Insurance: What Our Patients Need to Know

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"Does my insurance cover diabetes education and nutrition visits?" Although employers send benefits packages to their employees and Medicare recipients receive a copy of the *Medicare & You*[1] handbook, many never read this information. Here's what we need to know to answer our patients' insurance-related questions and what our patients need to know to ask the right questions.

Understanding Medicare Coverage

The Centers for Medicare and Medicaid Services (CMS) issued a final rule implementing expanded Medicare coverage of outpatient diabetes self-management training (DSMT) services authorized by the Balanced Budget Act of 1997. Effective 1 February 2001, only providers who hold an American Diabetes Association (ADA) Education Recognition Program certificate are eligible to be reimbursed for DSMT. In January 2002, Medicare approved payment for medical nutrition therapy (MNT) for patients with diabetes, gestational diabetes, and renal failure (pre-transplant). Physicians, health care providers, and diabetes educators around the country applauded these added benefits for Medicare recipients.

This rule change set a standard for diabetes patients and has led many private insurance companies to include both DSMT and MNT in their benefit packages. It must be noted, however, that there is still much work to be done, in that glucose intolerance and pre-diabetes are not considered a diagnosis of diabetes. Therefore, DSMT and MNT services are out-of-pocket expenses for patients with these conditions.

DSMT. CMS covers DSMT and MNT as two individual or separate programs. The CMS ruling also states that one complements the other and that they should be used together in the care of patients with diabetes. DSMT requires a referral from a physician (MD) or other health care provider (HCP), such as a nurse practitioner, physician's assistant, or other approved provider of Medicare services.

The DSMT benefit covers over the course of a patient's lifetime one 10-hour initial training within a rolling 12-month period and 2 hours of DSMT every 12 months thereafter. Additional DSMT may be requested for changes in therapy, such as initiation of insulin therapy or an insulin pump or more intensive insulin therapy, with an MD or HCP referral. CMS does not specify the amount of time allowed for additional training and may actually deny these services until it receives a letter of appeal. CMS uses the term "training" rather than "education" in describing DSMT.

MNT. Only an MD may refer a patient for MNT. The MNT benefit offers 3 hours of initial training during the first calendar year (1 January to 31 December) of the initial referral and 2 hours each calendar year thereafter. MDs may refer patients for additional MNT hours as often as necessary throughout any year. CMS has not put a limit on the number of additional hours that may be ordered for MNT.

Medicare reimburses medical charges two ways. First, Medicare carriers pay the MD or HCP offices or clinics. Hospitals are paid by a fiscal intermediary who is a contracted agent representing Medicare. Just as insurance tracks a patient's charges, Medicare can now track charges for DSMT and MNT.

Exploring Private Insurance Options

Authorization and verification of benefits. An insurance plan may require an MD or HCP office to obtain an authorization for DSMT or MNT before a patient is referred for services. If an appointment is scheduled without authorization, the insurance company will not reimburse the facility providing the service, leaving the patient responsible for the bill. Therefore, hospitals and other providers of DSMT and MNT services verify patients' benefits before appointments are scheduled.

To do so, providers inform the insurer of billing codes to be used. These codes come from the Healthcare Common Procedure Coding System (HCPCS). The codes G0108 or G0109 are used for DSMT, and the codes G0270, G0272, 97802, 97803, and 97804 are used for MNT. Diabetes diagnosis codes from the International Classification of Diseases, 9th Revision (ICD-9 codes) are also used. Both coding lists are required to bill for services. Providing codes to the insurance company makes it easier to verify coverage before visits are scheduled.

Another common issue involves insurance companies advertising their coverage for DSMT and MNT but having specifically negotiated contracts with patients' employers that may *not* include these services. All too often, patients believe services are covered because they do not believe their MD or HCP would order services that are not covered. Patients need to know that a referral by their MD or HCP does not guarantee that a service will be covered; it simply means the

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MD or HCP believes the service is necessary for their health.

Contesting Decisions
HCP offices should notify patients when their insurance company declines referral authorization for DSMT or MNT. Patients whose insurance does not require pre-authorization and who are referred for DSMT or MNT will be notified in the event that coverage of these services is denied. These patients should contact their employer human resources benefits department (HRBD) to discuss the issue.

In some cases, HRBDs have accommodated a patient by approving payment for a program and then added the benefit to their contract at the next negotiation period. These HRBDs have realized the importance of having "well trained" patients who will ultimately be healthier than those who do not receive necessary training. The insurance companies also realize savings, with fewer calims for hospitalizations and office visits. In such circumstances, some companies have authorized up to 12 hours of DSMT with additional approvals as needed.

If a denial is final, however, patients must pay "out of pocket" for DSMT and MNT services. Such patients should be encouraged to advocate for provision of DSMT and MNT coverage the next time their employer negotiates its benefits package. Patients can gather and present data about the health benefits of DSMT and MNT and can build support among other employees who have diabetes or family members with diabetes.

In order to contest decisions and advocate for better coverage, patients must read and understand their insurance plans. If they have questions, they should call the toll-free telephone number shown on the back of their insurance card.

Often, patients report that their insurance company will not pay for education programs, even though their benefits clearly state that there is coverage for DSMT and MNT. Patients should be counseled to use the proper terminology when calling their insurance companies. It is key to use the terms "diabetes self-management training" and "medical nutrition therapy" to describe these services instead of "diabetes education," "nutrition education," "diet education," or other terms that include the word "education." Companies that do indeed cover DSMT and MNT may respond to inquiries about "diabetes education" with an immediate, "No, we do not cover education." Call it "training" or "therapy," and the same services will be covered.

