• Measures have been taken, by the Utah Department of Health, Bureau of Health Promotions, to ensure no conflict of interest in this activity.

• CNE/CEU’s are available for this live webinar. You must take the pre and post tests. 80% is required on the post test to receive CNE/CEU’s.

• Certificates will be emailed out to you within two weeks.
Money Matters in MNT: Increase Your Insurance Reimbursement NOW!

Mary Ann Hodorowicz, RD, LDN, MBA, CDE
Certified Endocrinology Coder
Mary Ann Hodorowicz Consulting, LLC
Mary Ann Hodorowicz, RD, LDN, MBA, CDE, CEC, is a licensed registered dietitian and certified diabetes educator and earned her MBA with a focus on marketing. She is also a certified endocrinology coder and owns a private practice specializing in corporate clients in Palos Heights, IL. She is a consultant, professional speaker, trainer, and author for the health, food, and pharmaceutical industries in nutrition, wellness, diabetes, and Medicare and private insurance reimbursement. Her clients include healthcare entities, professional membership associations, pharmacies, medical CEU education and training firms, government agencies, food and pharmaceutical companies, academia, and employer groups. She serves on the Board of Directors of the American Association of Diabetes Educators.

Mary Ann Hodorowicz Consulting, LLC
www.maryannhodorowicz.com
hodorowicz@comcast.net  708-359-3864
Twitter: @mahodorowicz
LEARNING OBJECTIVES

1. Describe the beneficiary eligibility criteria for Medicare diabetes MNT.

2. List 3 of the Medicare coverage guidelines for telehealth MNT.

3. Name 2 of the CPT procedure codes that must be used when billing Medicare for initial and follow-up MNT.
Medicare MNT Reimbursement Rules:
COPIOUS, CONVOLUTED, CONFUSING, COMPLICATED, CONSTANTLY CHANGING!
The Golden Rule

• He who as 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…along with penalties and fines…will likely be out of a job!

**INSURER’S RULES RULE!**
MEDICARE BENEFICIARY
MNT ENTITLEMENT

- Must have Medicare Part B insurance
- Suggestion: Make copy of Medicare card for MR
MNT--DSMT: COMPLIMENTARY & DISTINCT

**MNT**

- **Individualized**, detailed and focused nutrition therapy
- **Personalized** meal plan, SMBG and exercise plans
- **Long-term** follow-up in pt’s life with extensive monitoring of labs, outcomes, behavior \( \Delta \) and meal plan adjustments

**DSMT**

- **General** and basic training in 7 key behaviors in primarily group format
- ↑ pt’s **knowledge of why** and **skill in how** to change behaviors
- **Shorter-term** follow-up with limited monitoring of labs, outcomes, etc.
Medicare covers MNT and DSMT but NOT on same day!

**MNT:** First Calendar Year, 3 Hrs
Individual or group. **Individualized**
assessment, nutrition dx, intervention (incl. meal plan) and monitoring & evaluation of outcomes.

**DSMT:** 12 Consecutive Months, 10 Hrs*
*Group classes* in 10 topic areas
on basic diabetes self-care outlined

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

for period of 36 months
after successful kidney transplant.

Nutrition is 1 of 10 topics presented
as overview of basic meal planning
for BG control (**not** individualized for pt).

*9 hrs of 10 to be *group*; 1 may be *individual*. 10 hrs may be individual if provider's documentation of special needs is in DSMT provider's pt chart or no program scheduled in 2 months of referral date.
MNT
RD or Nutrition Professional who meets below criteria:

BS degree from accredited school.
900 hours of supervised experience.

Licensed or certified in state where furnishing
if licensure or credentialing established.
CDE status not required for diabetes MNT.

