



Medicare Diabetes Prevention Program Enrollment Project Shared Learning Resource:

The Lifecycle of an MDPP Claim

In November 2023, the National Association of Chronic Disease Directors (NACDD's) [Medicare Diabetes Prevention Program \(MDPP\) Enrollment Project](#) team hosted the [Lifecycle of an MDPP Claim webinar](#) featuring Cassandra Stish from Welld Health, a billing and claims and data tracking platform. The purpose of the webinar was to give MDPP suppliers a better understanding of the MDPP billing claims submission process and how they might interact with health plans along that journey, including how to find, interpret, and resolve common barriers related to rejection and denial codes, partial or non-payment, and coverage validation issues.

The three phases of the Lifecycle of an MDPP claim—claim creation, adjudication, and revenue cycle management—are shown in Figure 1. Each of these phases is described in more detail in the sections that follow.

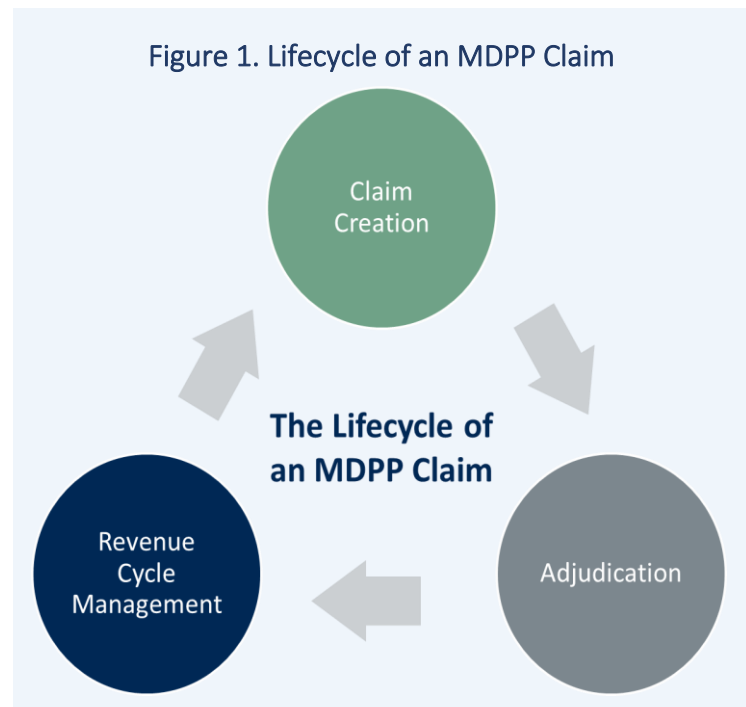
About This Resource

This resource details best practices for following the three stages of the lifecycle of an MDPP claim: claim creation, adjudication, and revenue cycle management. The resource is divided into the following sections:

[The Lifecycle of an MDPP Claim](#)

- 1) [Claim Creation](#)
- 2) [Adjudication](#)
- 3) [Revenue Cycle Management](#)

[Key MDPP Claim Terminology](#)



For more MDPP resources and webinars, including the MDPP [Billing Workshop 1](#) and MDPP [Billing Workshop 2](#), please visit the [MDPP Implementation Resources](#) page on the National DPP Coverage Toolkit (Coverage Toolkit Home Page → Medicare → MDPP Implementation Resources). To see the current PFS MDPP Payment Rates and other resources, visit the [CMS MDPP Webpage](#).



Claim Creation

Claim creation is the first step in the lifecycle of an MDPP claim. At this stage, participant data is transmitted to the health plan through an official claim. It is important to ensure that information is entered accurately, as this will improve and simplify the subsequent steps in the process.

Participant Registration and Health Plan Validation

Participant information should be entered exactly as it appears on the participant’s insurance card. This includes first and last name, date of birth, address, and gender. Note that some payment systems are not yet able to accept “unknown” as a gender. Please select the gender that is on the insurance card, regardless of the participant’s preferred identity. If the insurance card includes mistaken information, the participant will need to formally request to have this information updated with the health plan. To validate the health plan coverage, the member name, member date of birth, and member number will be required. **Note that the member number or ID is not the same as a plan or policy number.** Sometimes a group number or authorization number will also be required – these are payer-dependent.



