

MARY ANN HODOROWICZ CONSULTING, LLC
Mary Ann Hodorowicz, RDN, MBA, CDCES, Certified Endocrinology Coder

Nutrition, Diabetes Education, Health Promotion and Insurance Reimbursement for Professionals in the Healthcare and Food Industry
 12921 Sycamore • Palos Hts, IL 60463 • 708.359.3864 • mahodorowicz@yahoo.com • www.maryannhodorowicz.com

CLIENT NEEDS and GOALS ASSESSMENT
SPECIFIC TO DIABETES RELATED OUTPATIENT PROGRAMS v8

Please preserve as MS Word document (not pdf) with information typed in; email to: mahodorowicz@yahoo.com

CLIENT INFORMATION	
Date:	
Client Name:	
Client Title or Position:	
Designee Completing Table:	
Designee Title or Position:	
Name of Business/Company/Organization:	
Type of Business/Company/Organization (hospital, FQHC, etc.):	
Street Address:	City:
State:	Time Zone:
Zip:	Phone After Business Hours:
Phone During Business Hours:	Fax Number:
Cell Phone:	Alternate Email:
Email:	Email:
Point Person or Project Manager for Consulting: Name: Title:	Email:
Other Persons Expected to Participate in Consulting: Name: Title: Name: Title:	Email: Email:

CLIENT'S MAJOR EMPLOYMENT AREA(S) AND RESPONSIBILITIES (CHECK ALL THAT APPLY)	
<input type="checkbox"/> Business management or supervisor	<input type="checkbox"/> Medical Nutrition Therapy (MNT)
<input type="checkbox"/> Hospital food and nutrition services management	<input type="checkbox"/> Diabetes Self-Management Training/Education (DSMT/E)
<input type="checkbox"/> DSMES program coordinator	<input type="checkbox"/> Obesity/overweight counseling
<input type="checkbox"/> Hospital inpatient work	<input type="checkbox"/> Writing
<input type="checkbox"/> Hospital outpatient work	<input type="checkbox"/> Editing, publishing, media work
<input type="checkbox"/> Internship program director or educator in academia	<input type="checkbox"/> Information technology/communications
<input type="checkbox"/> CDE	<input type="checkbox"/> Marketing and/or public relations
<input type="checkbox"/> Consultant	<input type="checkbox"/> Insurance billing or medical record claims coding

<input type="checkbox"/> RDN/Dietitian <input type="checkbox"/> Clinical Nutrition Specialist	<input type="checkbox"/> Community nutrition/nutrition education
<input type="checkbox"/> RN	<input type="checkbox"/> Advocacy/association membership work
<input type="checkbox"/> Account Rep	<input type="checkbox"/> Teaching
<input type="checkbox"/> Physician; Specialty is:	<input type="checkbox"/> Health promotion, wellness
<input type="checkbox"/> NP	<input type="checkbox"/> Medical devices
<input type="checkbox"/> PA	<input type="checkbox"/> Medical foods
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Pharmaceuticals
<input type="checkbox"/> CNS (Clinical Nurse Specialist)	<input type="checkbox"/> Pharmacy

Please answer questions below in **RIGHT** column to the best of your ability. Rows expand as you type. N/A = not

I. IDENTIFICATION OF 1, MAIN PROGRAM OF INTEREST FOR THE TECHNICAL ASSISTANCE (USE NEW FORM FOR EACH PROGRAM)

- Please check the **1 main program** that you are requesting the original technical assistance/consulting for (* = Medicare benefit)
 - Diabetes self-management education and support program (DSMES)...Diabetes Self-Management Training (DSMT)*
 - Medical nutrition therapy program (MNT)*
 - Intensive behavior therapy for obesity program (IBT)*
 - Shared medical appointments (SMA) (components of may be covered by Medicare, depending on the type)
 - Continuous glucose monitoring (CGM): professional and therapeutic/personal*
 - Diabetes prevention program (DPP)*
 - Other (please indicate here):
 - Add CMS waivers for above Medicare benefits per the COVID-19 public health emergency

II. MAIN QUESTIONS, ISSUES OR PROBLEMS FOR THE TECHNICAL ASSISTANCE FROM THE 1, MAIN PROGRAM SELECTED ABOVE

- A.
- B.
- C.
- D.

