

Money Matters in DSMT:
Increase Your Medicare Reimbursement NOW!
Plus:

- **Pre-COVID-19 Coverage Guidelines**
- **CMS COVID-19 Waivers for DSMT**
- **How to Identify Private Payer Guidelines**
- **Meet Your Appendix**

2-5-21



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 Coder)

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I have no financial relationships to disclose.

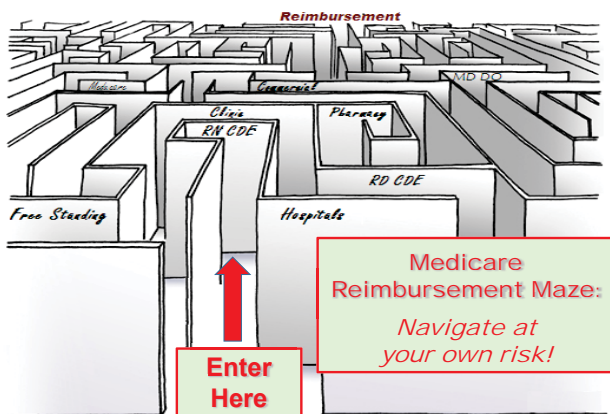
LEARNING OBJECTIVES

1. Describe the beneficiary eligibility criteria for Medicare **DSMT**.
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**.
4. Describe the quality standards for Medicare **DSMT**.
5. Name the approved referring providers for Medicare **DSMT**.
6. List the 3 conditions for reimbursement of 10 initial **DSMT** hours as individual visits.
7. Describe the CMS waivers for **DSMT** due to the COVID-19 PHE.

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!

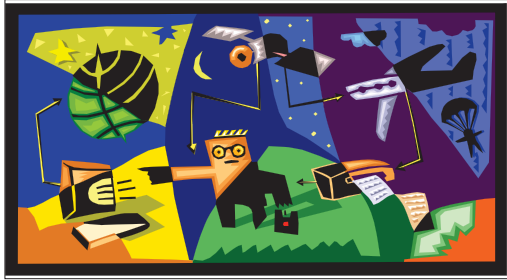


REIMBURSEMENT RULES for MEDICARE DSMT*
 are all about the:



*Diabetes Self-Management Training (Medicare's term for the benefit)
 *Medical Nutrition Therapy

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



CONSTANTLY CHANGING!

How to be keep abreast of changes?
Sign up for free CMS learning resources titled:



on CMS website:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo>

The Medicare Learning Network®



Free educational materials for health care professionals on CMS programs, policies, and initiatives. Get quick access to the information you need.

Publications & Multimedia



- Publications
- MLN Matters Articles
- Multimedia

Events & Training



- Calls & Webcasts
- Web-Based Training

News & Updates



- MLN Connects® Newsletter
- Electronic Mailing Lists
- Social Media

Association Continuing Education Credit



- Earn continuing education credit

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 and other benefits (MNT , 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

RDN OPTIONS for MEDICARE 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 DSMT ENTITLEMENT

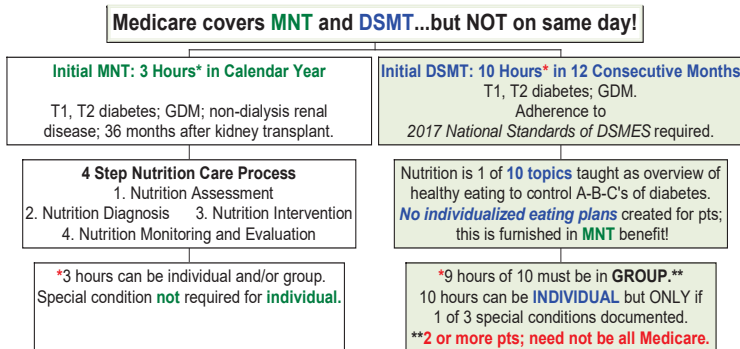
Must have Medicare Part B insurance or Medicare Advantage Plan.
Suggestion: make copy of Medicare card for medical record.



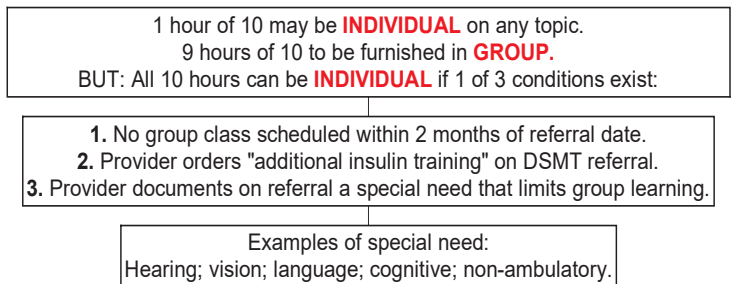
MEDICARE MNT and DSMT: COMPLIMENTARY but DISTINCT

MNT	DSMT
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

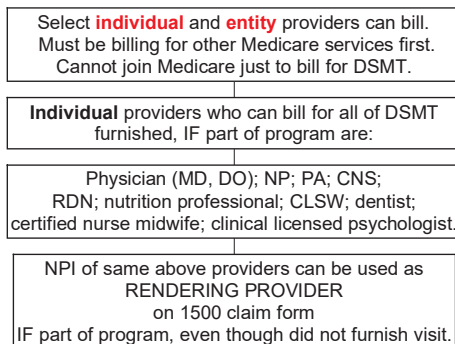
COORDINATION OF MEDICARE MNT -- DSMT



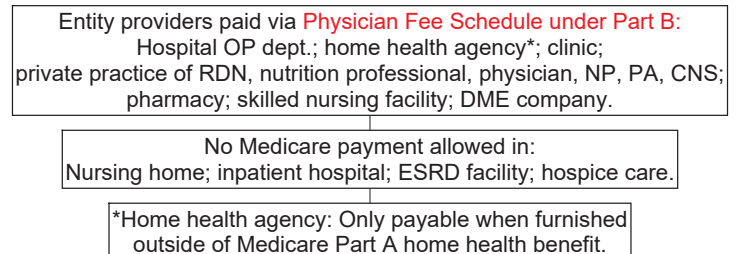
DSMT FORMAT of INITIAL 10 HOURS in FIRST 12 CONSECUTIVE MONTHS



MEDICARE DSMT BILLING PROVIDER ELIGIBILITY



MEDICARE DSMT BILLING PROVIDER ELIGIBILITY, CON'T



MEDICARE **DSMT** BILLING PROVIDER ELIGIBILITY, CONT

Entity **DSMT** Providers Paid via
OTHER Medicare Payment Models:

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

Rural Health Clinic: All-Inclusive Payment rate + cost reporting for all services.
ONLY INDIVIDUAL DSMT payable.

Critical Access Hospital:
Paid at 101% of CAH reasonable costs.

MEDICARE **DSMT** RENDERING PROVIDER ELIGIBILITY, CONT

Rural Health Clinic:
If single/solo instructor, must be RD-CDCES.

CMS gives designation of "RHC" to a clinic.



MEDICARE **DSMT** QUALITY STANDARDS

DSMT program "certification" required from ADA (recognition) or ADCES (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 DSMES** 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 **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.

MEDICARE **DSMT** LITTLE KNOWN RULES + ADVICE

Beneficiary on renal dialysis only eligible for non-nutrition topics for DSMT.

