Telehealth DSMT and Medicare Waivers Per Covid-19 Emergency

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Learning Objectives

1. Explain the very latest Medicare COVID-19 waivers for billing telehealth MNT and DSMT, including the rules for using the 1500 professional and hospital UB-04 claim forms (e.g., correct place of service codes, code modifiers, revenue codes, etc.)
2. Name some of the specific virtual platforms recommended and not recommended for the delivery of Medicare MNT and DSMT telehealth during the COVID-19 emergency.
3. Describe the new condition that CMS has approved for furnishing all 10 hours of initial DSMT as individual visits during the COVID-19 emergency.
4. Explain the latest Medicare waiver rules for RDNs and diabetes educators working from home during the COVID-19 emergency.

Important Disclaimer

The information in the deck is intended to provide users with information believed to be current and accurate at the time of the webinar. 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 MNT) and to further simplify the billing rules. The information is 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.

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 Telehealth DSMT* are All About the:

'C's

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

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

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

The Medicare Learning Network®

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


CONSTANTLY CHANGING!

Visit often the pages on these websites on COVID-19

- ADCES website

- Academy of Nutrition and Dietetics website
  - https://www.eatright.org/coronavirus

- CMS website
**Medicare MNT and DSMT: Complimentary But Distinct**

<table>
<thead>
<tr>
<th><strong>MNT</strong></th>
<th><strong>DSMT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• <em>Personalized</em> nutrition (and related) therapy to control A-B-C’s of diabetes, primarily as <em>individual</em> visits</td>
<td>• <em>General</em> training on key self-care behaviors to control A-B-C’s of diabetes, primarily in <em>group</em> format</td>
</tr>
<tr>
<td>• <em>Personalized</em> meal plan. Adjustments in SMBG, exercise &amp; medication plans are often suggested, due to pt’s lifestyle and diabetes management changes</td>
<td>• Objective is to increase patients’ <em>knowledge of why</em> and basic <em>skill in how</em> to: adopt healthier lifestyle behaviors; adhere to medication + SMBG regimen</td>
</tr>
<tr>
<td>• <em>Longer-term</em> follow-up with more <em>extensive</em> monitoring of labs, outcomes, behavior change, with adjustments in plans.</td>
<td>• <em>Shorter-term</em> follow-up with <em>less extensive</em> monitoring of labs, outcomes, behavior change, etc., over time.</td>
</tr>
</tbody>
</table>

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**Medicare DSMT Telehealth: Definition for DSMT**

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HIPAA-compliant, interactive audio and video telecommunication permitting <em>real time</em> <em>audio and visual communication</em></td>
<td>• Same as for original rules</td>
</tr>
</tbody>
</table>
### Medicare DSMT Referral (1)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treating provider’s referral required for:</td>
<td>• Same as Original Rules</td>
</tr>
<tr>
<td>o Initial DSMT and again for</td>
<td>• Added: new condition* related to COVID-19:</td>
</tr>
<tr>
<td>o Subsequent year DSMT</td>
<td>o COVID-19 emergency is condition that allows all 10 initial hours to be furnished individually</td>
</tr>
<tr>
<td>• Several items to be documented on referral</td>
<td>o Provider must document COVID-19 condition on referral</td>
</tr>
<tr>
<td>• 3 different conditions* exist for all 10 initial hours to be furnished individually</td>
<td>o If existing referral states “group”, need to obtain another referral that states this special condition, or another to do all 1:1</td>
</tr>
</tbody>
</table>

### Medicare DSMT Referral (2)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3 different conditions exist for all 10 initial hours to be furnished individually:</td>
<td></td>
</tr>
<tr>
<td>1. No group class scheduled within 2 months of initial DSMT referral date</td>
<td></td>
</tr>
<tr>
<td>On initial DSMT referral, treating provider:</td>
<td></td>
</tr>
<tr>
<td>2. Orders “additional insulin training”</td>
<td></td>
</tr>
<tr>
<td>3. Documents pt’s special need that limits group learning: hearing, vision, language, cognitive, non-ambulatory</td>
<td></td>
</tr>
</tbody>
</table>
**Mary Ann’s Medicare Referral Form**

**Patient Data**
- Name:
- Insurance type:
- NPI: 
- Does patient have clearance to exercise? YES NO

**Provider Data**
- Name:
- Address:
- Email:
- Signature:

---

**Services to Be Performed**

- **Initial DSNMT**
- **Initial MNT** (10 + 3 hours; Medicare Part B benefits)
- **Special Need**
  - COVID-19 Emergency Period
  - Vision Non-Ambulatory Physical disability Hearing Cognitive Language Other

- Consultations and Services:
  - Diabetes
  - Nutrition
  - Exercise
  - Medication
  - Goal Setting & Problem Solving
  - Coping Stress Control
  - Acute Complications
  - Chronic Complications
  - Pharmacology
  - Preconception/Pregnancy/ICM

