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Nutrition, Diabetes Education and Insurance Reimbursement for Professionals

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COVERAGE GUIDELINES FOR DIETITIAN'S SERVICES and/or DSME THAT ARE DEFINED BY HEALTH INSURANCE PAYERS

BENEFIT COVERAGE:

- 1) Are any dietitian/RD services and/or dietitian-related services covered?
- 2) What are specific names of benefits/services that are covered?
 - MNT
 - Diabetes Self-Management Education/Training (DSME/T)
 - Nutrition Education
 - Nutrition Counseling
 - Dietitian Consult
 - Dietary Surveillance and Counseling
 - Other?

PROVIDER ELIGIBILITY:

- 1) If any above services covered, who specifically can direct bill?
 - RDs
 - MDs
 - DOs
 - Mid-levels: NPs, PAs, CNSs
 - Pharmacists
 - Other?
- 2) If any above can direct bill:
 - Is an *in-network* provider contract required?
 - If yes, are you accepting applications from RDs to be in-network providers?
 - OR
 - Are out-of-network claims from healthcare professionals evaluated for payment on a case-by-case basis?
- 3) Are BG meters covered? If yes, what are coverage guidelines?
 - Physician Rx
 - Type covered (brand name)
 - CPT code
 - ICD-9 codes/diagnoses
 - Frequency for obtaining new meter (every 2 yrs, 3 yrs?)
 - Where and how to obtain supplies (strips, lancets, lancet pen, batteries, control solution)
 - Limit on amount of testing supplies and in what time period (utilization limits)

CLAIMS and CLAIMS CODING:

- 1) What CPT/HCPCS codes should be used on claims for above *covered* services for:
 - Initial visit

- Follow-up visit
 - Group visit
 - Individual visits
 - Educational materials
 - BG meter receipt
- 2) What is time limit for submitting a claim?
 - 3) What is process for a claims appeal if claim is denied or rejected?

REIMBURSEMENT:

- 1) What is payment rate per;
 - *Unit of service (e.g., 15 minutes = 1 unit of MNT or 30 minutes = 1 unit of DSME)*
 - *Visit*
 - *Does a “visit” have a time limit?*
- 2) Is there a contractual discount requirement?
- 4) Is there a pre-defined patient co-payment due at time of service?
- 5) Must dietitian/RD accept assignment (accept as payment in full the amount that the payer reimburses)?

PROVIDER CONDITIONS:

- 1) Provider’s place of service restrictions or requirements?
 - Private practice, outpatient hospital, physician office setting, dietitian’s home?
 - Does practice setting need to meet specific conditions (proof of fire insurance, exits, etc.)
 - Geographical requirements?
 - Must practice setting be in select geographical area (by zip code or other)?
- 2) If private practice setting NOT eligible, can dietitian still submit claims for payment and have claims evaluated for payment on case-by-case basis?
 - If yes, what is criteria for payment? (Medical necessity?)
- 3) Provider professional designations requirements?
 - State licensure/certification requirement
 - RD requirement
 - CDE requirement for DSME/T benefit
- 4) Proof of provider liability insurance?

PATIENT ELIGIBILITY:

- 1) What ICD-9 codes or diagnoses are required for the above services that are covered?
 - Specifically, is MNT covered for:
 - Obesity?
 - Pre-diabetes (impaired glucose tolerance, impaired fasting glucose)?
- 2) Are there required lab criteria for select diagnoses (e.g., FBG, GFR)?
- 3) Is there a gestational age of fetus requirement?
- 4) Is a written referral required?
 - What must be included on referral?
 - Who can make referral?
 - Physicians and DO’s only?
 - Chiropractors?
 - Mid-levels (NP’s, PA’s, CNS’s)
- 5) Is payer’s pre-authorization of service required?

SERVICE UTILIZATION LIMITS:

- 1) What defines 'episode of care' in *initial* visit and in *follow-up* visit?
 - A calendar year from date on Rx or from first date of service?
 - A rolling year (June 2010 to June 2011) from date on Rx or from first date of service?
- 2) How many units or hours or visits are payable in:
 - *Initial* episode of care?
 - *Follow-up* episode of care?
- 3) Is there a limit (cap) on the number of units or hours or visits for:
 - Each covered diagnosis?
 - For the subscriber, per calendar year or per rolling year, regardless of diagnoses?

OTHER REQUIRED CONDITIONS FOR PAYMENT:

- 1) Does payer have a chart audit requirement?
 - If yes, does payer do specific number of *planned* chart audits periodically, or does payer send auditors to audit by random selection?
- 2) Does payer need to do physical inspection of practice setting as a prerequisite for a provider contract?

FINAL REQUEST: MAY I PLEASE HAVE THESE COVERAGE GUIDELINES IN WRITING FOR MY COLLEAGUES, BILLERS AND CODERS.