additional info on ICD-10 coding.

Signature + NPI # of treating physician (MD, DO) or NPP.
Stamped signature not allowed.
E-signature in EMR is allowed.
Separate Rx required for: initial and follow-up DSMT.

For initial DSMT:
— Which of 10 topics to be taught.
— How many hours of 10 to be taught.
MEDICARE MNT REFERRAL REQUIREMENTS

Written or e-referral by treating MD or DO. Faxed referral allowed.
Order must state MNT or Medical Nutrition Therapy.

Rx date + beneficiary’s name.
Separate Rx for: initial, follow-up MNT and for extra hours.

Revised DSME/T and MNT Order Form from AND and AADE lists diagnostic lab criteria + asks provider to send diagnostic labs for pt eligibility and outcomes monitoring.

Signature and NPI # of treating MD or DO.
Stamped signature not allowed. E-signature is allowed.

Narrative dx or ICD-10 code.
Medicare prefers 5 character code for T1, T2 diabetes. See APPENDIX for additional info on ICD-10 coding.

Original Rx to be in pt's chart in MD or DO's office.

SNIPPETS of MARY ANN'S MEDICARE

DSMT, MNT

and

INTENSIVE BEHAVIOR THERAPY for OBESITY

REFERRAL FORM
Can download on websites of:
American Association of Diabetes Educators
Academy of Nutrition and Dietetics

MEDICARE MNT – DSMT FREQUENCY in FIRST YEAR and STRUCTURE

Medicare will not pay for MNT and DSMT provided on same day.

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<th>DSMT: 10 hours in 12 consecutive months. Cannot extend into next year. 1 hour individual (02018) may be used for insulin training or any topic or for assessment.</th>
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<td>Individual visit is &gt;/= 15 minutes. BUT can round 15 minute time-based codes: &gt;/= 8 min. to &lt; 23 min. = 1, 15 min. unit.</td>
<td>9 hours must be in group (02019) unless 1 of 3 special conditions exist. 10 hours may be used for only 1 topic (new).</td>
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<td>Group visit is &gt;/= 30 min. (1 billing unit; no rounding). Document start + end time to prove number of units of face-to-face time furnished in visit.</td>
<td>Visits are &gt;/= 30 min. (1 billing unit; no rounding). Document start + end time to prove number of whole 30 min. units of face-to-face time furnished in visit.</td>
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Enter code 1 time on claim + number of units of MNT code furnished in visit.

Enter code 1 time on claim + number of units of DSMT code furnished in visit.

CMS’ GUIDE for 15 MINUTE TIME-BASED CODES

<table>
<thead>
<tr>
<th>UNITS</th>
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<tbody>
<tr>
<td>1</td>
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<td>6</td>
<td>&gt; 83 &lt; 97</td>
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<tr>
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<td>&gt; 98 &lt; 112</td>
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<tr>
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www.cms.gov/manuals/downloads/clm104c05.pdf Accessed 3-26-12
**EXTRA HOURS in MNT -- DSMT in INITIAL and FOLLOW-UP EPISODES of CARE**

**EXTRA HOURS of MNT**
- Over the limit in both initial and follow-up episodes of care:
  - Payable if new Rx is obtained from treating MD or DO that documents:
  - Number of extra hours requested and medical necessity for.
    - See examples on next slide.

**EXTRA HOURS of DSMT**
- Over the limit in both initial and follow-up episodes of care:
  - Not payable.

**EXAMPLES OF MEDICAL NECESSITY FOR EXTRA HOURS of MNT**

<table>
<thead>
<tr>
<th>Change in medical condition, diagnosis or treatment regimen requiring change in MNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES MNT</strong></td>
</tr>
<tr>
<td>Oral meds to insulin</td>
</tr>
<tr>
<td>Lack of understanding of diabetes diet</td>
</tr>
<tr>
<td>GDM pt requires frequent diet changes</td>
</tr>
<tr>
<td>Diabetes complication requiring tighter diet control</td>
</tr>
<tr>
<td><strong>NON-DIALYSIS RENAL MNT</strong></td>
</tr>
<tr>
<td>Significant decrease in renal sufficiency</td>
</tr>
<tr>
<td>Lack of understanding of renal diet</td>
</tr>
<tr>
<td>Onset of malnutrition</td>
</tr>
<tr>
<td>Completes DSMT and develops renal condition</td>
</tr>
</tbody>
</table>

**NEW! MEDICARE MNT MEDICAL UNLIKELY EDITS (MUEs)**

<table>
<thead>
<tr>
<th>aka: Limits on number of units of code payable per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCPCS Code</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>97802 Individual Initial MNT</td>
</tr>
<tr>
<td>97803 Individual follow-up MNT</td>
</tr>
<tr>
<td>97804 Group MNT, Initial or Follow-Up</td>
</tr>
</tbody>
</table>
NEW! MEDICARE DSMT MEDICAL UNLIKELY EDITS (MUEs)
aka: Limits on number of units of code payable per 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 Individual DSMT</td>
<td>8, 30 minute units = 4 hours</td>
<td>6, 30 minute units = 3 hours</td>
</tr>
<tr>
<td>G0109 Group DSMT</td>
<td>12, 30 minute units = 6 hours</td>
<td>12, 30 minute units = 6 hours</td>
</tr>
</tbody>
</table>

MEDICARE DSMT FREQUENCY in FOLLOW-UP YEARS + STRUCTURE

Follow-Up DSMT After First 12 Consecutive Months

- 2 hours each 12 months after initial DSMT completed.
- Cannot extend hours into next 12 months.
- Individual, group or combination allowed.
- Special conditions not required for individual follow-up.

Individual or group visit: \( \geq 30 \text{ min} \) = 1 billing unit
(1 billing unit) No rounding.
New Rx required for follow-up.

Special needs do \textbf{NOT} need to be documented for individual follow-up.
Can obtain follow-up even if INITIAL DSMT was not received.

DOCUMENT “START” TIME and “END” TIME FOR EVERY VISIT!

MEDICARE MNT FREQUENCY in FOLLOW-UP YEARS + STRUCTURE

Follow-Up MNT After First Calendar Year

- 2 hours in each calendar year after first.
- Cannot extend hours to next year.
- Individual, group or combination allowed.
- Group visit: \( \geq 30 \text{ minutes} \) (1 billing unit).

Individual visit: \( \geq 15 \text{ min} \) = 1 billing unit.
Can round: \( \geq 8 \text{ min} \) to \( < 15 \text{ min} \) = 1 unit.
New Rx required for follow-up MNT.

After 3 Years 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.