Separate billing allowed: hosp OP, nursing home,
ESRD facility, FQHC, clinic, RD/physician practice,
home health. Not allowed: inpt hospital,
rural health clinic, skilled nursing home.
MEDICARE MNT BILLING PROVIDER ELIGIBILITY

• RD must be Medicare Part B provider to furnish MNT and then bill Medicare Part B for MNT
  – 1st = Obtain NPI # (www.pecos.cms.hhs.gov)
  – 2nd = Complete CMS 855I enrollment application

• If RD is employed* by entity Medicare provider (hospital, clinic, physician group, etc.) or individual Medicare provider (solo physician) must:
  – Reassign her/his Medicare MNT reimbursement to entity or individual by completing CMS 855R form
  – Entity or individual bills on behalf of RD
MEDICARE PAYMENT RULES
RE: ORDERING PROVIDERS

• Benefits must be ordered by physician or eligible professional who is:
  – Enrolled in Medicare, or in ‘opt out’ status

• Must BE specialty type that is eligible to order specific items/services….example:
  – Only MDs and DOs can order MNT
  – Only MDs, DOs, NPs, PAs, CNSs can order DSMT

• Provider’s NPI# must be on claim as referring provider
  – Organizational NPI # cannot be used as referring provider
Chiropractic physicians have limited coverage for services:

- Limited to manual manipulation of spine to correct a subluxation (that is, by use of the hands).

Home Health Agency (HHA) services may only be ordered by:

- MD
- DO
- DPM (Doctor of Podiatric Medicine)

MEDICARE PAYMENT RULES
RE: ORDERING PROVIDERS

- RDs can check if referring provider is enrolled in Medicare (or in opt out) via enrollment record in web-based:

  Provider Enrollment, Chain and Ownership System (PECOS)

  https://pecos.CMS.hhs.gov
PECOS can also be used to:

- Submit/track initial Medicare enrollment application
- View/change enrollment info
- Add/change reassignment of benefits
- Submit changes to Medicare enrollment info
- Reactivate existing enrollment record
- Withdraw from Medicare Program
RD’s OPTIONS: MEDICARE MNT

B: Become Medicare provider and Bill Medicare for MNT

R: Refer beneficiary for MNT to Medicare RD provider who is furnishing MNT

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: Exclude Medicare coverage rules for MNT in diseases not covered by Medicare Part B, BUT give beneficiary Advanced Beneficiary Notice (ABN) for completion before furnishing non-covered MNT
MEDICARE MNT QUALITY STANDARDS

MNT
Must use nationally recognized protocols such as current evidence-based Nutrition Practice Guidelines for disease state

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

www.eatright.org
www.nutritioncaremanual.org

Recommend that RD charts one time that evidence-based protocols used.
Help me to always give 100% at work...

12% on Monday
23% on Tuesday
40% on Wednesday
20% on Thursday
5% on Fridays
MEDICARE BENEFICIARY ELIGIBILITY for MNT

**Diabetes MNT**
Documentation of diabetes dx using 1 of 3 labs. Physician referral for initial, f/up, extra hrs.

**Pre-Dialysis Renal MNT**
Dx documentation of 1 of renal disease stages that supports diagnostic criteria:
Stage III, IV and V CKD

**Kidney Transplant MNT**
Successful kidney transplant. MNT is in 36 months following transplant.

**Best Practice Suggestion**
Use *DSME/T and MNT Services Order Form* (revised 8/2011) Access at: www.aadenet.org
MEDICARE DIAGNOSTIC LAB CRITERIA for MNT

**T1 and T2 Diabetes**
Medicare benefit states that T1, T2 diabetes is diagnosed using 1 of 3 tests below. Documentation must be maintained by referring physician in beneficiary's medical record. **Only treating MD/DO can Rx (= one coordinating care of beneficiary with diabetes or renal disease).**

- FPG $\geq 126$ mg on 2 tests, or
- 2 hr OGTT $\geq 200$ mg on 2 tests, or
- Random BG $\geq 200$ mg + uncontrolled DM symptom(s)  
  HbA1c **not** added as of April 2015

**Symptoms of uncontrolled diabetes:**
Excessive thirst, hunger, urination, fatigue, blurred vision, unintentional weight loss, wound that won't heal, etc.

**Gestational Diabetes**
Provider to provide documentation of gestational diabetes ICD-9 dx code.

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

**Best Practice Suggestions**
Obtain documentation of diagnostic lab.
Can use revised *DSME/T--MNT Services Order Form.*  
Download at: aadenet.org (revised 8/2011)

$^\wedge$HbA1c $\geq 6.5\%$ diagnostic for T1, T2 DM per ADbA, *Standards of Medical Care*, 2015
MNT

Written Rx by treating physician.
To include: Rx date + beneficiary's name.

