

Maryland Department of Health - HealthChoice Diabetes Prevention Program
Frequently Asked Questions and Answers for Medicaid's HealthChoice DPP Implementation
Updated: April 15, 2020¹

DPP Provider Enrollment

1. What type of NPI do organizations need to obtain to become a Maryland Medicaid DPP provider and how can they obtain one?

MDH Response: CDC-recognized organizations need to obtain a type 2 NPI. They may apply for an NPI here: <https://nppes.cms.hhs.gov/webhelp/nppeshelp/MAIN%20PAGE.html#apply-for-an-npi-for-an-organization>. All organizations must obtain a new, unique NPI unless the organization is enrolled with Medicare as an MDPP supplier only offering MDPP services; in this scenario they can use the same NPI. Please see the chart below:

Current Provider	Need a New NPI to Enroll as Medicaid DPP Provider?
None	Yes
Medicaid (Other services)	Yes
Medicare (Other services)	Yes
Medicare (MDPP Services Only)	No

2. Why do lifestyle coaches need to have NPI numbers if Medicaid is not requiring them to submit claims?

MDH Response: Upon enrollment, Medicaid requires CDC-recognized organizations to attest that their lifestyle coaches are in good standing with federal and state sanctioning bodies. Medicaid recommends that lifestyle coaches obtain an individual NPI, however, this is not required for HealthChoice DPP provider enrollment.

3. When will ePREP be opened for DPP provider registration?

MDH Response: ePREP is available for DPP provider applications as of May 13, 2019.

4. What would the taxonomy for the new DPP provider type be?

MDH Response: Since the MDH ePREP system does not edit on taxonomy and because taxonomies are self-attested in NPPES, the providers should select the taxonomy they believe most closely describes their type/classification/specialization (for instance Health Educator).

¹ Yellow highlights in this document indicate updates/changes that have been made since the previous version from 12/4/19.

5. Do our providers administering the in-person program need to be enrolled with ePREP? Also, will nutritionists/dieticians need to be enrolled?

MDH Response: All CDC-recognized organizations, both in-person and virtual, that wish to participate as a provider in the HealthChoice DPP must submit an application through ePREP to enroll as a Maryland Medicaid DPP Provider. The Department is not enrolling providers at the lifestyle coach level; therefore, to participate, Nutritionists/Dietitians will need to be an approved lifestyle coach on the roster of a Medicaid-enrolled CDC-recognized organization in order to provide HealthChoice DPP services to HealthChoice enrollees. Medicaid recommends that Individual lifestyle coaches still obtain an NPI number, however, this is not required for HealthChoice DPP provider enrollment.

6. Do I need to create a separate/new NPI to enroll as a DPP Provider if I am an existing organization enrolled with Maryland Medicaid offering other types of services?

MDH Response: Yes. Except for Medicare-enrolled providers only offering the Medicare Diabetes Prevention Program, who would be able to use the same type 2 NPI to enroll in Maryland Medicaid, any Medicaid- or Medicare-enrolled provider furnishing services other than the National DPP Lifestyle Change Program needs to obtain a new unique type 2 NPI to enroll with Maryland Medicaid as a DPP provider. See question 1 response and chart.

7. If I am a CDC-recognized organization with multiple practice locations (i.e. administrative locations where billing occurs) will I receive a site visit at all of these locations, or just a single primary location?

MDH response: Because CMS categorizes the DPP provider type as a “high risk” provider, a site visit must be conducted for each practice location at enrollment and revalidation. Therefore, DPP providers must use a separate NPI to enroll each practice location with Maryland Medicaid. A practice location is a primary “brick and mortar” building location from which an organization directs and/or coordinates DPP services. A practice location may also be a location where DPP services are provided. The examples below illustrate the distinction between practice locations that need to be enrolled and other service locations that do not need to be enrolled.

Example 1: A primary “brick and mortar” building, the practice location from which an organization coordinates DPP services, must enroll via a specific NPI. The actual services delivery may occur in the community at non-provider owned/rented spaces, such as a library or faith-based organization. In this case, only the practice location would receive a site visit because the library or faith-based organizations provide a space for service delivery but should not enroll as DPP providers. Additionally, the practice location should be the address identified as the “service address” within the DPP application.

Example 2: A single organization may open multiple unique DPP provider practice locations under the same organizational name, each of which may be implementing multiple community-based classes. In

this case, each of the DPP provider practice locations would be considered primary and receive a separate site visit. In this scenario, there are multiple “brick and mortar” buildings from which DPP services are directed and as such, each practice location should submit an application under a separate NPI. On each application, the practice location should be the address identified as the “service address” within the DPP application.

To bill for services from each CDC-recognized organization, providers must submit via ePREP an application for each practice location. Each submitted application must receive a site visit prior to enrollment.

8. If I am a CDC-recognized organization with two separate delivery modes applying for Maryland Medicaid, do I need to get a separate NPI for each of these modes?

MDH Response: If both delivery modes share the same administrative location (where billing occurs) then a separate NPI is not needed.

9. Do I need to create a separate/new NPI to enroll as a DPP Provider if I am an existing organization enrolled with Medicare offering other types of services?