DOCUMENT “START” TIME and “END” TIME FOR EVERY VISIT!
MEDICARE TIME FRAMES for FOLLOW-UP DSMT: CMS EXAMPLE

Completes Initial 10 Hours Spanning 2 Years: 2018, 2019
- Starts initial 10 hours in August 2018
- Completes initial 10 hours in August 2019
- Eligible for...and starts...2 hour follow-up in September, 2019
- Completes 2 hour follow-up in Dec., 2019
- Eligible for next 2 hour follow-up in Jan., 2020

Completes Initial 10 Hours in Same Calendar Year:
- Starts initial 10 hours in August 2019
- Completes initial 10 hours in Dec., 2019
- Eligible for...and starts...2 hours follow-up in Jan., 2020
- Completes 2 hour follow-up in July 2020
- Eligible for next 2 hour follow-up in Jan. 2021

PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

<table>
<thead>
<tr>
<th>Visit can be any # of units but must be &gt;1</th>
<th>1 Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802 MNT, initial episode of care (EOC), individual</td>
<td>15 min</td>
</tr>
<tr>
<td>Used ONLY 1 time for very first initial visit!</td>
<td></td>
</tr>
<tr>
<td>97803 MNT, follow-up EOC, individual</td>
<td>15 min</td>
</tr>
<tr>
<td>97804 MNT, initial or follow-up EOC, group</td>
<td>30 min</td>
</tr>
<tr>
<td>G0270 MNT, initial, individual, &gt;3 hours or follow-up, individual, ≥2 hours per 2nd referral, same year</td>
<td>15 min</td>
</tr>
<tr>
<td>G0271 MNT, initial, group, &gt;3 hours or follow-up, group, &gt;2 hours per 2nd referral, same year</td>
<td>30 min</td>
</tr>
<tr>
<td>G0108 DSMT, individual, initial or follow-up, 30 min.</td>
<td>30 min</td>
</tr>
<tr>
<td>G0109 DSMT, group, initial or follow-up, 30 min.</td>
<td>30 min</td>
</tr>
</tbody>
</table>

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 I: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 Required #2042, May 1, 2002, provides additional certification for medical nutrition therapy (MNT) services.
### MEDICARE DSMT and MNT NATIONAL UNADJUSTED REIMBURSEMENT RATES (www.cms.gov for Calendar Year 2019)

<table>
<thead>
<tr>
<th>National Unadjusted Rates</th>
<th>National Unadjusted Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare DSMT National Unadjusted Rates</td>
<td>Medicare MNT National Unadjusted Rates</td>
</tr>
<tr>
<td>are based on Medicare Physician Fee Schedule.</td>
<td>are based on Medicare Physician Fee Schedule.</td>
</tr>
<tr>
<td>Rate: 85% of MPFS. Beneficiary’s 20% copay waived, but paid by Medicare.</td>
<td>Medicare pays 80% of geographically adjusted rate. Beneficiary does pay 20% copay.</td>
</tr>
</tbody>
</table>

#### 97802: Individual, initial, 15 min.
- Facility: $85.60
- Non-facility: $87.84

**CODE IS USED ONLY 1 TIME FOR 1ST. INDIVIDUAL VISIT.**

#### 97803: Individual, follow-up, 10 min.
- Facility: $29.95
- Non-facility: $32.80

#### 97804: Group, initial or follow-up, 30 min.
- Facility: $16.22
- Non-facility: $17.30

**Rates are geographically adjusted for region.**

My mother taught me about contortionism:

**Will you look at the dirt on the back of your neck!**
**MEDICARE DSMT OFF-SITE LOCATION RULES IN HOSPITALS**

### HOSPITAL OUTPATIENT DSMT RULE

OP DSMT services must be furnished in:
- In the hospital
- OR
- In a provider-based hospital department

**DSMT not payable**

- if furnished at alternate non-hospital, off-site locations.

---

**AADE ACCREDITATION NOTE (NON-MEDICARE)**

AADE accredited **BRANCH DSMES** sites must be under same corporate umbrella as "parent" or "primary" site.

AADE accredited **COMMUNITY** sites do not have to meet this requirement.

---

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

<table>
<thead>
<tr>
<th>Home Health Agency</th>
<th>End Stage Renal Dialysis Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MNT</strong> YES separate Part B bill.</td>
<td><strong>MNT</strong> YES separate Part B bill but only for non-dialysis beneficiaries.</td>
</tr>
<tr>
<td><strong>DSMT</strong> YES separate Part B bill when outside of Part A treatment plan on 34x bill.</td>
<td><strong>DSMT</strong> NOT payable.</td>
</tr>
<tr>
<td><strong>DSMT</strong> Part A home health benefit and Part B DSMT can be received at same time.</td>
<td></td>
</tr>
</tbody>
</table>
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>MNT</td>
<td>MNT</td>
</tr>
<tr>
<td>NOT payable</td>
<td>YES, payable by Medicare Part B.</td>
</tr>
</tbody>
</table>

DSMT
YES, payable by Part B.

NOTE: Part A SNF benefit and Part B DSMT can be received at same time.

Set 22x, 23x type of bill
Revenue code 0942

FEDERALLY QUALIFIED HEALTH CENTER
OP PROSPECTIVE PAYMENT SYSTEM (PPS) RATE REIMBURSEMENT
and
RURAL HEALTH CLINIC
COST-BASED REIMBURSEMENT
for
DSMT and MNT

ABOUT OUTPATIENT PROSPECTIVE PAYMENT RATE

Definition of OP Prospective Payment System (PPS) Rate
Type of payment based on predetermined and fixed amount for specific classification of service.

Classification examples:
inpatient hospital, FQHC, RHC, etc.
FQHC – RHC MEDICARE BILLING FOR DSMT -- MNT

FQHC and RHC method of reimbursement based on:
OP Prospective Payment System (PPS) Rate

FQHC reimbursement based on:
OP PPS rate and claim-based.

RHC reimbursement based on:
OP PPS rate and cost-based.
Cost of MNT--DSMT put on annual cost report.
Reimbursed cost calculated via OP PPS rate.

FQHC MEDICARE BILLING FOR DSMT

Under Prospective Payment System Rate:
Individual DSMT not payable on same day as MEDICAL visit, as
DSMT also considered MEDICAL visit.
And 2 MEDICAL visits not payable on same day.

BUT: DSMT is payable on same day as BEHAVIORAL/MENTAL HEALTH visit.
2 visits both payable.

FQHC MEDICARE BILLING FOR DSMT, CONT

Medicare pays FQHC the LESSER* of its
total actual charges OR fixed OP PPS rate
for bundle of ALL services in qualifying visit furnished to beneficiary on SAME day.

* Qualifying visit code entered on claim.
Code identifies:
New or established pt visit.
Fixed PPS rate for ALL services furnished on SAME day.