Dx or code (5 digits for T1, T2 DM). Physician's NPI + signature (stamped not allowed). Faxed + e-referral allowed.
Separate Rx for: initial, f/up MNT and extra hours.

Revised DSME/T and MNT Order Form lists diagnostic lab criteria + asks provider to send labs for pt eligibility and outcomes monitoring. Original to be in pt's chart in provider's office.
Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information

Patient's Last Name  First Name  Middle
Date of Birth ______/_______/_______  Gender: □ Male  □ Female
Address  City  State  Zip Code
Home Phone  Other Phone  Email address

Diabetes Self-Management Education and Training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

**Diabetes Self-Management Education/Training (DSME/T)**
Check type of training services and number of hours requested:
- Initial group DSME/T: □ 10 hours or ________ ms. hrs. requested
- Follow-up DSME/T: □ 2 hours or ________ ms. hrs. requested
- Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T
Check all special needs that apply:
- Vision
- Hearing
- Physical
- Cognitive Impairment
- Language Limitations
- Additional training: □ additional hours requested ________
- Telehealth

**DSME/T Content**
- Monitoring disease
- Diabetes as disease process
- Psychological adjustment
- Physical activity
- Nutritional management
- Meal setting, problem solving
- Medications: □ Prevent, detect and treat acute complications
- Preconception/pregnancy management or ESM
- Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSME/T in 12 month period from the date of first class or staff

**DIAGNOSIS**
Please send recent labs for patient eligibility & outcome monitoring:
- Type 1 □ Type 2 □
- Complications/Comorbidities

- Hyperglycemia
- Hypertension
- Hyperlipidemia
- Stroke
- Nephropathy
- PVD
- Kidney disease
- Retinopathy
- CVD
- Heart disease
- Lower extremity
- AIDS
- Mental/affective disorder
- Other

**Medical Nutrition Therapy (MNT)**
Check the type of MNT and/or number of additional hours requested:
- Initial MNT: □ 3 hours or ________ ms. hrs. requested
- Formal follow-up MNT: □ 2 hours or ________ ms. hrs. requested
- Telehealth
- Additional MNT services in the same calendar year, per RD

Additional hrs. requested ________

Please specify change in medical condition, treatment and/or diagnosis:

**Definition of Diabetes (Medicare)**
Medicare coverage of DSME and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:
- A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dl on two different occasions; or
- A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.


Other payers may have other coverage requirements.

Signature and Code:

Provider name, address and phone:

Revised August 2011 by the Association of Diabetes Educators and the American Dietetic Association.
Are we confused yet?
Laws in states below specifically outline mandates re:

- Written physician referral for nutrition services/MNT, or
- Dietitian’s activities based on physician’s order, or
- Physician involvement when treatment/condition is medical
- Provisions for dietitian conduct when physicians involved

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Indiana</th>
<th>Connecticut</th>
<th>Tennessee</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Florida</td>
<td>Massachusetts</td>
<td>Maine</td>
<td>South Carolina</td>
</tr>
</tbody>
</table>

1. www.eatright.org/HealthProfessionals/content.aspx?id=6863 Accessed 3-26-12
MEDICARE MNT LIMITS in FIRST YEAR and STRUCTURE OF

Medicare MNT and DSMT in initial year may NOT be provided on same day!

**Initial MNT:** 3 hours in calendar year.
Cannot extend into next year.
Individual, group or combination.
Group visit to be ≥ 30 min. (30 min. billing unit).

**Individual** visit to be ≥ to 8 to ≤ to 23 min.
(= 1, 15 min. billing unit)
Rounding allowed on 15 min. time based codes but not on 30 min. codes.

**Additional Hrs >3 Reimbursable IF:**
RD obtains new Rx which documents # extra hrs to be furnished and medical necessity for.

