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

LEARNING OBJECTIVES
1. Describe the beneficiary eligibility criteria for Medicare MNT and DSMT.
2. List 3 of the Medicare coverage guidelines for telehealth MNT and DSMT.
3. Name the procedure codes used to bill Medicare for MNT and for DSMT.
4. Describe 3 of the key and unique Medicare coverage guidelines for MNT and DSMT telehealth.

THE GOLDEN RULE
• He who has the gold makes the rules!
• He who wants the gold must identify all the rules… and follow all 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… along with penalties and fines… will likely be out of a job!

INSURER’S RULES RULE!

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
• Conflicts of Interest and Financial Relationships Disclosures: Mary Ann Hodorowicz has no conflicts of interest or financial disclosures to disclose.
• Sponsorship / Commercial Support:
  – None
• 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:
  – Mary Ann Hodorowicz will not discuss any off-label use of OTC or prescription drugs.
• Activity-Type:
  – Knowledge-based
THERE’S LOTS OF BENEFITS TO PROVIDERS WHO JOIN MEDICARE!

M = Medicare’s benefits increase patient outcomes
E = Engagement with CDC (grant $ to state depts. of PH) to ↑ access to, and quality of, DSMT programs
D = Dependable transparency & timeliness with benefit coverage rules, reimbursement, rates, reminders
I = Increase in preventive benefits, esp. due to ACA
C = Captive audience of patients usually with many medical problems…and secondary insurance
A = Amenable to changes in coverage rules due to complaints, concerns, criticism (e.g., obesity benefit)
R = Regularly pays clean claims
E = Enormous # of new beneficiaries in 2–4 years

MNT—DSMT: COMPLIMENTARY but DISTINCT

MNT
- Individualized nutrition (and related) therapy to aid control of A-B-C’s of diabetes
- Personalized behavior change plans: eating, SMBG, exercise, stress control plans
- Long-term follow-up with extensive monitoring of labs, outcomes, behavior change with adjustments in plans*

DSMT
- General and basic training on AADE7™ self-care behaviors in primarily group format
- ↑ pt’s knowledge of why and skill in how to change key behaviors
- Shorter-term follow-up with limited monitoring of labs, outcomes, etc.

COORDINATION OF MEDICARE MNT–DSMT

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

MNT: First Calendar Year, 3 hrs
- Individual or group*. Individual assessment, nutrition dx, intervention and personalized meal plan; outcomes monitoring and evaluation.

DSMT: First 12 Consecutive Months, 10 hrs
- Group classes* in 10 topics (as needed by beneficiary) on basic diabetes self-care program must meet 2012 National Standards of DSME.

MEDICAL CONDITIONS
- Diabetes: Type 1, Type 2, GDM, Non-Dialysis Renal Disease, and

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MEDICARE BENEFICIARY
MNT–DSMT ENTITLEMENT
Must have Medicare Part B insurance
Suggestion: scan/make copy of Medicare card for MR

DSMT: HOW 10 INITIAL HOURS TO BE FURNISHED

DSMT: Format of Initial 10 Hours in First 12 Consecutive Months

- 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 program scheduled within 2 months of referral date.
  2. Provider orders "additional insulin training" on DSMT referral.
  3. Provider documents on referral beneficiary need that limits group learning; examples:

  learning; vision; language; cognitive; non-ambulatory
MEDIcare MNT—DSMT
PART B BILLING PROVIDER ELIGIBILITY

MNT
- RD or Dietitian Professional (NP) who is Medicare provider and has met below criteria
  - Licensed or certified in state where furnishing MNT
  - 500 hrs of practical experience

DSMT
- Select individual + entity Medicare providers can bill
- Must provide and bill for other Medicare services and be directly reimbursed
- Cannot join Medicare just to provide and bill for DSMT

Separate billing allowed:
- hosp.OP, nursing home, ESRD facility, FQHC, clinic, MD/RD practice, home health

NOT allowed:
- inpt hospital, rural health clinic, skilled nursing facility

Licensed or certified in state where furnishing MNT, if state has law regarding CDE status not required.

Separate billing allowed:
- hosp.OP, nursing home, ESRD facility, FQHC, clinic, MD/RD practice, home health

Separate DSME billing NOT allowed:
- hosp.OP, hospice care, nursing home, rural health center, ESRD facility

MEDIcare MNT—DSMT QUALITY STANDARDS

published by Academy of Nutrition and Dietetics (A.N.D.) and published in A.N.D’s online Nutrition Care Manual

- Must use nationally recognized protocols such as current evidence-based Nutrition Practice Guidelines for disease state
- Both require adherence to 2012 National Standards of DSME. Standard 5: RD or pharmacist can be solo instructor, but multi-disciplinary team recommended.