Entered on DSMT claim:
--Procedure code G0108 (individual)
--Qualifying visit code G0467 (FQHC visit, established pt)
--Actual charge for DSMT visit
FQHC MEDICARE BILLING OF DSMT and MNT

Must also enter **REVENUE CODE** on claim:
- **0522** = Home visit by FQHC practitioner.
- **0521** = Clinic visit by member to FQHC.

Use TOB 77x in Field Locator (FL) 4 on UB-04 claim form.
No Part B deductible applies to approved FQHC services.

FQHC MEDICARE BILLING FOR MNT

FQHC uses UB-04 claim form.
In Field Locator (FL) 46, number of "Service Units" are entered.
For revenue code 0521, Service Units represent "visits".
Thus, enter "1" for number of Service Units for revenue code 0521.

Only 1 visit is billed/day, unless pt leaves and later returns with different illness or injury suffered later on same day.*

For G0108 procedure code
(= DSMT, individual, 30 minute unit)
enter number of units of code furnished in DSMT visit.

---

FQHC MEDICARE BILLING OF DSMT and MNT, CONT

**DSMT:** Medicare pays 80% of LESSER of OP PPS rate or actual charge.

**DSMT:** Beneficiary pays 20%.

**MNT:** Medicare pays 100% of LESSER of OP PPS rate or actual charge.

**MNT:** Beneficiary pays 0%.

---

**INDIVIDUAL DSMT** and MNT are core FQHC services billable to Part B under OP PPS rate.

**BUT:**

GROUP DSMT nor GROUP MNT are NOT separately billable to Part B.

---

**EXAMPLE: PAYMENT CALCULATION OF DSMT VISIT IN FQHC**

2019 FQHC OP Prospective Payment System (PPS) Rate = $169.77

<table>
<thead>
<tr>
<th>REVENUE CODE</th>
<th>QUALIFYING VISIT CODE</th>
<th>DSMT PROCEDURE CODE</th>
<th>DSMT ACTUAL CHARGE</th>
<th>OP PPS RATE FOR QUALIFYING VISIT CODE 60467</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>G0467, medical visit, established patient</td>
<td>G0108, 60 minutes, 2 units of code</td>
<td>$106.00</td>
<td>$169.77</td>
</tr>
</tbody>
</table>

Lesser value is actual charge of $106.00. CMS pays 80% of lesser, or of $106.00, which is $84.80.
Separate payment to RURAL HEALTH CLINICS for these practitioners and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

Source: “MLN Matters® Number: MM6445 Revised, Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) DSMT: beneficiary copay + Part B deductible both apply. MNT: beneficiary copay is waived, and Part B deductible does NOT apply. Use revenue code 0521.”
RURAL HEALTH CLINIC MEDICARE MNT BILLING

MNT to be furnished by RD or nutrition professional enrolled in Medicare Part B. Must reassign MNT reimbursement to RHC by completing CMS 855R form. Beneficiary copay is waived for MNT. Part B deductible does NOT apply.

Source: Medicare Claims Processing Manual, Chap. 9, Rev. 3000, 07-25-14, Rural Health Clinics and FQHCs.

REFERENCES FOR INFORMATION ON FQHC and RHC MEDICARE DSMT and MNT BILLING

Main references used for DSMT + MNT billing in FQHCs and RHCs:
Medicare Benefit Policy Manual, Chap. 13, RHC/FQHC Services, Rev. 12-09-16
Medicare Benefit Policy Manual, Chap. 9, RHCs/FQHCs, Rev 12-31-15

WE GOT RID OF THE KIDS..... THE CAT WAS ALLERGIC
CHANGES IN BILLABLE ICD-10 CODES FOR MEDICARE DSMT AND MNT: EFFECTIVE 2016

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

* Invalid ICD-10 dx codes end-dated effective 9/30/16:
  o E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

* DSMT: Added new 2017 ICD-10 dx codes effective 10/1/16:
  o E08.3221, E08.3222, E08.3223, E08.3291, E08.3292, E08.3293, E08.3311
  o E08.3321, E08.3322, E08.3323, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412
  o E08.3411, E08.3412, E08.3413, E08.3414, E08.3415, E08.3416, E08.3417, E08.3418
  o E08.3511, E08.3512, E08.3513, E08.3514, E08.3515, E08.3516, E08.3517, E08.3518
  o E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541
  o E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592
  o E08.3593, E08.37X1, E08.37X2, E08.37X3
DSMT: Added new 2017 ICD-10 dx codes effective 10/1/16:

- E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311
- E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412
- E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513
- E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541
- E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592
- E09.3593, E09.37X1, E09.37X2, E09.37X3

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

- E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412
- E10.3593, E10.37X1, E10.37X2, E10.37X3

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

- E11.3593, E11.37X1, E11.37X2, E11.37X3
DSMT: Added new 2017 ICD-10 dx codes effective 10/1/16:
  - O24.415, O24.425, O24.435

Unspecified codes deleted effective 1/1/17:
  - O24.019, O24.119, O24.819

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

Remove ICD-10 dx codes effective 1/1/17:
  - N18.6 and N18.9

ICD-10 DIAGNOSIS CODES FOR NON-DIALYSIS CHRONIC KIDNEY DISEASE MNT

- ICD-10 dx codes that align with Medicare non-dialysis chronic disease MNT requirement of GFR 13 - 50 (inclusive) for beneficiary eligibility:
  - N18.3
    - IIIA – GFR 45-59
    - IIIB – GFR 30-44
  - N18.4
    - GFR 15-29
  - N18.5
    - GFR <15 w/o dialysis treatment
• Remove ICD-10 dx codes effective 1/1/17:
  o E08.21, E08.311, E08.319, E08.36, E08.39, E08.65
  o E09.21, E09.311, E09.319, E09.36, E09.39
  o E10.311, E10.319, E10.36, E10.39
  o E11.311, E11.319, E11.36, E11.39

CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

• ICD-10 dx codes expire and end-dated effective 9/30/2016:
  o E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359
CMS CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

*Add new ICD-10 dx codes effective 10/1/16:

- O24.83
- E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311
- E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412
- E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513
- E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541
- E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592
- E08.3593, E08.37X1, E08.37X2, E08.37X3

CMS CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

*Add new ICD-10 dx codes effective 10/1/16:

- E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311
- E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412
- E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513
- E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541
- E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592
- E09.3593, E09.37X1, E09.37X2, E09.37X3

CMS CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

*Add new ICD-10 dx codes effective 10/1/16:

- E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411
- E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511
- E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531
- E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551
- E10.3552, E10.3553, E10.3591, E10.3592, E10.37X1
- E10.37X2, E10.37X3, E10.3211, E10.3212, E10.3213, E10.3291
- E10.3292, E10.3293, E10.3311
CMS’ CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

• Add new ICD-10 dx codes effective 10/1/16:

NATIONAL COVERAGE DETERMINATION (NCD40.1):
DATE: JANUARY 18, 2018 CHANGE REQUEST: 10318
EFFECTIVE DATE: APRIL 1, 2018

Diabetes Self-Management Training (DSMT):

• DELETE ketoacidosis-related ICD-10 dx:
  o E08.10, E09.10, E10.10, E13.10

  ▪ These patients are cared for in an inpatient setting and DSMT is conducted on an outpatient basis

**DEFINITION OF:**
HiPAA-compliant, interactive audio and video telecommunication permitting *real time* communication and visualization.

