Diabetes Education Services

Reimbursement Tips for Primary Care Practice

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The information provided in this booklet is intended as guidance only and is not intended as legal advice. Please contact each payor to determine the specific coverage and reimbursement practices and policies.

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Diabetes self-management education/training (DSME/T) is cost-effective and improves health outcomes as patients maintain better control of their A1C. Diabetes educators provide education/training services and enable physicians to provide comprehensive high quality care for their patients with diabetes and those at high risk of developing diabetes.

Diabetes educators bring a unique skill set to the physician's practice and are important adjuncts to primary care. These educators:

- help patients with diabetes develop the skills for managing their illness.
- increase a practice's efficiency by assuming time consuming patient training, counseling,, and follow-up duties.
- serve as an extension of the physician's practice
- enhance the quality of care delivered.

Diabetes educators are nurses, pharmacists, dietitians, and other healthcare professionals with special training in diabetes care who counsel patients on how to incorporate healthy behaviors into their lives.

Diabetes self-management education/training is an interactive, collaborative, ongoing process involving the person with diabetes (or the caregiver or families) and a diabetes educator(s). Diabetes self-management education/training addresses 7 self-care behaviors known as the AADE7™. These behaviors are:

1. Healthy eating
2. Being active
3. Monitoring
4. Taking medication
5. Problem solving
6. Healthy coping
7. Reducing risk

These are further defined at: http://www.diabeteseducator.org/ProfessionalResources/AADE7/

Physicians will benefit by establishing a relationship with a diabetes educator who can provide these services for their patients with diabetes. The following information applies to services provided by diabetes educators who contract with or are employees in physician offices.

Most payors cover and pay for DSME/T in the primary care setting, although they may use different terminology, e.g., diabetes self management training (DSMT) or diabetes education. Unfortunately, diabetes education is an underused service, perhaps because of a lack of clarity about how to obtain reimbursement. Additionally, services for discipline-specific counseling, such as nutrition therapy provided by dietitians/nutritionists or medication management services provided by pharmacists can also be billed and are frequently reimbursed by third party payors.

Appropriate billing for the services of a diabetes educator and the resultant reimbursement will allow the physician to enhance the care that his/her practice offers to patients with diabetes.

Payment for claims varies by payor. The same is true for coverage and adjudication practices. Because coverage policies vary, the physician will wish to check each payor's coverage policies, coding requirements, and reimbursement guidelines.

Physician billing involves a range of codes—from commonly used Medicare codes to unique codes used by private payors. This booklet provides helpful examples and tips for coding and billing practices used by physicians and billing managers for diabetes education that is provided by diabetes educators including:

- Private Payor and Medicare Coverage and Reimbursement for Diabetes Education
- Coding for Diabetes Education
- CPT® Codes for Diabetes Education
    - Evaluation and Management (E&M)
    - Services that are "incident to" a visit
    - Devices and related therapy/training
- HCPCS Procedure Codes including S Codes
- ICD-9-CM including E and V codes
- Billing for Devices and Related Therapy

Coverage for Diabetes Education/Training

Reimbursement for DSME/T depends on the policies of the payor as well as the location in which the services are provided. Health plans may cover all diabetes education/training provided under a physician's supervision to patients with type 1, type 2, gestational diabetes, non-dialysis kidney disease, and post kidney transplants. A non-physician healthcare professional may be able to provide diabetes services, and do so based on a physician referral or independently, based on their expertise and scope of practice. In other instances, claims may only be submitted for an American Diabetes Association (ADA) recognized patient education program or an AADE accredited program that is supported by a standardized curriculum and is provided by a professional, typically, but not always, a certified diabetes educator (CDE) in a physician's office.

In some cases, the non-physician health care professional may be able to provide diabetes services, based on his/her expertise and scope of practice. Such independent contractor practices may offer DSME/T services in the physician's office or community setting.

Coverage and reimbursement policies vary across geographic locations. Each state has its own specific requirements.

- As of January 2010, at least 46 required private payor coverage for diabetes-related services/supplies.
- 44 states also specifically required provisions for diabetes education/training.
- As of 2007, 27 states required nutrition therapy services for people with diabetes.