- **<10 initial hours requested, number of hours is:**

- **DSNMT services are needed, as per patient’s plan of care.**

- **Additional Insulin Training**
- **Initial MNT**
- **Additional MNT**
- **Obesity Management/Weight Management**
- **Continuous Glucose Monitoring** (Medicare: patient must be on insulin for coverage)
- **Remote Patient Monitoring** (Medicare benefit)
- **Subsequent Year DSNMT**
- **Subsequent Year MNT**

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**Order Form**

**Please Fax Completed Order To:** (800) 900-0000 Before Giving to Patient

**Diabetes Connect Clinic**

123 Any Street, Suite 111, City, State, Zip

P: (800) 900-0000  F: (800) 900-0001

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4/2/2020
**MEDICARE LAB ELIGIBILITY:**

DSMT and diabetes MNT (1 lab of 3 below is required):
1. FBG ≥ 126 mg/dl on 2 tests: FBG: ___ and ___
2. 2 hr OGTT ≥ 200 mg/dl on 2 tests: 2 hr OGTT: ___ and ___
3. Random BG ≥ 200 mg/dl with symptoms of uncontrolled diabetes: Random BG: ___
   - Excessive thirst
   - Excessive urination
   - Excessive hunger
   - Blurry vision
   - Excessive tiredness
   - Unintentional weight loss
   - Tingling in extremities
   - Other: ___

Renal MNT lab required: GER: ___

**OBSERVATIONS:**

**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 Z79.4 (long term or current insulin use)
* = Medicare prefers additional diagnosis code for any associated underlying condition(s)
Medicare DSMT Telehealth: About Platforms/Technologies (1)

- **“Non-public facing”** remote communication platforms:
  - Allows only intended parties to participate in communication
- **“Public-facing”** platforms not acceptable platforms for telehealth as designed to be open to public... or allow wide or indiscriminate access to communication

Medicare DSMT Telehealth Excluded Platforms/Technologies (2)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluded: public-facing and without audio and visual communication in real time:</td>
<td>Excluded: public facing</td>
</tr>
<tr>
<td>• Telephone calls and faxes</td>
<td>• Facebook Live, Twitch, TikTok</td>
</tr>
<tr>
<td>• Email without audio and visual</td>
<td><strong>Phone only for only 3 codes:</strong> Waivers only allow coverage of “phone only” for 3 codes used by physicians and qualified non-physician practitioners (NPs, PAs, CNSs) for medical management. These codes <strong>not</strong> covered by Medicare previously: 98966, 98967 and 98968</td>
</tr>
<tr>
<td>• Online without audio and visual</td>
<td></td>
</tr>
<tr>
<td>• Real time texts</td>
<td></td>
</tr>
<tr>
<td>• Stored and delayed transmissions of images of beneficiary</td>
<td></td>
</tr>
</tbody>
</table>
### Original Medicare Rules

<table>
<thead>
<tr>
<th>Original Medicare Rules</th>
<th>Covid-19 Waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved <strong>non-public facing</strong> audio and visual platforms in real time that are HIPAA-compliant and vendor will enter into HIPAA BAA:</td>
<td>Same as Original Rules. Other approved <strong>non-public-facing</strong> platforms:</td>
</tr>
<tr>
<td>• Skype for Business / Microsoft Teams</td>
<td>• Smart phone apps allowing visual and audio communication in real time:</td>
</tr>
<tr>
<td>• Updox</td>
<td>o Apple FaceTime</td>
</tr>
<tr>
<td>• VSee</td>
<td>o Facebook Messenger video chat</td>
</tr>
<tr>
<td>• Zoom for Healthcare</td>
<td>o Google Hangouts video</td>
</tr>
<tr>
<td>• Doxy.me</td>
<td>o Skype</td>
</tr>
<tr>
<td>• Google G Suite Hangouts Meet</td>
<td>o Whatsapp video chat</td>
</tr>
<tr>
<td>• Cisco Webex Meetings / Webex Teams</td>
<td>o Signal, Jabber</td>
</tr>
<tr>
<td>• Amazon Chime</td>
<td></td>
</tr>
<tr>
<td>• GoToMeeting</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare DSMT Telehealth HIPAA Rules for Telehealth Platforms/Technologies (1)

<table>
<thead>
<tr>
<th>Original Medicare Rules</th>
<th>Covid-19 Waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some telehealth platforms/technologies may not fully comply with HIPAA rules</td>
<td></td>
</tr>
<tr>
<td>• CMS and OCR* will not impose penalties for non-compliance with HIPAA rules in connection with good faith provision of telehealth during COVID-19 emergency</td>
<td></td>
</tr>
<tr>
<td>• Applies whether telehealth related to dx and treatment of health conditions related to COVID-19....or not</td>
<td></td>
</tr>
</tbody>
</table>

*OCR = Office of Civil Rights
### Medicare DSMT Telehealth HIPAA Rules for Telehealth Platforms/Technologies (2)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Providers to use private settings/locations</td>
</tr>
<tr>
<td></td>
<td>• Patients should not receive telehealth in public or semi-public settings (absent pt consent or exigent circumstances)</td>
</tr>
<tr>
<td></td>
<td>• If not in private setting, implement reasonable HIPAA safeguards to limit uses/disclosures of protected health information (PHI):</td>
</tr>
<tr>
<td></td>
<td>o Lowered voices</td>
</tr>
<tr>
<td></td>
<td>o Not using speakerphone</td>
</tr>
<tr>
<td></td>
<td>o Recommending that patient move to reasonable distance from others when discussing PHI</td>
</tr>
</tbody>
</table>

*OCR = Office of Civil Rights

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Help me to always give 100% at work...

