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HEALTHCON

OPTIMAL CODING FOR DIABETES SUPPORT TEAM

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Today’s Goals

- Understand the need for diabetes education
- Discuss how to build a program at your practice
- Review opportunities associated with existing diabetes programs and future pre-diabetes program opportunities reimbursed by CMS and some private payers

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Why Diabetes?

Diabetes

8.3% of U.S. adult population

- 30.5 million primary diagnosis outpatient visits annually
- 700,000 principal diagnosis for inpatient with length of stay of 5 days

215,000 children and teens also have diabetes (0.26%)

- *Source: NIH Publication No. 11–3892*

Diabetes

National costs: $176 billion/year direct; $69 billion indirect

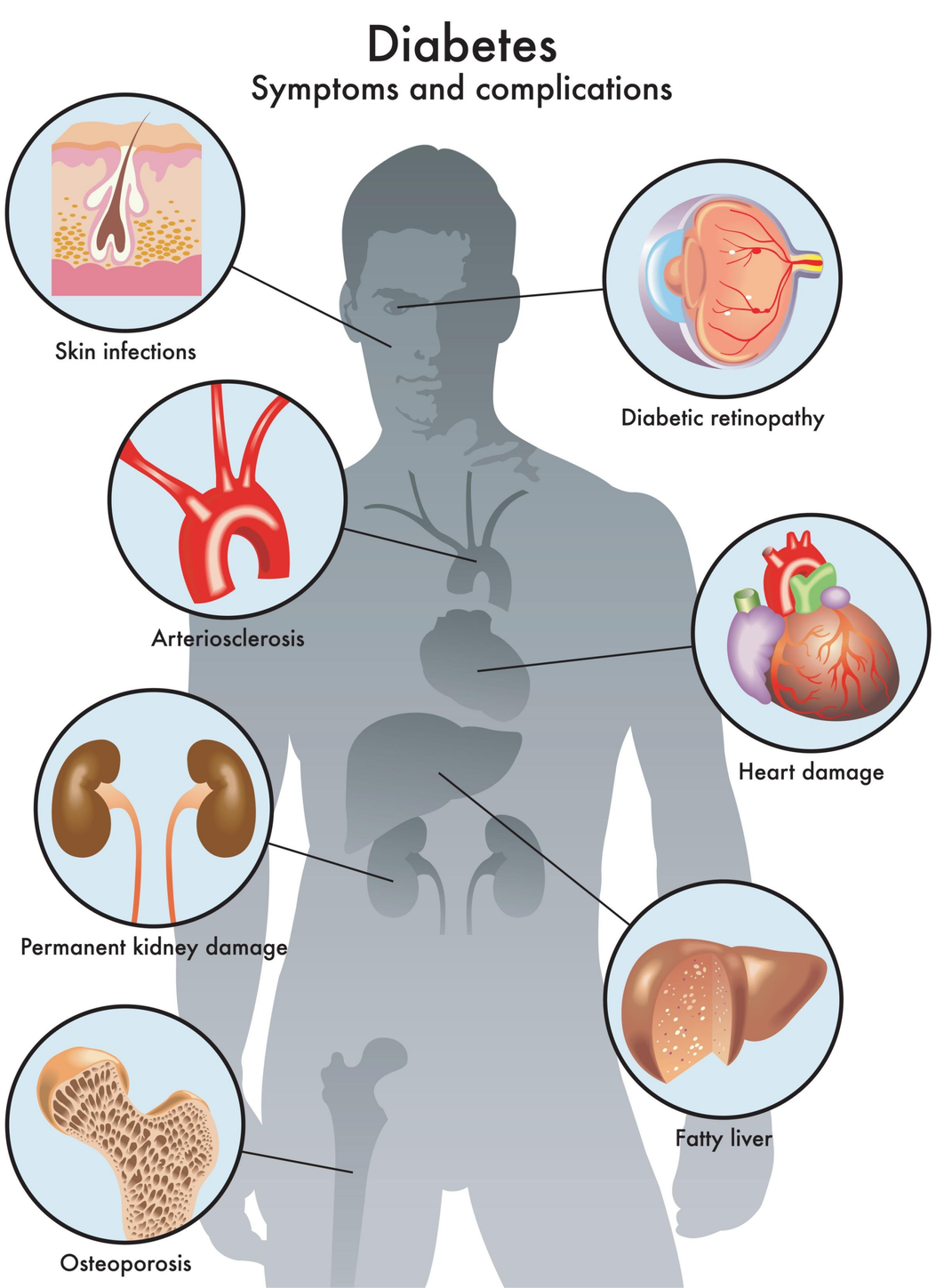
- $1 in every $5 health care dollar is spent on diabetic patients
- 18% pregnancies affected by gestational diabetes
- Heart disease noted on 68% if death certificates for diabetic patients