Medicaid coverage also varies by state. Typically, reimbursement is available for diabetes self-management education/training if the provider number is acceptable. Physicians will wish to know their state's requirements. State regulations requiring coverage supersede any coverage limitations in a health plan design. The National Conference of State Legislatures provides information about state laws at the website:
http://www.ncsl.org/programs/health/diabetes.htm

Private Payor Coverage and Reimbursement

Private payors may use Current Procedural Terminology (CPT®) codes for diabetes education and nutrition therapy. They may also use HCPCS Level II codes and/or develop their own codes to handle unique aspects of their benefit coverage or claims system. They may pay via fee schedule or also estimate their payment level based on "usual, customary, and reasonable" charges for specific services in a locale.

Specificity and accuracy are the keys to successful billing. Codes are the language of reimbursement and may seem complex and arcane, but accuracy on billing forms ultimately affects patient access to care and the bottom line. Payors depend on physicians and their billers to accurately code for specificity and level to ensure that claims can be processed in an orderly, consistent and timely manner.

Most, but not all, private payors have adopted Medicare's Healthcare Common Procedure Code System (HCPCS) Level II, G codes G0108 and G0109 for DSMT.

Nutrition is one component of DSME/T while it is the focus of MNT services. Medicare allows separate reimbursement for both services when provided by an RD but not on the same date. Most payors follow Medicare instructions to claim DSME/T program under one of the instructors who has been issued an NPI number. This can be a physician or NPP (NP, PA or CNS). MNT services can only be claimed by an RD who has their own NPI number and has assigned their benefits to the group which claims reimbursement. For both DSME/T and MNT, payors distinguish between group and individual diabetes education services. Moreover, the number of sessions covered is likely to be limited. Copayments are considered an integral part of many Medicare's and many private insurers' reimbursement policies.

As with other services paid under the Medicare physician fee schedule, the actual payment amounts may vary among geographic areas to reflect differences in costs of practice. The physician can ask each insurer if they establish fee schedules by relative value units (RVUs), and if so, how this relates to diabetes education and nutrition therapy.

Additionally, some pay-for-performance programs include incentives to reward primary care physicians (PCPs) who offer diabetes education.

The physician is urged to verify that coverage of diabetes education is a payable benefit by contacting the payors that he/she bills.

> ►**TIP** Physicians who provide diabetes care via shared medical (i.e., group) visits which coincide with the services of an RD or PhD psychologist may find that a portion of the encounter is billable under the non-physician's NPI number. In this instance, codes for medical nutrition therapy (97804) or health and behavior intervention (96153) may be relevant.

> ►**TIP** Physicians may wish to encourage patients who have insurance to file claims with their insurance plan.

Medicare Reimbursement of Diabetes Self-Management Training (DSMT)

Medicare has very specific coverage policies for DSMT. DSMT services are covered if the treating physician or qualified non-physician practitioner who is managing the Medicare beneficiary with diabetes certifies that such services are needed. Physicians need to document the:

- Need for education/training and maintain the plan of care in the beneficiary's medical
- record.
- Topics to be covered in education/training.
    - Initial education/training hours can be used for the full initial education/training program or specific areas such as nutrition or insulin education/training.
- Number of hours of group or individual education/training (up to 10 may be ordered). Medicare has assigned specific G codes for DSMT services. These codes can be used to bill most government and commercial payors.

Medicare Coverage of DSMT on an Individual Basis

Medicare covers education/training on an individual basis for a Medicare beneficiary if:

- No group session is available within 2 months.
- The patient has special needs resulting from conditions, such as severe vision, hearing, or
- language limitations, that hinder effective participation in a group education/training
- session. This must be documented in the patient record.
- The physician orders additional insulin education/training.
- The need for individual education/training must be identified by the physician or nonphysician practitioner in the written referral.

►**TIP** Payment to non-physician practitioners for DSMT program services (G0108 or G0109) are paid at the full fee schedule rate (*not* at 85% of the fee schedule).

►**TIP** A DSMT program may include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. A hospital that has an accredited DSMT program can be the biller. If a physician is part of the DSMT program, (i.e. a physician advisor), he or she can be the certified provider and bill Medicare using the physician's Medicare provider number. There may, however, be exceptions. Physicians will wish to check with the Medicare representative.