12% on Monday
23% on Tuesday
40% on Wednesday
20% on Thursday
5% on Fridays
### Medicare DSMT Telehealth: New vs. Established Patient

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Waivers now include furnishing telehealth DSMT to:</td>
</tr>
<tr>
<td></td>
<td>o Established patients</td>
</tr>
<tr>
<td></td>
<td>o New patients</td>
</tr>
<tr>
<td></td>
<td>• CMS will <strong>not</strong> conduct audits to ensure that such a prior relationship existed for claims submitted during COVID-19 emergency</td>
</tr>
</tbody>
</table>

### Medicare Telehealth Educator Documentation Requirements

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DSMT procedure codes are <strong>time-based</strong></td>
<td>• Same as for Original Rules</td>
</tr>
<tr>
<td>• Document <strong>start</strong> and <strong>end</strong> time when educator is face-to-face with pt to identify no. of units to bill (no rounding allowed):</td>
<td></td>
</tr>
<tr>
<td>o G0108: individual DSMT</td>
<td></td>
</tr>
<tr>
<td>• 1 unit = 30 minutes</td>
<td></td>
</tr>
<tr>
<td>o G0109: Group DSMT (2–20 pts)</td>
<td></td>
</tr>
<tr>
<td>• 1 unit = 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth Reimbursement

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• National unadjusted rates, 2020, facility* and non-facility:</td>
<td>• <strong>SAME</strong> reimbursement rates as face-to-face DSMT</td>
</tr>
<tr>
<td>o G0108, 1 unit, individual = $57.02</td>
<td>• Can reduce or waive cost-sharing (co-pay and deductible) for telehealth DSMT visits</td>
</tr>
<tr>
<td>o G0109, 1 unit, group = $15.88</td>
<td>o But not require to do so</td>
</tr>
<tr>
<td>• Beneficiary pays deductible and 20% of adjusted payment rate</td>
<td></td>
</tr>
</tbody>
</table>

* Facility = hospital

---

### Medicare DSMT Telehealth Individual vs. Group Visits

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>In-person</strong> initial DSMT:</td>
<td>• Telehealth initial DSMT:</td>
</tr>
<tr>
<td>o 9 hours to be group</td>
<td>o All 10 hours can be individual if treating provider documents 1 or more of 4 special conditions allowing all 1:1</td>
</tr>
<tr>
<td>o 1 hour can be individual</td>
<td>o COVID-19 emergency is special condition</td>
</tr>
<tr>
<td>▪ All 10 hours can be individual if 1 of 3 special conditions met</td>
<td>o In-person requirement for injectable medication training not required</td>
</tr>
<tr>
<td>• <strong>Telehealth</strong> DSMT:</td>
<td></td>
</tr>
<tr>
<td>• &gt;1 hour of 10 hours in initial yr and</td>
<td></td>
</tr>
<tr>
<td>• &gt;1 hour of 2 hours in follow-up years to be furnished in-person for training on injectable meds (individual or group)</td>
<td>• Telehealth initial DSMT:</td>
</tr>
<tr>
<td>be furnished in-person for training on injectable meds</td>
<td></td>
</tr>
<tr>
<td>(individual or group)</td>
<td></td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth Procedure Code Modifiers

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Critical Access Hospitals Method II</td>
<td>• Same as for Original Rules</td>
</tr>
<tr>
<td>o GT modifier required on their institutional claims</td>
<td>• On 1500 professional claim and hospital UB-04 claim, add modifier “95”:</td>
</tr>
<tr>
<td>▪ GT is “via interactive audio and video telecommunications system”</td>
<td>o <em>Synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system</em></td>
</tr>
</tbody>
</table>

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

### Medicare DSMT Telehealth Billing on Professional 1500 Claim Form (NOT Hospitals)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1500 professional claim form:</td>
<td>• Same as Original Rules</td>
</tr>
<tr>
<td>o Report place of service (POS) code “02” (telehealth visit)</td>
<td>• Report modifier “95” on DSMT procedure code:</td>
</tr>
<tr>
<td>• CMS has eliminated requirement to use GT modifier (via interactive audio and video telecommunications systems) on 1500 professional claims for telehealth services, except for CAHs Method II</td>
<td>o <em>Synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system</em></td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth Billing by Hospitals on UB-04 Claim Form

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Report <strong>revenue code</strong> 780 on UB-04 claim:</td>
<td>• Report <strong>revenue code</strong> 780 on claim:</td>
</tr>
<tr>
<td>o <strong>Telemedicine, general</strong></td>
<td>o <strong>Telemedicine, general</strong></td>
</tr>
<tr>
<td>• There is <strong>NO</strong> place of service (POS) field on hospital UB-04 claim form</td>
<td>• Report <strong>modifier 95</strong> on DSMT procedure code:</td>
</tr>
<tr>
<td>o Thus, cannot use POS code “02” (telehealth services) on form</td>
<td>o <strong>Synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system</strong></td>
</tr>
</tbody>
</table>