Beneficiary must sign attendance sheet at each visit.
ADCES stated that beneficiaries who sign in on EMRs will qualify as meeting this requirement.

MEDICARE **DSMT** LITTLE KNOWN RULES + ADVICE, CON'T

6 Ways to Determine if Beneficiary Had Any Initial **DSMT** in Past

1. Ask bene to call **1-800-MEDICARE** and ask
2. Ask bene 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 this type of vendor

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

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

MNT: Only treating* MDs and DOs can Rx.

*Treating means provider who is treating beneficiary's diabetes (or pre-dialysis renal disease or kidney transplant for MNT). not just eyes, feet, etc.

DOCUMENTATION OF MEDICARE DIAGNOSTIC LABS for **DSMT**

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

Best Practice Suggestions:

1) Ask your **Medicare Compliance Officer** and your regional **Medicare Administrative Contractor** if **YOUR PROGRAM** needs the lab documentation.

2) Do obtain the lab documentation, as this will NOT trigger any Medicare red flags.

DOCUMENTATION OF MEDICARE DIAGNOSTIC LABS for DIABETES **DSMT**, CONT.

Medicare states that T1 and T2 diabetes is diagnosed with 1 of the following:

- 1) Fasting plasma glucose x 2 tests
- 2) Two hour OGTT x 2 tests
- 3) Random BG x 1 test with high blood glucose symptom(s)

DOCUMENTATION OF MEDICARE DIAGNOSTIC LABS for DIABETES **DSMT**, CONT.

FPG: ≥ 126 mg on 2 tests, or
2 hr OGTT: ≥ 200 mg on 2 tests, or
Random BG: ≥ 200 mg + uncontrolled DM symptom*.
A1c not yet added to lab values*.

Gestational Diabetes
Provider to provide documentation of gestational diabetes dx code.

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

***But:** A1c $\geq 6.5\%$ is diagnostic for T1, T2 DM per current ADA's Diabetes Clinical Standards of Medical Care
*Federal Register, Vol. 68, #216, 11-7-03, p.63261

MEDICARE **DSMT** REFERRAL REQUIREMENTS

Written, faxed or e-referral by treating physician (MD, DO) or treating qualified non-physician practitioner (NPP): NP, PA, CNS.
Order to state: Initial **DSMT** or Diabetes Self-Management Training or Education

For **initial DSMT***: whether **group** or **individual**.
If **individual**: documentation on referral of:
1) special need that **limits group learning**, such as: hearing, language, vision, cognitive, non-ambulatory

OR
documentation on referral of:
"additional insulin training"

MEDICARE **DSMT** REFERRAL REQUIREMENTS

MEDICARE **DSMT** REFERRAL REQUIREMENTS, CONT

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

For **initial DSMT**:
-- Which of 10 topics to be taught.
Medicare itemizes 10 topics.

How many hours of 10 to be taught.
Can be less than 10.

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 and NPI # already in EMR database is allowed.
Separate Rx required for: **initial** and **follow-up DSMT**.

MARY ANN'S MEDICARE REFERRAL FORM
for
DSMT, MNT, INTENSIVE BEHAVIOR THERAPY for OBESITY
and
OTHER BENEFITS

MEDICARE LAB ELIGIBILITY

→ DSMT and diabetes MNT: 1 lab of 3 below required):

1. FBG ≥126 mg/dl on 2 tests: FBG _____ and FBG _____
2. 2 hr OGTT ≥200 mg/dl on 2 tests: 2 hr OGTT _____ and 2 hr OGTT _____
3. Random BG >200 mg/dl with symptoms of uncontrolled diabetes: Random BG _____ excessive thirst excessive urination excessive hunger blurry vision excessive tiredness unintentional wt loss tingling in extremities other _____

→ Renal MNT lab required: GFR: 13 to 50 GFR: _____

OTHER LABS A1c _____ T-Chol _____ LDL-C _____ HDL-C _____ TG _____ BP _____ BMI _____ Other _____

DIAGNOSIS MEDICARE: = Medicare prefers 5 digit T1, T2 diabetes code for diagnosed manifestation, state of disease/condition or other clinical detail

- = If on insulin, must add additional dx code Z78.4 (long term or current insulin use)
- * = Medicare prefers additional diagnosis code(s) for any associated underlying condition(s)

Check, or insert narrative diagnosis(es)					
E10.1* <input type="checkbox"/> T1DM w ketoacidosis	E11.69* <input type="checkbox"/> T2 w other specified category	Z79.4	Long term/intermittent insulin use	N18.30	Chronic kidney disease, stage 3, unspecified
E10.2* <input type="checkbox"/> T1 w other specified category	E11.71* <input type="checkbox"/> T2 w unspecified category	Z79.84	Long term/intermittent oral hypoglycemic drug	N18.31	Chronic kidney disease, stage 3a
E10.3* <input type="checkbox"/> T1 w unspecified category	E11.72* <input type="checkbox"/> T2 w unspecified category	Z79.89	Other long-term drug therapy for hypoglycemia (non-insulin drug)	N18.32	Chronic kidney disease, stage 3b
E10.4* <input type="checkbox"/> T1 w complications	O04.410	GDM in pregnancy, diet controlled		N18.4	CKD, stage 4
E11.0* <input type="checkbox"/> T2 w other specified category	O04.41*	GDM in pregnancy	Z66.2* <input type="checkbox"/> BM 30.0 - 30.9, adult (>15 yrs)	N18.5	CKD, stage 5
E11.64* <input type="checkbox"/> T2 w hypoglycemia	O04.1*	Pre-existing DM, T2, in pregnancy	Z66.31* <input type="checkbox"/> BM 31.0 - 31.9, adult	Z94.0	Kidney transplant status
E11.65* <input type="checkbox"/> T2 w hyperglycemia	O04.01*	Pre-existing DM, T1, in pregnancy	Z66.32* <input type="checkbox"/> BM 32.0 - 32.9, adult	E66.01	Marked obesity due to excess calories

*American Diabetes Association, 2021 **OVER**

Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information: Name _____, DOB _____, Sex _____, Race _____, Ethnicity _____, Address _____, City _____, State _____, Zip _____, Phone _____, Email _____

Physician Information: Name _____, DOB _____, Sex _____, Race _____, Ethnicity _____, Address _____, City _____, State _____, Zip _____, Phone _____, Email _____

Diabetes Self-Management Education/Training (DSMT) and Medical Nutrition Therapy (MNT) check for any of the following conditions or symptoms:

Diabetes type 1 Diabetes type 2 Gestational diabetes Prediabetes Other (specify) _____

Impaired fasting glucose Impaired glucose tolerance Fasting glucose ≥126 mg/dL 2-hr OGTT ≥200 mg/dL Random glucose ≥200 mg/dL with symptoms of uncontrolled diabetes

Excessive thirst Excessive urination Excessive hunger Blurry vision Excessive tiredness Unintentional weight loss Tingling in extremities Other _____

Additional information: Reason for referral _____, Referral source _____, Referral date _____, Referral type _____, Referral status _____, Referral notes _____

Physician signature: _____, Date: _____

Revised August 2011

Can download on websites of:

American Association of Diabetes Educators

Academy of Nutrition and Dietetics

MEDICARE DSMT FREQUENCY in FIRST YEAR and STRUCTURE

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

DSMT: 10 hours in 12 consecutive months.
Cannot extend into next year.
1 hour individual (G0108) may be used for insulin training, or any topic, or for assessment.