Examples of medical necessity:
Change in medical condition, diagnosis and/or treatment regimen requiring additional MNT.
CHANGES THAT MAY JUSTIFY EXTRA HOURS of MEDICARE MNT

<table>
<thead>
<tr>
<th>DIABETES MNT</th>
<th>NON-DIALYSIS RENAL MNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oral meds to insulin</td>
<td>• Significant decrease in renal sufficiency</td>
</tr>
<tr>
<td>• Lack of understanding of diabetes diet</td>
<td>• Lack of understanding of renal diet</td>
</tr>
<tr>
<td>• GDM pt requires frequent diet changes</td>
<td>• Onset of malnutrition</td>
</tr>
<tr>
<td>• Diabetes complication requiring tighter diet control</td>
<td>• Completes DSMT and develops renal condition</td>
</tr>
</tbody>
</table>
MEDICARE MNT LIMITS in FOLLOW-UP YEARS and STRUCTURE OF

F/Up MNT After First Calendar Year

2 hrs in each calendar yr after first.
Cannot extend hrs to next yr.
Individual, group or combination.

**Group** visit: \( \geq 30 \text{ min.} \) (30 min. billing unit)

**Individual** visit: \( \geq 8 \) to \( \leq 23 \) min.
(\( = 15 \text{ min. billing unit} \))
Required: new Rx for f/up, documentation of dx and reason for f/up.
DIAGNOSES for MEDICARE MNT

Diagnosis is Required Documentation:
1) In MR maintained by educator/RD
2) In MR maintained by MD/DO

On REFERRAL and in MR, diagnosis can be narrative description OR ICD-9 dx code

On CLAIMS, use 5 digit code when possible:
250.02 = Type 2 uncontrolled diabetes vs. 250 = diabetes mellitus.
Claim may be denied if 5th digit not used

Select professionals authorized to select ICD-9 codes for narrative diagnosis:
PHYSICIANS, QUALIFIED NPPs and LICENSED MEDICAL RECORD CODERS
# DIAGNOSES for MEDICARE MNT

4th digit = clinical manifestation/complication of diabetes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.0</td>
<td>Diabetes mellitus without mention of complication</td>
</tr>
<tr>
<td>250.1</td>
<td>with ketoacidosis</td>
</tr>
<tr>
<td>250.2</td>
<td>with hyperosmolarity</td>
</tr>
<tr>
<td>250.3</td>
<td>with other coma</td>
</tr>
<tr>
<td>250.4</td>
<td>with renal manifestations</td>
</tr>
<tr>
<td>250.5</td>
<td>with ophthalmic manifestations</td>
</tr>
<tr>
<td>250.6</td>
<td>with neurological manifestations</td>
</tr>
<tr>
<td>250.7</td>
<td>with peripheral circulatory disorders</td>
</tr>
<tr>
<td>250.8</td>
<td>with other specified manifestations</td>
</tr>
<tr>
<td>250.9</td>
<td>with unspecified complications</td>
</tr>
</tbody>
</table>
DIAGNOSES for MEDICARE MNT

5th digit identifies:

- T1 or T2 diabetes
- Controlled or uncontrolled

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.X0</td>
<td>Type 2 controlled</td>
</tr>
<tr>
<td>250.X1</td>
<td>Type 1 controlled</td>
</tr>
<tr>
<td>250.X2</td>
<td>Type 2 uncontrolled</td>
</tr>
<tr>
<td>250.X3</td>
<td>Type 1 uncontrolled</td>
</tr>
</tbody>
</table>
MNT PROCEDURE CODES REQUIRED by MEDICARE and COMMONLY ACCEPTED by PRIVATE PAYERS

Initial Visit (CPT® Codes):
Individual, new pt: 97802 (1 unit = 15 min)
Used only 1 time for initial visit in first year.
Group, new pt: 97804 (1 unit = 30 min)

Follow-Up Visits:
Individual, est. pt: 97803 (1 unit = 15 min)
Group, est. pt: 97804 (1 unit = 30 min)

Codes for Hrs Beyond Limit (HCPCS®):
2nd Rx, same year, Individ: G0270 (1 unit = 15 min)
2nd Rx, same year, Group: G0271 (1 unit = 30 min)