### Medicare DSMT Telehealth Originating Sites

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where <strong>beneficiary</strong> is during DSMT visit:</td>
<td>• Rural and site limitations are removed</td>
</tr>
<tr>
<td>1. Physician or qualified non-physician practitioner office</td>
<td>• Telehealth services can now be provided regardless of where beneficiary located geographically</td>
</tr>
<tr>
<td>2. Hospital</td>
<td>• Added: beneficiary’s home</td>
</tr>
<tr>
<td>3. Critical Access Hospital (CAH)</td>
<td></td>
</tr>
<tr>
<td>4. Rural Health Clinic (RHC)</td>
<td></td>
</tr>
<tr>
<td>5. Federally Qualified Health Center (FQHC)</td>
<td></td>
</tr>
<tr>
<td>6. Skilled nursing facility (SNF)</td>
<td></td>
</tr>
<tr>
<td>7. Community mental health center</td>
<td></td>
</tr>
<tr>
<td>8. Mobile stroke units</td>
<td></td>
</tr>
<tr>
<td>9. Renal dialysis facilities</td>
<td></td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth Originating Sites (2)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Homes of ESRD beneficiaries receiving home dialysis</td>
<td></td>
</tr>
<tr>
<td>• For sites 9 and 10 to qualify as originating sites beneficiary must have:</td>
<td></td>
</tr>
<tr>
<td>o In-person visit 1x/month for first 3 months and</td>
<td></td>
</tr>
<tr>
<td>o Once every 3 months thereafter</td>
<td></td>
</tr>
<tr>
<td>11. Hospital-based and CAH-based renal dialysis centers</td>
<td></td>
</tr>
<tr>
<td>• Medicare does NOT apply originating site geographic conditions to 9, 10, and 11 when practitioners furnish monthly home dialysis ESRD-related medical evaluations</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare DSMT Telehealth Originating Sites (3)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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</td>
<td>• This rule waived</td>
</tr>
</tbody>
</table>
My mother taught me about the science of Osmosis…

“Shut your mouth and eat your supper!”

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where diabetes educator is during DSMT visit</td>
<td>• Same as Original Rules, BUT</td>
</tr>
<tr>
<td><strong>Excluded:</strong></td>
<td>• Added:</td>
</tr>
<tr>
<td>• Independent renal dialysis facilities</td>
<td>o Rural health clinics</td>
</tr>
<tr>
<td>• Pharmacies</td>
<td>o Federally qualified health centers</td>
</tr>
<tr>
<td>• Beneficiary’s home</td>
<td></td>
</tr>
<tr>
<td>• Rural health clinics, federally qualified health centers</td>
<td></td>
</tr>
<tr>
<td><strong>Included:</strong></td>
<td></td>
</tr>
<tr>
<td>• Hospitals</td>
<td></td>
</tr>
<tr>
<td>• Clinics</td>
<td></td>
</tr>
<tr>
<td>• Physician offices, and other practitioners’ offices</td>
<td></td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth: DSMT Educator Working From Home (1)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not allowed</td>
<td>• Allow practitioners to render their telehealth services from their homes</td>
</tr>
</tbody>
</table>


### Medicare DSMT Telehealth: DSMT Educator Working From Home (2)

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
</table>
| • Not allowed           | o Providers do NOT have to add their “home” to their Medicare enrollment file$^1$  
                          | o Bill Medicare under your regular practice location when doing DSMT from “home” |

### Medicare DSMT Telehealth: **DSMT Educator Working From Home (2)**

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>o If DSMT program has AADE accreditation, go online to DEAP Dashboard and add “home” as an AADE accreditation community site (free)</td>
<td></td>
</tr>
<tr>
<td>o If program has ADA recognition, go to ADA ERP Portal and add “home” as expansion site</td>
<td></td>
</tr>
<tr>
<td>o Continue to bill as usual</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare DSMT Telehealth: **Beneficiary Out-Of-Pocket Payments**

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beneficiary’s DSMT co-pay is 20% of Medicare’s geographically adjusted reimbursement rate for current calendar year</td>
<td>• DSMT providers have flexibility to reduce or waive beneficiary DSMT co-pays</td>
</tr>
</tbody>
</table>
### Medicare DSMT Telehealth

#### State Licensure Requirements for Rendering (R) and Billing (B) Providers

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• R and B provider must be licensed or certified:</td>
<td>• DSMT telehealth providers subject to</td>
</tr>
<tr>
<td>o In state where <strong>provider furnishes</strong></td>
<td>telehealth <strong>state</strong> laws</td>
</tr>
<tr>
<td>telehealth DSMT</td>
<td>• Licensure requirements vary in states</td>
</tr>
<tr>
<td>and</td>
<td>o Certain states have waived licensure</td>
</tr>
<tr>
<td>o In state where <strong>beneficiary receives</strong></td>
<td>requirements during COVID-19</td>
</tr>
<tr>
<td>telehealth DSMT</td>
<td>o Check with your own:</td>
</tr>
<tr>
<td></td>
<td>▪ State’s licensure board</td>
</tr>
<tr>
<td></td>
<td>▪ Medicare Administrative Contractor</td>
</tr>
</tbody>
</table>