9 hours must be in group (G0109) unless 1 of 3 special conditions exist.
10 hours may be used for only 1 topic.

Visits are ≥/= 30 min. (1 billing unit; no rounding).
Document start + end time to prove number of whole 30 min. unit(s) of face-to-face time furnished in visit.

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

MEDICARE DSMT MEDICAL UNLIKELY EDITS (MUEs)

aka: Limits on number of units of code payable per visit

HCCPS Code	OP Hospital Services MUE Values	Practitioner Services MUE Values
G0108 Individual DSMT	8, 30 minute units = 4 hours	6, 30 minute units = 3 hours
G0109 Group DSMT	12, 30 minute units = 6 hours	12, 30 minute units = 6 hours

MEDICARE DSMT FRQUENCY 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: ≥/ = 30 min = 1 billing unit (1 billing unit). No rounding.
New Rx required for follow-up.

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

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: 2019, 2020**
- Starts initial 10 hours on August 1, 2019
 - Completes initial 10 hours on September 9, 2020
 - Eligible for 2 hour follow-up **next day**, on September 10, 2020
 - Starts 2 hour follow-up on November 13, 2020
 - Completes 2 hours follow-up on December 20, 2020
 - Eligible for next 2 hour follow-up in January 1, 2021
- Completes Initial 10 Hours in Same Calendar Year:**
- Starts initial 10 hours on August 1, 2020
 - Completes initial 10 hours in December 15, 2020
 - Eligible for 2 hours follow-up on January 1, 2021
 - Completes 2 hour follow-up on July 7, 2021
 - Eligible for next 2 hour follow-up on January 1, 2022

MEDICARE TIME FRAMES for FOLLOW-UP DSMT: CMS EXAMPLE

Easy Explanation!

- **INITIAL** benefit...first 12 months...beneficiary starts 10 hour benefit
 - Timing clock **starts** on the **first DSMT visit date ... Aug. 1, 2019**
 - Time clock **ends** on the **last visit DSMT date ... Sept. 9, 2020**
 - **FOLLOW-UP** benefit...year 2...starts next day.....**Sept. 10, 2020**
 - Year 3, 4, etc. now based on **calendar** year, renewing every **January 1**



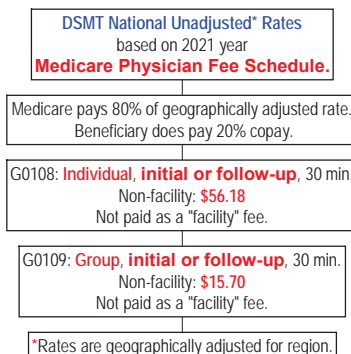
DSMT PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

Visit can be any # of units but must be ≥1		1 Unit
G0108	DSMT , individual, initial or follow-up, 30 min.	30 min
G0109	DSMT , group, initial or follow-up, 30 min.	30 min

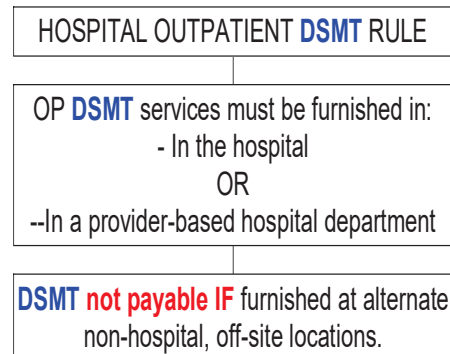
DOCUMENT
“START” and “END” TIME
 that is
FACE-TO-FACE
 for
EVERY VISIT
 for
TIME-BASED CODES



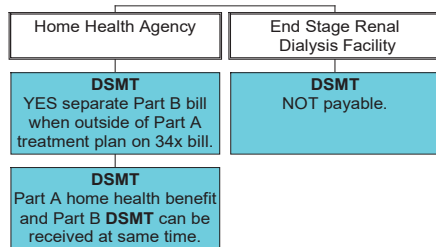
MEDICARE **DSMT** NATIONAL UNADJUSTED REIMBURSEMENT RATES
 (www.cms.gov for Calendar Year 2021) (as of 2-5-21, 2021)



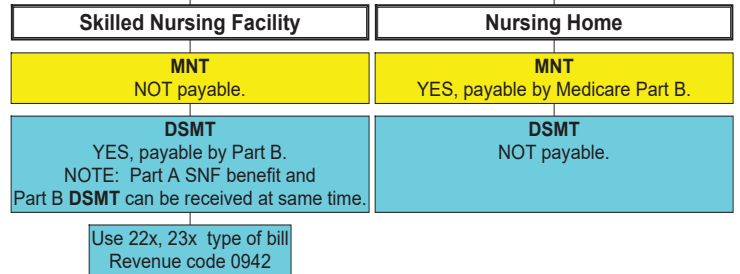
MEDICARE **DSMT** OFF-SITE LOCATION RULE IN HOSPITALS



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

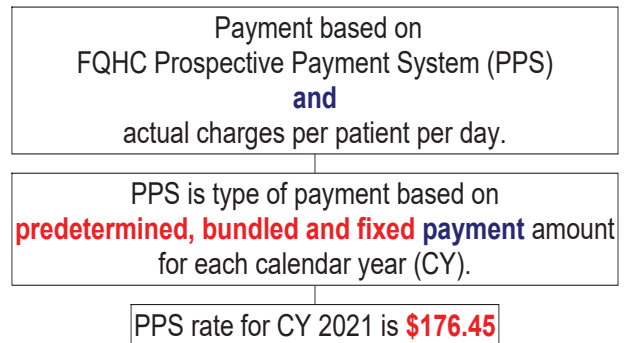


SKILLED NURSING FACILITY and NURSING HOME
MEDICARE **DSMT** BILLING

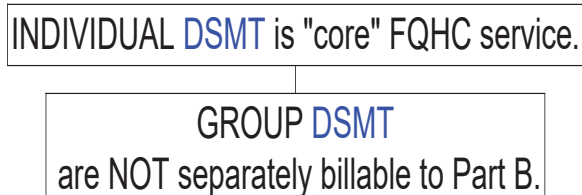


**FEDERALLY QUALIFIED HEALTH CENTER
PROSPECTIVE PAYMENT SYSTEM (PPS) RATE REIMBURSEMENT**
for
DSMT

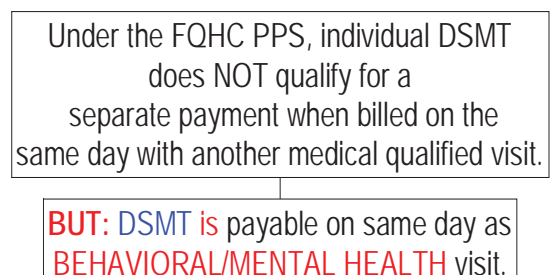
FQHC BILLING FOR **DSMT**



FQHC BILLING OF **DSMT**, CONT



FQHC BILLING OF **DSMT**, CONT



FQHC BILLING OF **DSMT**, CON'T

DSMT is considered **MEDICAL** visit.
In FQHCs, 2 **MEDICAL** visits are
NOT
both payable on same day.

FQHC MEDICARE BILLING FOR **DSMT OK**

DSMT: Medicare pays FQHC the 80% of **LESSER*** of its
total actual charges OR **fixed PPS rate**
or bundle of ALL services in **qualifying visit** furnished to beneficiary on **SAME** day.