MDH Response: Yes. See question 6 response.

10. Do I need to create a separate/new NPI to enroll as a DPP Provider if I am an existing organization enrolled with Medicare offering the Medicare Diabetes Prevention Program Expanded Model only?

MDH Response: No. See question 6 response.

11. If I have already obtained a unique NPI to apply to Maryland Medicaid, can I use that to also apply to Medicare DPP?

MDH Response: Yes.

12. How often will the Maryland DPP Providers list be updated and will MCOs be informed?

MDH Response: The list of DPP Providers who have enrolled successfully with Maryland Medicaid will be monitored frequently and shared at least monthly with MCOs through the implementation period.

13. Before being credentialed as a DPP provider, are they assessed on their sustainability?

MDH Response: Providers are not formally assessed by MDH on their sustainability prior to enrollment with Maryland Medicaid. However, as part of the ePREP enrollment process, Maryland Medicaid checks that all provider applicants are in “[good standing](#)” with the State Department of Assessment and

Taxation (SDAT). Additionally, to enroll as a DPP provider with Maryland Medicaid, the organization must have obtained either a pending, preliminary or full recognition status from the Centers for Disease Control and Prevention (CDC), and attest that all of their lifestyle coaches are trained on a CDC-approved curriculum and in good standing. It is the MCO's decision how they prefer to assess new providers for sustainability as part of standard contracting processes.

14. What is the numeric code for the DPP Provider type in ePREP?

MDH Response: The DPP provider type in ePREP is listed as "DPP Provider" - Diabetes Prevention Program Provider. For the purposes of mirroring MCO system edits to Maryland Medicaid's provider enrollment system, the two digit provider type code is "DP."

15. I am an out of state virtual CDC-recognized organization; how do I meet the site visit requirement to enroll with Maryland Medicaid?

MDH Response: Out of state virtual CDC-recognized organizations may use documentation of a successful enrollment site visit of their administrative location conducted by another state's Medicaid agency to meet this requirement. Organizations should indicate that they are an out of state provider on their ePREP application addendum, and upload proof (a dated letter and/or certificate etc.) of the successful site visit. If the organization has never received a successful enrollment site visit of their administrative location by another Medicaid agency, they should indicate this on their ePREP application addendum and will receive further follow up from Maryland Medicaid. **COVID-19 Update: Site visits will be waived during the COVID-19 emergency period; when the COVID-19 threat is lifted, the site visits will be conducted within a reasonable timeframe.**

16. Which CDC delivery modes are considered "virtual DPP providers"?

MDH Response: Online, distance learning, and combination delivery modes (only if the combination is online and distance learning) are considered virtual DPP providers.

17. What do not-for-profit health systems with no owners put for the ownership disclosure section in ePREP and who would need to be fingerprinted?

MDH Response: Not-for-profit health systems with no owners must still disclose all managing employees, owners with control interest, and/or agents (MOCAs), such as members of a Board of Directors.

Below are definitions of agents and managing employees.

- Agent means a person who has been delegated the authority to obligate or act on behalf of an applicant or provider.
- Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an applicant or provider.

Additionally, site visitors typically check/confirm Managing Employees, Owners, and Control Interests and Agents (MOCAs) information.

MCO Credentialing

18. Is there specific credentialing criteria for DPP organizations outside of pending/full CDC recognition?

MDH Response: It is up to Managed Care Organizations (MCOs) to determine how to credential DPP providers. One approach may be to treat the DPP providers as they would other ancillary style providers.

19. Do MCOs need to obtain an ownership and disclosure form from DPP Providers?

MDH Response: No, the ownership and disclosure information will be obtained through the ePREP enrollment process.

Changes in Program Participation and MCO enrollment

20. Are HealthChoice enrollees allowed to switch from one DPP Provider to another within the MCO's network during their year of service eligibility?

MDH Response: Yes. MCOs have flexibility to decide whether or not they will allow an enrollee to begin in one in-network DPP Provider and switch to another in-network DPP Provider. MCOs may decide to manage these requests on a case by case basis. MDH encourages MCOs wishing to allow switches between in-network DPP providers to consider the following administrative requirements, and other issues, as they develop their policies and member communications:

- HIPAA-compliant data exchanges between DPP Providers
- Continuity of billing for the enrollee after a provider switch
- Limits on how often enrollees can switch between DPP Providers
- Impact of enrollee switches on DPP Providers' CDC recognition status
- Assignment of new participant identification numbers and data tracking
- Continuity of billing milestones

21. If the HealthChoice enrollee switches MCOs are they allowed to switch from one DPP Provider to another during their year of service eligibility?

MDH Response: Yes. In this case, the enrollee would restart the year-long program with the new MCO and select a new in-network DPP Provider. If upon enrollment, the enrollee communicates to the new MCO that he/she would like to continue with the same DPP Provider, assuming that DPP Provider is in-network, then the enrollee may continue the program with that same DPP Provider. In compliance with federal regulation [42 CFR 438.62](#), the new MCO would follow existing processes for ensuring continuity of care when members transition from one MCO to the new MCO.