#### Medicare DSMT Telehealth

### Distant Site Practitioners: Who is Allowed to Furnish DSMT Telehealth

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “......Medicare telehealth services, including individual DSMT services furnished as a telehealth service, can only be furnished by a:</td>
<td></td>
</tr>
<tr>
<td>o Licensed physician assistant (PA)</td>
<td>• Same as Original Rules</td>
</tr>
<tr>
<td>o Nurse practitioner (NP)</td>
<td></td>
</tr>
<tr>
<td>o Clinical nurse specialist (CNS)</td>
<td></td>
</tr>
<tr>
<td>o Certified nurse-midwife (CNM)</td>
<td></td>
</tr>
<tr>
<td>o Clinical psychologist</td>
<td></td>
</tr>
<tr>
<td>o Clinical social worker, or</td>
<td></td>
</tr>
<tr>
<td>o Registered dietitian or nutrition professional.”</td>
<td></td>
</tr>
</tbody>
</table>

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)
### Medicare DSMT Telehealth: *Originating Site Can Claim Facility Fee IF Pt is In-Person*

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bill procedure code Q3014 (telehealth originating site facility fee) + DSMT procedure code</td>
<td>• If beneficiary <em>does</em> receive DSMT telehealth <em>in-person</em> at originating site during COVID-19 emergency, then <strong>ORIGINAL RULES</strong> apply</td>
</tr>
<tr>
<td>• Report Type of Service is &quot;9&quot; on claim (other items and services)</td>
<td></td>
</tr>
<tr>
<td>• Report telehealth place of service (POS) code is &quot;02&quot; on 1500 professional claim form</td>
<td></td>
</tr>
<tr>
<td>o Location where health services and health related services are provided or received, through telecommunication technology</td>
<td></td>
</tr>
<tr>
<td>• Fee is a Part B payment</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare DSMT Telehealth: *Originating Site Can Claim Facility Fee IF Pt is In-Person*

<table>
<thead>
<tr>
<th>ORIGINAL MEDICARE RULES</th>
<th>COVID-19 WAIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>2020</strong> Medicare telehealth facility fee:</td>
<td>• Same as Original Rules if medical entity is acting as originating site</td>
</tr>
<tr>
<td>o Payment is 80% of the lesser of the actual charge, or $26.65</td>
<td></td>
</tr>
<tr>
<td>o FQHCs and RHCs use <strong>revenue code “780”</strong> on UB-04 claim form</td>
<td></td>
</tr>
<tr>
<td>▪ To bill procedure code Q3014 and revenue code 780 on separate lines on claim form</td>
<td></td>
</tr>
<tr>
<td>o Beneficiary responsible for unmet deductible amount and 20% co-pay</td>
<td></td>
</tr>
</tbody>
</table>
Medicare Benefits Not Defined as Telehealth

• NOT defined as telehealth:
  o Phone call codes: 99441 - 99443, 98966 – 96968
  o On-line digital evaluation and management codes: 99421 – 99423 and G2061 – G2063
  o Virtual check codes: G2010, G2012
  o Remote patient monitoring codes
    ▪ Do not use POS 02 or modifier 95 with these

Medicare Provider Enrollment (1)

COVID-19 WAIVERS

• Medicare temporarily waived Medicare/Medicaid’s requirements that qualified practitioners be licensed in state where they are providing services for whom following conditions met:
  o Must be enrolled as such in Medicare program
  o Must possess valid license to practice in State of Medicare enrollment
  o Is furnishing services – whether in-person or via telehealth – in State in which emergency is occurring in order to contribute to relief efforts in his/her professional capacity, and
  o Not excluded from practice in State/other State that is part of COVID emergency

• State requirements will still apply

**COVID-19 WAIVERS**

- CMS provides following flexibilities for provider enrollment:
  - Waive certain screening requirements
  - Postpone all revalidation actions
  - Allow licensed physicians/other practitioners to bill Medicare for services provided outside of their state of enrollment
  - Expedite any pending or new applications from providers
  - Allow practitioners to render telehealth services from their home w/o reporting their home address on Medicare enrollment while continuing to bill from currently enrolled location
  - Allow opted-out practitioners to terminate opt-out status early and enroll in Medicare to provide care to more patients

---

**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 Jan., 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**

---

6 Ways to Determine if a Beneficiary Had Any Initial DSMT in the 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
Parting, Warmest Thoughts

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!

I can do this!