DSMES / DSMT PROGRAM ONLY

ANSWERS

<ul style="list-style-type: none"> • Is DSMES program currently accredited by ADCES or recognized by ADA? <ul style="list-style-type: none"> ○ If NO, have you applied for either in the past? <ul style="list-style-type: none"> ■ Do you wish to apply in the near future? • What type of entity is the parent/primary site of the program (hospital, physician group, FQHC, rural health clinic, independent clinic, pharmacy, RDN private practice)? • If you are not the primary site, what type of entity are you? (e.g., health department). • Is the program being furnished in any off-site locations? • Does the program have ADCES Branch or Community sites? Or ADA Multi or Expansion sites? • If no off-site locations, do you wish to add any? If yes, which types of locations? (AAA site, church, recreation dept., library, physician group, health department)? • What is the name of your DSMES curriculum? • Do you use a peer-led curriculum such as Stanford DSMP or DEEP? <ul style="list-style-type: none"> ○ If YES, how many lay instructors (community health workers) furnish the education? <ul style="list-style-type: none"> ■ What type of health care professional oversees the lay instructors? ■ Have the lay instructors completed your initial training on their role in the DSMES 	
<ul style="list-style-type: none"> • How is your program designed? Please specify: <ul style="list-style-type: none"> ○ Number of individual and group visits in 1 complete program. ○ Time frame for individual and group visits. ○ Time frame in-between visits. ○ How many weeks or months it takes for OPs to complete the program. ○ Number of programs furnished in 12 months or 1 calendar year. ○ What tools you use to guide your clinical decisions and the diabetes care of your 	
<ul style="list-style-type: none"> • What is the current staffing structure of the program? <ul style="list-style-type: none"> ○ Types of health care professionals and number of. ○ Secretarial support: if YES, number of hours per week. ○ Other non-billable program activities that staff is responsible for (e.g., marketing, data 	

<ul style="list-style-type: none"> • Re: your scheduling model used for the health care professionals (HCP) furnishing the program: <i>On average</i>, for one HCP who works an 8 hour day: <ul style="list-style-type: none"> ○ How many 1 hour individual OP visits are scheduled? ○ How many ½ hour individual OP visits are scheduled? ○ How many group OP visits are scheduled? <ul style="list-style-type: none"> ■ How many hours is the group visit? ■ How many group visits are in the complete program? ■ How many OPs typically attend the group visits? ■ Does attendance start to decrease after the first group visit in the program? ○ What percent of the time do the individual & group visits last longer than the time scheduled? ○ How much time does it take (or is scheduled) for the HCP to: <ul style="list-style-type: none"> ■ Prepare for the 1 or ½ hour individual OP visit (pre-visit time)? ■ Complete the documentation after the 1 or ½ hour individual OP visit (post-visit time)? 	
<ul style="list-style-type: none"> • List any other services or programs being furnished, in addition to the one main program you have been answering questions on (e.g., MNT, CGM, DPP, etc.). <ul style="list-style-type: none"> ○ Is your entity billing health care insurers for these services or programs? ○ If YES, are you receiving reimbursement from the insurers? 	
III. FINANCES AND BILLING OF HEALTH CARE INSURERS FOR THE MAIN PROGRAM	
<ul style="list-style-type: none"> • Is the program making money, losing money or breaking even? 	
<ul style="list-style-type: none"> • Are any health care insurers being billed for this main program? • If NO, what are the reasons for not billing? • IF YES, PLEASE CONTINUE: 	
<ul style="list-style-type: none"> • What is the type of entity...or entities...that are billing for the main program? <ul style="list-style-type: none"> ○ Hospital? FQHC? RHC? Critical Access Hospital? Pharmacy? Physician group? Multiple physician groups affiliated with the entity? Other (please specify)? ○ What other services is the entity or entities billing Medicare Part B for? ○ Is the entity or entities Medicare Part B organizational providers? 	
<ul style="list-style-type: none"> • Are any individual health care professionals billing for the main program under their NPI number? <ul style="list-style-type: none"> ○ If YES: <ul style="list-style-type: none"> ■ Who are they: Physicians? RDNs? NPs? Other? 	
<ul style="list-style-type: none"> • Is the billing done on the UB-04 claim or the professional 1500 claim? 	
<ul style="list-style-type: none"> • If the billing is done on the professional 1500 claim, who is the rendering provider on the claims? 	
<ul style="list-style-type: none"> • Who is the billing provider on the claims? <ul style="list-style-type: none"> ○ If the billing provider is a hospital, what revenue code is used on the UB-04 claims? 	
<ul style="list-style-type: none"> • What procedure codes are used on the claims for the main program? 	