Medicare Coverage of Medical Nutrition Therapy (MNT)

Medical nutrition therapy (MNT) services provided to a patient with Medicare Part B must be provided by a dietitian or nutritionist who meets specific criteria and ordered by a treating physician. Up to 3 hours of MNT is allowable in the first year and 2 hours in subsequent years. However, additional covered hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis, medical condition, or treatment regimen within such episode of care that makes a change in diet necessary. Both DSMT and MNT can be covered if the treating physician deems both are necessary during the same episode of care; however, both services may not be covered on the same date of

service. Medical nutrition therapy services provided by an RD may continue to be offered after DSMT services have been exhausted, provided it is justified in the patient's chart.

Allowable Number of Visits for DSMT and/or MNT

Year	DSMT		MNT
	Initial Visit	**Follow-Up Visits**	**Visits** (Group or Individual)
Year 1	One hour	Maximum nine hours	Up to 3 hours (Additional hours may apply as ordered by the physician)
Subsequent Years	N/A	Maximum two hours	2 hours (Additional hours may apply as ordered by the physician)

►**TIP** Certain diabetes educators, e.g., those who are "Certified Diabetes Education eligible,"
can provide care if working under a DSME/T program accredited by AADE, or recognized by ADA or IHS (Indian Health Service). They will not necessarily have a National Provider Identifier (NPI) or be able to bill Medicare.

►**TIP** The physician or qualified non-physician provider (NP, PA, or CNS) can make referrals for DSMT, but only the treating physician can make referrals for MNT.

►**TIP** An RD is able to determine the length of the initial and follow-up visits, e.g., more or less than one hour.

Example 1 A Medicare beneficiary with newly diagnosed type 2 diabetes is referred by his/her treating physician to an RD Medicare provider for initial MNT (3 hours initially — additional hours may be available based on medical necessity and if the treating physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change). In the course of the nutrition assessment, the RD determines that the Medicare beneficiary would benefit from a DSMT program offered at a local hospital. The RD contacts the physician to discuss medical necessity for initial DSMT and the physician determines that DSMT is medically necessary and refers beneficiary for initial DSMT. Total hours: 13 (3 hours MNT and 10 hours DSMT).

Medicare Coverage Depends on Location and Setting of Care

Coverage of diabetes education and nutrition therapy varies by the setting in which it is offered. Medicare Part B, for example, covers DSMT services in most settings of care. Many states have specific requirements relating to nutrition therapy. Physicians will wish to become familiar with their state and local requirements.

DSMT services provided at a Federally Qualified Health Center (FQHC) or Rural Health Care Center (RHC) have Medicare specific reimbursement polices. FQHCs may not bill for group services for DSMT or MNT services as a separate qualifying encounter. Group services do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. DSMT and MNT services may be provided in a group setting, but do not meet the

criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate.

> ►**TIP** Claims for DSMT group services with HCPCS code G0109 and MNT group services with HCPCS codes 97804 or G0271 will be denied by Medicare using group code CO and claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded).

FQHCs may bill for DSMT and MNT services when they are provided in a one-on-one face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes.

> ►**TIP** To receive payment for DSMT services, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above.

> ►**TIP** To receive payment for MNT services, the MNT services must be billed on TOB 73X and with the appropriate site of service revenue code in the 052X revenue code series and the appropriate HCPCS code (97802, 97803, or G0270).

> ►**TIP** This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services as long as the claim for MNT services contains the appropriate coding specified above.

Separate payment to RHCs for DSMT is precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates.

> ►**TIP** services by registered dietitians or nutritional professionals might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

Coding for Diabetes Education

The following pages address CPT® and HCPCS codes that may be applicable to physician practices that use the services of a diabetes educator. As there is considerable variation in coverage and reimbursement practices, only some of these codes are accepted by commercial payors. Likewise not all of this information is applicable to Medicare reimbursement.

Current Procedural Terminology (CPT®)

CPT® codes are used to report Education and Training for Patient Self-Management services prescribed by a physician and provided by a qualified, non-physician healthcare professional using a standardized curriculum to an individual or a group of patients for the treatment of established illness(s), disease(s), or to delay comorbidities. Physicians will wish to check with private payors to see if they accept these codes and how they might be used. At this time the following codes are not paid separately by Medicare.