**EXCLUDED:**
- Telephone calls, faxes, email *without* audio and visualization.
- Real time texts.
- Stored and delayed transmissions of images of beneficiary.


**REIMBURSEMENT:**
Same as for original face-to-face DSMT -- MNT benefits.

Beneficiary must be *present and participate* in telehealth visit.

**INDIVIDUAL and GROUP DSMT - MNT**
Both can be delivered via telehealth. All *original* billing and coding reimbursement rules apply.

**DSMT SPECIAL REQUIREMENTS OVER & ABOVE ORIGINAL:**
- ≥1 hour of 10 hours in *initial* year and
- ≥1 hour of 2 hours in *follow-up* years to be furnished *in-person* for training on injectable meds (individual or group).
By reporting place of service (POS) code 02 with HCPCS code G0108 or G0109, the distant site practitioner attests that beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated in initial DSMT service year or in any calendar year’s 2 hours of follow-up training.

**ORIGINATING SITE vs. DISTANT SITE**

**Originating site**: where beneficiary is during DSMT - MNT visit.

**Distant site**: where HCP is during DSMT – MNT visit.

**STATE LICENSURE/CERTIFICATION REQUIREMENT FOR INDIVIDUAL RENDERING AND BILLING PROVIDER**

Rendering and billing provider must be licensed or certified in state where the provider furnishes telehealth DSMT - MNT and in state where beneficiary receives the DSMT – MNT.

**INDIVIDUAL RENDERING PROVIDER: WHO IS ALLOWED TO FURNISH DSMT TELEHEALTH?**

“……Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.”

Source: 190.3.6 – Payment for Diabetes Self-management Training (DSMT) as a Telehealth Service (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16), Medicare Claims Processing Manual, Chapter 12 - Physicians and Non-physician Practitioners (Rev. 3076, 08-12-16)
APPROVED DISTANT SITE PRACTITIONERS OF DSMT TELEHEALTH

- Physicians (MDs, DOs)
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists (CNSs)
- Certified nurse midwives (CNMs)
- Clinical psychologists
- Clinical social workers (CSWs)
- Registered dietitians (RDs) and nutrition professionals

APPROVED DISTANT SITE PRACTITIONERS OF MNT TELEHEALTH

- Registered dietitians (RDs)
- Nutrition professionals
  - If employed by hospital, clinic, etc., must re-assign reimbursement to employer by completing CMS 855R form
  - Allows employer to bill Medicare on behalf on RD or nutrition professional and receive the reimbursement

EXCLUDED DISTANT SITES:
WHERE HCP IS DURING DSMT – MNT VISIT

- Independent renal dialysis facilities
- Pharmacies
- Beneficiary’s home
- Rural health clinics
- Federally qualified health centers
APPROVED ORIGINATING SITES: WHERE BENEFICIARY IS DURING DSMT—MNT 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

GEOGRAPHIC CRITERIA FOR ORIGINATING SITES

• Originating sites must be located in health professional shortage area (HPSAs) located in rural census tracts of urban areas as determined by Office of Rural Health Policy

OR

• County outside of metropolitan statistical area (MSA)

GEOGRAPHIC CRITERIA FOR ORIGINATING SITES, CONT.

• Originating sites NOT approved for DSMT–MNT telehealth:
  o In beneficiary’s home
  o In independent renal dialysis facility
  o In sites within a MSA or not within a HPSA
PLACE OF SERVICE (POS) CODE ON CLAIMS FOR DSMT – MNT TELEHEALTH VISIT

- Use of telehealth POS code 02 certifies that service meets telehealth requirements at distant and original site.
  - POS 02: “Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology.”
- NOTE: CMS has eliminated requirement to use GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services.

ORIGINATING SITES ELIGIBLE TO RECEIVE FACILITY FEE FOR DSMT – MNT TELEHEALTH 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”)
- Place of service (POS) code is “02”: location where health services and health related services are provided or received, through telecommunication technology

GT MODIFIER AND CRITICAL ACCESS HOSPITALS METHOD II DISTANT SITES

- Critical Access Hospitals Method II:
  - Distant site practitioners billing telehealth services under the CAH Optional Payment Method must submit institutional claims using GT modifier.
  - GT modifier is “via interactive audio and video telecommunications system”

Source: Revisions to the Telehealth Billing Requirements for Distant Site Services, MLN Matters No. MM10583 Revised
ORIGINATING SITES ELIGIBLE TO RECEIVE FACILITY FEE FOR DSMT – MNT TELEHEALTH VISIT

- Originating site facility fee is a Part B payment
  - Medicare pays it outside of current fee schedule or other payment methodologies

ORIGINATING SITES ELIGIBLE TO RECEIVE FACILITY FEE FOR DSMT – MNT TELEHEALTH VISIT

- 2019 Medicare facility fee:
  - Use HCPCS procedure code Q3014
    - Defined: “Telehealth originating site facility fee”
    - Payment is 80% of the lesser of the actual charge, or $26.15
  - Beneficiary is responsible for any unmet deductible amount and Medicare coinsurance
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!**

I can do this!

OTHERWISE, YOU'RE GOING TO WAKE UP ONE MORNING, AND REALIZE YOU'VE MADE A **SIGNIFICANT BOO-BOO!**

Really?