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

Really?
EFFECT OF INFORMATION OVERLOAD

MARY ANN WILL NOW ENTERTAIN YOUR QUESTIONS
Meet Your Appendix

CHANGES IN BILLABLE ICD-10 CODES FOR MEDICARE DSMT AND MNT:
EFFECTIVE 2016
CMS’ CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR DSMT

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

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

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

  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:


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

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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:

  E11.3593, 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
CMS’ CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 180.1 FOR CHRONIC KIDNEY DISEASE MNT

• Remove ICD-10 dx codes effective 1/1/17:

N18.6 and N18.9

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

• ICD-10 dx codes that align with Medicare non-dialysis chronic disease MNT requirement of GFR 13 - 50 (inclusive) for beneficiary eligibility:

  o N18.3
    ▪ IIIA – GFR 45-59
    ▪ IIIB – GFR 30-44
  o N18.4
    ▪ GFR 15-29
  o N18.5
    ▪ GFR <15 w/o dialysis treatment
CMS’ CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

• Remove ICD-10 dx codes effective 1/1/17:

E08.21, E08.311, E08.319, E08.36, E08.39, E08.65
E09.21, E09.311, E09.319, E09.36, E09.39
E10.311, E10.319, E10.36, E10.39
E11.311, E11.319, E11.36, E11.39
CMS' CR9861 MADE ADJUSTMENTS TO CMS NATIONAL COVERAGE DETERMINATION (NCD) 40.1 FOR MNT

• ICD-10 dx codes expire and end-dated effective 9/30/2016:
  
  E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359

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

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

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

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

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


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

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

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

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:

DSMT and diabetes-related services and supplies

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

Laws override any coverage limitations in health plan

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


REJECTED vs. DENIED CLAIMS

REJECTED CLAIM

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

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

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

DENIED CLAIM

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

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

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 submit denied claim to supplemental insurance
  - Some private payers may require Medicare denial *first* before considering to pay

• **GY:** Added to CPT procedure code to obtain denial

---

**FAQ: Is it financially worthwhile to furnish individual DSMT in FQHC?**

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

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

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

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

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

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

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

---

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

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

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

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

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

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, CON’T.

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

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

Category = first 3 characters = Family Code/General disease code. **NOT BILLABLE** when codes with more specificity (more characters) exist!

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

Please tell me there are no more characters in these codes!
ICD-10 DIAGNOSES CODES FOR DIABETES MNT--DSMT

- Category = **first 3 characters** = family code/general disease code
- **NOT BILLABLE** when codes exist with **GREATER SPECIFICITY** (more characters)
  - Examples of codes that are NOT billable:
    - E10 = T1 diabetes mellitus
    - E11 = T2 diabetes mellitus

**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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.4</td>
<td>T2 DM with neurological complications</td>
</tr>
<tr>
<td>E11.40</td>
<td>T2 DM with diabetic neuropathy, unspecified</td>
</tr>
<tr>
<td>E11.41</td>
<td>T2 DM with diabetic mono-neuropathy</td>
</tr>
<tr>
<td>E11.42</td>
<td>T2 DM with diabetic poly-neuropathy</td>
</tr>
<tr>
<td>E11.43</td>
<td>T2 DM with diabetic autonomic (poly) neuropathy</td>
</tr>
<tr>
<td>E11.44</td>
<td>T2 DM with diabetic amyotrophy</td>
</tr>
<tr>
<td>E11.49</td>
<td>T2 DM with other diabetic neurological complication</td>
</tr>
<tr>
<td>E11.5</td>
<td>T2 DM with circulatory complications</td>
</tr>
<tr>
<td>E11.51</td>
<td>Type 2 DM with PERIPHERAL ANGIOPATHY without GANGRENE</td>
</tr>
<tr>
<td>E11.52</td>
<td>Type 2 DM with PERIPHERAL ANGIOPATH with GANGRENE</td>
</tr>
<tr>
<td>E11.59</td>
<td>Type 2 DM with OTHER CIRCULATORY COMPLICATION</td>
</tr>
</tbody>
</table>
ICD-10 DIAGNOSES CODES FOR DIABETES MNT--DSMT

NOT BILLABLE as needs GREATER SPECIFICITY:

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

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

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

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

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

<table>
<thead>
<tr>
<th>Chapter (Character)</th>
<th>Chapter Title and (3 Character Category = Rubric)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. (A and B)</td>
<td>Certain infectious and parasitic diseases. (A00-B99)</td>
</tr>
<tr>
<td>II. (C00 to D48)</td>
<td>Neoplasms. (C00-D48)</td>
</tr>
<tr>
<td>III. (D50 to D89)</td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. (D50-D89)</td>
</tr>
<tr>
<td>IV. (E)</td>
<td>Endocrine, nutritional and metabolic diseases. (E00-E90)</td>
</tr>
<tr>
<td>V. (F)</td>
<td>Mental and behavioral disorders. (F01-F99)</td>
</tr>
</tbody>
</table>
ICD-10 STRUCTURE AND TERMINOLOGY

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

<table>
<thead>
<tr>
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<th>Chapter Title and (3 Character Category = Rubric) NOT BILLABLE when codes exist with greater specificity!</th>
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<tbody>
<tr>
<td>VI. (G)</td>
<td>Diseases of nervous system. (G00-G99)</td>
</tr>
<tr>
<td>VII. (H00 to H59)</td>
<td>Diseases of eye and adnexa. (H00 – H59)</td>
</tr>
<tr>
<td>VIII. (H60 to H95)</td>
<td>Diseases of ear and mastoid process. (H60 – H95)</td>
</tr>
<tr>
<td>IX. (I)</td>
<td>Diseases of circulatory system. (I00 – I99)</td>
</tr>
<tr>
<td>X. (J)</td>
<td>Diseases of respiratory system. (J00 – J99)</td>
</tr>
</tbody>
</table>