MEDIcare MNT—DSMT
SEPARATE BILLING TO MEDICARE PART B NOT ALLOWED BY THESE ORGANIZATIONAL PROVIDERS

MNT
- Providers who cannot bill Part B separately spell I.R.S.
  - I = Inpatient hospital
  - R = Rural health clinic
  - S = Skilled nursing home

DSMT
- Providers who cannot bill Part B separately spell H.E.N.R.I.
  - H = Hospice
  - E = ESRD facility
  - N = Nursing home
  - R = Rural health Clinic
  - I = Inpatient hospital

RD OPTIONS for MEDIcare MNT—DSMT

B: Become Medicare provider and Bill for MNT; can then bill for certified DSMT program
R: Refer beneficiary for MNT or DSMT to Medicare provider rendering MNT or certified DSMT program
O: Opt out of Medicare by filing opt out affidavit letter every 2 years; enter into private contract with each beneficiary, using Medicare contract & language
X: Execute ABN for diagnoses excluded in MNT benefit and for non-certified DSMT program

MEDICARE MNT—DSMT
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published by Academy of Nutrition and Dietetics (A.N.D.) and published in A.N.D’s online Nutrition Care Manual

- Must use nationally recognized protocols such as current evidence-based Nutrition Practice Guidelines for disease state
- Both require adherence to 2012 National Standards of DSME. Standard 5: RD or pharmacist can be solo instructor, but multi-disciplinary team recommended.

My mother taught me about the science of Osmosis...

"Shut your mouth and eat your supper!"
**OTHER LITTLE KNOWN RULES FOR MEDICARE MNT--DSMT**

**DIABETES MNT**
- Beneficiaries in each group or 1:1 visit to sign attendance sheet.
- Initial is once in a lifetime benefit.
- Once started, must be completed/billed within 12 consecutive months from date of 1st visit.

**DSMT**
- Diabetes can be diagnosed prior to Part B entry.
- Pre-Dialysis Renal Disease
  - GFR on 1 lab test of: 13 -- 50 ml/min.1.73m^2:
    - 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 DIABETES MNT and DSMT**

**Diabetes MNT**
- Documentation of diabetes diagnosis using 1 of 3 labs:
  - Fasting plasma glucose x 2 tests
  - 2 hour OGTT x 2 tests
  - Random BG x 1 test with 1 high BG symptom

**DSMT**
- Documentation of diabetes diagnosis using 1 of 3 labs:
  - Fasting plasma glucose x 2 tests
  - 2 hour OGTT x 2 tests
  - Random BG x 1 test with 1 high BG symptom

**MEDICARE DIAGNOSTIC LAB ELIGIBILITY for RENAL MNT**

**Pre-Dialysis Renal Disease**
- GFR on 1 lab test of: 13 -- 50 ml/min.1.73m^2:
  - Stage IV = 15 -- 29
- Stage III = 30 -- 50
- Stage V = <15

**Kidney Transplant**
- Period of 36 months after successful kidney transplant.

**WHO MUST HAVE DOCUMENTATION OF MEDICARE DIAGNOSTIC LAB ELIGIBILITY for MNT--DSMT**

**MNT**
- Only treating* MDs and DOs can Rx.

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

*Symptoms of uncontrolled diabetes:
- Excessive thirst, hunger, urination, fatigue, blurred vision; unintentional weight loss; tingling, numbness in extremities; non-healing ulcer/wound, etc.

**MEDICARE DIAGNOSTIC LAB ELIGIBILITY for RENAL MNT**

**Pre-Dialysis Renal Disease**
- GFR on 1 lab test of: 13 -- 50 ml/min.1.73m^2:
  - Stage IV = 15 -- 29
- Stage III = 30 -- 50
- Stage V = <15

**Kidney Transplant**
- Period of 36 months after successful kidney transplant.

**WHO MUST HAVE DOCUMENTATION OF MEDICARE DIAGNOSTIC LAB ELIGIBILITY for 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 your practice’s Medicare Compliance Officer and/or your regional Medicare Administrative Contractor (MAC) if YOU need copy of labs.
MEDICARE MNT REFERRAL REQUIREMENTS

**MNT**
- Written or e-referral by treating MD or DO.
- Fax referral allowed.
- Order must state MNT or Medical Nutrition Therapy.
- Rx date + beneficiary’s name.
- Separate Rx for initial, f/up MNT and extra hours.
- Revised DSMT and MNT Order Form from AND and AADE lists diagnostic lab criteria + asks provider to send diagnostic labs for pt eligibility and outcomes monitoring.
- Original Rx to be in pt’s chart in MD/DO’s office.
- Signature + NPI # of MD/DO (stamped not allowed).