EFFECT OF INFORMATION **OVERLOAD**
DSMT–MNT CLAIM FORMS for HOSPITALS and PRIVATE PRACTICES

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>PRIVATE PAYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital OP: If Hospital is Provider:</td>
<td>Private Practice: RD is provider:</td>
</tr>
<tr>
<td>CMS-1450</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>= UB04 claim* or HIPAA 837</td>
<td>= UB04 claim* or HIPAA 837</td>
</tr>
<tr>
<td>Instu ECF*</td>
<td>Prof ECF**</td>
</tr>
<tr>
<td>To Part A Intermediary, being replaced by Medicare Administrative Contractors, “MACs”</td>
<td>To Part B Carrier, being replaced by Medicare Administrative Contractors, “MACs”</td>
</tr>
<tr>
<td>To Private Insurance</td>
<td>To Private Insurance</td>
</tr>
</tbody>
</table>

* If paper claim used, must use new CMS-1500 paper claim (08-05) and new UB-04 paper claim.
*Instu ECF = Institutional electronic claim **Prof ECF = Professional electronic claim
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:

MNT, DSMT and diabetes-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)


REJECTED vs. DENIED CLAIMS

<table>
<thead>
<tr>
<th>REJECTED CLAIM</th>
<th>DENIED CLAIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare returns as unprocessable. Medicare cannot make payment decision until receipt of corrected, re-submitted claim.</td>
<td>Medicare made determination that coverage requirements not met; example: service is not medically necessary.</td>
</tr>
<tr>
<td>= INCOMPLETE Claim: Required info is missing or incomplete (ex: no NPI #).</td>
<td>If you feel this is an error, can pursue payment through Medicare's appeals process.</td>
</tr>
<tr>
<td>INVALID Claim: Info is illogical or incorrect (ex: wrong NPI #, hysterectomy billed for male pt. etc.)</td>
<td>BEFORE furnishing non-covered benefit, may give beneficiary Medicare's current ABN form.</td>
</tr>
</tbody>
</table>

ABN CPT CODE MODIFIERS

- **GA:** Service expected to be denied as not reasonable or necessary. Waiver of liability (ABN) on file.
- **GZ:** Service expected to be denied as not reasonable or necessary. Waiver of liability (ABN) NOT on file
- If provider knows that MNT/DSMT claim will be denied by Medicare, pt or provider may submit denied claim to supplemental insurance
  - Some private payers may require Medicare denial first before considering to pay
- **GY:** Added to CPT procedure code to obtain denial
FAQ: Is it financially worthwhile to furnish individual DSMT in FQHC?

Depends on several factors, necessitating creation of pro forma that takes into account at least these factors:

1. Significant expenses of salary/benefits paid to diabetes educator, teaching materials, marketing, claims processing, secretarial support, and computer hardware, software subscription fees for tracking data base, nutrition practice guidelines, etc.

2. Number of individual visits that comprise a full DSMT Program (4, 5, 6, 7, 8 or more)

3. Time frame of each individual DSMT visit

4. Total time that the educator dedicates to DSMT per period of time (patient time, pre- and post-visit time, completing other DSMT program responsibilities, etc.

5. Average number of DSMT visits completed by beneficiary (based on total number in program)

6. How much of the reimbursement via PPS rate will be credited to DSMT program

**TIP: FAILING TO PLAN IS PLANNING TO FAIL!**

To determine quick estimates only, may want to apply these easy “rules of thumb”:

1. For total expenses, multiply the educator’s hourly salary by 3
   - Ex: $40/hour x 3 = $120 total expenses for each 1 hour individual DSMT

2. For # of visits that beneficiary will attend in DSME program, assume 50%
   - Some people will attend 1 to 2 sessions; others will complete all sessions
   - Your team may assume differently, or have actual data

3. Use geographically adjusted PPS bundled base payment rate for FQHC, or the clinic’s actual reasonable charge for G0108, whichever is less.
4. Do the math:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of one hour visits per program:</td>
<td>10</td>
</tr>
<tr>
<td>Average number visits attended by beneficiary:</td>
<td>5</td>
</tr>
<tr>
<td>PPS payment rate of $160 per diem per beneficiary (80% of $160 paid by CMS, OR 80% of the All-Inclusive Rate is paid and is credited to program for the 60 minute individual initial visit for beneficiary:</td>
<td>+ $128</td>
</tr>
<tr>
<td>Beneficiary's 20% co-insurance payment:</td>
<td>+ $32</td>
</tr>
<tr>
<td>TOTAL PAYMENTS:</td>
<td>= $160</td>
</tr>
<tr>
<td>LESS estimated total expenses for visit:</td>
<td>$120</td>
</tr>
<tr>
<td>EQUALS estimated profit (loss):</td>
<td>= $30</td>
</tr>
<tr>
<td>PROFIT for five visits attended out of ten ($30 x 5):</td>
<td>= $150</td>
</tr>
</tbody>
</table>
CODING AND BILLING RULES OF THUMB, CONT.

- Re: billing "incident to physician services", always check FIRST with insurer to determine IF this billing method is allowed or mandated for benefit being billed
  - IF allowed or mandated, always identify insurer’s requirements for office physicians and ancillary staff
- Track your reimbursement retrospectively (quarter basis):
  - For claim denials and rejections:
    - Identify reason why
    - Fix problem
    - Re-bill asap (usually have limit of 12 months)

INFORMATION ON
ICD-10 DIAGNOSIS CODING
AND
PRIVATE PAYER REIMBURSEMENT FOR
MNT—DSMES/T

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

7 Characters in New Codes Spell:

- C. E. A. S. E.

  - **C** = Category
  - **E** = Etiology
  - **A** = Anatomic site
  - **S** = Severity or other clinical detail
  - **E** = Extension

  - **Initial or subsequent encounter**
  - **Laterality (left vs. right)**
  - **Other clinical detail (e.g., # weeks gestation)**
ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

Category = first 3 characters = family code/general disease code.

NOT BILLABLE when codes with greater specificity (more characters) exist!

---

Some codes with 4 characters are NOT BILLABLE when codes with more specificity (more characters) exist!

---

Examples of codes that are NOT billable:

- E10 = T1 diabetes mellitus
- E11 = T2 diabetes mellitus

---

ICD-10 DIAGNOSES CODES FOR DIABETES MNT--DSMT

- Category = first 3 characters = family code/general disease code

- NOT BILLABLE when codes exist with GREATER SPECIFICITY (more characters)

- Examples of codes that are NOT billable:
  - E10 = T1 diabetes mellitus
  - E11 = T2 diabetes mellitus

---

Please tell me there are no more characters in these codes!
### NOT BILLABLE as needs GREATER SPECIFICITY:

- E11.0 = T2 DM with hyperosmolarity
- E11.2 = T2 DM with kidney complications
- E11.3 = T2 DM with ophthalmic complications
- E11.4 = T2 DM with neurological complications
- E11.5 = T2 DM with circulatory complications
- E11.6 = T2 DM with other specified complications
- E11.8 = T2 DM with unspecified complications
- E11.9 = T2 DM without complications

### NOT BILLABLE as needs GREATER SPECIFICITY:

- E11 = T2 DM
- E11.5 = T2 DM with circulatory complications

### BILLABLE (5 characters!)

- E11.40 = T2 DM with diabetic neuropathy, unspecified
- E11.41 = T2 DM with diabetic mono-neuropathy
- E11.42 = T2 DM with diabetic poly-neuropathy
- E11.43 = T2 DM with diabetic autonomic (poly) neuropathy
- E11.44 = T2 DM with diabetic amyotrophy
- E11.49 = T2 DM with other diabetic neurological complication

- E11.51 = Type 2 DM with PERIPHERAL ANGIOPATHY without GANGRENE
- E11.52 = Type 2 DM with PERIPHERAL ANGIOPATH with GANGRENE
- E11.59 = Type 2 DM with OTHER CIRCULATORY COMPLICATION
ICD-10 DIAGNOSES CODES FOR DIABETES MNT–DSMT

NOT BILLABLE as needs GREATER SPECIFICITY:

• Z71 = Persons encountering health services for other counseling & medical advice, not elsewhere classified

BILLABLE...BUT, only if ADDITIONAL CODE is used!