Entered on claim:
Qualifying visit code to identify new or established pt visit.

Entered on **DSMT** claim:
--Procedure code **G0108** (individual **DSMT**).
--Actual charge for **DSMT** visit.

***DSMT** has a 20% beneficiary copayment.

FQHC BILLING OF **DSMT**

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

Use **TOB 77x** in locator **field 4** on **UB-04 claim form**.
No Part B deductible applies to approved FQHC services.

UB-04 Claim Form

FQHC BILLING OF **DSMT**, CON'T

Medicare pays **80%** of the **LESSER** of FQHC PPS rate
or
total actual charges per patient per day.
for bundle of all qualifying visits furnished to pt on same day.

Qualifying visit code entered on claim.
Code = new or established pt.

Also entered on claim:
Procedure code for **DSMT** individual visit.
Qualifying visit code **G0467** (FQHC visit, established pt).
Actual charge for **DSMT** visit.

Beneficiary pays **20% copayment**.

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

2021 FQHC Prospective Payment System (PPS) Rate = \$176.45

REVENUE CODE	QUALIFYING VISIT CODE	DSMT PROCEDURE CODE	DSMT ACTUAL CHARGE	PPS RATE
0521	G0467, medical visit, established patient	G0108, 60 minutes, 2 units of code	\$106.00 ↑	\$176.45 ↑

➡ **Lesser value is actual charge of \$106.00.**

CMS pays 80% of **lesser**, or of **\$106.00**, which is **\$84.80**

FQHC BILLING OF MNT OK

Medicare pays **100%** of the LESSER of FQHC PPS rate or total actual charges per patient per day. for bundle of all qualifying visits furnished to pt on same day.

Qualifying visit code entered on claim.
Code = new or established pt.

Also entered on claim:
Procedure code for MNT individual visit.
Qualifying visit code G0467 (FQHC visit, established pt).
Actual charge for MNT visit.

Beneficiary pays **0% copayment.**

My mother taught me about contortionism:

Will you look at the dirt on the back of your neck!



RURAL HEALTH CLINIC
ALL INCLUSIVE RATE and COST-BASED REIMBURSEMENT
for
DSMT

RHC BILLING OF DSMT

Only INDIVIDUAL DSMT payable
but NOT separately billable to Part B on UB-04 claim form.

All RHC services furnished per patient per day are also each reported with a charge.

Payment is based however on bundled **ALL INCLUSIVE RATE.**

RHC BILLING OF DSMT

RHC receives several "interim" AIR payments during fiscal year for all services furnished.

Payments then reconciled via **cost reporting** at end of year.

RHC BILLING OF DSMT, CON'T

How "interim" AIR payment determined:
Total allowable reported costs for all services divided by total # of visits furnished to RHC patients receiving core RHC services.

Beneficiary copay + Part B deductible both apply.

RHC BILLING OF **DSMT**, CON'T

Procedure code G0108 also entered with revenue code 0521 on additional service line on **TOB 71x** for **INDIVIDUAL** visits for CMS tracking.

IF telehealth: originating site facility fees billed using revenue code 0780.

Beneficiary copay + Part B deductible both apply.

RHC BILLING OF **DSMT**, CON'T

Encounters with >1 RHC practitioner on same day or multiple encounters with same practitioner on same day, constitute a single RHC visit payable as 1 visit under AIR rate

Exception:
Subsequent to 1st visit, patient suffers illness or injury that requires additional diagnosis or treatment on same day.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf>

*"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 G0109 will be denied."*

Source: *MLN Matters® Number: MM6445 Revised, Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC)

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

Main reference used for DSMT billing in FQHCs and RHCs:

Medicare Claims Processing Manual, Chap. 9, RHCs/FQHCs, Revised 10357, 09-18-20

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf>

CHANGES IN BILLABLE ICD-10
CODES FOR
MEDICARE **DSMT**:
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:**

- E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359
- E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359
- E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359
- E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359
- E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359

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:**

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 **DSMT**

• **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**

• **DSMT: Added new 2017 ICD-10 dx codes effective 10/1/16:**

E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, 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, E10.3593, E10.37X1, E10.37X2, E10.37X3

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:**

E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E11.37X1, E11.37X2, E11.37X3

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:**

O24.415, O24.425, O24.435

• **Unspecified codes deleted effective 1/1/17:**

O24.019, O24.119, O24.819

DSMT 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:

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



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

CMS COVID-19 Waivers for Medicare **DSMT**



Important Disclaimer Regarding CMS COVID-19 Waivers in this Deck

- The information in the deck is intended to provide users with information believed to be current and accurate **as of February 5, 2021**.
- CMS has been modifying its telehealth waivers on a **daily basis** in order to further expand the use of telehealth for select services (that includes **DSMT**) and to further simplify the billing rules.
- Information in this deck is not intended as, nor should it be construed as legal, financial, medical or other regulatory advice. Users are to exercise their professional judgment in connection with this information.

Medicare Hot Line at: <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>

CMS COVID-19 WAIVERS FOR **DSMT**

- Telehealth **DSMT**:
 - Can be **audio/phone** only
 - No procedure code modifier required on claim for **audio** only
 - Can also be **audio/visual online platform**
 - Use **non-public facing** online platforms
 - CMS will **not** strictly enforce HIPAA rules
 - Use procedure code **modifier 95 on G code** on claim form

CMS COVID-19 WAIVERS FOR **DSMT**

- Telehealth **DSMT**
 - Beneficiary can be in any location, including **home**
 - Diabetes educator can be in **own home** to furnish
 - Use same **place of service (POS) code** on claim used for **in-person**

CMS COVID-19 WAIVERS FOR **DSMT**

- **DSMT**: All **10 initial hours** can be **individual**, whether:
 - Telehealth
 - Live in-person
 - No "special condition" for all initial **individual** DSMT hours has to be documented on referral (COVID is the condition)

CMS COVID-19 WAIVERS FOR DSMT

- Telehealth **DSMT**
 - In **hospital OP depts**
 - Can bill for on **UB-04 claim**
 - Use **revenue code 780**

CMS COVID-19 WAIVERS FOR DSMT

- Telehealth **DSMT** in **FQHCs and RHCs**
 - Can now be **distant sites** for **DSMT** (where educator is at)

CMS COVID-19 WAIVERS FOR DSMT

Telehealth **DSMT** in **FQHCs and RHCs**:

- Practitioners can furnish from **any location**, including their **home**, during time that they are working for FQHC/RHC
- Can furnish **any telehealth service** that is approved as **distant site telehealth service** under Medicare Physician Fee Schedule (PFS)
 - **DSMT** procedure codes are on the Medicare PFS

CMS COVID-19 WAIVERS FOR DSMT

- Telehealth **DSMT** in **FQHCs and RHCs** acting as **distant site** (where educator is at)
 - Use procedure code **G2025** to identify services furnished via telehealth
 - PLUS enter **DSMT** procedure code and **revenue code 052X**
 - Beginning 7-1-20, RHCs not required to enter modifier CG on G2025 code, and modifier 95 is optional
 - Claims with new **G2025** code paid at fixed **\$92.03 rate** in 2021.