Initial or Established Pt

CPT® = Current Procedural Terminology Codes; copyright, American Medical Association
HCPCS® = Healthcare Common Procedure Coding System; maintained by CMS
## MEDICARE REQUIRED MNT, DSMT CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial, individual, 15 min.</td>
<td>15 min</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, follow-up, individual, 15 min.</td>
<td>15 min</td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or follow-up, group, 30 min.</td>
<td>30 min</td>
</tr>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, &gt;3 hours or follow-up, individual, &gt;2 hours, 2\textsuperscript{nd} referral in same year</td>
<td>15 min</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, &gt;3 hours or follow-up, group, &gt;2 hours, 2\textsuperscript{nd} referral in same year</td>
<td>30 min</td>
</tr>
<tr>
<td>G0108</td>
<td>DSMT, individual, initial or f/up, 30 min.</td>
<td>30 min</td>
</tr>
<tr>
<td>G0109</td>
<td>DSMT, group, initial or f/up, 30 min.</td>
<td>30 min</td>
</tr>
</tbody>
</table>

ALWAYS DOCUMENT START TIME and END TIME FOR EVERY VISIT!
CMS’ GUIDE for 15 MIN. TIME-BASED CODES

<table>
<thead>
<tr>
<th>UNITS</th>
<th>MINUTES to MINUTES¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 8 ≤ 23</td>
</tr>
<tr>
<td>2</td>
<td>≥ 24 ≤ 37</td>
</tr>
<tr>
<td>3</td>
<td>≥ 38 ≤ 52</td>
</tr>
<tr>
<td>4</td>
<td>≥ 53 ≤ 67</td>
</tr>
<tr>
<td>5</td>
<td>≥ 68 ≤ 82</td>
</tr>
<tr>
<td>6</td>
<td>≥ 83 ≤ 97</td>
</tr>
<tr>
<td>7</td>
<td>≥ 98 ≤ 112</td>
</tr>
<tr>
<td>8</td>
<td>≥ 113 ≤ 127</td>
</tr>
</tbody>
</table>

¹. www.cms.gov/manuals/downloads/clm104c05.pdf Accessed 3-26-12
MEDICARE MNT--DSMT
REIMBURSEMENT RATES, 2015

Medicare MNT Rates
Accessed 1-22-15 on CMS.gov

100% of Medicare Physician Fee Schedule (MPFS).
Medicare pays 100% of adjusted rate.
20% pt co-payment waived, BUT paid by Medicare.

Aver. Unadjusted Rates*: 97802, initial, 15 min:
  Non-Facility: $35.04
  Facility: $32.89

97803, follow-up, 15 min:
  Non-Facility: $30.03
  Facility: $27.53

97804, group, initial or f/up, 30 min:
  Non-Facility: $16.09
  Facility: $15.37

Medicare DSMT Rates
Accessed 1-22-15 on CMS.gov

100% of condensed MPFS for par providers,
but only 95% for non-par providers.
Medicare pays 80% of adjusted rate, pt pays 20%

Aver Unadjusted Rates*, Facility, Non-Facility:
  G0108, individual, 30 min: $53.27
  G0109, group, 30 min: $14.30

*Rates also vary per geographic region.
My mother taught me about contortionism

“Will you look at the dirt on the back of your neck!”
UPDATED PAYABLE PLACE of SERVICE (POS) NUMERIC CODES for MEDICARE MNT for CLAIMS SUBMITTED to MEDICARE

*References:

1. CMS Publication 100-03, Medicare National Coverage Determinations Manual, Part 1:180.1 Medical Nutrition Therapy
2. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4:300 Medical Nutrition Therapy (MNT) Services
3. CMS Transmittal No. AB-02-059, Program Memorandum Intermediaries/Carriers, Change Request #2142, May 1, 2002, provides additional clarification for medical nutrition therapy (MNT) services.
For CPT codes 97802, 97803, 97804: POS 99 (Other Unlisted Facility) may be used only if there is not a more appropriate POS code to describe current place of service.
HOME HEALTH AGENCY and ESRD FACILITY
MEDICARE MNT BILLING

Home Health Agency

- MNT
  - YES separate Part B bill

End Stage Renal Dialysis Facility

- MNT
  - YES separate Part B bill but only for non-dial bene's
SKILLED NURSING FACILITY and NURSING HOME MEDICARE MNT BILLING

Skilled Nursing Facility
- MNT
  - NO separate Part B bill

Nursing Home
- MNT
  - YES separate Part B bill
FEDERALLY QUALIFIED HEALTH CENTER and RURAL HEALTH CLINIC MEDICARE MNT and DSMT BILLING

**FQHC**

**MNT:** Type of Bill (TOB) 73x/77x; revenue code 0521. 1:1 only is separately billable with MNT codes but paid at all-inclusive FQHC rate. No co-insurance. RD may be able to bill incident to*.