• Z71.3 = Dietary counseling and surveillance
  o Must use ADDITIONAL CODE:
    ▪ For any associated underlying condition
    ▪ To identify BMI, if known (Z68._)

---

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

Conditions that RDs and/or diabetes educators typically encounter are in RED.

<table>
<thead>
<tr>
<th>Chapter (Character)</th>
<th>Chapter Title and (3 Character Category = Rubric)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. (A and B)</td>
<td>Certain infectious and parasitic diseases. (A00-B99)</td>
</tr>
<tr>
<td>II. (C00 to D48)</td>
<td>Neoplasms. (C00-D48)</td>
</tr>
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<td>III. (D50 to D89)</td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. (D50-D89)</td>
</tr>
<tr>
<td>IV. (E)</td>
<td>Endocrine, nutritional and metabolic diseases. (E00-E90)</td>
</tr>
<tr>
<td>V. (F)</td>
<td>Mental and behavioral disorders. (F01-F99)</td>
</tr>
</tbody>
</table>

---

ICD-10 STRUCTURE AND TERMINOLOGY

Conditions that RDs and/or diabetes educators typically encounter are RED. See Section 13 for codes.

<table>
<thead>
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<th>Chapter Title and (3 Character Category = Rubric)</th>
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</tr>
<tr>
<td>V. (F)</td>
<td>Mental and behavioral disorders. (F01-F99)</td>
</tr>
</tbody>
</table>
### VI. (G) Diseases of nervous system. (G00–G99)

- VII. (H00 to H59) Diseases of eye and adnexa. (H00 – H59)
- VIII. (H60 to H95) Diseases of ear and mastoid process. (H60 – H95)
- IX. (I) Diseases of circulatory system. (I00 – I99)
- X. (J) Diseases of respiratory system. (J00 – J99)

Chapter I codes begin with capital "I"; not to be confused with number "1".

### XI. (K) Diseases of digestive system. (K00 – K99)

- XII. (L) Diseases of skin and subcutaneous tissue. (L00 – L99)
- XIII. (M) Diseases of musculoskeletal system and connective tissue. (M00 – M99)
- XIV. (N) Diseases of genitourinary system. (N00 – N99)
- XV. (O) Pregnancy, childbirth and puerperium. (O00 – O99)
- XVI. (P) Certain conditions originating in perinatal period. (P00 – P99)

Pregnancy Chapter codes begin with capital letter "O"; not to be confused with number "0".

### XVII. (Q) Congenital malformations, deformations and chromosomal abnormalities. (Q00 – Q99)

- XVIII. (R) Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. (R00 – R99)
- XIX. (S and T) Injury, poisoning and certain other consequences of external causes. (S00 – T98)
- XX. (U, V, W, X, Y) External causes of morbidity and mortality. (V00 – Y98)
- XXI. (Z) Factors influencing health status and contact with health services. (Z00–Z99)
- XXII. (U) Special purposes. (U00 – U99)
Sequencing of Codes on MR and Claims

- Overarching sequencing rule of thumb:
  - **Code first** the principle diagnosis:
    - Defines primary reason for encounter
    - Is sequenced 1st on medical record and claim
    - Determined by provider at end of encounter

Sequencing codes in MR and claims (which are listed 1st, 2nd):

- **Code first** the etiology/underlying condition:
  
  **Example:**
  
  E08 Diabetes mellitus due to underlying condition
  
  **Code first** the underlying condition, such as:
  - Congenital rubella (P35.0)
  - Cystic fibrosis (E84.-)
  - Malignant neoplasm (C00-C96)
  - Malnutrition (E40-E46)
  - Pancreatitis and other diseases of pancreas (K85-K86.-)

Sequencing codes in MR and claims (which are listed 1st, 2nd):

- Sometimes instructional note says "**code first**" note and "**use additional code**"

- Instructional notes do indicate how to sequence codes:
  - **Code first** the underlying etiology
  - **Code second** the additional code(s)

  **Example:**
  
  E09 Drug or chemical induced diabetes mellitus
  
  **Code first** (T36-T65) poisoning due to drug or toxin
  
  Use additional code to identify drug (T36 – T50)
  
  Use additional code to identify any insulin use (Z79.4)
**ICD-10 Diagnoses Structure and Terminology**

- **Combination Codes:**
  - Single code used to classify 2 diagnoses, or
  - Dx with associated sign or symptom, or
  - Dx with associated complication
    - Multiple codes are **not** to be used when combination code clearly IDs all elements in the documentation

Examples of diabetes combination codes:

- E11.51 = T2 DM w/peripheral angiopathy w/o gangrene
- E11.52 = T2 DM w/peripheral angiopathy w/ gangrene
- E11.59 = T2 DM w/ other circulatory complication

---

**ICD-10 Diagnoses Structure and Terminology**

Example of combination code:

- **T2 DM pt on insulin** is seen for stage 3 CKD:

  How is this coded and sequenced on claim?
  - E11.22 = T2 DM with diabetic chronic kidney disease
  - N18.3 = Chronic kidney disease, stage 3 (moderate)
  - Z79.4 = Long term (current) use of insulin
Examples of combination code:

- **T2 DM pt on insulin** evaluated for a **chronic diabetic left foot ulcer with necrosis of muscle**:
  - How is this coded and sequenced on claim?
    - E11.621 = Type 2 diabetes mellitus with foot ulcer
    - L97.523 = Non-pressure chronic ulcer of other part of left foot with necrosis of muscle
    - Z79.4 = Long term (current) use of insulin

Examples of combination codes:

- **T1 DM** seen for **severe non-proliferative diabetic retinopathy with macular edema**
  - How is this coded and sequenced on claim?
    - E10.341 = T1 DM with severe non-proliferative diabetic retinopathy with macular edema
    - E10.622 = Type 1 DM with other skin ulcer
      - Use additional code to identify site of ulcer (L97.1-L97.9, L98.41-L98.49)

---

**I DON'T ALWAYS GET SUCKED INTO A JET ENGINE**

**BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD**
Only Use ALPHABETICAL INDEX to Find CHAPTER That Code is in with INSTRUCTIONAL NOTES!