**MNT**
- Narrative dx or ICD-10 code.
- Full narrative of dx and ICD-10 code:
- DSMT

MEDICARE DSMT REFERRAL REQUIREMENTS

**DSMT**
- Written or e-referral by treating MD, DO or qualified non-physician practitioner (NPP): NP, PA, CNS.
- For initial: whether group or individual DSMT.
- MD, DO, NPP to maintain pt’s plan of care in chart maintained in his/her office.
- For follow-up: can be group or individual.
- Special needs/conditions NOT required for individual follow-up.

**DSMT**
- Rx date + beneficiary’s name.
- Narrative dx or ICD-10 code.
- Signature + NPI # of MD, DO, NPP.
- Separate Rx for initial and f/up DSMT.
- For initial: which of 10 topics to be taught and how many hours of 10 to be taught.

**DSMT**
- 3 hrs in initial calendar year. Cannot extend into next year.
- Individual (97802 initial; 97803 follow-up) or group (97804) or combination allowed.
- 10 hrs in 12 consecutive months. Cannot extend into next year.
- Individual (G0108) or group (G0109) unless 1 of 3 conditions exist.
- 10 hours may be used for only 1 topic (new).
- Group visit is >= 30 min. (1 billing unit; no rounding).
- Document start + end time to prove that units of face-to-face time furnished.
- Issue code one time + # of units furnished on claim.

**DSMT**
- 10 hrs can be individual IF 1 of 3 conditions exist:
- Referring provider documents on Rx pt’s need limiting group learning (vision, hearing, language, cognitive) OR
- 2. No group program starting within 2 months of Rx date OR
- 3. Referring provider orders additional insulin training on Rx.

Examples of medical necessity:
- Change in medical condition, diagnosis, or treatment regimen requiring additional DSMT.
- Examples of medical necessity:
- Additional Hours Not Cited as Payable.
- 10 hrs can be individual if 1 of 3 conditions exist:
- Referring provider documents on Rx pt’s need limiting group learning (vision, hearing).
- Additional Hrs + 3 Reimbursable If:
- Additional Hours Not Cited as Payable.
- Additional Hrs + 3 Reimbursable If:
- Reimbursement is available for additional insulin training on Rx provided.

Medicare will not pay for MNT and DSMT provided on same day!
CHANGES THAT MAY JUSTIFY EXTRA HOURS of MEDICARE MNT

DIABETES MNT
- Oral meds to insulin
- Lack of understanding of diabetes diet
- GDM pt requires frequent diet changes
- Diabetes complication requiring tighter diet control

NON-DIALYSIS RENAL MNT
- Significant decrease in renal sufficiency
- Lack of understanding of renal diet
- Onset of malnutrition
- Completes DSMT and develops renal condition

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

Completes Initial 10 Hours in Same Calendar Year:
- Starts initial 10 hours in August 2014
- Completes initial 10 hours in Dec., 2014
- Eligible for...and starts...2 hours follow-up in Jan., 2015
- Completes 2 hour follow-up in July 2015
- Eligible for next 2 hour follow-up in Jan. 2016

NEW! MEDICARE DSMT MEDICAL UNLIKELY EDITS (MUEs) EFFECTIVE 7/1/15
aka: Limits on number of units of code payable/visit

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>OP Hospital Services MUE Values</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>8 units</td>
<td>6 units</td>
<td>Clinical: Data</td>
</tr>
<tr>
<td>Individ DSMT</td>
<td>4 hours</td>
<td>3 hours</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>G0109</td>
<td>12 units</td>
<td>12 units</td>
<td>Nature of Service/Procedure</td>
</tr>
<tr>
<td>Group DSMT</td>
<td>6 hours</td>
<td>6 hours</td>
<td>Nature of Service/Procedure</td>
</tr>
</tbody>
</table>

PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE Payers

Visit can be any # of units but must be >1 1 Unit

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

DOCUMENT “START” TIME and “END” TIME for EVERY VISIT!
CMS' GUIDE for 15 MINUTE TIME-BASED CODES

<table>
<thead>
<tr>
<th>UNITS</th>
<th>MINUTES to MINUTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&gt; 8 8</td>
</tr>
<tr>
<td>2</td>
<td>&gt; 24 &lt; 37</td>
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<td>3</td>
<td>&gt; 38 &lt; 52</td>
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<tr>
<td>6</td>
<td>&gt; 83 &lt; 97</td>
</tr>
<tr>
<td>7</td>
<td>&gt; 98 &lt; 112</td>
</tr>
<tr>
<td>8</td>
<td>&gt; 113 &lt; 127</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
3. CMS Transmittal No. AB-02-059, Program Memorandum Intermediaries/Carriers, Change Implementation Date 1 May 1, 2002, provides additional clarification for medical nutrition therapy (MNT) services.

**HOME HEALTH AGENCY and ESRD FACILITY MEDICARE MNT–DSMT BILLING**
When on COST REPORT, group visit calculated for inclusion in these payment rates: All-Inclusive Rate (AIR) or Prospective Payment Rate (PPS). Check with Medicare Administrative Contractor (MAC) if allowable. FQHCs converting from AIR to PPS in 2014–2016.

MEDICARE MNT–DSMT TELEHEALTH BILLING BASICS

**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.


INDIVIDUAL and GROUP MNT–DSMT

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).

Beneficiary must be present and participate in telehealth visit.

ORIGINATING SITE vs. DISTANT SITE

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

**Distant site:** where HCP is during MNT–DSMT 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 MNT–DSMT and in state where beneficiary receives the MNT–DSMT.

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

HPCPS CODE MODIFIER REQUIRED:
HCPCS code modifier GT to be added to MNT–DSMT procedure code on claim: "interactive audio and video telecommunications system"
Subject to State Licensing Laws:
Approved INDIVIDUAL BILLING Providers of Medicare Telehealth MNT

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

Excluded DISTANT Sites:
Where HCP is During MNT–DSMT Visit

- Home health
- Independent renal dialysis facilities
- Pharmacies

Approved ORIGINATING Sites:
Where Beneficiary is During 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

Originating Sites Eligible to Receive Facility Fee for MNT–DSMT 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”)
- Originating site facility fee is a Part B payment. Medicare pays it outside of current fee schedule or other payment methodologies

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
- County outside of metropolitan statistical area.

Deductible and coinsurance rules apply to facility fee code Q3014

- For carrier-processed claims, “office” place of service (code 11) is only payable setting for code Q3014
- 2016 Medicare facility fee = 80% of lesser of actual charge, or $25.10; beneficiary pay unmet deductible + coinsurance
Extra Information About Facility Fee Billing

Hospital OP Dept.: Fee payment is as described on previous slide and not under OP prospective payment system (OPPS). Part A is billed.

CAH: Fee payment is separate from cost-based reimbursement methodology and is 80% of originating site facility fee. Part A is billed.

Physicians’ and practitioners’ offices: Fee payment is lesser of 80% of actual charge or 80% of originating site facility fee, regardless of location. Part B contractor does not apply geographic practice cost index to fee; fee is statutorily set; not subject to geographic payment adjustments authorized under Physician Fee Schedule. Part B is billed.

Renal dialysis center (or satellite) based in hospital or CAH: Fee covered in addition to any composite rate or MCP amount. Bills Part A and must use revenue code 78x.

Skilled nursing facility (SNF): Fee outside SNF prospective payment system bundle and not subject to SNF consolidated billing; separately billable Part B payment. Bills Part A and must use revenue code 78x.

Community Mental Health Center (CMHC): Fee not partial hospital service; does not count towards number of services used to determine payment for partial hospitalization services. Fee not bundled in per Diem payment for partial hospitalization; separately billable Part B payment. Bills Part A and must use revenue code 78x.

Independent and provider-based RHCs and FQHCs: Fee billed to Part A using RHC or FQHC bill type and billing number. Code Q3014 is only non-RHC/FQHC service that is billed using clinic/center bill type and provider number. Must use revenue code 078x.

MNT--DSMT 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>Hospital OP: If Hospital is Provider:</td>
</tr>
<tr>
<td>CMS 1500 claim or HPFA 837 Invoice E51*</td>
<td>CMS 1500 claim or HPFA 837 Invoice E51*</td>
</tr>
</tbody>
</table>

REJECTED vs. DENIED CLAIMS

REJECTED CLAIM
Medicare returns as unprocessable. Medicare cannot make payment decision until receipt of corrected, re-submitted claim.