CMS COVID-19 WAIVERS FOR DSMT

- Telehealth **DSMT** in **FQHCs and RHCs** acting as **distant site** (where educator is at)
 - CMS will **not use costs** for furnishing distant site telehealth services to decide RHC AIR or the FQHC PPS rate; but costs must be reported on proper cost report form
 - RHCs must report **both originating and distant site telehealth costs** on Form CMS-222-17 on line 79 of Worksheet A, in section "Cost Other Than RHC Services."
 - FQHCs must report **both originating and distant site telehealth costs** on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of Worksheet A, in section "Other FQHC Services".

CMS COVID-19 WAIVERS FOR DSMT

- Telehealth **DSMT** in **FQHCs and RHCs** acting as **distant site** (where educator is at)
 - Can furnish any Medicare-approved telehealth service under Medicare PFS
 - For list of: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/TelehealthCodes>
 - Patient coinsurance (as of 12-3-20):
 - For codes in list above (includes DSMT and MNT codes):
 - ❖ Patient coinsurance: 20% of lesser of allowed amount (\$92.03) or charges
 - Payment to FQHC and RHC: 80% of lesser of allowed amount (\$92.03) or charges

CMS COVID-19 WAIVERS FOR **DSMT**

- Telehealth **DSMT at distant sites** (where educator is at)
 - **RNs** and **pharmacists** now allowed to furnish at any Medicare-approved DSMT **distant site**
 - Includes **hospital OP depts, FQHCs, RHCs, etc.**

PRE-COVID MEDICARE **DSMT TELEHEALTH** BILLING BASICS

PRE-COVID MEDICARE **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.

Source: www.cms.gov/transmittals/downloads/R140BP.pdf

PRE-COVID MEDICARE **DSMT TELEHEALTH** BILLING BASICS

REIMBURSEMENT:

Same as for original face-to-face **DSMT** benefit.

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

PRE-COVID MEDICARE **DSMT TELEHEALTH** BILLING BASICS

INDIVIDUAL and GROUP **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).

PRE-COVID MEDICARE **DSMT TELEHEALTH** BILLING BASICS

By reporting **telehealth 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.

PRE-COVID MEDICARE DSMT TELEHEALTH BILLING BASICS

ORIGINATING SITE vs. DISTANT SITE

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

Distant site: where **HCP** is during **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 **DSMT** **AND** in state where beneficiary **receives** the **DSMT**.

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. 3678, 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

CRITICAL ACCESS HOSPITALS METHOD II DISTANT SITES

- Critical Access Hospitals Optional Payment Method II:
 - As of Oct. 1, 2018, **GT modifier** is required on DSMT G code on their institutional claims
 - GT is “via interactive audio and video telecommunications system”

Source: Revisions to the Telehealth Billing Requirements for Distant Site Services, MLN Matters No.: MM10583 Revised

EXCLUDED DISTANT SITES: WHERE EDUCATOR IS DURING DSMT VISIT

- Independent renal dialysis facilities
- Pharmacies
- Beneficiary’s home
- Rural health clinics
- Federally qualified health centers

APPROVED ORIGINATING SITES: WHERE BENEFICIARY IS AT DURING DSMT

1. Physician or qualified non-physician practitioner office
2. Hospital
3. Critical Access Hospital (CAH)
4. Rural Health Clinic (RHC)
5. Federally Qualified Health Center (FQHC)
6. Skilled nursing facility (SNF)
7. Community mental health center
8. Mobile stroke units

APPROVED **ORIGINATING** SITES: WHERE BENEFICIARY IS AT DURING **DSMT**

9. Renal dialysis facilities
10. Homes of ESRD beneficiaries receiving home dialysis
 - For sites 9 and 10 to qualify as originating sites beneficiary must have:
 - In-person visit once per month for first 3 months and
 - Once every 3 months thereafter
11. Hospital-based and CAH-based renal dialysis centers
 - Medicare does NOT apply **originating site geographic conditions** to 9, 10, and 11 when practitioners furnish monthly home dialysis ESRD-related medical evaluations

Source: CMS MLN Booklet: TELEHEALTH SERVICES 2019 ICN 901705 January 2019

APPROVED **ORIGINATING** SITES: WHERE BENEFICIARY IS AT DURING **DSMT**

Regarding:

- Rural Health Clinics + Federally Qualified Health Centers
 - **Originating site facility fee** for telehealth services is NOT a RHC or FQHC service when the site is acting as originating site
 - **Originating site facility fee** must be **paid separately** from the RHC all-inclusive bundled rate or the FQHC Outpatient Prospective Payment System (OPPS) rate

Transmittal 3476 **Change Request 9428** **March 11, 2016**

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** telehealth:
 - Beneficiary's **home**, *except for beneficiaries receiving home dialysis*
 - Independent renal dialysis facility
 - Sites within a MSA or not within a HPSA

PLACE OF SERVICE (POS) CODE ON CLAIMS FOR **DSMT** TELEHEALTH VISIT

- Use of the telehealth **POS code 02** certifies that service meets the telehealth requirements at the 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, **except for CAHs Method II**

ORIGINATING SITES ELIGIBLE TO RECEIVE **FACILITY FEE** FOR **DSMT** 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")
- **Telehealth place of service (POS) code** is **"02"**: location where health services and health related services are provided or received, through telecommunication technology

ORIGINATING SITES ELIGIBLE TO RECEIVE
FACILITY FEE FOR **DSMT** 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 TELEHEALTH
FACILITY FEE FOR **DSMT** TELEHEALTH VISIT

- **2021** Medicare telehealth facility fee:
 - Use HCPCS procedure code **Q3014**
 - Defined: “Telehealth originating site facility fee”
 - Payment is 80% of the lesser of the actual charge, or **\$27.02**
 - FQHCs and RHCs must use **revenue code 78X** (bill Q3014 and 78X on separate lines on claim form)
 - Beneficiary responsible for unmet deductible amount + coinsurance

My Parting, Warmest Thoughts to You



Be B. E. S. T. ...

Better, Ever Stronger... Together!

*I think this should be our own
new “mantra” during this trying period!*

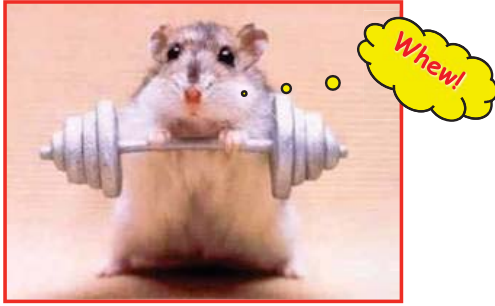


IGNORE MEDICARE AND YOU MAY FIND YOURSELF UP
A CREEK **WITHOUT A PADDLE**



INCREASE REIMBURSEMENT NOW!

ALL IT TAKES IS A LITTLE **DESIRE** AND **STRENGTH** ON YOUR PART!



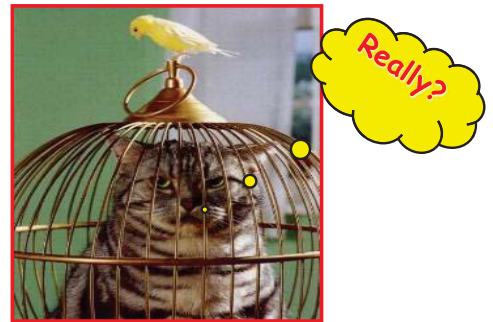
YOUR PATIENTS, PROVIDERS & STAFF WILL **LOVE** YOU FOR IT!