22. Can a member switch to a virtual provider after starting the program with an in-person provider? If so, would they start the program over or continue from where they left off in the curriculum?

MDH Response: Yes, MCOs have flexibility to decide if they will allow this and if they would require the individual to restart the program or allow them to continue where they left off. However, in this specific case, if an MCO decides they would like to allow members to switch from an in-network in-person DPP provider to an in-network virtual DPP provider, the MCO would need to reimburse for the virtual scale. See also response to question 14.

Coding and Billing

23. We are operating under the assumption that the fee schedule will mirror Medicare and would like to clarify what the fee schedule will be for the codes that MDH has designated for this benefit.

MDH Response: The HealthChoice DPP session and performance-based reimbursement methodology for in-person and virtual DPP providers uses the same HCPCS codes as Medicare; however, the minimum fee schedule is not the same. This minimum fee schedule is outlined in HealthChoice DPP Policy Transmittal No. 1, issued September 30, 2019, currently posted on the [HealthChoice DPP website](#). This policy transmittal also outlines a milestone/bundled reimbursement methodology which is available only for virtual DPP providers (online, distance learning, and combination (only if distance learning and online) delivery modes). In this methodology, MDH will accept one of three possible codes for enrollment or initiation into the program as a first milestone and allow claiming for the scale using either 1) G9873; 2) E1639; or 3) 0488T.

24. Will these codes be added to the broader physician fee schedule or is this a stand-alone fee schedule?

MDH Response: The codes will be not be added to the broader fee physician fee schedule as both available reimbursement methodologies are standalone minimum fee schedules.

25. Would the type 2 NPI number be the only one listed on a claim? If so, would we list it twice? One for the billing & once for the rendering provider?

MDH Response: Yes, the type 2 NPI will be the only NPI number listed on the claim. There won't be a rendering provider indicated.

26. Is there is a finalized, or more formal, list of the eligibility criteria, CPT codes & Modifiers, and ICD-10 codes?

MDH Response: Eligibility criteria for the HealthChoice DPP is listed in the final approved Special Terms and Conditions (STCs), #31, [here](#). The HealthChoice DPP Policy Transmittal No. 1, issued September 30, 2019, outlines eligibility criteria, available reimbursement frameworks and coding structures. **This**

information is also contained in the HealthChoice DPP Program Manual. Both documents are posted on the [HealthChoice DPP website](#).

27. How can we ensure the DPP codes (0403T and 0488T) are only used by DPP providers?

MDH Response: MCOs may audit HealthChoice DPP claims to make sure appropriate codes are used. The code 0403T is not included in either available HealthChoice DPP reimbursement methodology.

28. When and how should MCOs test the encounter system?

MDH Response: There will be a testing process for encounter provider enrollment edits in winter of 2019. If MCOs want, they may add a DPP encounter to their samples in order to see if it goes through successfully and appropriately. MDH does not anticipate creating a special encounter testing window solely for HealthChoice DPP.

29. Can DPP providers bill more than one type of session for an enrollee (virtual or in-person)?

MDH Response: A DPP provider can only bill for the types of sessions allowed through their CDC-recognition status delivery mode (i.e., in-person organizations can only bill for in-person sessions; combination organizations may bill for a mixture of in-person and virtual sessions). CDC-recognized organizations with recognition status in more than one delivery mode (i.e., offers an in-person program as well as a virtual program) with separate CDC DPRP organization codes cannot allow the individual to participate in both programs simultaneously; individuals may be enrolled in one cohort at a time.

30. If a virtual DPP provider doesn't bill with a GT modifier then the claim will be denied?

MDH Response: Yes. MCOs should build into their claims rules that if a GT modifier is not used on claims submitted for virtual sessions, then the claim would be rejected.

31. What does the billing look like, for a third party supplier like Solera? Will there be any billing changes or exceptions for this type of product? Can Solera directly contract with MCOs? Would their payment be considered a pass-through payment?

MDH Response: Solera, as a network integrator model, would contract directly with MCOs who wish to engage them for their services. Solera submits medical claims to the MCO on behalf of CDC-recognized lifestyle change organizations for members who meet program milestones. The claim is paid by the MCO, and Solera pays its network providers after they receive payment. Solera's network would be comprised of CDC-recognized organizations who have successfully enrolled with Maryland Medicaid.

Solera is not a CDC-recognized organization itself, but would be acting as a delegated administrative vendor. Their preferred compensation approach under the delegated agreement with the MCO would be to serve as a billing agent for the CDC-recognized DPPs in its network. The CDC-recognized DPP would

be identified as the billing/pay-to provider and rendering provider for claims and encounter purposes, since Solera would not enroll with Maryland Medicaid.

Solera's payment structure is not considered a pass-through payment since it does not meet the definition for pass-through. Pass-through payments are amounts paid to Medicaid managed care plans as supplemental payments or "add-ons" to the base capitation rate. The state is not requiring any amounts to be added to contracted payment rates between the managed care plans and DPP providers for the purposes of delivering HealthChoice DPP services.

