Learning Objectives

1. Name the 2 distinct components of a typical 2 hour SMA.
2. List 3 reasons (of many) for why to have diabetes SMAs.
3. Name at least 15 of the 35 essential elements and benefits of SMAs.
4. List 8 of the 19 health care benefits furnished by a behaviorist/educator (e.g., RD, pharmacist, RN, CDE) that can potentially be rendered and billed to insurers for the behavior change/education intervention of a SMA.
5. Explain the response received from CMS regarding the billing by providers for their medical visits in a SMA.

Abbreviations and Condensed Terms Used in Slides

<table>
<thead>
<tr>
<th>SMA</th>
<th>Shared medical appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPs</td>
<td>Private payers</td>
</tr>
<tr>
<td>MCR</td>
<td>Medicare</td>
</tr>
<tr>
<td>MCD</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Mid-Levels</td>
<td>Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and Management (name of procedure codes used by providers)</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedure Terminology</td>
</tr>
<tr>
<td>ACA</td>
<td>Accountable Care Act</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective Payment System (new in MCR for FQHCs)</td>
</tr>
<tr>
<td>MINT</td>
<td>Medical nutrition therapy</td>
</tr>
<tr>
<td>DSME/T</td>
<td>Diabetes self-management education/training</td>
</tr>
<tr>
<td>HBI</td>
<td>Health behavior intervention</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services (governing body of MCR)</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor (processes Part A &amp; B claims both)</td>
</tr>
<tr>
<td>IPPE, AWV</td>
<td>Initial Preventive Physical Exam, Annual Wellness Visit (new MDC benefits)</td>
</tr>
</tbody>
</table>

IN ~2 HOURS, ~10 - 12 OUTPATIENTS PARTICIPATE IN INDIVIDUAL FOLLOW-UP MEDICAL VISITS BY PROVIDER plus LIFESTYLE/BEHAVIOR CHANGE EDUCATION BY EDUCATOR in INTERACTIVE GROUP SETTING
2 Distinct Components of SMA

**Component 1:**
Provider’s individual follow-up evaluation and management (E/M) medical visits within the group

**Component 2:**
Educator’s lifestyle/behavior change education intervention (separate from provider’s visits) — examples:
- 30 minutes of:
  - Group DSMT or group MNT (FQHCs & RHCs have unique reimbursement rules related DSMT/MNT)
  - Group intensive behavior counseling for obesity

Why Have SMAs? Many Good Reasons!

**High patient satisfaction due to:**
- Provision of secure but interactive setting in which pts:
  - Can actively participate in own care
  - Pts learning from each other and supporting each other — VERY powerful behavior change tools
  - Have more time with physician at medical visit

**High educator satisfaction due to:**
- Great opportunity to furnish pts with behavior change/education interventions such as diabetes self-management education (DSMT) or medical nutrition therapy (MNT)

### Why Have SMAs? Many Good Reasons!

- **Improve patient outcomes:**
  - Knowledge
  - Behavior
  - Clinical/health
  - Quality of life
  - Cost-savings
  - Satisfaction

- **Pt outcomes lead to decreased costly medical services:**
  - ER visits, inpt hospitalizations, therapies, Rx meds, etc.

- **Improved process and financial outcomes:**
  - Save time and resources while increasing revenue
    - Provide makes more $ in far less time

<table>
<thead>
<tr>
<th>2 Hour SMA: 1:1 E/M Visits and DSME in Group</th>
<th>Traditional 1:1 E/M Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aver. # pts seen</td>
<td>10</td>
</tr>
<tr>
<td>Total time spent</td>
<td>2 hrs; but 1 hr for provider</td>
</tr>
<tr>
<td>Lifestyle/behavior education code billed</td>
<td>1 x 10 pts @ ~ $20/pt</td>
</tr>
<tr>
<td># individual E/M visits billed by physician/NPP and typical level of</td>
<td>10 x code 99214** @ ~ $100/pt</td>
</tr>
<tr>
<td>Average insurance reimbursement</td>
<td>DSMT: $200/1 hr E/M: $1000/1 hr</td>
</tr>
<tr>
<td>Total insurance reimbursement revenue</td>
<td>Lifestyle + E/M: $1200/2 hr E/M only: $1000/1 hr</td>
</tr>
</tbody>
</table>

DO THE MATH! WIN-WIN FOR PROVIDERS + EDUCATORS


*From SMA OP at Cleveland Clinic*
http://www.clevelandclinicmeded.com/live/courses/smachanginghealth/overview.asp
**ESSENTIAL ELEMENTS and BENEFITS**

**S**elect a homogenous OP group...examples:
- All adult OPs with type 2 diabetes
- All adult OPs with type 1 diabetes
- All adolescents (12 - 18 years old) with type 1 diabetes

*Use patient registry to select OP group that share same dx and characteristics*

**INVITATIONS**

**H**ave secretaries send invitation letters to select OP group to attend in SMA:
- Frequency before 1st SMA:
  - ~ 2 months before
  - Again, 1 month before
  - Again, 1 week before
- Identify as ‘enhancement’ to regular PCP visits to increase frequency of highly customized medical care and self-management education

**ESSENTIAL ELEMENTS and BENEFITS**

**A**lways have pts sign confidentiality agreement and medical waiver at each SMA

**A**lso remind pts about confidentiality rules at start of each SMA

**CONFIDENTIALITY**

**ESSENTIAL ELEMENTS and BENEFITS**

**R**ecommended way to determine number of pts to be in SMA group:
- Multiply by 4 the number of pts that provider sees in 1 hour in traditional appointments (in exam room)....example:
  - Provider see 3 pts in 1 hour in traditional appointments
  - 3 pts x 4 = 12 pts in SMA

**ESSENTIAL ELEMENTS and BENEFITS**

**E**valuation and management (E&M) individual follow-up visits are furnished by provider in group SMA

**INDIVIDUAL FOLLOW-UP E&M VISITS**

**ESSENTIAL ELEMENTS and BENEFITS**

**D**o allow pts to visit with provider 1:1 in private room, if so requested by patient or by provider

**1:1 PRIVATE VISITS ALLOWED BY REQUEST**
### Essential Elements and Benefits

#### Many benefits derived for patients, staff, provider, and educator:

**Patients** feel they receive enhanced:
- Support and relevant self-care strategies from each other
- Care from healthcare team
- Time with provider (entire hour)

**Patients** have improved outcomes, including satisfaction, per numerous studies

#### Many Patient Benefits

#### Many benefits are derived for staff

- **Staff** has opportunity to form multi-disciplinary team which:
  - Leads to enhanced communication and collaboration, which
  - Leads to enhanced knowledge and skills, which
  - Leads to improved patient care, which
  - Leads to enhanced self-efficacy and job satisfaction

#### Many Staff Benefits

#### Many benefits are derived for provider

- **Provider** can work smarter...not harder!
  - Can furnish 4 times as many individual follow-up E&M visits in SMA than in 1 hour of traditional exam room visits, which
  - Thus, can earn 4x as much revenue in same amount of time, while enhancing quality of care and patient outcomes
  - May then earn incentive, bonus revenue in pay-for-quality reimbursement models

#### Many Provider Benefits

#### Many benefits are derived for educator:

- **Educator** has:
  - "Captive" (built-in) group of patients for lifestyle/behavior change education class
  - Several different group* procedure codes insurer may cover...examples:
    - MNT or DSME/T
    - Pt education & self-management training
    - See more codes in this deck
  - *But group MNT and DSMT are NOT separately billable for additional payment on claim by Medicare in FQHCs and RHCs

#### Many Educator Benefits

#### Educator furnishes group lifestyle behavior change education to patients after provider completes E&M visits

- Educator portion of SMA typically lasts 30 minutes
- Provider typically not present as leaves after E&M visits

**Tip:** Encourage pts to select own topics, to participate fully in discussion and to offer self-care strategies that work well.

#### Lifestyle Behavior Change Education

#### Documentation of E&M visits

Documentation of provider’s individual follow-up E&M visits is best done by scribe (e.g., MA) simultaneous to provider’s visits (consider template progress note)

- Saves time
- Improves efficiency
- Improves accuracy and thoroughness of documentation

- All above leads to improved patient care
- Thorough documentation is essential for reimbursement

#### Documentation of E&M Visits
### Individual Follow-Up E&M Visits

- Yes, individual follow-up E&M visits are billable to insurers when furnished in group format.
- Medicare has statement indicating above.

