

MARY ANN HODOROWICZ CONSULTING, LLC

Nutrition, Health Promotion, Diabetes Education and Insurance Reimbursement for Professionals for the Healthcare and Food Industry

12921 Sycamore • Palos Heights, IL 60463 • W: 708.359.3864 Fax: 866.869.6279
 hodorowicz@comcast.net • www.maryannhodorowicz.com



DETAILED “SUCCESS CHECKLIST” FOR MNT and DSME PROGRAMS

UPDATED
 11-1-10

EOC	Episode Of Care	FiPPS	Forms, Policies, Procedures, Systems
S-R-O's	Support - Resources - Opportunities	EBNPGs	Evidence-Based Nutrition Practice Guidelines
QOC	Quality Of Care	NCP	Nutrition Care Process
DSME	Diabetes Self-Management Education	SOC	Standards of Care (Nationally Recognized)
NSDSME	National Standards for DSME	AADE-DEAP	AADE's Diabetes Education Accreditation Program

A	PROCEDURES and RESOURCES APPLICABLE TO MNT and DSME PROGRAMS THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
	COMPETENCY of Instructors To Provide MNT, DSMT				
	1. Initial and ongoing training given to RDs, RNs, pharmacists + other DSME team members on Medicare DSMT, NSDSME, AADE-DEAP and other diabetes SOC				
	2. Initial training given to RDs in Medicare MNT, EBNPGs and NCP to insure excellent competencies				
	3. Determine RD's scope of practice in state's dietitian licensure law or certification act (skin piercing allowed?)				
	PRE-PROGRAM				
	1. Support of CEO/administration/BOD for programs				
	2. Business plan: <ul style="list-style-type: none"> Plan includes detailed <i>marketing</i> plan, which calls for team members (for DSME) and RD (for MNT) to visit physician offices to survey this target market's needs, promote programs and increase awareness 				
	3. Knowledge of MNT + DSME insurance reimbursement				
	4. Pro forma (income statement with <i>projected</i> expenses, revenue and net income in yr 1 plus subsequent yrs (with +/- 10% variance) until breakeven point reached				
	5. Cost centers specific for DSME and MNT programs with own operating budgets + regular financial reports				
	6. Financial resources for start-up + ongoing expenses				
	7. Accounting and bookkeeping systems <ul style="list-style-type: none"> DSME and MNT chargemaster Pt data base/registry (includes outcome tracking) 				
	8. Pt registration (registers into MNT or DSME cost center). Includes printouts for pt signature of: <ul style="list-style-type: none"> HIPAA notice Financial responsibility statement 				

<ul style="list-style-type: none"> • Cancellation policy and notice (fee, no fee?) • Payment policy • Consent to treat • “Welcome to Our Office” brochure <p>Also includes verification of Medicare Part B coverage</p>				
9. Entity that is billing for MNT, DSME is provider with major private health plans and Medicare				
10. Individuals who are billing for MNT, DSME (RDs) are providers with major private health plans and Medicare				
11. Marketing and advertising resources: <ul style="list-style-type: none"> • Flyer or brochure <ul style="list-style-type: none"> > For menu of services > For special promotions > For start of program (when offered q ___ wks) • Community newsletters • Newspaper ads, free publicity 				
12. Sources of additional revenue: <ul style="list-style-type: none"> • Weight loss program • Classes on exercise, pre-diabetes, healthy heart lifestyle • Grocery store tours • CGM • Diabetes screenings • Lipid screenings 				
13. Sources of unrestricted funds to offset uninsured and underinsured pts (pharmaceutical companies)				
14. Large, stable physician referral base (= large pt base)				
15. Customized DSME-MNT Referral form				
16. DSME and MNT fees appropriately determined by evaluating competition, insurance payment rates, expenses and required revenue for time period				
17. DSME, MNT, nutrition counseling fees that are charged are same for all pts, including Medicare pts				
18. SOC “compliance aids and procedures” (real time prompts) to assure that pts scheduled for 1 st DSME and 1 st MNT visit asap when faxed referrals received, or when pt calls for appointment				
18. Medicare MNT and DSME not provided on same day				
19. Electronic management information system				
20. Electronic system for pt appointment scheduling				
21. Clerical staff for pt scheduling: <ul style="list-style-type: none"> • Who schedules pts? • What process is used for initial apptment scheduling • What process is used for apptment reminder calls • Use of Initial Intake and Appointment Form 				
22. Hours of operation: evening + Sat. hours				
23. Office or room for furnishing MNT and/or DSME				
24. Office for MNT RD and/or DSME team members with: <ul style="list-style-type: none"> • Lockable cabinets for charts • Dedicated phone line 				
25. System for pt eligibility screening for MNT and/or DSMT <ul style="list-style-type: none"> • Pt has Medicare Part B; copy of insurance card made • Documentation of lab criteria (see Pre-MNT and Pre-DSME sections) 				