Addressing Limitations of Coverage
It has been 3 years since the adoption of Medicare's current rules. Remember that these rules allow coverage of a single 10-hour initial DSMT program and then 2 hours/year of additional training starting 12 months after the initial program is completed. Because of these limitations in coverage, certain difficulties are starting to become more common.

In some cases, HCPs are referring patients for initial 10-hour DSMT programs who have already attended a program as a Medicare beneficiary. Because Medicare covers only one 10-hour initial training program for its members, patients referred a second time for a 10-hour program will be denied coverage for anything beyond the 2 hours/year of additional training they are allowed. Similarly, patients who have attended a 10-hour initial program and then submit a claim for an additional 2-hour training before 12 months has elapsed will also be denied coverage.

To address these concerns, pre-admission questionnaires for diabetes training programs should include a question such as, "Have you previously attended a diabetes training program or been instructed on diabetes by a physician, nurse, or dietitian?" This will help to ensure that attendees have exceeded neither the quantitative nor the temporal limitations of their coverage for these services.

There is one caveat, however. If a patient attended a DSMT program *before* becoming a Medicare beneficiary, that patient may attend a 10-hour program once again after becoming a Medicare beneficiary. Also, if a Medicare patient attended a DSMT program before February 2001, that person may receive a full 10-hour DSMT program once after February 2001 because CMS did not maintain tracking records for these services before February 2001.

Explaining Patients' Responsibility to Pay
When patients call their providers about denial-of-payment notices they receive, the hospital or clinic accounting office should inform them of the reasons given by their insurer and why it is now the patient's responsibility to pay.

Patients must have a diagnosis of diabetes to receive the DSMT and MNT benefits under Medicare or their insurance plan. Glucose intolerance and pre-diabetes (ICD 9 codes 277.7 and 790.22) are not considered a diagnosis of diabetes. Therefore, DSMT and MNT services will be out-of-pocket expenses for patients with these conditions.

Medicare requires its members to sign advance beneficiary notice (ABN) forms for any services that will not be covered by Medicare. HCPs must complete these forms, which show the services recommended, and the costs of the service, and patients must sign them before receiving services. This gives Medicare documentation that proves the patients were informed of the costs and agreed to pay out-of-pocket before receiving the services in question. The patient can refuse to sign, and staff will make note of the patient's comments on the ABN. A copy will remain on the patient's chart, the original is sent to the finance department to be placed in the patient's billing data. Without a signed ABN form on file, patients may not be required to pay, and the service cannot be billed to either the patient or Medicare and thus would have to become a write-off for the service provider.

Dealing With Co-Payments and Deductibles
Patients frequently express surprise that a co-payment is due for their visit. Some call the provider's office after a visit upset by their insurance company notice that the visit had to be paid out-of-pocket as part of their deductible. "What deductible?" they ask.

Occasionally, a patient may respond to such notices by stating that the visit did not take place. As a result, many clinics and hospitals have

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instituted a new protocol: photocopying a patient's driver's license or legal photo identification card, or in some cases actually taking an instant photo of the patient at the visit, to prove that they did indeed present for a visit. This may seem extreme, but such procedures also serve to protect patients' privacy and prevent fraud and identification theft.

Aiding Those Without Insurance

All too often, people do not have, nor can they obtain, private insurance coverage for chronic health conditions such as diabetes. Many states have "high-risk insurance" or a "comprehensive health association," but these programs include very high annual deductibles. Providers should always refer such patients to their local ADA office or call the ADA National Center at 800-DIABETES for advice and more information.

Finding Additional Information

Every year, the Centers for Medicare and Medicaid Services (CMS) publishes the handbook mentioned above, *Medicare & You*.[1] This document outlines Medicare benefits, gives an introduction to Medicare health plans and the Medicare + Choice program, explains how to report Medicare fraud, and much more. It includes specific information for each of Medicare's 10 regions of the country: Boston, Mass.; New York; Philadelphia, Pa.; Atlanta, Ga.; Chicago; Dallas, Tex.; Kansas City, Mo.; Denver, Colo.; San Francisco, Calif.; and Seattle, Wash.

CMS information is also available online. Although one may have trouble imagining a grandmother conducting online research, many of our "seasoned" generation are indeed quite Internet savvy. Patients who do not have access to the Internet may ask family members, neighbors, or the staff of their local library for help.

CMS information us located at www.cms.hhs.gov/medicare or www.medicare.gov. Additional regional information can be obtained from www.cms.hhs.gov/about/regions/consumers.asp (for consumers) and www.cms.hhs.gov/about/regions/professionals.asp (for professionals).

Within the CMS website, one informative area is the public affairs section www.cms.hhs.gov/media/?media=pressr. This is an online archive of press releases such as, "Medicare Implements New Steps to Prevent Drug Card Fraud" and "Medicare Announces New Initiatives on Power Wheelchair Coverage and Payment Policy." A publication titled "Medicare Coverage of Diabetes Supplies and Services" can be found at www.medicare.gov/Publications/Pubs/pdf/11022.pdf.

HCPs are also encouraged to visit these sites. Although more people are becoming aware of their benefits, many patients still depend on their providers to inform them about Medicare and insurance matters.

Reference

[1]U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services: *Medicare & You 2004*. Washington, D.C., U.S. Govt. Printing Office, 2004 (CMS publ. no. CMS-10050)

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