*Always best to verify billing codes with commercial payers and state Medicaid plans.*

### Champion

- Champion for your SMA concept to be identified (as well as other stakeholders) approval from administration to be obtained.
  - Recommended that champion is physician.
    - Can leverage support at various levels within facility or practice.
    - Has solid understanding of target population (e.g., diabetes) and care challenges.
  - Other stakeholders:
    - Staff (healthcare team).
    - Patients.
    - Patients’ family and caregivers.

### Allow Patients to Bring to SMA:

- Caregivers.
- Significant other who helps with patient care:
  - Spouse.
  - Parent.
  - Sibling.
  - Other relative.
  - Neighbor.
  - Adult children.

### Lifestyle/Behavior Change Education

- Procedure code billed by:
  - Educator, or
  - Facility in which SMA furnished...examples:
    - Provider’s practice, hospital, clinic.

*But group MNT and DSMT are NOT separately billable for additional payment on claim by Medicare in FQHCs and RHCs.*

### Patient Satisfaction

- Patient satisfaction with SMAs is very high, per numerous studies.
  - SMAs turn ‘tension of the moment’ into fun-filled experience.
  - High satisfaction leads to higher utilization of SMAs by patients.
**ESSENTIAL ELEMENTS and BENEFITS**

**Planning in advance**
- Every detail of SMA by entire healthcare team is key to success.

Seasoned SMA teams highly recommend practicing the “flow” of an SMA in real time before first live event to iron out wrinkles and unexpected issues.

**Obtain room**
- Room for SMA that is large enough to comfortably sit 10 – 12 pts in circle or semi-circle, along with moderator, provider, educator, nurse, scribe, etc.

**Interaction by patients**
- Interaction in SMA is key.
  - Keep patients talking with one another
  - Questions/interaction to be aimed at facilitating/promoting peer interaction
  - Sometimes you have to work harder to get patients interacting
    - Avoid falling into lecturing style
    - Ask questions, ask for stories, rephrase question with examples
    - You have to fill the silence with information!

**Never lecture, lead, stand**
- Sit with patients in semi-circle or at round table to promote:
  - Provider-patient, and educator-patient partnership
  - Relationship building
  - Open communication
  - Camaraderie
  - Sharing
  - Group problem solving

**Time frame of SMA**
- Typically 2 hours and includes 5 basic parts and 1 optional part:
  1. Private triage in separate exam room (either before SMA starts or during SMA) by RN
  2. Moderator (RN) part: introduction, housekeeping, review of ‘rules of the road’ (confidentiality, completion of forms, etc.)
  3. Provider part
  4. Educator part
  5. Moderator (RN) part: Wrap-up; next SMA date

**Roles of each team member**

- RN
- Moderator (may be RN, educator)
- Provider (MD, DO, NP, PA, CNS)
- Scribe/dedicated documenter
  - May be MA, RN, LPN, educator
- Educator
ESSENTIAL ELEMENTS and BENEFITS

Establish detailed agenda for exactly what will occur and who will be responsible for each step:

- Prior to start of SMA
  - 1 or 2 days before SMA
  - Day of SMA
  - When pts start arriving
- During SMA
- After SMA

ESTABLISH AGENDA

NUMBER of SMAs in TIME PERIOD

Number of SMAs is approximately 1 per every 2 – 3 months as “supplement” to provider’s traditional visits in exam room...not replacement

Tip: Be aware that billing insurers for large number of provider individual E&M follow-up visits during the year can trigger an audit by insurer.

TAKE PATIENT VITALS INDIVIDUALLY

Take patients’ vitals individually in separate room. Best time is:

- Just before SMA (ask pts to arrive 20 min. before start time), or
- During SMA

TAKE PATIENT VITALS INDIVIDUALLY

MOTIVATIONAL INTERVIEWING

Navigate to motivational interviewing and adult learning tools to increase:

- Learning outcomes
- Behavior change outcomes
- Clinical outcomes
- Quality of life outcomes
- Cost-savings outcomes
- Satisfaction outcomes

WISHING WON'T MAKE IT HAPPEN

Wishing won’t make it happen! Proven process to achieve goals you set for your team consists of 4 steps:

WISHING WON'T MAKE IT HAPPEN

SMAs for OTHER CONDITIONS

Offer SMAs for whole host of:

- Medical conditions
- Behavior conditions (e.g., ADHD)
Insurance Reimbursement Maze: Navigate at your own risk!

Healthcare Insurance Reimbursement Rules Are All About These “C’s”:
- Confusing
- Complicated
- Complex
- Convoluted
- Copious
- Cumbersome
- Constantly Changing

Buckle you seat belts...here we go!

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!

SMA Physician/Mid-Level Billing to PP, MCR, MCD

Physician/mid-level billing in all settings

- Private Payer, Medicare, Medicaid
  - Bill individual established E/M visit code for each OP
    - CPT codes are: 99213, 99214, 99215
    - Select code for each pt that matches level of service provided to pt, and supported by documentation
  - Cannot bill according to counseling time on the clock
  - Some PPs require code modifier TT be appended to E/M code claimed (= individualized services with multiple pts)
  - Medicare does NOT recognize this modifier

SMA Physician/Mid-Level Billing to PP, MCR, MCD

- What does Medicare say?
  - No official payment or coding rules published by Medicare
  - The question of "the most appropriate CPT code to submit when billing for a documented face-to-face evaluation and management service performed in the course of a shared medical appointment, the context of which is educational" was sent to CMS with request for an official response.
  - Request further clarified, "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?"

SMA Physician/Mid-Level Billing to PP, MCR, MCD

- Response from CMS was:
  - "...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary."

- CMS' letter went on to state that any activities of the group (including group counseling activities) should not impact the level of code reported for the individual patient.
Some private payers have instructed physicians to bill office visit (99212 - 99215) based on entire group visit.

For compliance purposes, it is recommend that you ask for these instructions in writing and keep them on file as you would any other advice from a payer.

**SMA Physician/Mid-Level Billing to PP, MCR, MCD**

- Some private payers have instructed physicians to bill office visit (99212 - 99215) based on entire group visit.
- For compliance purposes, it is recommend that you ask for these instructions in writing and keep them on file as you would any other advice from a payer.

**SMA Behaviorist Billing to MCR: NOT in FQHCs**

**Behaviorist billing for lifestyle/behavior education**

- **FIRST**: Most diabetes SMAs include 2nd separate ‘lifestyle change’ component that occurs after physician E/M visits:
  - Medical Nutrition Therapy (MNT)
  - Diabetes Self-Management Education/Training (DSME/T)
  - Health Behavior Intervention (HBI)
  - Other similar interventions with established procedure codes for this type of lifestyle change intervention (see slides in deck for further details)
    - Each healthcare insurance company decides which codes are covered by each of their plans

- **SECOND**: know that some diabetes SMAs:
  - Do NOT always include MNT/DSME/HBI component....but may provide non-billable lifestyle change component; e.g.:
    - Podiatrist gives 30-min. foot care review that is NOT part of certified DSME program
    - Thus, not billable education...and does NOT allow physician to level of E/M code
    - Physician bills only for individual, established pt E/M encounter for each OP in SMA

**SMA Behaviorist Billing: 2 Things to Know Upfront**

**Behaviorist billing for lifestyle/behavior education**

- Information on these SMA Behaviorist Billing do NOT apply to FQHCs and RHCs when billing Medicare for DSMT and MNT, as group DSMT and MNT not separately payable for additional reimbursement on claims in these entities.