32. Are the virtual sessions paid at 100% of the in person sessions? What percentage are the virtual make up sessions paid?

MDH Response: Yes, for the session and performance-based reimbursement methodology for minimum payment levels for in-person and virtual DPP providers (see HealthChoice DPP Policy Transmittal No. 1, 9/30/19), virtual sessions and virtual makeup sessions are paid at an equivalent level to in-person sessions. Virtual programs will use specific modifiers to indicate it is a virtual session or a virtual make-up session. The alternative HealthChoice DPP milestone/bundled reimbursement methodology for virtual DPP providers has its own unique fee schedule.

33. Can you please provide documentation on the billing rules around make-up sessions? For example, can a DPP provider bill for a virtual make up session when the member is enrolled in the in-person program? Is there a restriction on the number of make-up sessions? Is a member allowed to change in-person programs or use another in-person program for a make-up session?

MDH Response: Participating in-person and virtual CDC-recognized type 2 diabetes prevention programs must use the make-up modifiers when submitting claims for make-up sessions using TS and VM modifiers with any code that has a session attached to it (except for the first session). In-person programs should always use the TS modifier for makeup sessions. Virtual programs should always use the VM modifier for their makeup sessions. According to the CDC, organizations that conduct make-up sessions online, via some other virtual modality, or over the phone are still considered to be delivering the program in-person. When make-up sessions are needed, following up with participants outside of class if they were unable to attend a session that week (during months 1-6) or month (during months 7-12) to offer a make-up session. (Make-up sessions should consist of a one hour, in-person discussion or can be delivered via phone, video conference, or virtual session). If participants miss a session during any phase of the intervention, organizations may offer a make-up session. This make-up session can be held either on a day other than a regular class session day or, for the convenience of the participant, on the same day as a regular class session. Only one make-up session per participant can be held per week. Members cannot use a different in-person DPP provider only for a make-up session

34. Will a distance learning program be considered an in-person or virtual program?

MDH Response: CDC-recognized type 2 diabetes prevention programs using a "Distance learning mode of delivery (see DPRP registry to verify recognized mode of delivery) are considered a virtual DPP

provider; as such, they would need to bill using one of the two available methodologies, using the virtual codes/modifiers.

35. If we do a make-up session by phone for our in-person DPP, is that considered a “virtual session” and would it require the modifier?

MDH Response: You would use the modifier “TS” for any in-person make up session. In-person programs may conduct make-up sessions online, via some other virtual modality, or over the phone; these are still considered to be delivering the program in-person.

36. Which CDC delivery modes can use the HealthChoice DPP Milestone/Bundled Reimbursement Methodology?

MDH Response: The milestone/bundled reimbursement methodology is intended only for Virtual DPP providers (CDC-recognized organizations with online, distance learning, or combination (only when online and distance learning are combined)).

37. In each of the reimbursement mechanisms do all codes need to be billed including the non-payable codes?

MDH Response: Yes.

HealthChoice DPP MCO Participation

38. Is there an update on the approval of the 1115 waiver amendment?

MDH Response: Yes, the waiver amendment has been approved by the Centers for Medicare and Medicaid Services (CMS), as of April 2019. Final STCs are now posted [here](#).

39. Is there a fee schedule available for us to begin implementing?

MDH Response: The minimum fee schedule was outlined in HealthChoice DPP Policy Transmittal No. 1, first issued June 10, 2019, and subsequently updated and issued September 30, 2019. This policy transmittal is currently posted on the [HealthChoice DPP website](#).

40. Can you confirm that there are no requirements surrounding the number of enrollee members needing to be enrolled in the Medicaid DPP program? When we originally inquired about this, it was confirmed that there were no parameters as this program was now embedded in our capitated payment. However, I located the final submitted waiver, and on page 7 it talks about budget neutrality and a limited number of slots:

“Budget Neutrality the Department and the Department of Budget Management (DBM) have allocated an initial budget of \$700,000 Total Funds annually to provide National DPP services to eligible Medicaid participants in the HealthChoice program. This would limit the number

that could be served annually to 1,400 participants. Based on DBM approval, this may be increased up to \$1.4 million Total Funds annually, which could serve up to 2,800 participants.”

Is the above information correct – are there parameters (minimum/maximum) for enrollment? Or are we confusing this with the pilot program where there were parameters in place? We are a bit confused and are seeking clarification.

MDH Response: The budget neutrality figures you are referring to was a part of the §1115 HealthChoice waiver amendment application that MDH initially submitted to CMS. Between the original submission and final approval of the waiver amendment, modifications were made to the HealthChoice DPP which resulted in the program expanding from a limited pilot to a statewide program including all nine MCOs, and including payment through the MCO capitation rates, making it no longer a “pilot” per se. While utilization estimates will be provided to MCOs, at this time MDH does not anticipate issuing enrollment target requirements for MCOs.