**DSMT:** Type of bill 73x/77x; revenue code 0521. 1:1 only is separately billable with G0108 but paid at all-inclusive FQHC rate. Co-insurance applies.

**DSMT:** Not paid with additional physician visit on same day but paid with initial preventive physical exam. MNT + DSMT provided on same day are not paid.

**Rural Health Clinic**

**MNT:** TOB 71x; revenue code 0521. NO separate billing with MNT codes. RD may be able to bill incident to*. Report cost on cost report; paid at all-inclusive RHC rate.

**DSMT:** TOB 71x; revenue code 0521. Sole instructor to be RD-CDE. No separate billing with G codes. Report cost on cost report; paid at all-inclusive RHC rate.

MEDICARE MNT TELEHEALTH

INDIVIDUAL + GROUP MNT can be delivered via telehealth¹

REIMBURSEMENT: Same as in original MNT benefit

WHAT IT IS: Interactive audio & video telecommunications system permitting real time communication + visualization

Excluded: Telephone calls, faxes, email without visualization, stored and delayed transmissions of images of pt.

MNT Provider Eligibility: Licensed or certified in state where provider works **AND** in state where patient located.

If pt in 1 state and provider location in another, provider must usually be licensed or certified in both states; exceptions apply.

Beneficiary receiving MNT must be present and participate in telehealth visit.

CPT code modifier “**GT**” added to MNT code on claim: “Interactive audio and video telecommunications system”
**Originating Sites:** Location of *beneficiary* at time of MNT visit.

**Approved Distant Sites (where MNT provider 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) and community mental health center.

**Excluded:** Home health, independent renal dialysis facilities, pharmacies.

Medicare pays same for telehealth services under Medicare Physician Fee Schedule (MPFS) as for original benefits, including MNT.*

*Exception:* For physicians/practitioners in CAH who have reassigned their billing rights to CAH that has elected Optional Payment Method II, CAH bills Part A for telehealth services with revenue codes 096x, 097x or 098x. Payment amount is 80% of MPFS.
More About Originating Sites:
Geographic criteria for eligible telehealth originating sites include health professional shortage areas (HPSAs) located in rural census tracts of urban areas as determined by Office of Rural Health Policy or a county outside of metropolitan statistical area.
See: www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Originating site that houses beneficiary during MNT eligible to receive facility fee.

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”).

Deductible and coinsurance rules apply to facility fee code Q3014.

The 2015 Medicare facility fee as 4-1-15 = $28.22
MNT CLAIM FORMS for HOSPITAL and PRIVATE PRACTICE

**MEDICARE**

**Hospital OP:** If Hospital is Provider:

- CMS 1450 = UB04 claim
  - or HIPAA 837
  - Institu ECF*

  **To Part A Intermediary; being replaced by Medicare Administrative Contractors**

**Private Practice:** RD is provider:

- CMS 1500 claim or HIPAA 837
  - Prof ECF**

  **To Part B Carrier; being replaced by Medicare Administrative Contractors..."MACs"**

**PRIVATE PAYER**

**Hospital OP:** If Hospital is Provider:

- CMS 1450 = UB04 claim
  - or HIPAA 837
  - Institu ECF*

  **To Private Insurance**

**Private Practice:** RD is provider:

- CMS 1500 claim or HIPAA 837
  - Prof ECF**

  **To Private Insurance**

---

*Institu ECF = Institutional electronic claim

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

**Prof ECF = Professional electronic claim**
REJECTED vs. DENIED CLAIMS

REJECTED CLAIM

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

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

= INCOMPLETE Claim:
Required info is missing or incomplete (ex: no NPI #).

DENIED CLAIM

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

To pursue payment, provider can go through Medicare's appeals process.