- **BILL**: group DSMT code G0109 or group MNT code 97804
  2 ways to reimbursement success on 1500 claim form:
  1. Bill these 2 SMA components on 2 separate claim forms for same beneficiary:
     - Provider E/M visit
     - Group DSMT code or group MNT code
  2. Bill 2 SMA components on 1 claim for same beneficiary, but use 2 different rendering provider NPI numbers for provider E/M visit and group DSMT or group MNT
     - Obtain NPI number for certified DSMT program

- My mother taught me about the science of Osmosis…

"Shut your mouth and eat your supper!"
Behaviorist billing for lifestyle/behavior education

- Private payers
  - Identify which lifestyle/behavior education benefits are covered by private payers’ various health plans
  - These will be the benefits to be billed to private payers

<table>
<thead>
<tr>
<th>SMA Behaviorist Billing: To PPs, HOW TO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behaviorist billing for lifestyle/behavior education</strong></td>
</tr>
<tr>
<td><strong>• Private payers</strong></td>
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<thead>
<tr>
<th>SMA Behaviorist Billing: To PPs, HOW TO</th>
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</thead>
<tbody>
<tr>
<td><strong>Lifestyle/behavior education benefits</strong></td>
</tr>
<tr>
<td>10. Diabetes Outpatient Self-Management Training</td>
</tr>
<tr>
<td>11. Diabetic Management Program, Follow-Up Visit to Non-MD Provider</td>
</tr>
<tr>
<td>12. Diabetic Management Program, Follow-Up Visit to MD Provider</td>
</tr>
<tr>
<td>13. Diabetic Management Program, Nurse Visit</td>
</tr>
<tr>
<td>14. Diabetic Management Program, Dietician Visit</td>
</tr>
<tr>
<td>15. Diabetic Management Program, Group</td>
</tr>
</tbody>
</table>

How to Identify IF Benefits Covered by Health Plans

- How? 6 possible ways:
  1. Review all of your providers’ in-network provider contracts
  2. Contact insurer’s Provider Relations Dept. by phone, citing in-network providers’ contract numbers, and ask about coverage using:
     - Names of benefits in this slide deck, and/or
     - Procedure codes of benefits

How to Identify IF Benefits Covered by Health Plans

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

Lifestyle/behavior education benefits

1. Medical Nutrition Therapy
2. Behavioral Therapy for Obesity
3. Behavioral Therapy for Cardiovascular Disease
4. Education and Training for Patient Self-Management
5. Weight Management Classes, Non-Physician Provider
6. Nutrition Classes, Non-Physician Provider
7. Nutrition Counseling, Dietitian Visit
8. Preventive Medicine Counseling and/or Risk Factor Reduction
9. Educational Services Rendered to Patients in Group Setting
10. Diabetes Outpatient Self-Management Training
11. Diabetic Management Program, Follow-Up Visit to Non-MD Provider
12. Diabetic Management Program, Follow-Up Visit to MD Provider
13. Diabetic Management Program, Nurse Visit
14. Diabetic Management Program, Dietician Visit
15. Diabetic Management Program, Group
16. Preventive medicine evaluation and management of individual that is age and gender appropriate
17. Health and behavior assessment and intervention
18. Dietary Behavioral Counseling in Primary Care*
   *Is ACA Preventive Service that must be covered by non-grandfathered (new as of 9-23-10) health plans
19. Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in group setting; e.g., prenatal, obesity, or diabetic instructions
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.

---

**Identify IF Benefits are Covered by Health Plans**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>Medical nutrition therapy, initial individual, 15 min.</td>
<td>Medicare Part B benefit</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, follow-up individual, 15 min.</td>
<td></td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or follow-up, group, 30 min.</td>
<td></td>
</tr>
</tbody>
</table>

Private payers: Contact to determine

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**Identify IF Benefits are Covered by Health Plans**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, over 3 hours or follow-up, individual, over 2 hrs, 2nd referral, same year, 15 min.</td>
<td>Medicare Part B benefit</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, over 3 hours or follow-up, group, over 2 hrs, 2nd referral, same year, 30 min.</td>
<td>Private payers: Contact to determine</td>
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</table>

Private payers: Contact to determine

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**Identify IF Benefits are Covered by Health Plans**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0447</td>
<td>Behavioral counseling for obesity, 15 min., individual; aka: Intensive Behavior Therapy for Obesity</td>
<td>Medicare Part B benefit</td>
</tr>
<tr>
<td>G0473</td>
<td>Behavioral counseling for obesity, 30 min., group (2 - 10)</td>
<td>Effective 1-1-15</td>
</tr>
</tbody>
</table>

Private payers: Contact to determine

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**Are You Sure We’re Not Done Yet?**

Picture of Magnetic Swipe Insurance Card Reader:

Keep database of results, and update regularly!
### Identify IF Benefits are Covered by Health Plans

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private payers: Contact to determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960</td>
<td>Education and training for patient self-management by qualified, non-physician health care professional using standardized curriculum, (could include caregiver/family) 30 min.; individual pt</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>98961</td>
<td>Group, 2 - 4 pts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98962</td>
<td>Group, 5 - 8 pts</td>
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</tbody>
</table>

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### Identify IF Benefits are Covered by Health Plans

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<th>Medicare</th>
<th>Private payers: Contact to determine</th>
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</thead>
<tbody>
<tr>
<td>99078</td>
<td>Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) for educational services, group; e.g., • Prenatal • Obesity, or • Diabetic instructions</td>
<td>Not covered</td>
<td>Contact to determine</td>
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</tbody>
</table>

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### Identify IF Benefits are Covered by Health Plans

<table>
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<th>Code</th>
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<th>Medicare</th>
<th>Private payers: Contact to determine</th>
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<tbody>
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<td>G0108</td>
<td>DSMT, individual, initial or follow-up, 30 min.</td>
<td>Part B benefit</td>
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<tr>
<td>G0109</td>
<td>DSMT, group, (2 or more), initial or follow-up, 30 min.</td>
<td></td>
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### Identify IF Benefits are Covered by Health Plans

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>Private payers: Contact to determine</th>
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<tbody>
<tr>
<td>S9140</td>
<td>Diabetic management program, follow-up visit to non-MD provider</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetic management program, follow-up to MD provider</td>
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</tbody>
</table>

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### Identify If Benefits are Covered by Health Plans

<table>
<thead>
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<th>Procedure Code</th>
<th>Description</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9460</td>
<td>Diabetic management program, <strong>nurse visit</strong>, individual, 15 min.</td>
<td><strong>Not covered</strong></td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, <strong>dietician visit</strong>, individual, 15 min.</td>
<td></td>
</tr>
<tr>
<td>S9455</td>
<td>Diabetic management program, <strong>group</strong>, 2 or more, 30 min.</td>
<td></td>
</tr>
</tbody>
</table>

**Private Payers:** Contact to determine

---

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior initial assessment, individual</td>
<td><strong>Not covered</strong></td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment, each 15 min., face-to-face with pt</td>
<td></td>
</tr>
</tbody>
</table>

Created for use by nonphysician providers. May be billed by APNs, clinical psychologists, social workers, and other HCPs; services must be within scope of practice for provider. Used to bill for services provided to pts who do NOT have psychiatric dx, but whose behavioral function impacts health problem.

---

### Intensive Dietary Behavioral Counseling in Primary Care

For patients with:
- Hyperlipidemia
- Risk factors for CVD
- Higher risk of chronic disease
- Diet-related chronic disease

**Affordable Care Act (ACA) mandated “Preventive Service”** that must be covered by non-grandfathered health plans (new plans as of 9-23-10) with no cost sharing by patient.

---

<table>
<thead>
<tr>
<th>Intensive Dietary Behavioral Counseling in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure codes are selected by each insurer.</td>
</tr>
<tr>
<td>Example of typical codes by select plans follow.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Intensive Dietary Behavioral Counseling in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary behavioral counseling can be rendered by:</td>
</tr>
<tr>
<td>- Primary care physicians (PCPs)</td>
</tr>
<tr>
<td>- Non-physician practitioners (NPPs)</td>
</tr>
<tr>
<td>- Referral from PCPs or NPPs to other specialists, such as:</td>
</tr>
<tr>
<td>- RDs and Nutritionists</td>
</tr>
</tbody>
</table>

---

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---

Identify psychological, behavior, emotional, cognitive, social factors important to prevention, treatment or management of physical health problems. If pt has mental health dx, codes not appropriate. Services do not represent preventive medicine counseling and risk factors reduction interventions.
## Identify IF Benefits are Covered by Health Plans

### Behavioral Therapy for Obesity

Plans vary widely in how they cover; examples:
- Telephone counseling with health coach
- Group sessions that offer lifestyle advice
- Referring patients to Weight Watchers™

Affordable Care Act (ACA) mandated “Preventive Service” that must be covered by non-grandfathered health plans (new plans as of 9-23-10) with no cost sharing by patient.