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)
Sequencing of Codes on MR and Claims

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

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

• *Code first* the etiology/underlying condition:

  Example:

  **E08 Diabetes mellitus due to underlying condition**

  *Code first* the underlying condition, such as:

  • Congenital rubella (P35.0)
  • 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 1\textsuperscript{st}, 2\textsuperscript{nd}):

- Sometimes instructional note says “\textit{code first}” note and \textit{"use additional code"}

- Instructional notes do indicate how to sequence codes:
  - Code \textbf{first} the underlying \textit{etiology}
  - Code \textbf{second} the \textit{additional code(s)}

\textbf{Example:}

\textbf{E09 Drug or chemical induced diabetes mellitus}

\textit{Code first} (T36-T65) poisoning due to drug or toxin

\textit{Use additional code} to identify drug (T36 – T50)

\textit{Use additional code} to identify any insulin use (Z79.4)

---

**ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY**

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

\textbf{Examples of diabetes combination codes:}

\textbf{E11.51} = T2 DM w/peripheral angiopathy w/o gangrene

\textbf{E11.52} = T2 DM w/peripheral angiopathy w/ gangrene

\textbf{E11.59} = T2 DM w/ other circulatory complication
Z79.4 = Long term (current) use of insulin.  
If pt on insulin, must report Z79.4 with all codes from Category BLOCKS below:

- **E08** = DM Due to Underlying Conditions*  
  Code **first** underlying condition
- **E09** = Drug or Chemical Induced DM*  
  Code **first** (T36 - T65) to identify the drug or chemical
- **O24** = Diabetes in Pregnancy, Childbirth and the Puerperium
  - Use “**Additional Code**” from category **E10** or **E11** to identify manifestations
  - **Note:** “O” Category codes trump any other code

*Types of secondary diabetes mellitus

---

ICD-10 DIAGNOSES STRUCTURE AND TERMINOLOGY

Example of **combination code**:

- **T2 DM pt on insulin** is seen for **stage 3 CKD**:
  
  How is this coded and sequenced on claim?

  - **E11.22** = **T2 DM** with **diabetic chronic kidney disease**
  - **N18.3** = **Chronic kidney disease, stage 3 (moderate)**
  - **Z79.4** = **Long term (current) use of insulin**
Examples of combination code:

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

Examples of combination codes:

- T1 DM seen for severe non-proliferative diabetic retinopathy with macular edema

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

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 Contraction, joint
Aberrant (congenital) — see also Malposition, congenital
- adrenal gland Q89.1
- artery (peripheral) Q27.8
- basal 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 (Z88.-)
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

<table>
<thead>
<tr>
<th><strong>Z68.30</strong> BMI 30.0-30.9, adult</th>
<th><strong>Z68.38</strong> BMI 38.0-38.9, adult</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Z68.32</strong> BMI 32.0-32.9, adult</td>
<td><strong>Z68.39</strong> BMI 39.0-39.9, adult</td>
</tr>
<tr>
<td><strong>Z68.33</strong> BMI 33.0-33.9, adult</td>
<td><strong>Z68.41</strong> BMI 40.0-44.9, adult</td>
</tr>
<tr>
<td><strong>Z68.34</strong> BMI 34.0-34.9, adult</td>
<td><strong>Z68.42</strong> BMI 45.0-49.9, adult</td>
</tr>
<tr>
<td><strong>Z68.35</strong> BMI 35.0-35.9, adult</td>
<td><strong>Z68-43</strong> BMI 50.0-59.9, adult</td>
</tr>
<tr>
<td><strong>Z68.36</strong> BMI 36.0-36.9, adult</td>
<td><strong>Z68.44</strong> BMI 60.0-69.9, adult</td>
</tr>
<tr>
<td><strong>Z68.37</strong> BMI 37.0-37.9, adult</td>
<td><strong>Z68.45</strong> BMI &gt; 70.0, adult</td>
</tr>
</tbody>
</table>
**ICD-10-CM Index** entries contain back-references to **Z71.3**:

- Admission (for) - see also Encounter (for)
  - dietary surveillance and counseling Z71.3
- Counseling
  - see also Counseling dietary Z71.3
- Allergy, allergic (reaction) (to) T78.40, 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
  o allergy (food) Z71.3
  o colitis Z71.3
  o diabetes mellitus Z71.3
  o food allergy or intolerance Z71.3
  o gastritis Z71.3
  o hypercholesterolemia Z71.3
  o hypoglycemia Z71.3
  o intolerance (food) Z71.3
  o obesity Z71.3
  o specified NEC Z71.3
• Surveillance (of) (for) - see also Observation
  o dietary Z71.3