Diabetes

- 1 in 4 Medicare recipients
- Spending exceeded $42 billion MORE in 2016 for Medicare beneficiaries with DM in 2016 than it would have for the same beneficiaries if they had NOT had diabetes
  - $20 billion Part A
  - $17 billion Part B
  - $5 billion Part D

Diabetes

- CAD and stroke rates 2-4 times that of nondiabetics, accounting for 65% of deaths for diabetic patients
- 45% of new cases of ESRD each year
- Leading cause of blindness and non-traumatic amputation
- Affects microvessels throughout body
- What helps: tight control of BG, exercise



Diabetes

- Now considered a preventable disease – for those diagnosed with **prediabetes**

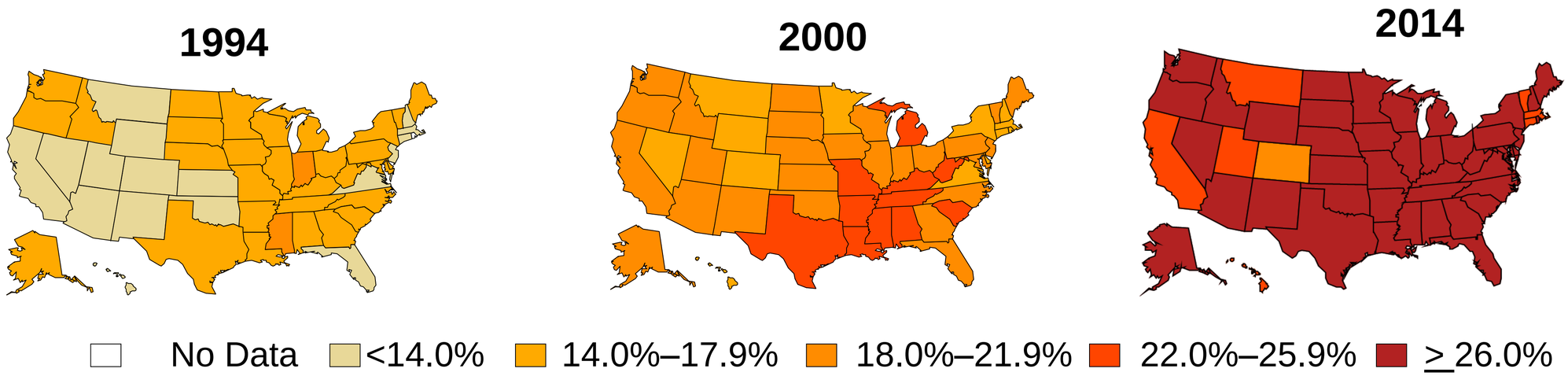
R73.03 *Prediabetes* AKA borderline diabetes

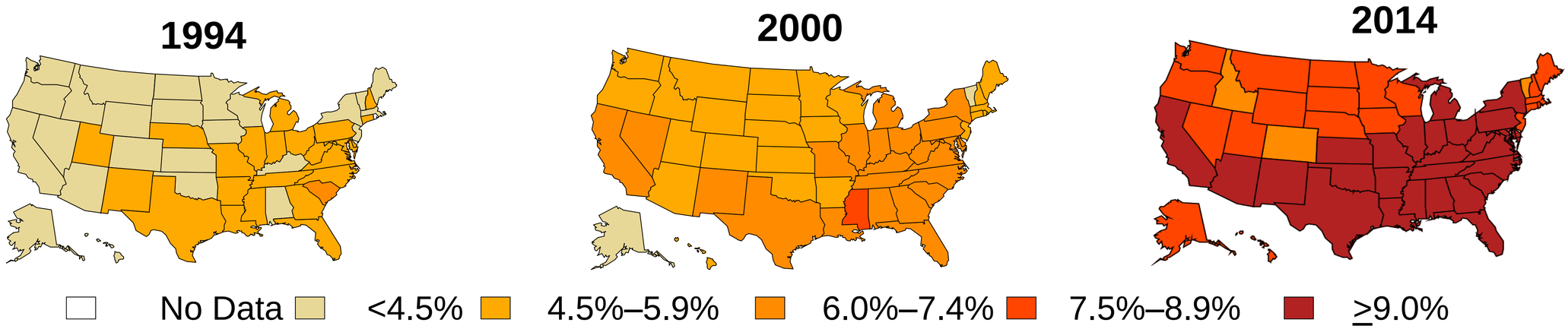
- Elevated A1C, impaired fasting glucose or impaired glucose tolerance, but not enough to be considered diabetic