### Blue Cross of Arkansas Preventive Services Coverage Policy

- **Nutrition (Dietary) Counseling, Adults**
  - USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia & other known risk factors for cardiovascular and diet-related chronic disease.Intensive counseling can be delivered by primary care clinicians or by referral to other specialists such as nutritionists or dieticians (Grade B)

### Blue Cross of Arkansas Preventive Services Coverage Policy

- **Obesity in Adults, Screening and Counseling**
  - USPSTF recommends screening all adults for obesity
  - Clinicians should offer or refer patients with BMI of 30 kg/m² or higher to intensive multicomponent behavioral interventions. (Grade B)

### CPT/HCPCS Procedure Codes:

- 97802 – 97803: Medical Nutrition Therapy, individual (not reported by physicians)
- 99401 – 99404: Preventive medicine counseling (15, 30, 45, 65 min.)
- G0108: Diabetes training services
- G0270: Medical nutrition therapy
- S9140: Diabetic management program, follow-up visit to non-MD provider
- S9141: Diabetic management program, follow-up to MD provider
- S9452: Nutrition classes, non-physician provider, per session

### Blue Cross of Arkansas Preventive Services Coverage Policy

- **Primary ICD-10 Codes:**
  - Z71.3: Dietary surveillance and counseling

### Frequency:

- Allowed up to 8 visits a year if medically necessary

### Examples of Health Insurers’ Preventive Services Coverage Policies for These ACA Preventive Services

- **Intensive Dietary Behavioral Counseling in Primary Care**
- **Behavioral Therapy for Obesity**

**Blue Cross of Arkansas**

**Blue Cross Blue Shield of Vermont**

**United Health Care**
Blue Cross of Arkansas Preventive Services Coverage Policy

CPT/HCPCS Procedure Codes:
- 97802 – 97803: Individual Medical Nutrition Therapy
- 97804: Group Medical Nutrition Therapy
- 99401 – 99404: Preventive medicine counseling, individual (15, 30, 45, 60 min. respectively)
- S9452: Nutrition classes, non-physician provider
- S9470: Nutrition counseling, dietitian visit

Frequency: Allowed up to 12 visits per year

1. [www.arkansasbluecross.com/docs/forms/manual/PPACA%20Wellness%20article%20and%20chart%20preventive%20services.pdf](http://www.arkansasbluecross.com/docs/forms/manual/PPACA%20Wellness%20article%20and%20chart%20preventive%20services.pdf)

Blue Cross of Arkansas Preventive Services Coverage Policy

Behavioral Counseling in Primary Care to Promote a Healthy Diet

Frequency: Not specified

Blue Cross of Arkansas Preventive Services Coverage Policy

Behavioral Counseling in Primary Care to Promote a Healthy Diet

Primary ICD-10 Codes:
- For nutrition-related procedure codes:
  - Z71.3 – Dietary surveillance and counseling
- For preventive medicine counseling procedure codes:
  - Any eligible diagnoses

Frequency: Not specified

United Healthcare Preventive Services Coverage Policy

Coding Summary for Providers, Effective January 1, 2015

See Preventive Care Services Coverage Determination Guideline for details.

Behavioral Counseling in Primary Care to Promote a Healthy Diet (No age or gender limit)

CPT/HCPCS Procedure Codes:
- 97802, 97803, 97804, G0270, G0271 – MNT, individual & group
- 99401 – 99404 - Preventive medicine counseling and/or risk factor reduction intervention, individual
- G0446 - Behavioral therapy for CVD, individual
- G0447 - Behavioral counseling for obesity, individual
- G0473 - Behavioral counseling for obesity, group
- 99411 – 99412 - Preventive medicine counseling and/or risk factor reduction intervention, group

United Healthcare Preventive Services Coverage Policy

Screening and Treatment for Obesity in Adults

CPT/HCPCS Procedure Codes:
- 97802, 97803, 97804 - MNT, individual & group
- 99401 – 99404: Preventive medicine counseling and/or risk factor reduction intervention, individual
- G0446: Behavioral therapy for CVD, individual
- G0447: Behavioral counseling for obesity, individual
- G0473: Behavioral counseling for obesity, group
- 99411 – 99412 - Preventive medicine counseling and/or risk factor reduction intervention, group
### United Healthcare Preventive Services Coverage Policy

**Screening and Treatment for Obesity in Adults**

**CPT/HCPCS Procedure Codes:**
- 99385 – 99387 - Initial comprehensive preventive medicine evaluation and management of individual for age and gender
- 99395 – 99397 - Periodic comprehensive preventive medicine reevaluation and management of an individual including for age and gender

**ICD-10 Diagnosis Codes:**
- Required for 97802 – 97804 and 99401 – 99404:
  - BMI ≥ 30 + obesity dx code

### United Healthcare Preventive Services Coverage Policy

**Screening and Treatment for Obesity in Children, Adolescents**

**CPT/HCPCS Procedure Codes:**
- 97802, 97803, 97804 - MNT, individual and group
- 99401 - 99404 - Preventive medicine counseling and/or risk factor reduction intervention, individual
- G0446 - Intensive behavioral therapy for cardiovascular disease
- G0447 - Behavioral counseling for obesity, individual
- G0473 - Behavioral counseling for obesity, group
- 99411 – 99412 - Preventive medicine counseling and/or risk factor reduction intervention, group

**ICD-10 Diagnosis Codes:**
- Required for 97802 – 97804 and 99401 – 99404:
  - BMI ≥ 30 + obesity dx code

### For Each Covered Benefit, in Each Plan, Identify Procedure Codes, Frequency (Hours, Visits) and Time Frame for Initial and Follow-Up Interventions

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare Part B Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial, individual, 15 min.</td>
<td>3 hrs in initial calendar year. Use code only 1x at 1st visit.</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, individual, follow-up, 15 min.</td>
<td>2 hrs in subsequent calendar years</td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or follow-up, group, 30 min.</td>
<td></td>
</tr>
</tbody>
</table>

*Private payers: Contact to determine*

### For Each Covered Benefit, in Each Plan, Identify Procedure Codes, Frequency (Hours, Visits) and Time Frame for Initial and Follow-Up Interventions

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare Part B Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, over 3 hrs, or follow-up, individual, over 2 hours, 2nd referral, same yr, 15 min.</td>
<td>Has NOT yet set limit on number of extra hours payable</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, over 3 hrs or MNT, follow-up, group, over 2 hrs, 2nd referral, same yr, 30 min.</td>
<td></td>
</tr>
</tbody>
</table>

*Private payers: Contact to determine*
### Behavioral Counseling for Obesity

**G0447**  
Behavioral counseling for obesity, individual, 15 min. aka: Intensive Behavior Therapy for Obesity  
Medicare Part B:  
- 22 visits every 12 months  
- 1x/week during 1st month  
- 2x/month...every other week...months 2-6 (intensive)  
- By end of 6th month, must lose 6.6# to continue months 7-12  
  - If not, wait until 12th month & reassess readiness, criteria  
- Only bill 1 unit of code/visit.  

**G0473**  
Behavioral counseling for obesity, group (2-10), 30 min.  

Private payers: Contact to determine.

### Behavioral Counseling for Obesity - Group

**98960**  
Education and training for patient self-management by qualified, non-physician health care professional using standardized curriculum (could include caregiver or family) 30 min.; individual patient  
Medicare: Not covered

**98961**  
Group, 2 - 4 patients

**98962**  
Group, 5 - 8 patients  
Private payers: Contact to determine

### Weight Management Classes

**S9449**  
Weight management classes, non-physician provider,  
Medicare: Not covered

**S9452**  
Nutrition classes, non-physician provider,

**S9470**  
Nutrition counseling, dietitian visit  
Private payers: Contact to determine

### Preventive Medicine Counseling and/or Risk Factor Reduction Intervention

**99401**  
Preventive medicine counseling and/or risk factor reduction intervention individual, 15 min.  
Medicare: Not covered

**99402**  
Individual, 30 min.

**99403**  
Individual, 45 min.

**99404**  
Individual, 60 min.

**99411**  
Group, 30 min.

**99412**  
Group, 60 min.  
Private payers: Contact to determine

### Diabetic Management Program

**S9140**  
Diabetic management program, follow-up visit to non-MD provider  
Medicare: Not covered

**S9141**  
Diabetic management program, follow-up to MD provider  
Private payers: Contact to determine

### DSMT (Diabetes Self-Management Training)

**G0108**  
DSMT, individual, Initial or follow-up, 30 min.  
Medicare:  
- 10 hrs in initial in first 12 continuous months from 1st visit date  
- 9 hrs to be group; 1 hr may be 1:1  
- 10 hrs may be 1:1 if there is no group class scheduled w/in 2 months of referral date or ordering provider’s documentation of:  
  - Additional insulin training  
  - Special need prohibiting group learning

**G0109**  
DSMT, group (≥2), 30 min.  
2 hrs in each subsequent years after initial. Separate referral required. Group or 1:1 allowed.  
Private payers: contact to determine

**S9140**  
Diabetic management program, follow-up visit to non-MD provider  
Medicare: Not covered

**S9141**  
Diabetic management program, follow-up to MD provider  
Private payers: Contact to determine
### For Each Covered Benefit, in Each Plan, Identify Procedure Codes, Frequency (Hours, Visits) and Time Frame for Initial and Follow-Up Interventions

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9460</td>
<td>Diabetic management program, nurse visit, individual, 15 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, dietician visit, individual, 15 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9455</td>
<td>Diabetic management program, group, 2 or more, 30 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Feeling like this right about now??