26. Documentation of non-Medicare pt's health insurance, ID number, phone, address and copy of card made				
27. Pt-signed HIPAA privacy statement + copy of to pt				
28. Pt-signed financial disclosure statement + copy of to pt				
29. Attempt made to determine number of previously used initial + follow-up Medicare MNT or DSME hrs elsewhere				
30. Pts called 24 - 48 hours prior to appointment to confirm				
31. Miscellaneous: <ul style="list-style-type: none"> • Customized fax cover sheets • RD business cards • Pt appointment cards • Notice to physician when services not rendered 				
MNT and/or DSMT PROGRAM INTERVENTION				
1. Pt Attendance and Charge Submission Form used for each visit (individual and group)				
2. Up-to-date, professional educational materials for pts Based on standardized curriculum, protocols, EBG				
3. Customized behavior change tools for pts: <ul style="list-style-type: none"> • Exercise and food diaries, blood glucose logs, hunger – fullness rating logs, etc. 				
POST-PROGRAM				
1. Effective billing and claims processing system and staff				
2. Effective system for submitting charges to billing dept. or staff responsible for on same day as DSME/MNT visit				
3. Effective system for tracking all claims sent to insurers				
4. Good working relationship with billing department staff				
5. Effective process for taking action (A) on denied claims: First, ID reason (R) for denial <ul style="list-style-type: none"> • R = Lack of medical necessity A = Assure use of correct diagnosis code(s) A = Write appeal letter and cite own outcomes and MNT/DSMT cost-effectiveness studies • R = Incorrect or missing entry in data field A = Make corrections and resubmit claim • R = Invalid or incorrect CPT procedure code A = Make corrections and resubmit claim • R = Provider not certified by payer A = Request provider application and submit • R = Service not a covered benefit A = Write appeal letter and cite own outcomes and MNT/DSME cost-effectiveness studies 				
6. Documentation of reason for additional Medicare DSME hrs and Medicare MNT hrs in initial and/or follow-up EOC beyond number stipulated in benefit				
7. Copy of DSME and/or MNT documentation sent to PCP and to referral source (may be different)				
8. Billing only for face-to-face Medicare DSMT and MNT				
9. Neither DSME nor MNT is given free to Medicare pts				
10. Billing private insurers for all MNT and DSMT provided				
11. Knowledge that CMS1500 claim used for billing non-hospital MNT and DSME				
12. UB04 claim form for hospital billing of DSME, MNT				
13. Revenue code 942 on UB04 claim form				

MNT and DSME OUTCOMES MANAGEMENT SYSTEM				
1. Outcomes management system for MNT/DSME programs: <ul style="list-style-type: none"> • Primary outcomes* routinely measured + evaluated to measure QOC and effectiveness of programs and benchmarked against 'best practice' outcomes * Behavior, clinical, cost-savings and pt satisfaction • FiPPS revised when QOC sub-standard 				
2. Pt. satisfaction outcomes measured via pt evaluations				
3. To help insure QOC, S-R-O's for RDs and/or DSME team members to find and communicate with best practice MNT and/or DSME programs				
4. Per policy, pts allowed to bring pets to MNT visit				

B	PRE - MNT: SPECIFIC MNT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
	1. RDs are certified Medicare providers, or submit CMS 855I form to regional MAC to receive individual NPI#				
	2. If RDs are employees, reassign Medicare payment to hospital by submitting CMS 855R form to regional MAC				
	3. Hospital submits CMS 855B (business) form to MAC to become single supplier of RD group furnishing MNT and obtains group NPI# which is used on MNT claims				
	4. MNT fee stated per 15 minute or 30 minute unit of time				
	5. Physician MNT referrals for all pts including Medicare for: <ul style="list-style-type: none"> • Initial MNT • Follow-up MNT • Additional MNT hours in initial and/or follow-up EOC beyond number stipulated in benefit 				
	6. Documentation of reason for additional Medicare MNT hrs in initial or f/up EOC beyond # stipulated in benefit				
	7. MNT program format = combination group + individual MNT to utilize time effectively: 2 hr group + 1 hr individual for customized meal plan & behavior change counseling				
	8. Required documentation on Medicare MNT referrals: <ul style="list-style-type: none"> • Order for MNT • Pt's name • Physician's signature • Covered diagnosis or 5 digit ICD-9 code (diabetes or pre-dialysis renal disease or condition for 36 months after kidney transplant) • Physician's Medicare NPI# • Date (preceeds, or is same as 1st MNT visit) 				
	9. Documentation of one lab criteria for Medicare MNT:* Diabetes MNT: <ul style="list-style-type: none"> • FBS \geq 126 mg/dl on 2 tests • 2 hr post glucose challenge test of \geq 200 mg on 2 tests • Random BG \geq 200 mg w/symptoms of uncontrolled DM Non-dialysis MNT: <ul style="list-style-type: none"> • GFR \geq 13 – 50 * If lab criteria not on referral, must obtain from other source before furnishing MNT benefit: e.g., lab report or				