- Without lifestyle changes, will usually become diabetes within 5 years

- With intervention, diabetes can be delayed or avoided altogether

Age-adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults





NOTE: Survey method changes in 2011 may impact trends
http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html.

CDC's Division of Diabetes Translation. United States Diabetes Surveillance System available at http://www.cdc.gov/diabetes/data

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Medicare Diabetes Prevention Program (MDPP)

Medicare Diabetes Prevention Program

- Diabetes Prevention Program (DPP), a pilot study reduced or delayed by at least 10 years the incidence of DM in patients with prediabetes by counseling on lifestyle changes

- Full implementation streamlined for 2018 implementation

Medicare Diabetes Prevention Program

- **Structured behavioral change intervention** to prevent Type 2 DM in people with prediabetes
- CMS expanded DMPP coverage beginning January 1, 2018
  - Under section 115A(c) of Social Security Act
- Initial appointment a preventive service with no cost-sharing
- 86,000,000 people have prediabetes in the United States (33% of adults)
- **It's time to prepare!**

Medicare Diabetes Prevention Program

- **Eligible beneficiaries**
  - Enrolled in Part B
  - BMI at first session 25 or greater (23 or greater if self-identified as Asian)
  - A1C in prior 12 mo of between 5.7 and 6.4, fasting glucose of 110-125, or 2 hr glucose of 140-199
  - No previous DM diagnosis (except gestational) or ESRD
  - More info at https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-11-02-2.html

Prediabetes testing

- Adult screening begins:
  - at age 45
  - or in adults with BMI greater than 25 (23 or greater in Asian Americans)
  - or adults who have other risk factors (dyslipidemia, high triglycerides, low HDL, HTN)
- Child screening for those who are overweight or obese and who have 2 or more risk factors for DM

Prediabetes testing

- Screening? Use these tests and codes:
- **82947** Glucose; quantitative, blood (except reagent strip)
- **82950** Glucose; post glucose dose (includes glucose)
- **82951** Glucose; tolerance test (GTT), three specimens (includes glucose)
- Report **Z13.1** Encounter for screening for diabetes mellitus
- Append modifier TS if patient has pre-diabetes (Follow-up, not screening)

MDPP Under Medicare

- 16 weekly core hour-long sessions, over months 1-6
- 6 monthly maintenance sessions, over months 7-12
- PLUS
- 3 month intervals of ongoing maintenance thereafter if they achieve and maintain a 5% weight loss in the preceding 3 months
- No cost-sharing

MDPP

- **Eligible providers/suppliers**
  - Trained community coaches or health professionals
  - Enrolled in Medicare with active and valid NPIs
  - Recognized by CDC as Diabetes Prevention Recognition Program
  - Virtual attendance may be considered
  - Payment structure (new codes?) will originate in 2017 rulemaking

MDPP

- **Core 16 sessions must include**

Welcome to NDPP
Self-monitoring weight and food intake
Strategies for healthy eating out
Reversing negative thoughts
Dealing with slips in lifestyle change
Introduction to physical activity
Overcoming barriers to success
Environmental cues to eating
Problem solving
Eating less
Healthy eating
Social cues
Managing stress
Staying motivated
Balancing intake and output
Aerobic fitness

MDPP

- **Where to go to follow advancement of MDPP rules**
  https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

Current Options for Programs for Diabetic Patients

The Need

- **Diabetes Control and Complications Trial** (DCCT) proved that intense glucose control reduces or delays long-term complications of diabetes