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

If you feel this is an error, can pursue payment through Medicare’s appeals process.

INVALID Claim: Information is illogical or incorrect (ex: wrong NPI #, hysterectomy billed for male pt., etc.)

BEFORE furnishing non-covered benefit, may give beneficiary Medicare’s current ABN form.

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 DM-related services and supplies

* 4 states with no laws: AL, ID, ND, OH

Laws override any coverage limitations in health plan Exclusions exist (e.g., state/federal employer health plans often exempt from state mandates)

National Conference of State Legislatures

WE GOT RID OF THE KIDS..... THE CAT WAS ALLERGIC
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

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)

NOT BILLABLE as need GREATER SPECIFICITY:

• E11 = T2 DM
• 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 need GREATER SPECIFICITY:

• E11.4 = T2 DM w/ neurological 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 complications

Category = first 3 characters = Family Code/General disease code.
NOT BILLABLE when codes with more specificity (more characters) exist!
NOT BILLABLE as need GREATER SPECIFICITY:
• E11 = T2 DM
• E11.5 = T2 DM w/ circulatory complications
BILLABLE (5 characters!)
• E11.51 = Type 2 DM with PERIPHERAL ANGIOPATHY without GANGRENE
• E11.52 = Type 2 DM with PERIPHERAL ANGIOPATHY with GANGRENE
• E11.59 = Type 2 DM with OTHER CIRCULATORY COMPLICATION

NOT BILLABLE as need 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 (Z68.9)

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY
Chapter (Character) | Chapter Title and (3 Character Category = Rubric) | NOT BILLABLE when codes exist with greater specificity!
--- | --- | ---
I. (A and B) | Certain infectious and parasitic diseases. (A00-B99) | 
II. (C00 to D48) | Neoplasms. (C00-D48) | 
III. (D50 to D89) | Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. (D50-D89) | 
IV. (E) | Endocrine, nutritional and metabolic diseases. (E00-E90) | 
V. (F) | Mental and behavioral disorders. (F01-F99) | 

Chapter (Character) | Chapter Title and (3 Character Category = Rubric) | NOT BILLABLE when codes exist with greater specificity!
--- | --- | ---
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”

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

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

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

   AADE16

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)
    - Cushing’s syndrome (E24.-)
    - Cystic fibrosis (E84.-)
    - Malignant neoplasm (C00-C96)
    - Malnutrition (E40-E46)
    - Pancreatitis and other diseases of pancreas (K85-K86.-)

- 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 of 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

Z79.4 = Long term (current) use of insulin. If pt on insulin, must report Z79.4 with all codes from Category BLOCKS below:

E08 = DM Due to Underlying Conditions*
  - Code first underlying condition

E09 = Drug or Chemical Induced DM*
  - Code first (T36 - T65) to identify the drug or chemical

O24 = Diabetes in Pregnancy, Childbirth and the Puerperium
  - Use “Additional Code” from category E10 or E11 to identify manifestations
  - Note: “O” Category codes trump any other code

*Types of secondary diabetes mellitus

AADE16
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 (L97.1-197.9, L98.41-L98.49)

ABOUT MARY ANN’S NEW MNT–DSMT REFERRAL FORM

See Mary Ann’s MNT–DSMT REFERRAL FORM with ICD-10 Codes

- **DIAGNOSIS:**
  - = Diagnosis for which you must add a diagnosed manifestation, state of disease/condition or other clinical detail.
  - * = Unacceptable as principle diagnosis; must add additional diagnosis code for any associated underlying condition(s).
  - ✱ = Use additional code Z79.4 to identify any insulin use.
SNIPPET OF NEW MNT--DSMT REFERRAL FORM

<table>
<thead>
<tr>
<th>MNT</th>
<th>1 DM w/ complications</th>
<th>Type 2 DM w/ complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 DM w/ kidney complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 DM w/ nephropathy complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADVANCE BENEFICIARY NOTICE (ABN), CONT.

- Not required for benefits statutorily excluded by Medicare (e.g. MNT for HTN).
- Should be used by RD/provider for Medicare benefit when
  – Unsure that service will be considered medically necessary
  – Service may exceed frequency/duration of covered service
- Can also be issued voluntarily in place of Notice of Exclusion from Medicare Benefits (NEMB) to inform beneficiary that service is not covered by Medicare:
  – Beneficiary acknowledges this in section G, and
  – Accepts financial responsibility

ADVANCE BENEFICIARY NOTICE (ABN), CONT.