ICD-10 Look Up Tools

• http://www.icd10data.com (below is what you see; click on icon boxed in red to determine if code is “billable”)

  ▶ 2017 ICD-10-CM Code Z71.3
  Persons encountering health services for other counseling and medical advice, not elsewhere classified

• http://icd10coded.com/

• AAPC Website

• CMS Website on ICD-10:
  • https://implementicd10.noblis.org/
ICD-10 Resources

• www.AHIMA.org
• 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:
  o 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:

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 amd 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 MNT-DSMT REIMBURSEMENT SUCCESS**

1. Identify the area **healthcare insurers** you will bill:

   - Medicare Part B
   - Medicaid in your state
   - Private healthcare plans (e.g., Blue Cross, Blue Shield, Aetna, etc.)
2. Know that each insurer has **multiple health plans**.

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

---

**Example of “categories” of health plans:**

- **Exclusive Provider Organization (EPO) Plans**
  
  o Subscriber must use **in-network** doctors, specialists or hospitals for coverage, except in emergency.

- **Health Maintenance Organization (HMO) Plans**

  o Coverage usually limited to care from doctors who work for/contract with HMO
  
  o Generally **out-of-network** care **not** covered except in emergency
  
  o For coverage, subscriber may have to live in service area
  
  o Integrated care, prevention and wellness provided.
• **Point of Service (POS) Plans**
  
  o Subscriber pays **less** if uses plan’s **in-network** doctors, hospitals and other health care providers

  o Referral is required from primary care doctor in order to see specialist and not pay additional cost

• **Preferred Provider Organization (PPO) Plans**
  
  o Subscriber pays **less** if uses plan’s **in-network** doctors, hospitals and other health care providers

  o No referral required from primary care doctor to use **outside of network** doctors, hospitals and providers; does **not** pay additional cost to do so
3. Identify IF MNT--DSMT is covered by the health plans

There are 6 ways to identify coverage!

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

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

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

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

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
<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>
</tbody>
</table>

**PROCEDURES CODES THAT ALIGN WITH DSMT**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960</td>
<td>Individual, initial or f/up face-to-face education, training &amp; self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.</td>
</tr>
<tr>
<td>98961</td>
<td>Group of 2 - 4 pts, initial or f/up, each 30 min.</td>
</tr>
<tr>
<td>98962</td>
<td>Group of 5 - 8 pts, initial or f/up, each 30 min.</td>
</tr>
</tbody>
</table>
### PROCEDURES CODES THAT ALIGN WITH DSMT

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

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### PROCEDURES CODES THAT ALIGN WITH DSMT

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<tr>
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</tr>
</tbody>
</table>

- For pts with established illnesses/diseases or to delay co-morbidities
- Physician/NPP must Rx education and training
- Non-physician's qualifications and program's contents must be consistent with guidelines or standards established or recognized by physician society, non-physician HCP society/association, or other appropriate source
10 STEPS TO INCREASE PRIVATE PAYER AND MEDICAID MNT-DSMT REIMBURSEMENT SUCCESS

5. If any codes covered, identify frequency (hours, visits) and time frames (calendar or rolling year) for initial and follow-up 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

9. If covered, identify the approved places of service and patient eligibility (e.g., FPG ≥126 mg on 2 tests)

10. Know coding and billing rules of thumb

“Homework? Me?” YES!
REFERENCES

1. Medicare Coverage Policy Decision: Duration and Frequency of the Medical Nutrition Therapy (MNT) Benefit (#CAG-00097N); www.cms.gov/coverage/8b3-ggg.asp


3. CMS Program Memorandum, Additional Clarification for MNT Services for Beneficiaries with Diabetes or Renal Disease. Published May 1, 2001; www.cms.hhs.gov/manuals/pm_trans/AB02059.pdf

4. CMS Medicare Claims Processing Manual, Chapter 12, Section 190, Rev. 2282, 08-26-11 (Medicare telehealth services and regulations for providing MNT or DSMT via telehealth).


7. AADE Reimbursement Primer, American Association of Diabetes Educators, 2000; www.aadenet.org


9. Medical Nutrition Therapy Works tool kit, revised 2010, Academy of Nutrition and Dietetics


11. Medicare MNT Provider, 2010 and 2011 monthly newsletters (provide continuous updates of the Medicare program and its requirements, guidelines for practice, billing, compliance, etc.), Academy of Nutrition and Dietetics

12. CMS Program Memorandum, MNT Services for Beneficiaries with Diabetes or Renal Disease. Published August 7, 2001; www.cms.hhs.gov/manuals/pm_trans/B0148.pdf, Program Transmittals, AB-01-48

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20. Web sites:
   • Centers for Medicare and Medicaid Services (formerly HCFA): www.cms.gov
   • Academy of Nutrition and Dietetics: www.eatright.org/mnt
   • American Diabetes Association: www.diabetes.org
   • American Association of Diabetes Educators: www.aadenet.org
REFERENCES, CONT.


23. Diabetes Self-Management Education/Training Reimbursement Toolkit, 2013, Delmarva Foundation for Medical Care, the Disparities National Coordinating Center, under contract with the Center, for CMS