- **Medical Home and Chronic Care models** provide frameworks for effective care of DM, using team care for delivery

- **But are prevention programs effective?**

VA PACT

Prevention Amputation Care and Treatment (PACT)

- Multidisciplinary team
- Targets patients with DM, ESRD, PAD
- Screens for foot-risk factors, referrals and interventions
  - Monofilament test for LOPS, pedal pulses, visual inspection
  - **Amputation rate has been cut in half (from 8.5 to 4.2 per 1000)**

Diabetes screening

- **Medicare Eligibility**

Z13.1 Encounter for diabetes screening

- One of these factors:
  HTN, dyslipidemia, BMI of 30 or greater, previous elevated BG
- OR two of these factors:
  Family history, age 65 or older, history gestational DM or delivery of baby greater than 9 lbs, BMI greater than 25
- One test per year for patients without prediabetes; two for those with prediabetes

What's the next step?

- **The diabetes novice "enters the system."**

“Diabetes Support Team”

- **Multidisciplinary team led by primary care provider or endocrinologist**
  - Includes, as appropriate, PA, NP, dietician, certified diabetes educator, social worker, mental health professional, dental care professional, pharmacist, medical specialists, school nurses
  - Approach:
    - Shared appointments, group education, telehealth, shared records

Patient referrals

- Ophthalmologist, annual dilated eye exam
- Family planning for women of reproductive age
- MNT with registered dietician
- DSME/DSMT diabetes self management education / training
- Dentist
- Mental health, foot care, kidney care

“Diabetes Support Team”

- **Benefits**
  - Facilitates DM management
  - Lowers risk of chronic disease complications
  - Educates regarding risk factors for patient and family members
  - Cost effective on several levels
    - Reduced testing; reduction in long-term complications

Diabetes Self-Management Education/Training

- **Diabetes self-management education (DSME/DSMT)**
  - National standards first published by ADA in 1984, programs recognized in 1987, updated in 1995, 2000, 2007, 2012
    - Revisions to standards made for 2017
  - Medicare began reimbursing in 1997

ADA 2017 changes DSME

- Differentiation of beta cell dysfunction and disease stage to achieve personalized diabetes care
- Psychosocial care
- Expanded physical fitness
- Metabolic surgery
- Hypoglycemia

ADA 2017 changes DSME

- **Differentiation of beta cell dysfunction and disease stage to achieve personalized diabetes care**
  - Does the patient have Type 1, Type 2 or other form of diabetes?
  - Is the DM treated with oral meds or insulin or both?
  - What is the overall health of the individual? What are the potentials?
  - What can prevent the patient from achieving success?

ADA 2017 changes DSME

- **Psychosocial care**
  - Screening of adults and youths for depression, anxiety, eating disorders, with criteria for referral to behavioral health specialists
  - Assessment of comorbidities as part of patient-centered evaluation, for example, autoimmune disease, HIV, anxiety disorders, depression, eating disorders, or serious behavioral disorders

ADA 2017 changes DSME

- **Expanded physical fitness**
  - Recommendation to interrupt prolonged inactivity every 30 minutes
  - Sleep pattern assessments (may be associated with BG management)

ADA 2017 changes DSME

- **Metabolic surgery for type 2 adult patients revised**
  - Include patients with poorly controlled DM with a BMI of 30 or greater; 27.5 or greater for Asian Americans
  - Emphasis on treatment for HTN
  - New insulin algorithm for type 2 diabetics
  - Additional medications for patients with DM and CAD or PAD

ADA 2017 changes DSME

- **Hypoglycemia**
  - Noted that any BG value of less than 54 is “serious clinically important hypoglycemia” even without symptoms

2017 changes DSME

- “To help reduce health disparities, the Standards now recommend people with diabetes receive self-management support from lay health coaches, navigators, and community health workers.”

What is covered?

- Part B covers 10 hours of initial training/education to beneficiary with DM diagnosis, and 2 hours of follow-up training each calendar year thereafter
  - Increments must be at least 30 minutes each
  - Only 1 hour of initial training must be individual
  - Follow-up training can be individual, or group of up to 20 individuals

Referral from qualified health care professional (usually MD, PA, NP)

How is it covered?