copy of physician chart note in which lab value noted. Medicare does not allow lab values to be obtained from home-based or inpt (bedside) BG meter.				
10. ABN form used when potential exists that Medicare may not pay for covered MNT as time limit in EOC will be exceeded: > 3 hrs in initial EOC, > 2 hrs in follow-up • CPT code modifier GA on claim form when ABN used				
C MNT INTERVENTION: SPECIFIC MNT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
1. EBSC: ADA's MNT Evidence-Based Guides for Practice (Nutrition Protocols or Practice Guidelines)				
2. EBSC: ADA's 4 step Nutrition Care Process and Model: <i>Nutrition Assessment + Nutrition Diagnosis + Nutrition Intervention + Nutrition Monitoring/Evaluation/Reporting</i>				
3. EBSC 'compliance aids' (real time prompts) to assure proactive scheduling of pts at 1 st visit (or prior) of initial 3 hrs within calendar year				
4. For nutrition counseling: standardized protocols, latest research/standards of care/treatment from healthcare associations				
5. Customized disease-specific MNT forms for RDs: • Nutrition assessment + MNT documentation form • MNT flow sheet + MNT outcome tracking form				
6. Customized MNT worksheets for RDs: • Nutrition Diagnosis Worksheet Specific for Diabetes • Nutrition Diagnosis Worksheet for Any Disease • Nutrition Calculation and Prescription Worksheet • Worksheet for Calculating Carb-Pro-Fat-Calorie Level				
D POST MNT: SPECIFIC MNT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
1. Documentation by RD of NCPM steps in providing MNT				
2. Billing Medicare for only diabetes and pre-dialysis MNT				
3. Not billing Medicare for non-covered MNT • Billing Medicare pts directly for non-covered MNT				
4. RD accepts assignment of Medicare MNT payment • Hospital not charging beneficiary, nor supplemental insurance, for difference between hospital's MNT fee and Medicare's allowed, adjusted MNT payment				
5. MNT CPT codes on Medicare claims. CPT code used only 1 time on claim but # of units provided are entered: • 97802: Initial EOC, 1 st calendar yr, 1 unit = 15 min. • 97803: F/up EOC, each yr after 1 st , 1 unit = 15 min. • 97804: Group MNT, ≥ pts, 1 unit = 30 min. • G270: Initial or f/up <u>individual</u> MNT, time > 3, > 2 hrs per second physician's referral in same year • G271: Initial or f/up <u>group</u> MNT, time > 3, > 2 hrs per second physician's referral in same year				

6. Billing with NEW Education and Training CPT Codes As of 1/1/06, 3 new CPT codes approved by AMA for education, training and self-management for pts with established diseases to treat or prevent co-morbidities. Codes can be used for nutrition services other than MNT, such as for pt with HTN, gout, etc.: 98960 Education and training for pt self-management by qualified, non-physician health-care professional using standardized curriculum, face-to-face with pt (could include caregiver/family) each 30 min. individual pt. 98961 2 – 4 pts 98962 5 – 8 patients				
7. EBSC 'compliance aids and procedures' (real time prompts) to assure that pts: <ul style="list-style-type: none"> Scheduled for 2 hrs follow-up MNT each year Rescheduled asap when class/appointment missed 				
8. MNT charts audited by outside reviewer to evaluate RD compliance to MNT- EBG, Nutrition Care Process and Model and hospital requirements				
9. Disease-specific, customized chart audit worksheets				

E PRE – DSME: SPECIFIC DSMT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
1. Interpersonal skills of DSME team: Team puts high priority on collaboration, cooperation, consideration, communication and respect				
2. Team member roles clearly defined				
3. Team members' roles match members' knowledge, skills, professional license and certifications				
4. Curriculum and clinical protocols based on EBSC and not on opinion, turf wars or autocratic rule of team leader				
5. DSME fee stated per 30 minute unit of time				
6. If billing Medicare, DSME program certified by AADE, American Diabetes Association or Indian Health Services				
7. Referral obtained for DSME from physician or qualified non-physician practitioner for initial DSME and separate referral for follow-up DSME				
8. Documentation required on Medicare DSME referrals: <ul style="list-style-type: none"> Statement that DSME needed Whether DSME to be individual or group <ul style="list-style-type: none"> For individual DSME, substantiating reason for Topics to be addressed Number of initial or follow-up hrs to be given <ul style="list-style-type: none"> <10 may be ordered 10 hrs can be used for only topics Rx'd or all topics Whether DSME is initial or follow-up <ul style="list-style-type: none"> On follow-up order, reason for DSME to be given Diabetes dx or 5 digit ICD-9 code Date (preceeds or is same as 1st DSME visit) Patient's name Physician's signature (stamped signature not allowed) 				
9. Documentation of one lab criteria for Medicare DSME				