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**



Meet Your Appendix



Medicare Payments in Rural Health Clinics

Rural Health Clinic

- Direct billing to Medicare Part B is **not** allowed in RHCs due to the bundled payment methodology used in RHCs
- RHCs are paid an **All-Inclusive Rate (AIR)** when a medically necessary, face-to-face visit is furnished by an RHC practitioner
- **All-Inclusive Rate** includes all **services** and **supplies** furnished **'incident to the physician services'** for the visit

Medicare Payments in Federally Qualified Health Centers

Federally Qualified Health Center

- FQHCs paid 80% of lesser of actual charges or **FQHC Prospective Payment System (PPS)** rate for the CY
- FQHC **Prospective Payment System** rate includes all **services** and **supplies** furnished **'incident to the physician services'** for the visit

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- OPPTS payment applies to designated hospital outpatient services furnished in all classes of hospitals, **except in:**
 - **Hospitals furnishing only inpatient Part B services**
 - **Critical Access Hospitals (CAHs)**
 - **Indian Health Service (IHS) and Tribal hospitals, including IHS Tribal CAHs**
 - **Hospitals located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands**
 - **Hospitals in Maryland and those paid under Maryland All-Payer Model**

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- Key part of OPPTS = **Ambulatory Payment Classification (APC) codes**
 - CMS assigns APC code to select procedure codes based on similar clinical characteristics and similar costs
 - Each APC code has:
 - Its own payment rate for each covered procedure code
 - The beneficiary's copayment amount
- APC and OPPTS systems are used only by hospitals
- Every procedure or medication has its own unique APC code that must be submitted on Medicare claim by the hospital in order to receive reimbursement for services

CRITICAL CARE HOSPITALS do NOT use the APC system nor the OPPTS

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- Key OPPTS feature is **"packaging,"** or "bundling of charges":
 - This is grouping integral, ancillary, supportive, dependent and adjunctive services into the **one single payment** (= comprehensive APC) for the associated **primary** procedure or service

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- Inpatient hospital billing is done with another system called **Diagnosis-Related Group (DRGs)**

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- How APC Codes Work**
 - For single patient visit, hospital can receive several separate APC payments
 - Anything used during a procedure is billable expense; hospital's coding specialists determine which APC codes are used
 - APC codes are chosen by: 1) size of facility; 2) complexity of service; 3) services or procedures furnished to pt
 - Reimbursement is geographically adjusted in regional areas in U.S.
- What Can Be Billed**
 - Hospitals can bill for everything from lab and diagnostic testing, durable medical equipment, pharmacy, surgery, anesthesiology, ambulance service, and emergency and ICU care, and more.

EXAMPLE OF PAYMENT FOR PROFESSIONAL and THERAPEUTIC CGM and RPM CODES in MEDICARE OPSS, APC Codes and Status Indicator (SI) Codes for CALENDAR YEAR 2021

HCPCS Cod	Short Desc	SI	APC	Relative W	Payment R	National U	Minimum I	Note: Actu Drug Pass-*
95249	Cont gluc r S		5733	0.6722	\$55.66		\$11.14	
95250	Cont gluc r V		5012	1.4341	\$118.74		\$23.75	
95251	Cont gluc r B							
99453	Rem mntr V		5012	1.4341	\$118.74		\$23.75	
99454	Rem mntr Q1		5741	0.4487	\$37.15		\$7.44	
99457	Rem phys B							
99458	Rem phys B							

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates>

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example: <ul style="list-style-type: none"> • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided as a Certified Dialysis Unit of a Hospital • Diagnostic Radiology • Selective Manicures 	Not paid under OPSS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPSS.
B	Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x). <ul style="list-style-type: none"> • An alternate code that is recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available. 	Not paid under OPSS. May be paid by intermediaries when submitted on a different bill type, for example, 7x (COR), but not paid under OPSS.
C	Impound Procedures	Not paid under OPSS. Admit patient bill as appropriate.
D	Discontinued Codes	Not paid under OPSS or any other Medicare payment system.
E	Items, Codes, and Services: <ul style="list-style-type: none"> • That are not covered by Medicare based on statutory exclusion. 	Not paid under OPSS or any other Medicare payment system.

Indicator	Item/Code/Service	OPPS Payment Status
	<ul style="list-style-type: none"> • That are not covered by Medicare for reasons other than statutory exclusion • That are not recognized by Medicare but for which an alternate code for the same item or service may be available • For which separate payment is not provided by Medicare 	Not paid under OPSS. Paid at reasonable cost.
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatin B Vaccines	Not paid under OPSS. Paid at reasonable cost.
G	Pass Through Drugs and Biologicals	Not paid under OPSS. Separate APC payment includes pass-through amount.
H	(1) Pass-Through Device Categories (2) Radiopharmaceutical Agents	(1) Separate cost-based pass-through payment. Not subject to co-insurance. (2) Separate cost-based non-pass-through payment.
K	(1) Non-Pass Through Drugs, Biologicals, and (2) Biocatheter Sources	(1) Paid under OPSS. Separate APC payment. (2) Paid under OPSS. Separate APC payment.
L	(1) Blood and Blood Products (2) Influenza Vaccine, Pneumococcal Pneumonia Vaccine	(1) Paid under OPSS. Separate APC payment. (2) Not paid under OPSS. Paid at reasonable cost. Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPSS.
N	Items and Services Packaged into APC Rates	Not paid under OPSS. Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Not paid under OPSS. Per item APC payment.

CMS-1506-P

Addendum D1

Indicator	Item/Code/Service	OPPS Payment Status
Q	Packaged Services Subject to Separate Payment Under OPSS Payment Criteria.	Paid under OPSS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPSS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPSS, Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPSS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPSS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPSS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPSS; Separate APC payment.

Outpatient Prospective Payment System (OPSS) Used by Medicare to Reimburse Hospitals and Community Mental Health Centers for Patient Services

Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPSS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPSS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPSS Pricer changes that are part of the quarterly OPSS recurring update notification transmittals.

Show entries: 5 per page Filter On Apply

Showing 1-10 of 172 entries

Release Date	Subject	Year
January 2021	Addendum B	2021
January 2021	Addendum A	2021

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates>

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

- OPSS and APC coding systems are **NOT** used to reimburse hospitals for:
 - Select hospital OP dept. services
 - Services that cannot be paid under the OPSS by statute,
 - Services separately paid as required by statute
 - **Includes:**
 - ❖ **DSMT**
 - ❖ **MNT**
 - ❖ **Physician Part B services**
 - ❖ **Select services of other Medicare Part B providers**

Medicare Payments in Hospitals: Outpatient Prospective Payment System + APC Codes

OPSS and APC coding systems **ARE** used to reimburse hospitals for (CY 2021) for:

Benefit	Procedure Code	APC Code
Intensive Behavior Therapy for Obesity: Individual	G0447	5822
Intensive Behavior Therapy for Obesity: Group	G0473	5821
Professional CGM: Placement, Training, etc.	95250	5012
Therapeutic CGM: Training, etc.	95249	5377
Remote Patient Monitoring: Training	99453	5012
Remote Patient Monitoring: Device supply	99454	5741
Chronic Care Management, 20 min/calendar month	99490	5822
Chronic Care Management, 60 min/calendar month	99487	5823
Principal Care Management, 30 min/calendar month	G2065	5822