- DSMT/DSME must be ordered by acceptable provider managing the patient's diabetes
- ABN should be issued only if patient is expected to go over allowable number of education visits. No other reason allowed (ie, no ABN if educators are not qualified)
- POS not covered: hospital inpatient, hospice, nursing home, rural health center, ESRD facility

When is it covered?

- **ADA says**
  - At diagnosis
  - Annually for assessment of education, nutrition, emotional needs
  - When new complicating factors arise that influence self management
  - When transitions in care occur

Certifications

- Diabetes self-management education (DSME/DMST) taught by those certified through
- American Diabetes Association or
- American Association of Diabetes Educators
- Or anyone with a higher level of certification

What is covered?

- **G0108** Diabetes outpatient self-management training services, individual, per 30 minutes

- **G0109** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Assessing patient

- Eating patterns, nutritional status, weight history, sleep,
- Screening for diabetes distress, psychosocial problems like support, financial, logistical
- Tobacco, alcohol, substance use
- Treatment regiment
- Medication taking behaviors, DKA frequency, severity, cause

Medical nutritional therapy

- Individualized nutrition therapy to aid control of blood glucose
- Personalized behavioral changes including exercise, testing, stress reduction
- Long term follow-up with labs, tracking outcomes and adjusting behavior modifications

MNT

- Registered dietician or nutritional professional (NP), Medicare provider (BS in nutrition/dietetics from accredited school and 900 hours of practical experience, licensed or certified)
- Follow MNT payment rules from CMS
- Carb counting for all Type 1 and some Type 2
- Portion control, glycemic control
- Individualized planning
- Weight goals

MNT

- Referral from treating physician. Qualified non-physician practitioners cannot make the referral for MNT
- Separately billable from DSMT services, but cannot be received on same day as DSMT services
- 3 hours in first calendar year
- POS not covered: inpatient hospital, skilled nursing facility, rural health clinic

MNT codes

- **G0270** Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes

- **G0271** Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

MNT codes

- **97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97803** reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97804** group (2 or more individual(s)), each 30 minutes

Other codes

- **Case Management Services**

  Physician or other qualified health care professional

  - 99366-99368 Medical team conference (99368 is not a provider)
  - 99490-99489 Chronic care management (2015)

Growing a Program

Huge Pool of Potential

- According to CMS statistics, the new programs will be available to 86 million prediabetics, and all current diabetics
- This is a huge population base!
- Where do we dip our toe?

Targeting Patients

- **Identify sub-population of patients at highest risk**
  - **With DM**: A1C, HTN, lipids, CAD, GFR, smoking, BMI, duration of disease, comorbidities, literacy, social support, hypoglycemia history, family history
  - **Without DM:** BMI, Family history, race, history of gestational DM, HNT, lipids, PAD, inactivity, PCOS
  - **With DM with new issues:** new DM, new complications, frequent hypoglycemia, pregnancy, initiation of insulin

Targeting Patients

- Conduct ongoing self-management education and behavioral interventions
- Provide remote management of sugars
- Promote risk-factor reduction
- Periodic examinations

Targeting Patients

- **Improvements the programs bring:**
- Better control of blood sugar, lipids, and blood pressure
- Better patient follow-up
- Better patient satisfaction
- Fewer or delayed complications
- Better quality of life
- Lower health care costs

Steps to Growing a Program

- Commitment of leadership
- Identify team members (internal and external)
- Target patient population
  - Stratified for programs: new diagnoses; patients with complications; type 1 vs 2; divided by age
- Determine the goals, philosophy and objectives and create tools and policies that reflect these
- Determine payment mechanisms and payment systems
- Monitor outcomes and continue to remodel the program to improve them

Assessing Barriers to Care

- Literacy
- Visual impairment
- Mathematical ability
- Finances
- Cognitive impairment
- Physical ability (self-examination of feet, for example)
- Transportation or physical location

Telehealth

- Real-time video conferencing between provider and patient
- Real-time video-conferencing for group and individual education or counseling
- Real-time dietary counseling
- Remote monitoring of blood glucose and blood pressures
- Patient portals

Telehealth

- Digital retinal screenings in remote areas
- 4 year study of Indian Health Service netted a 50 percent increase in compliance with annual eye exams and a 51 percent increase in laser treatments to prevent blindness from diabetic retinopathy
- **92227** Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral

Thank you!

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