- Medicare:
  - 95250: Ambulatory CGM calibration, patient training, sensor removal, download, etc. (Professional CGM limited to 1x per month)

*If 95250 billed on same day as provider visit, add modifier -25 to provider’s E/M code (e.g., 99214-25). Some private payers use codes for personal CGM (pt owns device) while others require DSMT or MNT. May inquire with billers re: furnishing 95250 in group setting to enhance pt outcomes and revenue.

### For Each Covered Benefit, in Each Plan, Identify Procedure Codes, Frequency (Hours, Visits) and Time Frame for Initial and Follow-Up Interventions

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>95250</td>
<td>Ambulatory CGM calibration, patient training, sensor removal, download, etc.</td>
<td>Medicare: Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>95251</td>
<td>CGM: Provider interpretation &amp; report. Can be done remotely.</td>
<td>Same</td>
<td></td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Procedure Codes, Frequency (Hours, Visits) and Time Frame for Initial and Follow-Up Interventions

<table>
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<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior initial assessment, individual</td>
<td>Medicare Part B: Max of 4 units of 96150 billed/calendar yr. Additional time will be denied. If redetermination is requested, documentation showing medical necessity to be submitted.</td>
<td></td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment, each 15 min., face-to-face with pt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96152</td>
<td>Health and behavior intervention Individual, each 15 min., face-to-face</td>
<td>Medicare Part B: Max of 15 hours of 96152 and 96153 allowed per calendar year</td>
<td></td>
</tr>
<tr>
<td>96153</td>
<td>Group (2 or more pts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96154</td>
<td>Family (with pt present)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96155</td>
<td>Family (w/o pt present)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Typically, address range of physical health issues, incl. pt adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to physical illness.
For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B benefit:</th>
<th>Private payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial, individual, 15 min.</td>
<td>• Diabetes code from:</td>
<td>Contact each to determine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o E00-E09: Endocrine, nutritional and metabolic diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o O20-O29: Other maternal disorders r/t pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z00-Z99: Factors influencing health status &amp; contact with health services (insulin use, # wks gestation; dietary surveillance and counseling Z71.3, BMI)</td>
<td></td>
</tr>
<tr>
<td>97803</td>
<td>MNT, follow-up, individual, 15 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97804</td>
<td>MNT, initial or follow-up, group, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, over 3 hours or follow-up, individual, over 2 hours, 2nd referral, same year, 15 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, beyond 3 hours or follow-up, group, over 2 hours, 2nd referral, same year, 30 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Private payers: Contact each to determine

For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B:</th>
<th>Private payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0447</td>
<td>Behavioral counseling for obesity, individual, 15 min.; aka: Intensive Behavior Therapy for Obesity</td>
<td>• ICD-10 code for BMI ≥30.0:</td>
<td>Contact to determine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.30 BMI 30.0-30.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.32 BMI 32.0-32.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.33 BMI 33.0-33.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.34 BMI 34.0-34.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.35 BMI 35.0-35.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.36 BMI 36.0-36.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Z68.37 BMI 37.0-37.9, adult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• From: E65-E68 Overweight, obesity and other hyperalimentation</td>
<td></td>
</tr>
<tr>
<td>G0473</td>
<td>Behavioral counseling for obesity, group (2 - 10), 30 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Private payers: Contact to determine

For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare:</th>
<th>Private payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9449</td>
<td>Weight management classes, non-physician provider</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes, non-physician provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9470</td>
<td>Nutrition counseling, dietitian visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Private payers: Contact to determine

For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare:</th>
<th>Private payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention, individual, 15 min.</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>99402</td>
<td>Individual, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99403</td>
<td>Individual, 45 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99404</td>
<td>Individual, 60 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99411</td>
<td>Group, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99412</td>
<td>Group, 60 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicare: Not Covered

Private payers, IF covered: Require dx codes for other than illness from:
• Z00 - Z99: Factors influencing health status and contact with health services (e.g., dietary surveillance and counseling Z71.3)
### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>DSMT, individual, initial or follow-up, 30 min.</td>
<td></td>
<td>Contact each to determine</td>
</tr>
<tr>
<td>G0109</td>
<td>DSMT, group, (2 or more), initial or follow-up, 30 min.</td>
<td></td>
<td>Contact each to determine</td>
</tr>
</tbody>
</table>

**Medicare Part B:**
- Diabetes code from:
  - E00-E90: Endocrine, nutritional and metabolic diseases
  - O20-029: Other maternal disorders r/t pregnancy
  - Z00-Z99: Factors influencing health status & contact with health services (insulin use, # weeks gestation)

### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetic management program, follow-up visit to non-MD provider</td>
<td></td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetic management program, follow-up to MD provider</td>
<td></td>
<td>Contact to determine</td>
</tr>
</tbody>
</table>

**Medicare:**
- Diabetes code from:
  - E00-E90: Endocrine, nutritional and metabolic diseases
  - O20-029: Other maternal disorders r/t pregnancy
  - Code from:
    - Z00-Z99: Factors influencing health status & contact with health services (e.g., dietary surveillance and counseling Z71.1)

### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9460</td>
<td>Diabetic management program, nurse visit, individual, 15 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9465</td>
<td>Diabetic management program, dietician visit, individual, 15 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9455</td>
<td>Diabetic management program, group, 2 or more, 30 min.</td>
<td></td>
<td>Contact to determine</td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
</table>
| 99078  | Physician or other qualified health care professional qualified by education, training, licensure or regulation (when applicable), educational services, group setting; e.g.,
  - Prenatal
  - Obesity, or
  - Diabetic instructions | Not covered | Contact to determine |

### For Each Covered Benefit, in Each Plan, Identify Payable ICD-19 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>95250</td>
<td>Ambulatory CGM of interstitial fluid via subcutaneous sensor for minimum of 72 hrs; sensor placement, hook-up, monitor calibration, pt training, sensor removal, data download and printout of recording.</td>
<td>Not covered</td>
</tr>
<tr>
<td>95251</td>
<td>Provider interpretation and report. Can be done remotely.</td>
<td></td>
</tr>
</tbody>
</table>

**Private Payers:** Contact to determine
### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior initial assessment, individual</td>
<td>Diagnoses that Support Medical Necessity. Medical diagnoses only (not psychiatric).</td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment, each 15 min., face-to-face with pt</td>
<td></td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

- Insurers require providers to meet specific qualification requirements for providers to be reimbursed:
  - Must be **qualified** to perform specific services billed
    - Qualifications typically in State Scope of Practice Act
  - To be performed within State Scope of Practice Act
  - Must be licensed or certified to perform services as defined by State law (state in which services performed) if licensure or certification exists

### For Each Covered Benefit, in Each Plan, Identify Payable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>96152</td>
<td>Health and behavior intervention each 15 min., face-to-face; individual</td>
<td></td>
</tr>
<tr>
<td>96153</td>
<td>Group (2 or more pts)</td>
<td></td>
</tr>
<tr>
<td>96154</td>
<td>Family (with pt present)</td>
<td></td>
</tr>
<tr>
<td>96155</td>
<td>Family (w/o pt present)</td>
<td></td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Billing Provider</th>
<th>Rendering Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802 MNT, initial, individual</td>
<td>Medicare Part B: • RD</td>
</tr>
<tr>
<td>97803 MNT, follow-up, individual</td>
<td>• Nutritional professional</td>
</tr>
<tr>
<td>97804 MNT, initial or follow-up group</td>
<td>• Medicare entity provider (which is approved place of service) to whom above has reassigned her/his reimbursement to</td>
</tr>
</tbody>
</table>