CPT® Codes that May Be Accepted by Private Insurers

CPT® Code	Summary	Time
Diabetes Self-Management Education/Training		
98960*	Education and training for patient self-management by a qualified, non- physician healthcare professional using a standardized curriculum, face-to-face with the individual patient (could include caregiver/family)	Each 30 minutes
98961*	Education and training for patient self-management for 2–4 patients	30 minutes
98962*	Education and training for patient self-management for 5–8 patients	30 minutes
Medical Nutrition Therapy		
97802**	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, *This code is to be used only once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803 All subsequent Group Visits are to be billed as 97804.*	Each 15 minutes.
97803**	Re-assessment and intervention, individual, face-to-face with the patient. *This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient.*	Each 15 minutes.
97804**	Group (2 or more individual(s)), each 30 minutes. *This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.*	Each 30 minutes
Prenatal, Obesity, or Diabetic Instruction		
99078*	Physician educational services rendered to patients in group setting (prenatal, obesity, or diabetic instruction)	Check with the insurer

* Codes not payable by Medicare at this time.

**MNT can be provided by an RD or a nutrition professional in ambulatory settings.

Please contact each payor to determine the specific coverage and reimbursement practices and policies.

CPT Coding for Physician Educational Services

CPT® code, 99078, denotes "Physician educational services rendered to patients in a group setting, e.g., prenatal, obesity, or diabetic instruction." This code describes the time a physician spends performing special services adjunct to his/her basics services. This code may *not* be used to bill for "incident to" services. This code is not paid by Medicare because counseling and education services are components of an Evaluation and Management Service (CPT 99201 – 99255)

> ►**TIP** CPT code 99078 is often not paid by payors, including Medicare. On the Medicare Physician Fee Schedule database, this is a bundled service, which means it is never paid separately even if it is the only service provided to the patient on a particular day. This eliminates any possibility of asking the patient to pay for the service. Therefore, it is not advisable to use this CPT code to bill any services provided at a group visit. It is worth a check with other insurers to see if this service is allowed. Remember, services reported with this CPT code should be educational in nature.

Shared medical appointments (SMA) are gaining in popularity among patients and providers in patient care. Providers perform a series of one-on-one patient encounters in a group setting during a 90-minute visit and manage and advise each patient in front of the others. Patients benefit from improved access to their provider and significantly increased education, while providers can boost their access and productivity without increasing hours.

A SMA requires the provider to make a medical decision which is documented in each patient's record. Education provided by the provider or staff is considered incidental to the encounter and is not claimed separately. The total time involved in a SMA is usually 90 minutes depending on the number of patients in the group.

> ►**TIP** If an educator meets with the group of patients before or after the SMA, their DSMT or MNT services can be claimed so long as the NPI number used is different from the provider's number who provided the E&M services.

> ►**TIP** The individual time a provider spends with a patient can vary greatly but routinely it is no more than 5 minutes.

> ►**TIP** Several studies indicate that patient outcomes improve through their A1C when a provider incorporates SMA's and a referral to a diabetes educator in their chronic care model.

> ►**TIP** SMAs are coded based upon the documentation in each patients record (CPT® 99212-99215).

Face to Face time with a patient cannot be the controlling factor for the patient encounter unless they are seen outside of the shared medical appointment on the same calendar date. Some payers may require HCPSC II modifier TT, indicating individualized services with multiple patients present be appended it to the E&M code claimed. Medicare does not recognize this modifier.

HCPCS Procedure Codes for DSMT and MNT

HCPCS Level II Codes fill gaps in the CPT® nomenclature and are used to define

procedures, services, and supplies. The Centers for Medicare and Medicaid Services (CMS) has specified two Level II HCPCS codes that certified providers must use to bill DSMT services (G0108 & G0109). Additional HCPCS codes relating to DMST and MNT are presented below. Physicians are urged to check with the Medicare carrier and other payors for additional guidance.