41. Where should MCOs obtain information about DPP Provider’s CDC-Recognition Organization code?

MDH Response: A DPP provider’s CDC-recognition organization code, assigned by the DPRP, is not specifically verified as part of provider enrollment with Maryland Medicaid. CDC-recognized organizations applying do, however, have to submit evidence of their CDC Recognition status, as specified on the addendum. CDC-Recognized Organizations may also provide this to MCOs as well as part of contracting/credentialing

42. How can an MCO determine HealthChoice member enrollment by county?

MDH Response: MCO enrollment by county is captured in the 2019 [HealthChoice Evaluation, Appendix B, page 101](#).

Coding and Billing Systems Changes

43. As we continue to build the infrastructure for the DPP, a particular question came up re: In the instance that a member does not meet eligibility criteria. For example: Our process is that Omada conducts a telephonic screening of referred members to ascertain their eligibility to participate in the DPP program. Members must have specific diagnoses, blood levels, etc. to qualify. In the instance that a member does not meet eligibility criteria, Omada would generally issue a notice to the member following the screening to confirm they do not qualify to receive services from Omada at this time. Accordingly, would this be considered an adverse benefit determination? If so, should they (we) be sending a standard denial letter? Or is the Dept. thinking something else? Please advise.

- a. Should MCOs track these denials separately or track them the same as other medical denials? For other services members can self-refer to, MCOs don’t hold this type of denial parameter, should this be treated differently?

b. Is the response time the same?

MDH response: If the DPP Provider determines that a member does not meet eligibility criteria, MDH would not consider this an adverse benefit determination, nor require that it be tracked as such with other medical denials. If the member disagrees, the DPP Provider must inform the member that they can file a grievance with the MCO. The MCO would classify the grievance as a non-emergency medically related grievance and is responsible for resolving the grievance within the 5 day timeframe. MCOs may instruct their DPP Providers to refer individuals found not eligible to the MCO. MCOs should make members aware that if they are found not eligible by the DPP Provider, they may ask their MCO for further information.

44. What will the State allow regarding proof of blood test and how would a virtual vendor operationalize this?

MDH response: MDH will allow the secure transfer of the proof of blood test to be agreed upon by the virtual DPP Provider and the MCO. This may be accomplished in various ways (i.e. secure fax, upload of a picture, or PDF file) as long as the method is secure and auditable.

45. Is MCO lab data an acceptable form of proof of blood test?

MDH response: Yes, MCO lab data is an accepted form of proof of blood test.

46. Must a DPP provider store the lab results an MCO would submit via an eligibility file? Or would it be sufficient if the MCO sent the provider a list of confirmed eligible members with lab results on file with us only?

MDH response: It would be sufficient if the MCO sent the DPP provider a list of confirmed eligible members with lab results on file with the MCO. The DPP provider must then confirm that the participant is on that list prior to enrolling them into the program.

47. What proof will be required to confirm history of gestational diabetes?

MDH Response: Individuals should ask their MCO or healthcare provider to provide a note indicating history of gestational diabetes and/or a prior blood test indicating gestational diabetes.

48. Must a virtual provider store the lab results an MCO would submit via an eligibility file? Or would it be sufficient if the MCO sent the provider a list of confirmed eligible members with lab results on file with us only?

MDH response: It would be sufficient if the MCO sent the DPP provider a list of confirmed eligible members with lab results on file with the MCO. The DPP provider must then confirm that the participant is on that list prior to enrolling them into the program.

49. [MDH asked CMS-MDPP on 5/30/19]: Can you please clarify whether MDPP suppliers serving mixed cohort classes may bill Medicare for Medicare participants, and also provide free care to others in that same mixed cohort class? For instance, if a hospital based MDPP - who has a separate NPI for its MDPP program - starts a mixed cohort; can they bill Medicare for their Medicare participants, as well as offer services for free to those in that same class who may have low income or who have no other insurance coverage?

CMS-MDPP response received 6/11/19: You can mix Medicare beneficiaries and those not eligible in the same cohort. Cohorts may include:

- Medicare beneficiaries eligible to receive MDPP set of services
- Non-Medicare beneficiaries or
- Medicare beneficiaries who are not eligible to receive MDPP set of services

Note that only eligible Medicare beneficiaries are covered and paid for by Medicare and are subject to the Medicare regulations governing the MDPP services. Additionally, all participants, regardless of their Medicare status, would be subject to the requirements of the CDC's National DPP.

Once your organization is enrolled as an MDPP supplier, you must bill Medicare for MDPP services provided to eligible Medicare beneficiaries and **we advise your organization to seek legal counsel on whether you may continue to offer National DPP services to non-MDPP beneficiaries for free.**

For more information on charging for services, please review the [Billing and Claims Fact Sheet \(PDF\)](#). For any other questions related to billing and claims, please contact your [MAC](#).

2. For self-pay clients, including non-Medicare participants or Medicare beneficiaries that are not eligible but attend DPP services, MDPP suppliers should bill the client directly, but we advise that you seek legal counsel regarding the amount you charge for the delivery of services.

[NOTE: MDH requested further clarification on this response through NACDD/CDC on 6/17; NACDD/CDC confirmed on 6/25 that this question is under review by CMS-legal and no further information is available at this time.]