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

• Affordable Care Act mandates Medicare payments be made only via electronic funds transfer (EFT)

  – Part of CMS’ revalidation efforts
  – Providers not rec’ing EFT payments will be:
    • Identified
    • Required to submit CMS 588 EFT Form with Provider Enrollment Revalidation Application
MACs and clearing houses provide electronic claims software at little/no charge at:

www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage

Support for filing paper claims at:
www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp#TopOfPage
ADVANCE BENEFICIARY NOTICE (ABN)

- **ABN** (paper form CMS-R-131) can be used for cases where Medicare payment expected to be **denied**

- Notifies beneficiary **prior to** service that:
  - Medicare will probably deny payment for service
  - Reason *why* Medicare may deny payment
  - Beneficiary will be responsible for payment if Medicare denies payment
ADVANCE BENEFICIARY NOTICE (ABN)

- NOT required for benefits statutorily excluded by Medicare (e.g. cosmetic surgery), but can be used.
- IS required when service IS Medicare benefit but will not be covered in this particular case (e.g., HTN MNT)
- Can also used when:
  - Unsure service is medically necessary, or
  - Service may exceed frequency or duration limit
  - It will be in place of Notice of Exclusion from Medicare Benefits to inform beneficiary that service is not covered by Medicare
MODIFIERS for PROCEDURE CODES

• **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 **NOT** on file.

• If provider knows that MNT claim will be denied, pt or provider can submit denied claim to supplemental insurance
  
  – Some private payers may require Medicare denial *first* before considering to pay

• **GY** modifier added to code to obtain denial
PRIVATE PAYER and MEDICAID COVERAGE of MNT

• Coverage policies and, if paid, coverage rules, do vary:
  – From **state to state** among major plans (BCBS of IL. vs. BCBS of CA.)
  – Among plans in payer company (HMO vs. PPO)
  – Among state Medicaid plans

• Some cover pre-diabetes (glucose intolerance, IFG)
RULES OF THUMB

Call each and every payer in local area (or check website) to inquire about payer’s MNT-DSMT:

1. Coverage policy
   • Does payer cover services?

2. Coverage guidelines re:
   • Referring provider eligibility
   • Who can bill
   • Pt eligibility and entitlement
   • Benefit structure, utilization limits, place of service
   • Billing codes, claim types, etc.
   • Reimbursement rates
STATE INSURANCE MANDATES for PRIVATE PAYERS

- 46 states* and DC have state insurance laws that require private payer coverage for:
  - DSMT, MNT, DM-related services and supplies¹
  - 4 states with no laws: AL, ID, ND, OH

- Laws supersede any coverage limitations in health plan

- Exclusions do exist (e.g., state/federal employer health plans often exempt from state mandates)

PROCEDURE CODES for MNT and DSMT

**NOT** PAID by MEDICARE

BUT **MAY** be REQUIRED by PRIVATE PAYERS and MEDICAID
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetes management program, f/up visit to non-MD provider</td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetes management program, f/up visit to MD provider</td>
</tr>
<tr>
<td>S9145</td>
<td>Insulin pump initiation, instruction in initial use of pump (pump not included)</td>
</tr>
<tr>
<td>S9455</td>
<td>Diabetic management program, group session</td>
</tr>
<tr>
<td>S9460</td>
<td>Diabetic management program, nurse visit</td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, dietitian visit</td>
</tr>
<tr>
<td>S9470</td>
<td>Nutritional counseling, dietitian visit</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>98960</td>
<td>Individual, initial or f/up face-to-face education, training &amp; self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.</td>
</tr>
<tr>
<td>98961</td>
<td>Group of 2 - 4 pts, initial or f/up, each 30 min.</td>
</tr>
<tr>
<td>98962</td>
<td>Group, 5 - 8 pts, initial or f/up, each 30 min.</td>
</tr>
</tbody>
</table>

Do NOT require DSMT program accreditation.
98960, 98961, 98962:

- 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
WE GOT RID OF THE KIDS.....
THE CAT WAS ALLERGIC
I'm sleepy after all that info!
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
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 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 or American Diabetes Association’s Standards of Medical Care in Diabetes. As always, the reader’s clinical judgment and expertise must be applied to any and all information in this document.
• **Turn Key Materials for AADE DSME Program Accreditation**
  - DSME Program Policy & Procedure Manual Consistent with NSDSME (69 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 MNT and DSME/T Teaching Aids ‘How-To’ Kit**
  - Kit of 23 monographs describing how to make Mary Ann’s 23 separate 3-D teaching aids plus fun teaching points, evidence-based guidelines and references


• **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