HCPCS Level II G Codes

Code	Summary	Time
G0108	G0108 Diabetes outpatient self-management training services, individual	Each 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two persons or more)	Each 30 minutes
G0270	MNT, 2nd referral, same year, individual, face-toface reassessment and subsequent intervention(s)	Each 15 minutes
G0271	MNT, 2nd referral, same year, group; reassessment and subsequent intervention(s)	Each 30 minutes

►**TIP** Only DSMT programs that have submitted their Certificate of Recognition from the AADE, ADA or IHS may bill Medicare for DSMT services. Other payors might not require this, assuming any practice that bills using DSMT service codes G0108 or G0109 has a certificate. While Medicare will cover MNT that is provided by a RD or nutrition professional who meets specific requirements, other payor's coverage may extend to nutrition services provided by a diabetes educator.

Education and Counseling S Codes

HCPCS 'S' codes, shown in the table below, also relate to diabetes education/training and counseling but are not covered by Medicare. As with all medical services provided to patients, the physician must maintain documentation that supports the procedure code selected. To help ensure that a claim reflects medical necessity, keep detailed records of education/training dates, time spent with patients, whether it is a group or individual session, the topics covered in each session, and sign-in sheets indicating the names of patients attending and the names of the diabetes educators who taught the session.

Non-Medicare HCPCS Codes and Summary

S9140	Diabetic management program, follow-up visit to non-MD provider
S9141	Diabetic management program, follow-up visit to MD provider
S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)
S9455	Diabetic management program, group session
S9460	Diabetic management program, nurse visit
S9465	Diabetic management program, dietitian visit
S9470	Nutritional counseling, dietitian visit

►**TIP** Some commercial insurers require prior authorization for diabetes education.

Contact the insurer if claims are being denied to determine if prior authorization is the reason for the denial. In addition, if a payor does not accept the HCPCS DSMT codes, ask if they would accept the CPT® Codes for self-management education and training.

►**TIP** Private payors usually do not cap benefits for diabetes education or nutrition therapy in the outpatient setting. In some areas, these services may be paid at 105%–115% of the Medicare Physician Fee Schedule (MPFS).

ICD-9-CM Diagnosis Codes for Diabetes Education

Diagnosis codes are important to support the medical necessity for a claim of services. Payors use ICD-9-CM codes to identify the diagnosis for which DSME/T services are provided. Be sure to use all digits available for a diagnosis code. This is referred to a 'coding to the highest level of specificity' as explained below. Always keep in mind the old saying 'if it is not documented, it never happened and can not be coded'.

If a provider states probably or suspected diabetes, select a ICD-9 code that reflects their signs or symptom, i.e., abnormal glucose. If a provider documents that a patient has diabetes 'due to' another condition or event, select the diabetes code from category 249 rather than 250.

►**TIP** Secondary diabetes is always caused by another condition or event e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or and would be under the 249 diagnosis codes.

►**TIP** A fourth-digit is required for all category 249 codes to identify a manifestation.

►**TIP** A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled. 0 = not stated as uncontrolled or unspecified or 1 = stated as uncontrolled.

Under the ICD-9-CM coding structure, codes 249.00 through 250.93 refer specifically to diabetes mellitus and its complications. A fifth digit (0–3) is added to these codes to indicate type 1 or type 2 diabetes and whether the disease appears to be under control or uncontrolled. Gestational diabetes mellitus carries a unique code.

Sequencing diabetic codes and associated conditions can be difficult. The codes from categories 249- 250 must be reported before codes for any associated conditions. All diabetes codes from category 250 that are identified should be reported. These will be followed by the corresponding secondary codes, which are listed under each of the diabetes codes.

►**TIP** An overdose due to pump malfunction would be reported with code 996.57, but also report code 962.3 for poisoning by insulin and anti-diabetic agents as the secondary code.

Other commonly used codes relating to diabetes include:

- ICD-9 648.80 – 648.84 – Gestational diabetes
- ICD-9 585.1 – 585.9 – Chronic renal failure
- V code V42.0 – Organ replacement (Kidney)

►**TIP** Be complete and specific. The claim should show all applicable diagnosis codes, not just the one(s) for diabetes.

►**TIP** Specific codes related to the patient's condition can be used to clearly communicate to the payor the severity of the patient's illness, e.g., 250.4, diabetes with renal manifestations and the complexity of the services provided, as indicated by CPT® codes. Remember to document and code manifestations as the 4th digit. When coding, sequence the diabetes code which includes the manifestation followed by the code for the manifestation.