Updated CMS MDPP response received 9/13/19:

It depends on the structure of the organization and its policies. MDPP suppliers can include non-Medicare beneficiaries or Medicare beneficiaries who are not eligible to receive MDPP in sessions with Medicare beneficiaries eligible to receive MDPP, but only eligible Medicare beneficiaries are covered and paid for by Medicare and are subject to the Medicare regulations governing the MDPP services. Additionally, while MDPP services provided to eligible Medicare beneficiaries are subject to MDPP regulations, all participants would be subject to the requirements of the CDC's National DPP. If an individual has private insurance that covers DPP services, the supplier would bill that private health plan. For non-Medicare participants or Medicare beneficiaries that are not eligible for MDPP, but attend DPP

services, suppliers should seek their own legal counsel regarding charging for the delivery of these services and their ability to offer classes for free based on low income or inability to pay. For more information on charging for services, please review the Billing and Claims Fact Sheet at <https://innovation.cms.gov/Files/fact-sheet/mdpp-billingclaims-fs.pdf>. For more information on billing, please see the Billing and Payment Quick Reference Guide at <https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf>

50. What claims form should be used for billing HealthChoice DPP services an institutional or professional claims form?

MDH Response: A CMS 1500 professional claims form should be used.

51. Will the DPP provider NPI numbers be the separation factor for providers (in-Person versus Virtual providers)? I.e. the Brancati Center would not be able to bill for both services with the same NPI we have to be able to track the services and to assure the modifiers billed by the In Person versus Virtual are correct?

MDH Response: No, the separation factor would be the use of the virtual modifier. In the case of the Brancati Center, they have one administrative location; therefore they are able to bill using one NPI. Following the rule explained in question 7, if the Brancati Center, as a Medicare-enrolled supplier, has an NPI specific to DPP then they may use this NPI also to enroll with Maryland Medicaid.

52. Can members that do not complete the in-person or virtual program be able to start the program over within the same year. (finished 1-3 core sessions then stopped)?

MDH Response: No, HealthChoice enrollees who discontinue the program cannot then restart the program in the same year. They may restart the program 365 days after they started the previous program.

53. If this is a self-referred service and the member can go to any Certified facility, how is the servicing provider going to know if the member has already been in a program within that year? What would be the verification process?

MDH Response: To clarify, the member can go to any in-network DPP Provider with their MCO. If the member has previously enrolled with an in-network DPP Provider and chooses to switch to a different DPP Provider without informing the MCO, then a claim submitted by the new DPP provider would be denied. MCOs may set up verification processes with their DPP providers and communicate to members about program limitations.

54. Verify that the total \$670.00 is the max that can be billed within the year no exceptions.

MDH Response: The Department intends to require MCOs to pay contracted CDC-recognized type 2 diabetes prevention programs at least the minimum rates outlined in the HealthChoice DPP Policy Transmittal and Program Manual. Assuming the enrollee attends all sessions and all performance outcomes are met, the maximum payment for CDC-recognized DPP providers based on these minimum payment rates is \$670.

55. What if the member has missed visits and the makeup sessions end up falling outside the 365 days are those sessions to be denied? The program looks to be set-up to be completed within the year?

MDH Response: Yes, sessions falling outside of the 365 days should be denied. The National DPP lifestyle change program is structured to be a year-long lifestyle change program. DPP providers should conduct any make-up sessions within the week of the missed class if possible.

56. Verify what process should be used if we receive claims from members that are receiving DPP services that do not fit the criteria within the transmittal. Age under 17 years old/over 64 years old, have a pregnancy diagnosis, or a type 1 or type 2 diagnosis. Question due to the fact that the members have 12 month of high risk numbers and circumstances can change by the time they start the first session from when they agree to enroll in the program?

MDH Response: Eligibility criteria must be met at the time the member goes to enroll with the DPP provider. If eligibility is not met at that time, then follow the process outlined in question 43.

57. We still have not heard anything concerning coordination of benefits. Medicare covers the program. Not sure if commercial insurers cover. How will MDH process in the event a member has other insurance?

MDH Response: When an MCO member enrolls in the program, the DPP Provider will check Medicaid's Electronic Verification System (EVS) for current Medicaid eligibility status. If the individual is not eligible for Medicaid at the time of that check, then he/she is not eligible for HealthChoice DPP. If a member has insurance other than Medicaid, then they may not be eligible for HealthChoice DPP. Dual-eligible individuals who are enrolled in Medicare and Medicaid fee-for-service are not eligible for HealthChoice DPP. Individuals with both commercial insurance and Medicaid fee-for-service are not eligible for HealthChoice DPP.

58. Will MDH be sending a sample CMS-1500 form of how the claims should be submitted? Similar to what was shared with MCOs during DPP 1.0?

MDH Response: Yes, MDH is targeting to provide a similar document and hold a webinar in early 2020.

59. The transmittal states, pregnant enrollees and enrollees previously diagnosed with type 1 or type 2 diabetes are not eligible to participate in HealthChoice DPP. Looks like if the member is

diagnosed with diabetes type I or II during the program it may be okay as long as they were not diagnosed prior to? How about if the member becomes pregnant?