<ul style="list-style-type: none"> • FBS \geq126 mg/dl* on 2 separate tests • 2 hr post glucose challenge test of \geq200 mg* on 2 separate tests • Random BG \geq200 mg w/symptoms of uncontrolled DM* 				
10. ABN form used when potential exists that Medicare may not pay for DSME as time limit in EOC will be exceeded: > 10 hrs in initial EOC, > 2 hrs in follow-up <ul style="list-style-type: none"> • CPT code modifier GA on claim form when ABN used 				
F DSME INTERVENTION: SPECIFIC DSMT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
1. EBSC: National Standards for Diabetes Self-Management Education (DSME)				
2. Knowledge that NSDSME: do not require CDE on instructional team; do require RD + RN receive specific # and type of CEUs/period, based on whether CDE or not				
3. EBSC 'compliance aids and procedures' (real time prompts) to assure proactively scheduling of pts at 1 st visit (or prior) of initial 10 hrs in 12 consecutive months				
4. Knowledge that: <ul style="list-style-type: none"> • 9 hrs of DSME to be in group and 1 hr may be used for individual instruction or assessment (unless barriers to group learning documented by referring source) • All 10 hrs may be used for only 1 topic • Pt may receive f/up DSME without having rec'd initial 				
5. Effective coordination of patient care delivered by different members of DSME team				
6. Customized DSME-specific forms for team: <ul style="list-style-type: none"> • DSME assessment + DSME documentation forms • DSMT flow sheets + DSME outcome tracking forms 				
7. Customized DSME worksheets for team to: <ul style="list-style-type: none"> • Log telephone reporting of pt's BG • Log all telephone messages 				
8. Medicare beneficiary is scheduled for maximum hrs in for both MNT and DSME (if both programs in place)				
G POST DSME: SPECIFIC DSMT PROCEDURES and RESOURCES THAT SPELL SUCCESS	In Place or Done	Partly In Place	Not In Place	Notes
1. Documentation by team members of DSME provided				
2. Hospital bills Medicare for DSME as Medicare provider (Note: Individual Medicare providers can bill Medicare if already billing Medicare for other services and receiving direct reimbursement...this includes RDs)				
3. EBSC "compliance aids and procedures" (real time prompts) to assure that pts: <ul style="list-style-type: none"> • Scheduled for 2 hrs f/up DSME each calendar year • Rescheduled asap when class/appointment missed 				
4. Hospital does not accept assignment of Medicare DSME payment, and does charge beneficiary, or supplemental insurance, for difference between hospital's DSME fee and Medicare's allowed, adjusted DSME payment				
5. DSME CPT codes on Medicare claims. CPT code used				

only 1 time on claim but # of units provided are entered: <ul style="list-style-type: none"> • G0108: Individual DSME, initial or follow-up, new or established pt, 1 unit = 30 minutes • G0109: Group DSME, initial or follow-up, new or established pt, 1 unit = 30 minutes 				
6. DSME charts audited by outside reviewer to evaluate team compliance to NSDSME and hospital requirements				
7. Customized chart audit worksheets				

MEDICARE PREVENTIVE PHYSICAL EXAM
<p>A. As of January 1, 2005, Medicare covers 1 preventive physical examination in the first six months after a person enrolls in Part B. It is designed to determine physical conditions of new beneficiaries as they become eligible for Medicare. The exam will include:</p> <ul style="list-style-type: none"> • Measurement of height, weight and blood pressure and an electrocardiogram • Blood and laboratory tests to screen for: <ul style="list-style-type: none"> ▫ Cardiovascular disease (tests for cholesterol, lipids and triglyceride levels) ▫ Individuals at high-risk for diabetes ▫ Weak bones, glaucoma and cancers of the colon, breast, cervix, and prostate • Education and counseling for preventive care (physicians can make referrals for the counseling)

Disclaimer: This information is intended for educational and reference purposes only. It does not constitute legal, financial, medical or other professional advice. The information does not necessarily reflect opinions, policies and/or official positions of the Center for Medicare and Medicaid Services, private healthcare insurance companies, or other professional associations. Information contained herein is subject to change by these and other organizations at any moment, and is subject to interpretation by its legal representatives, end users and recipients. Readers should seek professional counsel for legal, ethical and business concerns. The reader's clinical judgment and professional expertise must be applied to any and all information in this document.