Example 2 A patient may be admitted to a hospital under type 2 without complications diabetes (diagnosis code 250.00) until tests reveal the full nature of their condition. When that patient later appears at an outpatient clinic for follow-up DSME/T, specific coding will help to clarify the claim.

Overview of ICD-9-CM Codes for Diabetes and Complications

Basic Codes	
249.00	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
249.01	Secondary diabetes mellitus without mention of complication, uncontrolled
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified
249.31	Secondary diabetes mellitus with other coma, uncontrolled
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled
249.50	Secondary diabetes with ophthalmic manifestations not stated as uncontrolled, or unspecified
249.51	Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled
249.60	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified
249.61	Secondary diabetes mellitus with neurological manifestations, uncontrolled
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified
249.71	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled
249.90	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified

249.91	Secondary diabetes mellitus with unspecified complication, uncontrolled
250.0x	Diabetes mellitus without mention of complication
250.1x	Diabetes with ketoacidosis (no mention of coma)
250.2x	Diabetes with hyperosmolarity (nonketotic coma)
250.3x	Diabetes with other coma (diabetic coma with ketoacidosis, hypoglycemic coma, insulin coma NOS (nonspecified)
250.4x	Diabetes with renal manifestations
250.5x	Diabetes with ophthalmic manifestations
250.6x	Diabetes with neurological manifestations
250.7x	Diabetes with peripheral circulatory disorders
250.8x	Diabetes with other specified manifestations
250.9x	Diabetes with unspecified complication
251.2	Hypoglycemia, unspecified
276.5	Volume depletion: dehydration, depletion of volume of plasma or extracellular fluid, hypovolemia. Excludes hypovolemic shock: postoperative (998.0) & traumatic (958.4)
277.7	Dysmetabolic syndrome X
362.01	Background diabetic retinopathy
362.02	Proliferative diabetic retinopathy
648.03	Pregnancy (Known DM)
648.83	Abnormal glucose tolerance complicating pregnancy (gestational diabetes)
790.22	Abnormal glucose tolerance test; excludes that complicating pregnancy, childbirth, or the puerperium (648.8*x)*

Fifth Digits: Category 250 (250.0x through 250.9x) requires the use of a fifth digit.	
0	Type 2 or unspecified type, not stated as uncontrolled, even if the patient requires insulin
1	Type 1, not stated as uncontrolled
2	Type 2 or unspecified type, uncontrolled, even if the patient requires insulin
3	Type 1, uncontrolled
For example, inserting the fifth digit with category 250.0 yields:	
250.00	Diabetes mellitus without complication, type 2
250.01	Diabetes mellitus without complication, type 1
250.02	Diabetes mellitus uncontrolled, type 2
250.03	Diabetes mellitus, uncontrolled, type 1

There may be additional codes required relating to complications. Please refer to the coding manuals and contact each payor to determine the specific coverage and reimbursement practices and policies.

V Codes

V codes are used in conjunction with other ICD-9-CM codes that indicate the primary diagnosis. These codes provide greater specificity and allow circumstances other than disease or injury to be recorded as problems.

V Codes Relevant to Diabetes and Summary

V65.3	Encounter for dietary surveillance and counseling (diabetes mellitus)
V58.67	Encounter for long term use of Insulin

V18.0	Family history diabetes mellitus
V53.91	Fitting/adjusting an insulin pump
V77.1	Screening for diabetes mellitus

►**TIP** Most V codes are not primary diagnoses but are classifications of factors that influence a patient's health status and contact with health services.

►**TIP** On form CMS-1500, list the ICD-9 diagnosis code first, e.g., 250.01, then add the V code indicating further detail, e.g., V65.3 for dietary surveillance and counseling.

Billing for Evaluation and Management

If a physician provides services to patients with diabetes, his/her practice can provide diabetes education/training, some of which may relate to evaluation and management (E&M). The range of CPT codes for E&M services is, 99211–99215 (established patient) and 99201–99205 (new patient). These describe a physician-patient encounter for the evaluation and management of a patient's condition(s). Patient education and counseling are components of the services described by these codes. The E&M codes are further defined by levels that clearly articulate the intensity of services provided.

Levels of Service for E&M Codes

There are five levels of service for CPT codes for established patients 99211–99215. The number 1 indicates the lowest level, e.g., nurse visit, while the number 5 indicates the highest level for complex encounters.