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates>

Medicare Payments in Critical Access Hospitals

Standard Payment Method I
Facility services: paid at 101% of CAH reasonable costs even if providers reassign their reimbursement to CAH
Professional OP services by providers: <ul style="list-style-type: none"> • Professional OP services by providers (physicians and qualified practitioners): <ul style="list-style-type: none"> ○ Paid under Medicare Physician Fee Schedule (PFS)

Medicare Payments in Critical Access Hospitals

Optional Payment Method II
Facility services: paid at 101% of CAH reasonable costs even if providers reassign their reimbursement to CAH
Professional OP services by providers: <ul style="list-style-type: none"> • Providers can choose 1 of 2 payment methods: <ul style="list-style-type: none"> ○ Reassign reimbursement to CAH and agree to get professional payment from CAH or ○ File own claims for professional services for standard payment under Medicare PFS; paid at 115% of Medicare Physician Fee Schedule allowable amount

Medicare Payments in Critical Access Hospitals

- Paid for **most** inpatient and OP services at 101% of reasonable costs
- CAH **not** included in hospital Inpatient Prospective Payment System or the hospital OPSS
- CAH **outpatient** services paid under 1 of 2 methods:

Medicare Payments in Critical Access Hospitals

1. Standard Payment Method (Method I)
 - **Facility services:**
 - ❖ Paid at 101 percent of reasonable costs
 - **Professional OP services by providers** (physicians and qualified practitioners):
 - ❖ Paid under Medicare Physician Fee Schedule (PFS)

Medicare Payments in Critical Access Hospitals

2. Optional Payment Method (Method II)

- **Facility services:**

- ❖ Paid at 101% of CAH reasonable costs even if providers reassign reimbursement to CAH

- **Professional OP services by providers:**

- ❖ Providers can choose 1 of 2 payment methods:
 1. Reassign reimbursement to CAH & agree to get professional payment from CAH, or
 2. File own claims for professional services for standard payment under Medicare Physician Fee Schedule (PFS); paid at 115% of Medicare PFS allowable amount

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctshst.pdf>

Medicare Payment Method for Telehealth Service to Critical Access Hospitals When Acting as Distant Site

- Distant site is where the HCP is during the telehealth visit
- About reimbursement to physicians and HCPs for telehealth services when CAH is distant site:
 - If provider is paid under **Optional Payment Method II**, and reassigns his/her reimbursement back to the CAH:
 - Medicare pays 80% of the Medicare Physician Fee Schedule for telehealth services

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctshst.pdf>

CPT® Procedure Codes

- Current Procedural Terminology (CPT®) procedure codes are copyrighted by the American Medical Association; all rights are reserved.

CLAIM FORMS for HOSPITALS and PRIVATE PRACTICES

MEDICARE		PRIVATE PAYER	
Hospital OP: If Hospital is Provider:	Private Practice: RD is provider:	Hospital OP: If Hospital is Provider:	Private Practice: RD is provider:
CMS 1450 = UB04 claim* or HIPAA 837 Institu ECF*	CMS 1500 claim or HIPAA 837 Prof ECF**	CMS 1450 = UB04 claim* or HIPAA 837 Institu ECF*	CMS 1500 claim or HIPAA 837 Prof ECF**
To Part A Intermediary; being replaced by Medicare Administrative Contractors	To Part B Carrier; being replaced by Medicare Administrative Contractors..."MACS"	To Private Insurance	To Private Insurance

^ If paper claim used, must use new CMS-1500 **paper** claim (08-05) and new UB-04 **paper** claim.
*Institu 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 supplies¹

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)

<http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx> (National Conference of State Legislatures)

REJECTED vs. DENIED CLAIMS

REJECTED CLAIM	DENIED CLAIM
Medicare returns as unprocessable. Medicare cannot make payment decision until receipt of corrected, re-submitted claim.	Medicare made determination that coverage requirements not met; example: service is not medically necessary.
= INCOMPLETE Claim: Required info is missing or incomplete (ex: no NPI #).	If you feel this is an error, can pursue payment through Medicare's appeals process.
INVALID Claim: Info 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.

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 **DSMT** claim will be denied by Medicare, pt or provider may can 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

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!

4. Do the math:

Total number of one hour visits per program:	10
Average number visits attended by beneficiary:	5
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:	+ \$128
Beneficiary's 20% co-insurance payment:	+ \$32
TOTAL PAYMENTS:	=\$160
LESS estimated total expenses for visit:	\$120
EQUALS estimated profit (loss):	=\$30
PROFIT for five visits attended out of ten (\$30 x 5):	=\$150

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

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 **DSMES** 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**.

CODING AND BILLING RULES OF THUMB

CODING AND BILLING RULES OF THUMB

- **Never** guess as to which procedure codes to use on claim!
 - Do your homework with each and every insurer!
- **Never** select procedure code JUST because of good reimbursement rate... always remember that:
 - Code must match code terminology and nature of service furnished
- Benefit's reimbursement rules must be met **100%**
- **Never** bill code that limits billing providers to **physicians only** for service furnished by **non-physician ancillary staff**, such as RD, CHES, MA, etc., **unless insurer allows**

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 DSMES/T

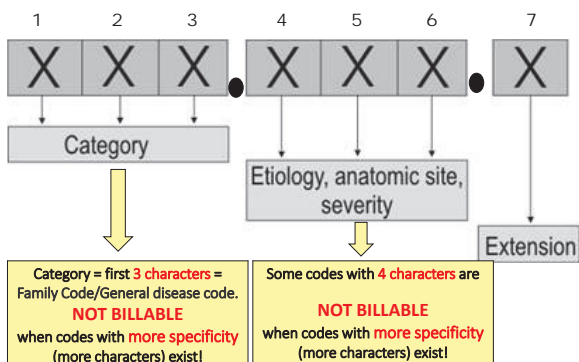
ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

7 Characters in New Codes Spell:

C. E. A. S. E.

- | | |
|---|-----------------------|
| C = Category | Characters 1-3 |
| E = Etiology | Characters 4-6 |
| A = Anatomic site | Characters 4-6 |
| S = Severity or other clinical detail | Characters 4-6 |
| E = Extension | Character 7 |
| <ul style="list-style-type: none"> ▪ Initial or subsequent encounter ▪ Laterality (left vs. right) ▪ Other clinical detail (e.g., # weeks gestation) | |

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY



Please tell me there are no more characters in these codes!

ICD-10 DIAGNOSES CODES FOR **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**

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:

- **E11.4 = 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 complication**

NOT BILLABLE as needs 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 ANGIOPATH with GANGRENE**
- **E11.59 = Type 2 DM with OTHER CIRCULATORY COMPLICATION**

ICD-10 DIAGNOSES CODES FOR **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**
 - 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.

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)

ICD-10 STRUCTURE AND TERMINOLOGY

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

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”

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

Chapter (Character)	Chapter Title and (3 Character Category = Rubric) NOT BILLABLE when codes exist with greater specificity
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. (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 – U00)

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

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

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.-)

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

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)

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**

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

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**

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 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

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**

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

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)



Only Use ALPHABETICAL INDEX to Find CHAPTER That Code is in with INSTRUCTIONAL NOTES!