MDH Response: Changes in health status, typically self-reported, may occur to enrollees while participating in HealthChoice DPP. If a member is diagnosed with type 1 or type 2 diabetes while participating in HealthChoice DPP, then they are no longer eligible to receive services through HealthChoice DPP. They should talk with their MCO and/or Healthcare Provider for referrals to other services designed to address their health needs. If the member becomes pregnant while participating in HealthChoice DPP, they are no longer eligible to receive services through HealthChoice DPP. They should talk with their MCO and/or Healthcare Provider for referrals to other services designed to address their health needs.

60. Would we ever pay non-par DPP providers (although certified with MDH)? If not, would we deny for an authorization or create a specific denial for the provider type = DPP services are to be provided by contracted DPP Provider only? If member transitions from one MCO to the other but would prefer to continue using current DPP provider that happens to be non-par with the MCO how would we handle?

MDH Response: If a member wants to participate in HealthChoice DPP with a non-participating DPP provider, the MCO may deny with the reason that the DPP provider must be a part of the MCO's network for the member to participate. If a member is transitioning from one MCO to another MCO, and the member's DPP provider does not participate with the MCO's network, the MCO must work with the member to transition to an in-network DPP Provider within 90 days of enrollment. See questions 20-22 for considerations when coordinating transitions between in-person and virtual DPP Providers.

61. Why is the makeup modifier only attached to the main codes and not the counter code?

MDH Response: The makeup modifier should be attached to both the main codes and the counter code (G9891), as appropriate, for all sessions except for the first session, for which a makeup class is not allowed.

62. How would we handle a member who turns 65 in the middle of DPP participation as they would be moved over to Medicare Primary?

MDH Response: If a member ages out of Medicaid within the first year of receiving the lifestyle change program, they will be discharged from HealthChoice DPP and subject to Medicare DPP requirements.

63. Can you confirm that two (2) ICD-10 diagnosis codes must be used for billing to demonstrate a participant's eligibility for the program? Providers must bill Elevated Blood Glucose Level or Gestational Diabetes ICD-10 Codes in addition to a BMI ICD-10?

MDH Response: Yes, for each initial claim, DPP Providers must indicate two ICD-10 codes: 1) for elevated blood glucose (R73.01, R73.02, R73.03), or history of Gestational Diabetes (Z86.32), and 2) for BMI. DPP providers, as lay health professionals, may indicate R codes for elevated blood glucose if one of three scenarios are met:

1. The enrollee presents a formal provider referral with R code indicated, or
2. DPP provider receives blood test results from the enrollee's MCO or health care provider, with proper consent and authorization by the enrollee, or
3. The enrollee presents blood test results which the DPP provider may use to identify appropriate R code according to the following prediabetes definitions.

Prediabetes Definitions:

Prediabetes (R73.03) is defined as any of the following 3 criteria:

- **Impaired glucose tolerance (IGT)** – Two-hour plasma glucose value during a 75 g OGTT between 140 and 199 mg/dL (7.8 to 11.0 mmol/L) = alone, this is the criterion for R73.02
- **Impaired fasting glucose (IFG)** – Fasting plasma glucose 100 to 125 mg/dL (5.6 to 6.9 mmol/L) = alone, this is the criterion for R73.01
- **Hemoglobin A1C** – A1C 5.7 to 6.4 percent

DPP providers, as lay health professionals, may indicate Z code for history of Gestational Diabetes if one of three scenarios are met:

1. The enrollee presents a formal provider referral with Z code indicated or,
2. DPP Provider receives blood test results or provider note from the enrollee's MCO or health care provider, with proper consent and authorization by the enrollee, or
3. The enrollee presents blood test results or provider note indicating history of GDM or normal postpartum A1C or glucose level and a GDM diagnosis during a previous pregnancy, which the DPP provider may use to indicate the Z code.

For each subsequent claim, DPP providers must indicate only the appropriate code initially used to indicate diagnosis of elevated blood glucose (R codes) or history of gestational diabetes (Z86.32); they do not need to include BMI codes on any subsequent claim.

DPP providers should follow MCO guidance on how to direct members to provide the necessary blood test documentation, confirmation or formal provider referral (i.e. fax, secure email, digital photo, etc.).

Further information on referral sources and assignment of ICD-10 codes by a DPP provider is included in the HealthChoice DPP Program Manual.

64. Will BMI ICD-10 Code Z68.34: Body Mass index (BMI) 34.0-34.9 be added to the program manual?

MDH Response: Yes, this was omitted in error; we have added this code to the most recent HealthChoice DPP Program Manual.

65. Can a virtual DPP provider bill using a milestone approach and/or bundled payment amounts?

MDH Response: Yes, MDH outlined an alternative milestone/bundled reimbursement methodology for virtual DPP providers in its HealthChoice Policy Transmittal No. 1, 9/30/19.

66. When MCOs negotiate reporting packages with DPP Providers, is there any additional data/information they should require as part of the contract?

MDH response: No additional information will be requested by MDH, although MCOs may decide to request additional information or reports.

67. Does Medicaid have the same requirement as Medicare where there is a weight loss requirement prior to members being eligible for referral to a DPP supplier (whether in-person or virtual)? If so, are bonus payments included for meeting those metrics?