Medical decision-making factors such as the number of diagnoses or management options, amount of information reviewed, and the patient's risk of complications define the level of service. Seven components determine the level of E&M code(s) that should be assigned to a case. The first three bulleted items on the next page are considered key components in CPT® for determination with the other components considered contributory factors.

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

►**TIP** Time is a determining factor for level of service when more than 50% of a visit is spent in counseling and coordination of care.

►**TIP** When billing for a patient's visit, codes are selected that best represent the services and level of intensity of those services furnished and documented in the medical record.

Add Modifiers to E&M Codes when Appropriate

Two modifiers, "32" and "25" are available to help clarify E&M Codes and may allow payors to process claims more quickly.

> ►**TIP** Modifier "25" can be used following the E&M code when circumstances allow. This tells the payor that a separately identifiable E&M service was provided on the same day as another procedure or service.

Diabetes Education Services as "Incident To"

Working with a diabetes educator can reduce the time physicians need to spend with each patient and increase efficiency. The term "incident to a physician's professional services" means that the service was furnished as an integral, although incidental, part of the physician's personal professional service in the course of diagnosis or treatment of an injury or illness. Physician supervision of the diabetes educator is a key component of "incident to" billing, particularly for non-certified diabetes educators.

In the physician's office, "incident to" services must be part of the patient's normal course of treatment. Physicians must perform an initial service, be actively involved in the course of treatment and record this in the patient's record. It is not necessary for the physician to be present in the treatment room while the services are provided by the diabetes educator, but the physician must provide direct supervision and take financial responsibility for the educator. Direct supervision means being available in the office suite.

The CPT® code 99211 is the only E&M code used for "incident to" billing available to physician clinic's ancillary staff members. Some of the other codes (in the range of 99212–99499) can however be billed "incident to" by non-physician providers (NP, PA, CNS). Please note that Medicare regulations stipulate that neither DSMT nor MNT can be provided incident to a physician's services when claiming the DSMT HCPCS G codes or the MNT CPT or HCPCS G codes.

"Incident to" billing may be relevant for physicians practicing in states that do not provide distinct coverage for DSME/T. Physicians should check with the Medicare Carrier and/or private payor to obtain additional guidance.

> ►**TIP** CMS may pay for a physician visit, but not for the diabetes education/training, if both the physician and the diabetes educator see the patient together, even if the physician does not stay for the entire visit and provided the educator does. Report only one CPT® code that includes the services provided by both the educator and the physician.

Coding for Devices and Related Therapy

In addition to reimbursement for DSME/T, MNT, E&M, additional services related to education on durable medical equipment (DME), such as continuous glucose monitors may qualify for reimbursement. The following section suggests some commonly used practices.

Continuous Glucose Monitoring (CGM)

Relevant Codes for Continuous Glucose Monitoring Services

CPT® Code	Summary
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report

►**TIP** CPT codes 95250 and 95251 were revised in 2009 to reflect ambulatory continuous glucose monitoring of interstitial tissue fluid for a minimum of up to 72 hours. Prior to 2009, code 95250 specified monitoring of up to 72 hours. This change is more reflective of current practice. Code 95251 has been revised by removing the specification of interpretation and report performed by a physician, because the interpretation and report may be performed by a health care professional other than a physician which include an NP, PA, or CNS.

►**TIP** Codes 95250 and 95251 may not be reported more than once per month, and instructional notes have been added in the CPT book following each code to indicate this code may not be reported in conjunction with the collection and interpretation of physiologic data code 99091.

Example 4 On the patient's first visit for pre-CGM evaluation, the physician uses the appropriate E&M codes 99212 - 99215. The RN, CDE, or other healthcare professional uses code 95250 for the technical component, e.g., when the sensor is inserted and then removed and downloaded. The physician or NPP will claim 99251 when they interpret the downloaded data. Codes 99212–99215 may be appropriate for post-CGM evaluation that occurs on follow-up visit.

Insulin Pump Therapy and Training on Pump Use

Patients who need or have an insulin pump will benefit from education/training on its use and maintenance. When these services are provided by an MD, DO, NP, PA or CNS they are reflected by CPT codes 99212-99215.