ICD-10-CM INDEX TO DISEASES and INJURIES

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

Aarskog's syndrome Q87.1
 Abandonment —see Maltreatment
 Abasia (-astasia) (hysterical) F44.4
 Abderhalden-Kaufmann-Lignac syndrome (cystinosis) E72.04
 Abdomen, abdominal —see also condition
 - acute R10.0
 - angina K55.1
 - muscle deficiency syndrome Q79.4
 Abdominalgia —see Pain, abdominal
 Abduction contracture, hip or other joint —see Contracture, joint
 Aberrant (congenital) —see also Malposition, congenital
 - adrenal gland Q80.1
 - artery (peripheral) Q27.8
 - - basilar NEC Q28.1
 - - cerebral Q28.3
 - - coronary Q24.5
 - - digestive system Q27.8
 - - eye Q15.8
 - - lower limb Q27.8

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

ICD-10-CM TABULAR LIST of DISEASES and INJURIES

E11 Type 2 diabetes mellitus

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 (E09.-)
 gestational diabetes (O24.4-)
 neonatal diabetes mellitus (P70.2)
 postpancreatectomy diabetes mellitus (E13.-)
 postprocedural diabetes mellitus (E13.-)
 secondary diabetes mellitus NEC (E13.-)
 type 1 diabetes mellitus (E10.-)

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

ICD-10-CM TABULAR LIST of DISEASES and INJURIES

Z71.3 Dietary counseling and surveillance

Use additional code for any associated underlying medical condition

Use additional code to identify body mass index (BMI), if known (Z68.-)

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._)
 - **Z94.0** = Kidney transplant status

DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

For Medicare Intensive Behavioral Therapy (IBT) for Obesity Benefit

Z68.30 BMI 30.0-30.9, adult	Z68.38 BMI 38.0-38.9, adult
Z68.32 BMI 32.0-32.9, adult	Z68.39 BMI 39.0-39.9, adult
Z68.33 BMI 33.0-33.9, adult	Z68.41 BMI 40.0-44.9, adult
Z68.34 BMI 34.0-34.9, adult	Z68.42 BMI 45.0-49.9, adult
Z68.35 BMI 35.0-35.9, adult	Z68.43 BMI 50.0-59.9, adult
Z68.36 BMI 36.0-36.9, adult	Z68.44 BMI 60.0-69.9, adult
Z68.37 BMI 37.0-37.9, adult	Z68.45 BMI > 70.0, adult

DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

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) T78.40, 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
 - *dietary counseling and surveillance Z71.3*
- Hypercholesterolemia (essential) (familial) (hereditary) (primary) (pure) E78.0
 - *dietary counseling and surveillance Z71.3*
- Hypoglycemia (spontaneous) E16.2
 - *dietary counseling and surveillance Z71.3*
- Intolerance food K90.4
 - *dietary counseling and surveillance Z71.3*
- Obesity E66.9
 - *dietary counseling and surveillance Z71.3*

DIETARY COUNSELING AND SURVEILLANCE + BMI CODES

- **Supervision (of) dietary (for) Z71.3**
 - *allergy (food) Z71.3*
 - *colitis Z71.3*
 - *diabetes mellitus Z71.3*
 - *food allergy or intolerance Z71.3*
 - *gastritis Z71.3*
 - *hypercholesterolemia Z71.3*
 - *hypoglycemia Z71.3*
 - *intolerance (food) Z71.3*
 - *obesity Z71.3*
 - *specified NEC Z71.3*
- Surveillance (of) (for) - see also Observation
 - *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 Code Z71.3
Persons encountering health services for other counseling and medical advice, not elsewhere classified
- <http://icd10coded.com/>
- AAPC Website
 - <http://www.aapc.com/ICD-10/index.aspx>
- CMS Website on ICD-10:
 - <https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx>
- <https://implementicd10.noblis.org/>

ICD-10 Resources

- www.AHIMA.org
- www.ICD10watch.com
- www.AAPC.com
- www.WEDI.org
- www.humanservices.Arkansas.gov/ICD10
- http://www.himss.org/ASP/topics_icd10playbook.asp
- For ICD-10 Coding of DIABETES MELLITUS:
 - http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049595.hcs?p?dDocName=bok1_049595
- For Automatic Conversion of ICD-9 Codes to ICD-10 Codes:
 - <http://www.icd9data.com/2014/Volume1/240-279/249-259/250/default.htm>

10 STEPS TO INCREASE

PRIVATE PAYER

AND

MEDICAID

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 and co-pays)

3. Increase collateral revenue for your entity via:

- Pts obtaining other services (lab tests, therapies)

10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID 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.)



10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID DSMT REIMBURSEMENT SUCCESS

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



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/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.

• **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

10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID DSMT REIMBURSEMENT SUCCESS

3. Identify IF DSMT is covered by the health plans

There are 6 ways to identify coverage!



6 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

6 Ways to Identify Coverage

- 4 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

6 Ways to Identify Coverage

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



6 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

6 Ways to Identify Coverage

- 5 Access subscriber's coverage via **electronic claims submission software** that may be provided by insurer

6 Ways to Identify Coverage

- 6 Insert patient's "swipe/scan healthcare ID card" in special card reader provided by insurer.



Keep database of results, and update regularly!

10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID DSMT REIMBURSEMENT SUCCESS

- 4. For each covered benefit, in each plan, identify **procedure codes** for initial and follow-up interventions

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 **DSMT**

98960	Individual, initial or f/up face-to-face education, training & self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.
98961	Group of 2 - 4 pts, initial or f/up, each 30 min.
98962	Group of 5 - 8 pts, initial or f/up, each 30 min.



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.

PROCEDURES CODES THAT ALIGN WITH **DSMT**

98960	Individual, initial or f/up face-to-face education, training & self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.
98961	Group of 2 - 4 pts, initial or f/up, each 30 min.
98962	Group of 5 - 8 pts, initial or f/up, each 30 min.

- 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 **DSMT**
6. If covered, identify payable **ICD-10 diagnosis codes**
7. If covered, identify approved **billing providers** and **rendering providers** for **DSMT**
8. If covered, identify **reimbursement rates**

10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID DSMT REIMBURSEMENT SUCCESS

9. If covered, identify the approved **places of service** and **patient eligibility** (e.g., FPG \geq 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 Association of Diabetes Care and Education Specialists nor any other related guidelines. As always, the reader's/user's clinical judgment and expertise must be applied to any and all information in this document.

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Resources by Mary Ann Hodorowicz

Turn-Key Materials for DSMES Program Accreditation from Association of Diabetes Care and Education Specialists

- DSMES Program Policy & Procedure Manual Consistent with 2017 NSDSMES (85 pages)
- Medicare, Medicaid and Private Payer Reimbursement
- Electronic and Copy-Ready/Modifiable Forms & Handouts
- Fun 3D Teaching Aids for AADE7 Self-Care Topics
- Complete Business Plan

3-D DSMES and Diabetes MNT Teaching Aids 'How-To-Make' Kit

- Kit of 24 monographs describing how to make Mary Ann's separate 3-D teaching aids plus fun teaching points, evidence-based guidelines and references

Money Matters in MNT and DSMES Increasing Reimbursement Success in All Practice Settings, The Complete Guide

Establishing a Successful MNT Clinic in Any Practice Setting

EZ Forms for the Busy RD©: 107 total, on CD-r; Modifiable; MS Word

- Package A: Diabetes and Hyperlipidemia MNT Intervention Forms, 18 Forms
- Package B: Diabetes and Hyperlipidemia MNT Chart Audit Worksheets: 5 Forms
- Package C: MNT Surveys, Referrals, Flyer, Screening, Intake, Analysis and Other Business/Office and Record Keeping Forms: 84 Forms

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