<table>
<thead>
<tr>
<th>ICD-10-CM INDEX TO DISEASES and INJURIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCDEFGHIJKLMNOPQRSTUVWXYZ</td>
</tr>
</tbody>
</table>

- Acute myelogenous leukemia
- Acute lymphoblastic leukemia
- Acute myeloid leukemia
- Acute lymphocytic leukemia
- Acute leukemia
- Acute lymphoblastic leukemia
- Acute myeloid leukemia
- Acute leukemia
- Acute myelogenous leukemia

Then, Do Use TABULAR LIST to Select Billable Code(s)!

<table>
<thead>
<tr>
<th>ICD-10-CM TABULAR LIST of DISEASES and INJURIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11 Type 2 diabetes mellitus</td>
</tr>
</tbody>
</table>

- Includes: diabetes mellitus due to insulin secretory defect
- diabetes NOS
- insulin resistant diabetes mellitus

- Use additional code to identify control using:
  - insulin (Z79.4)
  - oral antidiabetic drugs (Z79.84)
  - oral hypoglycemic drugs (Z79.84)

- Excludes1: diabetes mellitus due to underlying condition (E08-)
  - drug or chemical induced diabetes mellitus (E10-)
  - gestational diabetes (O24.8)
  - neonatal diabetes mellitus (E88.2)
  - postpartum diabetes mellitus (E13-)
  - postoperative diabetes mellitus (E88.1)
  - secondary diabetes mellitus NOS (E12-)
  - type 1 diabetes mellitus (E10-)

- Use additional code for any associated underlying medical condition
- Use additional code to identify body mass index (BMI), if known (Z08.-)

Then, Do Use TABULAR LIST to Select Billable Code(s)!

<table>
<thead>
<tr>
<th>ICD-10-CM TABULAR LIST of DISEASES and INJURIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z71.3 Dietary counseling and surveillance</td>
</tr>
</tbody>
</table>

- Use additional code for any associated underlying medical condition
- Use additional code to identify body mass index (BMI), if known (Z08.-)
DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

Z00-Z99: Factors influencing health status and contact with health services.

- **Z71** = Persons encountering health services for other counseling and medical advice, not elsewhere classified
  - **Z71.3** = Dietary counseling and surveillance
    - Use Additional:
      - Code for any associated underlying condition
      - Code to identify BMI, if known (Z68.3)
    - **Z94.0** = Kidney transplant status

---

**For Medicare Intensive Behavioral Therapy (IBT) for Obesity Benefit**

<table>
<thead>
<tr>
<th>BMI Range</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z68.30 30.0-30.9</td>
<td>Z68.38 38.0-38.9</td>
</tr>
<tr>
<td>Z68.32 32.0-32.9</td>
<td>Z68.39 39.0-39.9</td>
</tr>
<tr>
<td>Z68.33 33.0-33.9</td>
<td>Z68.41 40.0-44.9</td>
</tr>
<tr>
<td>Z68.34 34.0-34.9</td>
<td>Z68.42 45.0-49.9</td>
</tr>
<tr>
<td>Z68.35 35.0-35.9</td>
<td>Z68.43 50.0-59.9</td>
</tr>
<tr>
<td>Z68.36 36.0-36.9</td>
<td>Z68.44 60.0-69.9</td>
</tr>
<tr>
<td>Z68.37 37.0-37.9</td>
<td>Z68.45 &gt; 70.0</td>
</tr>
</tbody>
</table>

---

ICD-10-CM Index entries contain back-references to **Z71.3**:

- Admission (for) - see also Encounter (for)
  - dietary surveillance and counseling **Z71.3**
- Counseling
  - see also Counseling dietary **Z71.3**
- Allergy, allergic (reaction) (to) T78.30, food (any) (ingested) T78.1
  - dietary counseling and surveillance **Z71.3**
- Colitis (acute) (catarrhal) (chronic) (noninfective) (hemorrhagic) - see also Enteritis K52.9
  - dietary counseling and surveillance (for) **Z71.3**
- Counseling (for) Z71.9
  - dietary **Z71.3**
- Diabetes, diabetic (mellitus) (sugar) E11.9
  - dietary counseling and surveillance **Z71.3**
DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

• Dietary surveillance and counseling Z71.3
• Gastritis (simple) K29.70
  o dietary counseling and surveillance Z71.3
• Hypercholesterolemia (essential) (familial) (hereditary) (primary) (pure) E78.0
  o dietary counseling and surveillance Z71.3
• Hypoglycemia (spontaneous) E16.2
  o dietary counseling and surveillance Z71.3
• Intolerance food K90.4
  o dietary counseling and surveillance Z71.3
• Obesity E66.9
  o dietary counseling and surveillance Z71.3

DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

• Supervision (of) dietary (for) Z71.3
  o allergy (food) Z71.3
  o colitis Z71.3
  o diabetes mellitus Z71.3
  o food allergy or intolerance Z71.3
  o gastritis Z71.3
  o hypercholesterolemia Z71.3
  o hypoglycemia Z71.3
  o intolerance (food) Z71.3
  o obesity Z71.3
  o specified NEC Z71.3
• Surveillance (of) (for) - see also Observation
  o dietary Z71.3

ICD-10 Look Up Tools

• http://www.icd10data.com (below is what you see; click on icon boxed in red to determine if code is "billable")
  "2017 ICD-10-CM Codes 2017 Edition CPT®
  Lessons ensuring health services for other counseling and medical advice not elsewhere classified
• http://icd10coded.com/
• AAPC Website
• CMS Website on ICD-10:
  • https://implementicd10.noblis.org/
### ICD-10 Resources
- [www.AHIMA.org](http://www.AHIMA.org)
- [www.ICD10watch.com](http://www.ICD10watch.com)
- [www.AAPC.com](http://www.AAPC.com)
- [www.WEDI.org](http://www.WEDI.org)
- [http://www.himss.org/ASP/topics_icd10playbook.asp](http://www.himss.org/ASP/topics_icd10playbook.asp)
- For ICD-10 Coding of DIABETES MELLITUS:
- For Automatic Conversion of ICD-9 Codes to ICD-10 Codes:

### 10 STEPS TO INCREASE

#### PRIVATE PAYER

AND

#### MEDICAID

MNT—DSMT REIMBURSEMENT SUCCESS

- Steps designed to identify payers’ benefits and benefit reimbursement rules in order for you to:

1. **Increase your patient volume via:**
   - More referrals from ALL area providers
   - More patient self-referrals

2. **Increase your revenue via:**
   - Successful insurance reimbursement
   - Pts’ out-of-pocket payments (self-pays amd co-pays)

3. **Increase collateral revenue for your entity via:**
   - Pts obtaining other services (lab tests, therapies)
1. Identify the area healthcare insurers you will bill:
   • Medicare Part B
   • Medicaid in your state
   • Private healthcare plans (e.g., Blue Cross, Blue Shield, Aetna, etc.)