Private payers: Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Billing Provider</th>
<th>Rendering Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0270 MNT, initial, individual, over 3 hrs; f/up over 2 hrs, 2nd referral, same year, 15 min.</td>
<td>Medicare Part B: • RD</td>
</tr>
<tr>
<td>G0271 MNT, initial or group, over 3 hrs, or f/up over 2 hrs, 2nd referral, same year, 30 min.</td>
<td>• Nutritional professional</td>
</tr>
</tbody>
</table>

G0108 DSMT, individual, over 30 min. Medicare Part B: • Individuals*: MD, DO, RD, NP, PA, CNS, CLSW, clinical psychologist, clinical nurse midwife
• Entities*: OP hospital, clinic, RHC, home health agency, skilled nursing facility, physician group, health center (FQHC)
  *Must be billing Medicare for other services & paid

G0109 DSMT, group, (2 or more), over 30 min. Medicare Part B: • Individuals listed on left if provider is program’s coordinator
• NPI # of DSMT program; program can apply for Type 2 Organization NPI No. as a sub-part of organization

Private payers: Contact to determine
### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B</th>
<th>Medicare Part A</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0447</td>
<td>Behavioral counseling for obesity, individual, 15 min.</td>
<td>• PCP (MD, DO) enrolled in Medicare as: o General Practice o Family Practice o Internal Med. o OB/GYN o Pediatric Med. o Geriatric Med. • NP, PA, CNS</td>
<td>• PCP (MD, DO) • NP, PA, CNS or • Qualified auxiliary staff employed by above; e.g. RD or nutrition professional</td>
</tr>
<tr>
<td>G0473</td>
<td>Behavioral counseling for obesity, group (2-10 pts), 30 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

---

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960</td>
<td>Education &amp; training for pt self-management by qualified, non-physician healthcare professional, 30 min.; individual</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>98961</td>
<td>Group, 2 - 4 pts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98962</td>
<td>Group, 5 - 8 pts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

---

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9449</td>
<td>Weight management classes, non-physician provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes, non-physician provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9470</td>
<td>Nutrition counseling, dietitian visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

---

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

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<thead>
<tr>
<th>Code</th>
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<th>Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling, risk factor reduction, individual, 15 min.</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>99402</td>
<td>Individual, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99403</td>
<td>Individual, 45 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99404</td>
<td>Individual, 60 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99411</td>
<td>Group, 30 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

---

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetic management program, follow-up visit to non-MD provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetic management program, follow-up to MD provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine
### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9460</td>
<td>Diab management program, nurse visit, individual, 15 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9465</td>
<td>Diab management program, dietician visit, individual, 15 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9455</td>
<td>Diab management program, group, &gt;2, 30 min.</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
</tbody>
</table>

### Example of Procedure Code 99078 Payable by Minnesota Medicaid and List of Eligible Providers

For health and behavior assessment, individual, each 15 min., face-to-face with pt.

http://www.health.state.mn.us/healthreform/ship/docs/howtousecodingupdate.pdf

### For Each Covered Benefit, in Each Plan, Identify Approved Billing and Rendering Providers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>99078</td>
<td>Physician or other qualified health care professional's educational services, group setting; e.g., • Prenatal • Obesity or • DM instructions</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

<table>
<thead>
<tr>
<th>Payment Models</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B:</td>
<td>Only licensed clinical psychologist who is Medicare Part B provider may furnish &amp; bill code and only for medical dx, not psychiatric; medical dx to be made by physician or mid-level only. Can reassign NPI# to Medicare employer.</td>
</tr>
</tbody>
</table>

### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

| Health and behavior intervention each 15 min., face-to-face; individual | Medicare Part B: See previous slide |
| Group (2 or more pts) |
| Family (with pt present) |
| Family (without pt present) |

### Affordable Care Act Payment Models Designed to Improve Quality and Decrease Cost

- Shared Savings
- Bundled Payments
- Global Payments
- Reduced Payments
- Increased Payments
- Pay-for-Performance
- Pay-for-Quality
- Pay-for-Reporting
- Capitation
- Matching Payments
- Adjusted Payments
- Tax Reduction Incentives
- Federal Funding for Incremental Costs
- Small Business Tax Credits
- Bonus Payment for Meeting Quality Targets or Progress Toward
### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-facility and facility:</th>
<th>Medicare, 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0270</td>
<td>MNT, initial, individual, over 3 hours or follow-up, individual, over 2 hours, 2nd referral, same year, 15 min.</td>
<td>$30.03 - $27.53</td>
<td>Non-facility and facility: $30.03 - $27.53</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT, initial, group, over 3 hours or follow-up, group, over 2 hours, 2nd referral, same year, 30 min.</td>
<td>$16.09 - $15.37</td>
<td>Non-facility and facility: $16.09 - $15.37</td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-facility and facility:</th>
<th>Medicare, 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT, initial, individual, 15 min.</td>
<td>$35.04 - $32.89</td>
<td></td>
</tr>
<tr>
<td>97803</td>
<td>Follow-up, individual, 15 min.</td>
<td>$30.03 - $27.53</td>
<td></td>
</tr>
<tr>
<td>97804</td>
<td>Initial or follow-up, group, 30 min.</td>
<td>$16.09 - $15.37</td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-facility and facility:</th>
<th>Medicare, 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G047</td>
<td>Behavioral counseling for obesity, 15 min. aka: Intensive Behavior Therapy for Obesity</td>
<td>$26.10 - $23.96</td>
<td></td>
</tr>
<tr>
<td>G0473</td>
<td>Behavioral counseling for obesity, group (2 - 10), 30 min.</td>
<td>$12.51 - $11.80</td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare, 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960</td>
<td>Education and training for patient self-management by qualified, non-physician health care professional using standardized curriculum, (could include caregiver, family), 30 min.; individual pt</td>
<td>Not covered</td>
</tr>
<tr>
<td>98961</td>
<td>Group, 2 - 4 patients</td>
<td></td>
</tr>
<tr>
<td>98962</td>
<td>Group, 5 - 8 patients</td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>S9449</td>
<td>Weight management classes, non-physician provider</td>
<td>Not covered</td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes, non-physician provider,</td>
<td></td>
</tr>
<tr>
<td>S9470</td>
<td>Nutrition counseling, dietitian visit</td>
<td></td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

---

**DOG: Are We Done Yet?  CAT: Not Yet!**

![Image of a dog and a cat]
### Preventive Medicine Counseling and/or Risk Factor Reduction Intervention

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention,</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td></td>
<td><strong>individual</strong>, 15 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99402</td>
<td><strong>Individual</strong>, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99403</td>
<td><strong>Individual</strong>, 45 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99404</td>
<td><strong>Individual</strong>, 60 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99411</td>
<td><strong>Group</strong>, 30 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99412</td>
<td><strong>Group</strong>, 60 min.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diabetic Management Program

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9140</td>
<td>Diabetic management program, follow-up visit to non-MD provider</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td>S9141</td>
<td>Diabetic management program, follow-up to MD provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Educational Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>99078</td>
<td>Physician or other qualified health care professional qualified by education,</td>
<td>Not covered</td>
<td>Contact to determine</td>
</tr>
<tr>
<td></td>
<td>training, licensure or regulation (when applicable) <strong>educational services, group</strong> setting; e.g.,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prenatal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obesity, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diabetic instructions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health and Behavior Initial Assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare</th>
<th>Private Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior <strong>initial assessment, individual</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health-focused clinical interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Behavioral observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychophysiological monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health-oriented questionnaires, each 15 min., face-to-face with pt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment, each 15 min., face-to-face with pt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Codes NOT to be billed on same day for same pt with codes for: Evaluation & Management, Preventive Medicine Counseling (individual 99401 – 99404; group 99411 – 99412) or Psychiatric Service codes.
- Medicare Part B non-facility and facility: $21.81 - $21.45
- Medicare, 2015: Non-facility and facility: $53.27 - $53.27
- Non-facility and facility: $14.30 - $14.30
### For Each Covered Benefit, in Each Plan, Identify Reimbursement Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>96152</td>
<td>Health and behavior intervention, individual, each 15 min., face-to-face</td>
<td>Medicare Part B non-facility and facility: $19.67 - $19.31</td>
</tr>
<tr>
<td>96153</td>
<td>Group (2 or more pts)</td>
<td>$4.65 - $4.29</td>
</tr>
<tr>
<td>96154</td>
<td>Family (with pt present)</td>
<td>$19.31 - $18.95</td>
</tr>
</tbody>
</table>
| 96155 | Family (w/o pt present) | • Psychologist reimbursed at 100% of Physician Fee Schedule  
  o Modifier AH no longer required |