MDH Response: HealthChoice DPP does not require prior weight loss to be eligible for referral. HealthChoice DPP follows the requirement of the Diabetes Prevention Recognition Program (DPRP) Standards and Operating procedures for eligibility. Eligibility criteria for the HealthChoice DPP is listed in the final approved STCs, #31, [here](#).

Exclusion: participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment. Individuals who are currently pregnant are not eligible for HealthChoice DPP services.

For more information about the Medicare DPP Expanded Model's eligibility criteria and payment and billing framework visit <https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>.

68. Will MCOs be required to submit additional information to MDH or the CDC? If so, what information and in what format?

MDH Response: No, MCOs are not required to submit additional information to MDH or the CDC. MCOs participating in CDC/NACDD's Coverage 2.0 grant are asked to provide implementation updates on monthly calls based on work plan deliverables.

69. In the Medicare program, codes that incorporate weight loss and attendance goals are subject to validation by the CDC prior to payment – how will this work for the Maryland Medicaid benefit? Is this through a vendor/provider submission of codes and data to the CDC? How should MCOs determine whether to reimburse a provider billing these codes?

MDH Response: For HealthChoice DPP, CDC-recognized organizations must submit their data to CDC as required per CDC's DPRP standards. As CDC-recognized organizations enroll with Maryland Medicaid to become DPP providers, they will complete and sign an addendum to their application that includes an attestation of their record keeping. The attestation reads: "The organization's records will include an attestation from the CDC-recognized organization, as applicable, that the Medicaid participant for whom it is submitting a claim to the Managed Care Organization, has met the attendance and weight loss measures described in the Maryland Medicaid HealthChoice DPP Reimbursement Methodology." MCOs

may include similar language in their contracts with DPP providers to ensure proper record keeping and audibility.

70. Are there currently any materials created for Provider education about the Diabetes Prevention Program? Did the state or any of the other MCOs develop anything during the demonstration project to inform providers about the program or the enrollment qualifications?

MDH Response: MDH did not create any provider specific outreach documents during the demonstration; instead, MCOs deployed their own provider engagement marketing materials and education strategies. The [AMA provider tool kit](#) is a detailed resource for provider outreach and has many tools specifically geared towards educating providers about prediabetes, how to screen, test, and refer and the National DPP lifestyle change program. As HealthChoice DPP implementation continues, Medicaid will work with the Center for Chronic Disease Prevention and Control (the Center) to provide technical assistance around practice transformation, streamlining referrals and provider marketing, and will continue to engage MCOs to help identify best practices for provider engagement/outreach.

71. Our claims manager was reviewing the Medicare DPP billing methodology and pointed out that the G9890 bridge payment code looked like it would be beneficial to the Medicaid DPP program. We were wondering if this code was still on the table for inclusion in the Medicaid billing methodology?

MDH Response: MDH did not include the G9890 bridge payment code in either of the two available reimbursement methodologies.

HealthChoice DPP Provider Participation

72. Will there be assistance for Diabetes Prevention Program Providers (DPP providers) (especially smaller community organizations) who need startup money to begin classes?

MDH Response: Maryland Medicaid will not be providing startup funding for DPP providers; however, opportunities may become available through the Center, which leads the statewide DPP Network. Any organizations interested in future start-up funding opportunities should express interest by contacting sue.vaeth@maryland.gov to be placed on the appropriate distribution list.

73. How are smaller DPP providers supposed to account for the gap of payment between session 9 and 12 in the Medicare Diabetes Prevention Program MDPP Expanded Model reimbursement framework if the 5% weight loss doesn't occur?

MDH Response: This issue was raised through the Center's state-wide diabetes prevention program network. CDC-recognized organizations should be aware that not all participants will lose weight during the specified time built into the payment model. It is incumbent upon the CDC-recognized organization to provide as much support to participants to help them meet the goals set forth in the program. The uncertainty of payment is a factor to be addressed as part of an organization's broader business plan. The Center can provide technical assistance around this topic and will offer business training to Maryland CDC-recognized organizations in the winter of 2019. Organizations may contact Sue Vaeth, sue.vaeth@maryland.gov, to request technical assistance.

74. Are there any restrictions or concerns about a third party managing a DPP Provider's data?

MDH Response: No, there are no restrictions or concerns with a third party data administrator managing a DPP Provider's data because DPRP Standards allow for third party data administrators.

Another available resource is the Center's Workshop Wizard that has a data collection tool which Maryland programs may use to store the required CDC DPRP data. The Workshop Wizard will be enabled to create a completed electronic billing form, 837P, using participant data entered in the system. There is no cost to use the Workshop Wizard. Requests to use the Workshop Wizard may be made to Mia Matthews (mia.matthews@maryland.gov) or Sue Vaeth (sue.vaeth@maryland.gov). It usually takes one to three days for the user name and password to be provided.

75. How long does it take for a DPP provider to get paid by an MCO after the service is rendered?

MDH Response: Once the DPP provider submits a clean claim to an MCO, payment typically occurs within net 30 days.