2. Know that each insurer has multiple health plans.
   • Typically:
     o Insurer has POLICY that specific benefit is covered
     o Reimbursement rules (R/Rs) in policy apply to all the individual plans
     o BUT, know that R/Rs can and may vary among individual plans

Example of "categories" of health plans:
• Exclusive Provider Organization (EPO) Plans
  o Subscriber must use in-network doctors, specialists or hospitals for coverage, except in emergency.

• Health Maintenance Organization (HMO) Plans
  o Coverage usually limited to care from doctors who work for/contract with HMO
  o Generally out-of-network care not covered except in emergency
  o For coverage, subscriber may have to live in service area
  o Integrated care, prevention and wellness provided.
• **Point of Service (POS) Plans**
  - Subscriber pays _less_ if uses plan’s _in-network_ doctors, hospitals and other health care providers
  - Referral is required from primary care doctor in order to see specialist and not pay additional cost

• **Preferred Provider Organization (PPO) Plans**
  - Subscriber pays _less_ if uses plan’s _in-network_ doctors, hospitals and other health care providers
  - No referral required from primary care doctor to use _outside of network_ doctors, hospitals and providers; does _not_ pay additional cost to do so

3. **Identify IF MNT–DSMT is covered by the health plans**

   There are **6** ways to identify coverage!
Ways to Identify Coverage

1. Review all of your providers' in-network provider-payer contracts to identify if coverage is stipulated.

Ways to Identify Coverage

2. Contact insurer’s Provider Relations Dept. by phone, citing in-network provider-payer contract number, and ask about coverage using:
   - Names of benefits in this slide deck, and/or
   - Procedure codes of benefits

Ways to Identify Coverage

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
Ways to Identify Coverage

1. 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.

2. Access subscriber’s coverage via electronic claims submission software that may be provided by insurer.

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

Keep database of results, and update regularly!
4. For each covered benefit, in each plan, identify procedure codes for initial and follow-up interventions.

**PROCEDURES CODES THAT ALIGN WITH MNT**

**Required by Medicare on claims for MNT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Time</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, reassessment, 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, beyond 3 hours, or MNT, follow-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, follow-up, group, beyond 2 hours per 2nd referral in same year</td>
<td>30 min</td>
</tr>
</tbody>
</table>

**PROCEDURES CODES THAT ALIGN WITH MNT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9449</td>
<td>Weight management classes, non-physician provider, per session</td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes, non-physician provider, per session</td>
</tr>
<tr>
<td>S9470</td>
<td>Nutrition counseling, dietitian visit</td>
</tr>
</tbody>
</table>

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### PROCEDURES CODES THAT ALIGN WITH DSMT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetes management program, f/up visit to <strong>non-MD provider</strong></td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetes management program, f/up visit to <strong>MD provider</strong></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, <strong>group session</strong></td>
</tr>
<tr>
<td>S9460</td>
<td>Diabetic management program, <strong>nurse visit</strong></td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, <strong>dietitian visit</strong></td>
</tr>
</tbody>
</table>

### PROCEDURES CODES THAT ALIGN WITH DSMT

<table>
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<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>

### PROCEDURES CODES THAT ALIGN WITH MNT - DSMT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an <strong>individual</strong> (separate procedure); approx. 15 min.</td>
</tr>
<tr>
<td>99402</td>
<td>Same approx. 30 min.</td>
</tr>
<tr>
<td>99403</td>
<td>Same approx. 45 min.</td>
</tr>
<tr>
<td>99404</td>
<td>Same approx. 60 min.</td>
</tr>
<tr>
<td>99411</td>
<td>Same <strong>group</strong> approx. 30 min.</td>
</tr>
<tr>
<td>99412</td>
<td>Same <strong>group</strong> approx. 60 min.</td>
</tr>
</tbody>
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</tr>
</tbody>
</table>

- 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

### 10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID MNT-DSMT REIMBURSEMENT SUCCESS

5. If any codes covered, identify frequency (hours, visits) and time frames (calendar or rolling year) for initial and follow-up MNT--DSMT
6. If covered, identify payable ICD-10 diagnosis codes
7. If covered, identify approved billing providers and rendering providers for MNT--DSMT
8. If covered, identify reimbursement rates
9. If covered, identify the approved places of service and patient eligibility (e.g., FPG ≥126 mg on 2 tests)
10. Know coding and billing rules of thumb

“Homework? Me?” YES!
This information is intended for educational and reference purposes only. It does not constitute legal, financial, medical or other professional advice. The information does not necessarily reflect opinions, policies and/or official positions of the Center for Medicare and Medicaid Services, private healthcare insurance companies, or other professional associations. Information contained herein is subject to change by these and other organizations at any moment, and is subject to interpretation by its legal representatives, end users and recipients. Readers/users should seek professional counsel for legal, ethical and business concerns. The information is not a replacement for the Academy of Nutrition and Dietetics’ Nutrition Practice Guidelines, the American Diabetes Association’s Standards of Medical Care in Diabetes, guidelines published by the American Association of Diabetes Educators nor any other related guidelines. As always, the reader/user’s clinical judgment and expertise must be applied to any and all information in this document.

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13. CMS Program Memorandum. Additional Clarification for MNT Services (includes instructions for carriers based on NCD. Published May 1, 2002; www.cms.gov/manuals/pm_trans/AB02059.pdf, Program Transmittals, AB-02-059
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18. Medicare Coverage Policy Decisions: Duration and Frequency of the Medical Nutrition Therapy (MNT) Benefit (HCAG-00007N); www.cms.gov/coverage/HCAG-00007N
20. Web Sites:
   • Centers for Medicare and Medicaid Services (formerly HCFA) www.cms.gov
   • Academy of Nutrition and Dietetics: www.eatright.org
   • American Diabetes Association: www.diabetes.org
   • American Association of Diabetes Educators: www.aadenet.org

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17. Medicare Program; Expanded Coverage for Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements; Final Rule and Notice; Federal Register, December 28, 2000; 42 CFR Parts 405, 410, 414, and 415, Vol. 65, No 251, p 83129-83154
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   • American Association of Diabetes Educators: www.aadenet.org
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