<ul style="list-style-type: none"> • Do you receive provider referrals for the main program? <ul style="list-style-type: none"> ○ If YES, how are the referrals received (EMR, faxed paper referral, combination, other)? ○ If YES, email Mary Ann a blank referral form or EMR screen shot of the referral. 	
<ul style="list-style-type: none"> • Has anyone from your main program discussed the billing process with your billing department? <ul style="list-style-type: none"> ○ If YES, what relevant information have the billers conveyed to you about the billing 	
<ul style="list-style-type: none"> • Do you receive a Reimbursement Tracking Report for your program(s) on a regular basis? <ul style="list-style-type: none"> ○ If YES, please email me a blank template of the Report. 	
<ul style="list-style-type: none"> • What health care insurers are currently billed for the program? <ul style="list-style-type: none"> ○ Medicare? ○ Medicaid? ○ Private payers? Which ones? 	
<ul style="list-style-type: none"> • Of these above health care insurers being billed, are the claims: <ul style="list-style-type: none"> ○ Paid? Denied? Rejected? 	
<ul style="list-style-type: none"> • If denied or rejected, what is insurer's reason/reasons? (are listed on insurer's remittance 	
IV. MARKETING TO PHYSICIANS, COMMUNITY PEOPLE and IN-HOUSE EMPLOYEES	
<ul style="list-style-type: none"> • Do you have a customized and branded referral form (paper and/or EMR) for your main program? <p>If YES:</p> <ul style="list-style-type: none"> ○ Are local area and in-house providers given this referral form? <ul style="list-style-type: none"> ■ If YES: <ul style="list-style-type: none"> ❖ Are the referral forms mailed, emailed or hand-delivered in person? ❖ Is the form designed to be Medicare compliant? ❖ Please mail Mary Ann a blank referral form or EMR screen shot of the referral 	
<ul style="list-style-type: none"> • Do you accept patient self-referrals? <ul style="list-style-type: none"> ○ If YES, what is your process for then obtaining a provider referral, if the insurer 	
<ul style="list-style-type: none"> • How many providers, on average, refer their patients to your main program? 	
<ul style="list-style-type: none"> • Have provider referrals been increasing, decreasing or staying the same? 	
<ul style="list-style-type: none"> • Are you interested in increasing the number of providers who refer? 	
<ul style="list-style-type: none"> • What marketing activities do you regularly use with providers to increase referrals? 	
<ul style="list-style-type: none"> • Are you having problems with maintaining a high attendance rate of patients in the program? <ul style="list-style-type: none"> ○ If YES, what do you think are the main barriers to patient attendance in the program? 	
<ul style="list-style-type: none"> • What marketing activities do you regularly use with community people to increase self- 	
<ul style="list-style-type: none"> • What marketing activities do you regularly use with in-house employees to increase self- 	

<ul style="list-style-type: none"> Do you conduct any program satisfaction ratings of your patients? Referring providers? If YES: <ul style="list-style-type: none"> How often are the ratings done? What are the ratings, on average (excellent, very good, good, etc.)? If NO: Are you interested in implementing satisfaction ratings? 	
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V. OTHER

<ul style="list-style-type: none"> Is there any other relevant information you would like to provide? 	
<ul style="list-style-type: none"> Do you have any other specific questions or other topics that you would like assistance with? Pretend you're a kid in a candy store! 	

VI. YOUR TIME FRAMES

<ul style="list-style-type: none"> What is your desired time frame for having your needs met? Do you have a <i>firm</i> deadline? OPTIONAL: How did you learn about MARY ANN HODOROWICZ CONSULTING, LLC? <input type="checkbox"/> Flyer <input type="checkbox"/> Web search <input type="checkbox"/> Health department <input type="checkbox"/> Referral <input type="checkbox"/> Heard Mary Ann speak <input type="checkbox"/> ADCES <input type="checkbox"/> Academy of Nutrition and Dietetics <input type="checkbox"/> LinkedIn <input type="checkbox"/> Networking <input type="checkbox"/> Former/current client of Mary Ann's <input type="checkbox"/> Lifescan Diabetes Institute <input type="checkbox"/> Twitter <input type="checkbox"/> Mary Ann's website <input type="checkbox"/> Other: _____ 	
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VII. TERMS OF THE TECHNICAL ASSISTANCE (TA), DISCLAIMER AND YOUR SIGNATURE

<ul style="list-style-type: none"> The technical assistance (i.e., telephone calls, emails, and resources provided) by Mary Ann Hodorowicz Consulting, LLC (the Consultant) to be received by the person completing this assessment, and/or by his/her entity-associated colleagues (the Client) is intended for educational, informational and reference purposes only. It does not constitute any form of legal, financial, medical or other professional advice. The TA: <ul style="list-style-type: none"> Does not necessarily reflect opinions, policies and/or official positions of the Centers for Medicare & Medicaid Services, Medicare Administrative Contractors (MACs), private healthcare insurance companies, or other professional associations (hereby known as Authoritative Sources). The benefit coverage guidelines and other guidance by these organizations are subject to change at any moment, and are subject to interpretation by its legal representatives, end users and recipients. Is not a replacement for the Academy of Nutrition and Dietetics' Nutrition Practice Guidelines, the American Diabetes Association's Standards of Medical Care in Diabetes, guidelines published by the Association of Diabetes Care and Education Specialists, nor any other related guidelines. The Consultant is not liable to the Client for any loss that the Client incurs as a result of the Client's independent interpretation of the Authoritative Sources, of the Consultant's information that she transmits verbally, electronically and in print to the Client, and the application of such. The Client should consult Authoritative Sources before making final decisions on billing, coding and reimbursement procedures. The recipients of the technical assistance, and their governing officials, should seek professional counsel for legal, ethical and business concerns. As always, the recipients' clinical judgment and expertise must be applied to any and all technical assistance provided. The Consultant uses the following references (and perhaps others), and also the opinions of experts throughout the country in the diabetes space: <ul style="list-style-type: none"> Association of Diabetes Care and Education Specialists Academy of Nutrition and Dietetics American Diabetes Association Centers for Disease Control American Medical Association Centers for Medicare and Medicaid Services American Academy of Professional Coders American Association of Clinical Endocrinologists American Health Information Management Association Healthcare Information and Management Systems Society ICD-10-CM Coding and CPT Coding Manual Others as may be required 	
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