*All Medicare ‘incident to rules’ apply: physician/mid-level practice setting only; established pt only; supervision by physician or mid-level; psychologist/LCSW employed by or contracted with physician practice; other rules.*

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Patient Eligibility</th>
</tr>
</thead>
</table>
| 97802 | MNT, initial, individ  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth  
  Medicare 97802  
  • Documentation of DM dx with 1 of 3 labs:  
    o FPS ≥126 mg on 2 tests  
    o 2 hr OGTT ≥200 on 2 tests  
    o Random BG ≥200 mg on 1 test with symptom(s) of uncontrolled DM  
    o GFR 13-50, pre-dialysis renal  
    o Post-kidney transplant |
| 97803 | MNT, f/up, individ  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth |
| 97804 | MNT, initial or f/up group  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth |

Private payers: Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Patient Eligibility</th>
</tr>
</thead>
</table>
| G0447 | Behavioral counseling for obesity, individual, 15 min.  
  Medicare:  
  • Primary care setting (OP)  
  • Telehealth  
  • BMI >30 kg  
  • Part B insurance  
  • Present at visit  
  • Competent & alert  
  • Lost 6.6 # by end of 6th month to continue in months 7-12  
  Private payers: Contact to determine |
| G0473 | Behavioral counseling for obesity, group (2-10), 30 min. |

Private payers: Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Patient Eligibility</th>
</tr>
</thead>
</table>
| 98960 | Education & training for pt self-management by qualified, non-physician health care professional, individual pt  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth  
  • DM dx  
  Medicare 98960  
  • Documentation of DM dx with 1 of 3 labs:  
    o FPS ≥126 mg on 2 tests  
    o 2 hr OGTT ≥200 on 2 tests  
    o Random BG ≥200 mg on 1 test with symptom(s) of uncontrolled DM  
    o GFR 13-50, pre-dialysis renal  
    o Post-kidney transplant  
  Medicare 98960  
  • Documentation of DM dx with 1 of 3 labs:  
    o FPS ≥126 mg on 2 tests  
    o 2 hr OGTT ≥200 on 2 tests  
    o Random BG ≥200 mg on 1 test with symptom(s) of uncontrolled DM  
    o GFR 13-50, pre-dialysis renal  
    o Post-kidney transplant |
| 98961 | Group, 2-4 pts  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth  
  • DM dx  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth |
| 98962 | Group, 5-8 pts  
  Medicare:  
  • Hospital OP  
  • Clinic  
  • Physician group  
  • Home health  
  • Renal dialysis facility (non-dial pt only)  
  • Nursing home  
  • Telehealth |

Private payers: Contact to determine
### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

<table>
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<tr>
<th>Place of Service</th>
<th>Patient Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S9449</strong> Wt management classes, non-physician provider</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>S9452</strong> Nutrition classes, non-physician provider</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>S9470</strong> Nutrition counseling, dietitian visit</td>
<td>Medicare: Not covered</td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>S9140</strong> Diabetic management program, follow-up visit to non-MD provider</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>S9141</strong> Diabetic management program, follow-up to MD provider</td>
<td>Medicare: Not covered</td>
</tr>
</tbody>
</table>

**Private payers:** Contact each to determine

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

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<tbody>
<tr>
<td><strong>99401</strong> Preventive medicine counseling and/or risk factor reduction intervention, individual, 15 min.</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>99402</strong> 30 min.</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>99403</strong> 45 min.</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>99404</strong> 60 min.</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>99411</strong> Group, 30 min.</td>
<td>Medicare: Not covered</td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### For Each Covered Benefit, in Each Plan, Identify Places of Service and Patient Eligibility

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<th>Patient Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0108</strong> DSMT, initial or follow-up individual, 30 min.</td>
<td>Medicare: Not covered</td>
</tr>
<tr>
<td><strong>G0109</strong> DSMT, initial or follow-up, group, (2 or more), 30 min.</td>
<td>Medicare: Not covered</td>
</tr>
</tbody>
</table>

**Private payers:** Contact to determine

### Know Coding and Billing Rules of Thumb

- **Never** “guess” as to which procedure codes to use
  - 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 coverage guidelines must be met 100%
**Know Coding and Billing Rules of Thumb**

NEVER bill a procedure code that limits billing providers to physicians, NPs, PAs, CNSs only when the service is actually rendered by non-physician ancillary staff or “physician extenders” such as RN, RD, CHES, MA, acupuncturist, etc., unless insurer specifically allows!

**Know Coding and Billing Rules of Thumb**

- Regarding billing method “incident to physician services”, physicians to ALWAYS check FIRST with each insurer to determine IF billing method is allowed, mandated or even statutorily prohibited* for benefit being billed
  - IF so, always identify insurer’s requirements for office physicians and ancillary staff for this type of billing!
  - *Statutorily prohibited for Medicare DSMT and MNT benefits!

**Know Coding and Billing Rules of Thumb**

- Track your reimbursement retrospectively (quarterly basis):
  - For claim denials and rejections:
    - Identify reason why
    - Fix problem (~80% of time it’s error by entity’s billers)
    - Re-bill asap (usually have limit of 12 months)

**Ask IT and/or Billing Dept. to Create Reimbursement Tracking Report!**

Snippet of Mary Ann’s Reimbursement Tracking Report

**Structure of SMA for Outpatients with Diabetes**

- Session: 2 hours, ~ 10 - 12 pts at same time in group setting
  - Average return diabetes SMA intervals: quarterly
- KEY pre-SMA activities:
  - All team members review pts’ charts before SMA
  - Pts complete Diabetes Follow-Up Assessment upon arrival
- Group activities by provider and educator:
  - Individual evaluation and management (E/M) visits
  - Review of labs
  - Goal setting
  - Rx management
  - Behavior change/education intervention

**RN Role (Varies)**

Act as moderator. Helps manage SMA and completes diabetes care tasks.

- Provides behavior change/education intervention
- Helps check pts into SMA and escorts into room
- May act as moderator
- Helps pts complete subjective section of Diabetes Assessment/Progress Note (DA/PN)
- Reviews info pt entered on DA/PN with pt
- Completes objective Nurse Section on DA/PN
### RN Role (Varies)
- Takes patients' vitals and documents on DA/PN
- Assists with Rx med refills
- Provides/assists with group behavior change intervention
- May assist physician with E/M tasks if necessary
- May act as provider’s documenter, if necessary
- Makes sure pts leave with:
  - Referrals and Rx’s
  - My Diabetes Action Plan
  - Take-Home Instruction Sheet
  - Post-Appointment Order Sheet

### Moderator Role: RN, RD, CDE, Pharmacist, Etc. (Varies)
- Collects Confidentiality Agreement and Medical Waiver
- Facilitates group discussion
- Manages confidentiality—reminds pts of rules
- Keeps group on schedule so all pts have needs met
- Makes sure no one pt dominates conversation
- Answers questions
- May act as documenter or assist if necessary
- May assist provider and/or educator if necessary
- Collects Patient Satisfaction Forms

### Provider Role: MD, DO, NP, CNS, PA
- Evaluates, examines, treats pts just as in individual visits
- Documents (or scribes documents and provider signs):
  - Individual f/up services provided to each pt, and
  - Services provided to group as a whole
- Completes ‘Provider” section on Diabetes Follow-Up Assessment
- Makes and documents medical decisions
- May furnish private exam outside of SMA in exam room

### Provider Role: MD, DO, NP, CNS, PA
- Completes individual evaluation & management (E/M) visits with all patients in group (and bills insurers for)
  - Reviews Diabetes Follow-Up Assessment
  - Discusses data, signs and symptoms
  - Reviews current medication list
  - Helps pts set goals
    - Documents on pt’s Take-Home Instruction Sheet