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SNIPPET OF MNT--DSMT REFERRAL FORM

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<thead>
<tr>
<th>SNIPPET OF MNT--DSMT REFERRAL FORM</th>
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<tr>
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</tr>
</tbody>
</table>

ADVANCE BENEFICIARY NOTICE (ABN)

- ABN (Form CMS-R-131) can be used for situations where Medicare payment expected to be denied
- Written notice given to beneficiary by provider prior to provision of service to notify beneficiary:
  – Medicare will probably deny payment for service/supply
  – Reason why Medicare may deny payment
  – Beneficiary will be responsible for payment if Medicare denies payment

ABN PROCEDURE 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 modifier added to CPT code to obtain denial

10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID MNT--DSMT REIMBURSEMENT SUCCESS
STEPS DESIGNED TO IDENTIFY PAYERS' BENEFITS AND BENEFIT REIMBURSEMENT RULES 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 & co-pays)
3. Increase collateral revenue for your entity via:
   - Pts obtaining other services (lab tests, therapies)

EXAMPLE OF “CATEGORIES” OF HEALTH PLANS:

- Exclusive Provider Organization (EPO) Plans
  - Subscriber must use in-network doctors, specialists or hospitals for coverage, except in emergency.
- Health Maintenance Organization (HMO) Plans
  - Coverage usually limited to care from doctors who work for, or contract with HMO
  - Generally out-of-network care not covered except in emergency
  - For coverage, subscriber may have to live in service area
  - Integrated care, prevention and wellness provided

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

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:
     - Insurer has POLICY that specific benefit is covered
     - Reimbursement rules (R/Rs) in policy apply to all the individual plans
     - BUT, know that R/Rs can and may vary among individual plans

3. Identify IF MNT-DSMT is covered by the health plans
   - There are 6 ways to identify coverage!
Review all of your providers’ in-network provider-payer contracts to identify if coverage is stipulated.

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

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

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

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.

Access subscriber’s coverage via electronic claims submission software that may be 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

- **Visit can be any # of units but must be > 1**
  - **97802** MNT, initial episode of care (EOC), individual
  - **97803** MNT, reassessment, follow-up EOC, individual
  - **97804** MNT, initial or follow-up EOC, group
  - **G0270** MNT, initial, individual, beyond 3 hours, or MNT, follow-up, individual, beyond 2 hours per 2nd referral in same year
  - **G0271** MNT, initial, group, beyond 3 hours, or MNT, follow-up, group, beyond 2 hours per 2nd referral in same year

### PROCEDURES CODES THAT ALIGN WITH DSMT

- **99401** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); …………………approx. 15 min.
  - **99402** Same……….approx. 30 min.
  - **99403** Same……….approx. 45 min.
  - **99404** Same……….approx. 60 min.
  - **99411** Same……….group….30 min.
  - **99412** Same………. group….60 min.

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**Required by Medicare on claims for MNT.**

- **S9449** Weight management classes, non-physician provider, per session
- **S9452** Nutrition classes, non-physician provider, per session
- **S9470** Nutrition counseling, dietitian visit

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**PROCEDURES CODES THAT ALIGN WITH DSMT**

- **S9140** Diabetes management program, f/up visit to non-MD provider
- **S9141** Diabetes management program, f/up visit to MD provider
- **S9145** Insulin pump initiation, instruction in initial use of pump (pump not included)
- **S9455** Diabetic management program, group session
- **S9460** Diabetic management program, nurse visit
- **S9465** Diabetic management program, dietitian visit
PROCEDURES CODES THAT ALIGN WITH MNT-DSMT

<table>
<thead>
<tr>
<th>98960</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<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>

- 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

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!
IGNORE MEDICARE AND YOU MAY FIND YOURSELF UP A CREEK WITHOUT A PADDLE

INCREASE REIMBURSEMENT NOW! ALL IT TAKES IS A LITTLE DESIRE AND STRENGTH ON YOUR PART!

YOUR PATIENTS, PROVIDERS & STAFF WILL LOVE YOU FOR IT!

DO YOUR HOMEWORK, BE PREPARED AND TAKE THE PLUNGE!

OTHERWISE, YOU’RE GOING TO WAKE UP ONE MORNING, AND REALIZE YOU’VE MADE A SIGNIFICANT BOO-BOO!
EFFECT OF INFORMATION OVERLOAD

MARY ANN WILL NOW ENTERTAIN YOUR QUESTIONS

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