When these services are provided by a certified pump trainer they are usually funded by the pump company whose device is being used by the patient.

Tools for Diabetes Education/Training

The AADE Diabetes Services Order Form is designed to be an easy and convenient way for a physician or a qualified non-physician practitioner to refer their Medicare patients with diabetes to a diabetes educator for DSMT and to a RD for MNT. The referral form may be used by any facility or healthcare professional and includes the key referral information required to meet

Medicare regulatory requirement for MNT and DSMT referrals. The form is available to the public at the following web page:
http://www.diabeteseducator.org/ProfessionalResources/Library/ServicesForm.html
More in-depth information on reimbursement is available in

AADE's *Online Reimbursement Guide for Diabetes Educators*, available at the following web page:_
https://www.diabeteseducator.org/ProfessionalResources/products/view.html?target=40&sub1=ONLRESOURC&sub2=Online

Information about accrediting a Diabetes Education Program is available at:
http://www.diabeteseducator.org/ProfessionalResources/accred/

Become a member of AADE at: http://www.diabeteseducator.org/Public/Join_Information.html

Tools for Physicians

If you would like to find a diabetes educator in your community, use our *Find an Educator* tool, which is available at: http://www.diabeteseducator.org/DiabetesEducation/Find.html
Join AADE at: http://www.diabeteseducator.org/Public/Join_Information.html

AMA's CPT book provides further details about CPT coding.
The "Tips" booklet you are reading is available free at:
http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/Reimbursement_Tips_2009.pdf

Additional tools for physicians who are interested in learning best practices can be found at the following websites:

- Institute for Healthcare Improvement (IHI): http://www.ihi.org/ihi
- The Centers for Disease Control and Prevention (CDC):
- http://www.betterdiabetescare.nih.gov/
- Medicare Learning Network (MLN)
  http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3185.pdf

Please address questions or comments related to the material in this publication to the 'Ask the Expert' feature on the AADE website, which is a free AADE member-benefit and can be found in the member center.

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Glossary

Diabetes Self-Management Education (DSME) - Diabetes education, also known as diabetes self-management education/training (DSME/T) or diabetes self-management training (DSMT) is a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions. DSME/T is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator(s). The intervention aims to achieve optimal health status, better quality of life, and reduce the need for costly health care.

Most professional diabetes educators are members of the American Association of Diabetes Educators. Some diabetes educators are certified diabetes educators (CDEs) or Board Certified Advanced Diabetes Managers (BC-ADMs), having met certain eligibility and exam requirements.

Diabetes Self-management Training (DSMT) - Medicare covers DSMT when these services are furnished by a certified provider who meets certain quality standards. This program, which is intended to educate beneficiaries in the successful self-management of diabetes, includes instructions in self-monitoring of blood glucose, education about diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patient to use the skills for self-management.

Medical Nutrition Therapy (MNT) - MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. This includes review and analysis of medical and diet history, laboratory values, and anthropometric measurements. Based on the assessment, nutrition modalities most appropriate to manage the condition or treat the injury are chosen and include the following:

- Diet modification and counseling leading to the development of a personal diet plan to achieve nutritional goals desired health outcomes.
- Specialized nutrition therapies including supplementation with medical foods for those unable to obtain adequate nutrients through food intake only, eternal nutrition delivered via tube feeding into the gastrointestinal tract for those unable to ingest or digest food, and parenteral nutrition delivered via intravenous infusion for those unable to absorb nutrients.

Medicare's Recognition Requirements for a DSMT Program

Unlike private insurers who may have the latitude to pay for services provided by a DSME/T program that has no formal recognition, Medicare requires the DSMT program to be accredited by the American Association of Diabetes Educators (AADE), American Diabetes Association (ADA) or the Indian Health Service (IHS) before it can be reimbursed. "The National Standards for Diabetes Self-Management Education" have been adopted by AADE's Diabetes Education Accreditation Program and ADA's Education Recognition Program. The National Standards (http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/accred/2007national_standards_for_dsme.pdf) establish the criteria for the structure and processes of a DSMT program. Physicians can learn more about achieving recognition by visiting AADE's website at: http://www.diabeteseducator.org/; ADA's website at: http://www.diabetes.org/home.jsp. Please call AADE at 1-800 338 3633 for additional information.

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