Watch 3 basic errors, frequency to beat high denial rates on diabetes training

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Medicare's two biggest educational services for diabetic patients have dismal denial rates, and experts say that providers who bill them have to be extra attentive to documentation details to beat the spread.

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are often recommended to beneficiaries newly diagnosed with diabetes. The former service is expressly for diabetic patients, while the latter is also indicated for patients suffering from some forms of renal disease for which that counseling is appropriate.

DSMT must be ordered by an enrolled Medicare physician and may be performed by a registered nurse, registered dietitian or other enrolled Medicare provider who is also a Certified Diabetes Educator accredited by either the American Diabetes Association (ADA) or the Association of Diabetes Care & Education Specialists (ADCES, formerly known as the American Association of Diabetes Educators or AADE).

According to CMS, DSMT instruction covers "eating healthy, being active, monitoring blood sugar, taking medicine and reducing risks." MNT, which focuses on dietary issues, must be rendered and billed directly to Medicare by a registered dietitian (RD) or nutrition professional, properly certified and enrolled.

Billing Medicare is a challenge

Both services are commonly covered by private insurers as well Medicare. In fact, private insurers may be more likely to accept claims than Medicare, says Lucille Hughes, DNP, MSN/Ed, RN, CDCES, director of diabetes education at Mount Sinai South Nassau in Oceanside, N.Y.

"I can't get back what I pay my CDCES [certified diabetes care and education specialist] per hour" on Medicare reimbursement, Hughes says. "So you hope to have commercial plan contracts, a couple of those, to offset the low reimbursement rate paid by Medicare.

Denials under Medicare for these services are historically steep, with DSMT claims denials running up into the 30% and MNT into the 60% range (*see benchmark, p. 5*). At the same time, there is evidence that it is vastly underprescribed: According to a 2015 study by CMS researchers, "approximately 5% of Medicare beneficiaries with newly diagnosed diabetes used DSMT services."

Hughes feels CMS makes reporting the services too difficult for providers. For one thing, DSMT has to be ordered by an enrolled physician, which means "a patient with diabetes needs to get permission to be educated about their disease and how to manage it," Hughes says.

For another, it's too easy for beneficiaries to lose their benefit. In the first year, for example, if a patient makes their initial DSMT appointment, they are eligible for up to nine covered group sessions within the first year; but if they miss any of them in that time period, those sessions will no longer be covered.

For this reason, the Association of Diabetes Care & Education Specialists (ADCES), on the board of which Hughes serves, is pushing an Expanding Access to the DSMT Act that would, among other things, allow "qualified nonphysician practitioners" to refer to DSMT, extend the nine-group-visit allowance indefinitely and remove cost-sharing. Currently, Part B beneficiaries pay 20% of the approved amount, and the deductible applies.

Watch 3 big DSMT issues

According to Sacha Uelmen, RDN, CDCES, director of diabetes education and prevention programs for ADCES, the three most common DSMT requirements that are missed, leading to denial, can be found in the Medicare manual, right after the requirement for a "statement signed by the physician that the service is needed." The three areas to focus on are:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training).
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas, such as nutrition or insulin training).
- A determination that the beneficiary should receive individual or group training.

Communication is a major problem, Uelmen says. "Referring providers do not typically know how many hours the person will need, do not know specifically what topics need to be covered or whether the individual will require individual or group

training," she says. The educator should assess the beneficiary to get this information and convey it to the provider before the referral is submitted.

Also note: "The only provider who can refer for DSMT is the provider treating the beneficiary's diabetes," Uelmen says. "In other words, if a referral comes from an ER physician, then the claim would be denied."

Avoid same-day service

The poor denial rates surrounding MNT are more of a puzzle. Claudia Hleap, MS, RD, LDN of Hleap Nutrition in Philadelphia, says a physician referral with a diagnosis of diabetes, non-dialysis kidney disease, or 36-months post kidney transplant, should earn the patient three hours completely covered in the first year, and two hours of MNT annually. There's no copay or deductible with the service.

One possible issue: DSMT and MNT services cannot be provided to the same patient on the same day.

To help providers and educators keep track, ADCES offers online resources, including an explainer that lays out the DSMT/MNT service requirements and a Diabetes Services Order Form that helps keep track of those requirements as they are met (*see resources, below*).

Resources

- ADCES, "Diabetes Services Order Form": www.diabeteseducator.org/docs/default-source/default-document-library/diabetes-services-order-formcb55dc36a05f68739c53ff0000b8561d.pdf?sfvrsn=4
- ADCES, "Diabetes Self-Management Education & Support/Training and Medical Nutrition Therapy Services": *www.diabeteseducator.org/docs/default-source/default-document-library/background-on-the-diabetes-services-order-form.pdf?sfvrsn=4*