### Dedicated Documenter/Scribe Role
- Requirements: Clinical background and medical terminology knowledge (e.g., medical assistant)
- Documents into EMR template during SMA info on:
  - Diabetes Follow-Up Assessment
  - Take-Home Instruction Sheet
- May assist with moderating the group, if necessary

### Educator Role: RD, RN, CDE, Pharmacist, Etc.
- Provides behavior change/education intervention
- May help check pts into SMA
- May act as moderator
- Reviews info pt entered on Diabetes Follow-Up Assessment
- Assists pts in completing My Diabetes Action Plan
- May assist physician with E/M tasks, if necessary
- May act as documenter/scribe, if necessary
- Documents behavior change visit on
  - Example: on DSME Education Record
Practical Tips for a Successful SMA

- Ask pts ahead of time who needs to leave early (so needs are met, such as new Rx or Rx renewal)
- Ensure team members have large depth of expertise
- Cross-train all team members
- Practice with a ‘mock’ SMA before real deal
- Before end of SMA:
  - Ask group what behavior change topic they would like to discuss at next SMA
  - Desired date of next SMA

Example of Diabetes Patient Registry

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Diabetic Status</th>
<th>Last Visit</th>
<th>A1C Resulted</th>
<th>Order Albumin Ratio</th>
<th>Resulted</th>
<th>Last Albumin Ratio</th>
<th>Order LDL Micro</th>
<th>Resulted</th>
<th>Last LDL Micro</th>
<th>Order Creat  Micro</th>
<th>Resulted</th>
<th>Last Creat  Micro</th>
<th>Order Protein Albumin Ratio</th>
<th>Resulted</th>
<th>Last Protein Albumin Ratio</th>
<th>Order h/o Albumin Ratio</th>
<th>Resulted</th>
<th>Last h/o Albumin Ratio</th>
</tr>
</thead>
</table>

Practical Tips for a Successful SMA

- Have behavior change topic prepared BUT:
  - Be ready to put hold on topic IF group wants another
- Maintain control of SMA:
  - Redirect if group gets too far off topic
- Address private issues (substance abuse, ED) in private room
  - If pt brings up touchy topic in group, then okay to discuss
- Maintain SMA patient registry that is disease specific (e.g., diabetes patient registry)

Content of Diabetes Follow-Up Assessment

- **HISTORY SECTION** (patient completes; subjective)
  - History of Present Illness (HPI):
    - Chief complaint
    - Symptoms since last visit
    - SMBG results
    - Lab results (lipids, A1c and BP)
    - Rx meds
    - Exercise
    - Diet
    - Changes in medical hx since last visit
  - Past/Family/Social History (PFSH)
  - Review of Systems (ROS)...what pt denies

Content of Diabetes Follow-Up Assessment

- **NURSE and EDUCATOR SECTION** (objective)
  - Physical exam and vitals
  - Details of behavior change/education intervention furnished (e.g., 30 minutes of group DSME or MNT)
  - Review of systems
- **PROVIDER SECTION** (medical decision making by provider)
  - Assessment of diabetes/co-morbidities
  - Plan (management options in check-off format)
  - Orders and referrals
  - F/up timeframe
  - Pt instructions
**DIABETES FOLLOW-UP ASSESSMENT:**

Subjective Sections are Patient Completed and Provider Reviewed

Objective Sections are completed by Nurse and Educator and Provider

---

Content of Patient’s Packet of Materials

- *Diabetes Follow-Up Assessment*
- *My Diabetes Action Plan*
- Handout for behavior change/education intervention (e.g., DSME or MNT)
- May also include:
  - Printout of pt’s personal medication list, recent labs, wt, BP and pulse trends
  - Daily weight log
  - Q&A sheet
  - *Patient Satisfaction Form*

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How Patient Confidentiality Is Addressed

- Print this info in all promotional materials and items
- Pts sign *Confidentiality Agreement & Medical Waiver*:
  - Before session starts
  - Reviewed by attorney
  - Made patient-friendly by administration
  - That states:
    - “Your medical issues will be discussed in group”
    - “Do not discuss patient information outside of group”
    - “Do not discuss others’ health problems after group”
- Reviewed in introduction

---

The How To:  Pre-SMA Tasks

- Pts given or mailed “invitation letter” explaining SMA and scheduled date
- Prepare patients’ *Packet of Materials*
- Day of SMA, the HCP team:
  - Prepares room
  - Reviews pts’ charts
  - Prepares provider’s, nurse’s, educator’s and patients’ required forms, handouts, etc.

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The How To:  Upon Patient Arrival

- Pts registered by secretary
- Pts given *Packet of Materials*
  - Asked to open and complete:
    - *HIPAA Notice*
    - *Confidentiality Agreement*
    - *Diabetes Follow-Up Assessment* (section 1)
- RN or MA triage patients individually:
  - Does simple physical exam, takes vitals, may test BG
  - Reviews data entered by pt on *Diabetes Follow-Up Assessment*
The How To: Moderator Begins SMA
- Welcomes group and introduces all team members
- Asks who will need to leave early
- Explains:
  - How and why SMA conducted
  - Housekeeping items, logistics, time frame, etc.

The How To: Provider Visit
- Individual E/M visits in front of group
- Provider addresses each pt’s medical issues and educates for benefit of group...e.g., controlling high BP
- Private exam room visits may occur at same time as behavior change/education intervention
- Scribe (RN or MA) documents pt visits in EMR or chart at same time that provider is furnishing individual E/M visits

The How To: Educator
- Furnishes behavior change/education intervention AFTER provider completes individual E/M visits and leaves SMA
- Welcomes group
- May discuss common social problems, prevention, etc.
- Furnishes behavior change/education intervention topic
- Asks patients what topics they want to discuss:
  - Today
  - Next SMA visit

The How To: Post-SMA Tasks
- Provider completes unfinished charting
- Provider conducts team conference to “put the pieces together”...i.e., determine each pt’s plan of care
- Physician may be able to bill private payers for HCP team conferences (not Medicare)

SMA Team’s “Golden Group Rules”
1. Focus on being:
   - Relationship-centered and patient-centered
   - Task-focused
2. Leader is privileged to have role, as
   - Group belongs to attendees
   - Group picks behaviour change/education topics
3. Do not hog airways during group interaction
   - Wrap up after minute of explaining
4. Finish on time

Common Mistakes in SMAs
- Inadequate meeting room space
- Not enough team members scheduled for SMA
- Lack of administrative support
- Lack of on-going communication with staff
- Inadequate disease-specific pt registry (is database from which patients are selected for SMA)
- Inadequate data management system
- Not keeping behavior change/education intervention topics fresh
- Allowing any pt to monopolize discussion
Common Mistakes in SMAs

- Not consistently meeting SMA pt census (~ 10 pts per 2 hour SMA)
  - Not overbooking for “no-shows”
- Not securing required administrative and staff support
- Poor planning
- Lack of staff training

Provider not:

- Completing documentation in SMA or immediately after
- Fully delegating to team
- Succinct and focused
- Finishing on time
- Educator not pacing group or controlling pts who want to dominate

Preventive services that non-grandfathered private health plans (new as of 9-23-15) must cover:

- Screenings:
  - Lipid disorders
  - High BP
  - Depression
  - Alcohol misuse
  - Tobacco use
  - Obesity

- Behavioral counseling interventions:
  - Tobacco cessation
  - Alcohol and other substance abuse
  - Depression support, treatment and follow-up
  - Intensive dietary behavior counseling in chronic disease
  - Obesity counseling

Martini, Anyone?

I’m Sleepy After All That Info!!
Effect of Information Overload

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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 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.

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Information at www.maryannhodorowicz.com

• Turn Key Policy & Procedure Manual, Forms, Training and Support for AADe DSME Program Accreditation and Reimbursement
  • DSME Policy & Procedure Manual & All Forms Consistent with Requirements for:
    ▪ AADe Accreditation of DSME Program
    ▪ Adherence to NSDSME
    ▪ Medicare/Private Payer Reimbursement
  • Plus Business Planning Support; Copy-Ready/Modifiable Forms & Handouts; Fun 3D Teaching Aids for all Self-Care Topics
• “Establishing a Successful MNT Clinic in Any Practice Setting“
• “EZ Forms for the Busy RD” ©: 107 total, on CD: c: 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