KEY TIP

Create a payer portal login for every health plan that you are billing for the MDPP. This allows direct access to claims and can streamline benefit validation.

Claim Coding for the MDPP

When billing for MDPP services, each session is considered a medical encounter. For each encounter, details including the rendering provider, service code, date of service*, and fee are included on the claim. The information on a claim is divided into two sections: the header and the claim service detail. The header section summarizes the key information including participant information, National Provider Identifiers ([NPIs](#)) for the attending physician and service facility, primary diagnosis code, diagnosis-related group, name of participant’s health plan, and the overall charge for the claim. The claim detail is made up of additional information about services performed during each MDPP session including the referring provider, diagnosis codes, dates of service, procedure codes, and the charge for each service. **For MDPP, the responsible party will always be “self,” and the Lifestyle Coach’s NPI will be included at the bottom of claim detail.**

MDPP is billed sequentially, and earliest dates of service must be submitted for billing first. When sessions are not billed in order, denials, duplicates, and non-covered services can slow or prevent proper reimbursement.

To learn more, see the [MDPP Implementation Resources](#) page on the National DPP Coverage Toolkit.

Questions? Reach out to the [CMMI MDPP Supplier Support Center](#)



Transmitting the Claim

It is recommended that claims are submitted electronically via a [clearinghouse](#) or directly through the health plan's payer portal. While some health plans (e.g., newer Medicare Advantage plans) have removed the electronic data interchange ([EDI](#)) enrollment requirement, others may still require it. EDI enrollment is the process in which the health plan enrolls in the claims clearinghouse ahead of claim submission. Prior to submitting a claim, it is important to verify that the following information is correctly entered in the claim:

- Participant demographic and contact information
- Health plan information
- Service dates, descriptions, and therapy codes
- Billing information



KEY TIP

Verify and re-verify all information on the claim prior to submitting to the health plan. This can prevent or mitigate future challenges in the adjudication stage.

The health plan will send a digital receipt indicating that the claim was received. At that point, a preliminary review may acknowledge receipt of the claim but may also reject it. Claims can be rejected at this phase for the following reasons:

- Member not found
- Member ID not formatted correctly
- Wrong health plan name
- Critical claim formatting errors ([NPIs](#), media code, responsible party code, etc.)
- Provider not enrolled

If the claim is acknowledged and not rejected, the claim has moved into the next phase: adjudication.



Adjudication

Adjudication is the internal review process that each claim undergoes after it is submitted to the health plan. Health plans evaluate claims for accurate coding and documentation, medical necessity, and appropriate authorization.

To learn more, see the [MDPP Implementation Resources](#) page on the National DPP Coverage Toolkit.

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Claim Errors

Claims are reviewed from the top down and will produce a denial code at the first error or incongruity recognized in the data. When an error is identified, this does not mean that it is the only error; rather, it indicates that it is the first error identified on the claim. That error will need to be fixed and the corrected claim resubmitted before additional errors can be identified. If there are subsequent errors, each one will need to be addressed one at a time in sequence with the denial or adjustment codes that appear on the explanation of benefits (EOB) or electronic remittance advice ([ERA](#)). Claim denials can occur for a variety of reasons. The following denial codes are some of the most common for MDPP suppliers to encounter:

Incorrect or Incomplete Information: Claims with errors in participant demographics, provider information, or missing data are often denied. Ensuring accurate and complete information is essential.

- CO-16: Claim lacks information or has errors

Coding Errors: Inaccurate procedure and diagnosis codes are a frequent cause of denials.

- CO-11: Diagnoses code does not match with procedure
- CO-22: Care covered by another health plan through coordination of benefits

Lack of Medical Necessity: Health plans scrutinize claims to ensure that the services provided are medically necessary. Claims for procedures or treatments that do not meet medical necessity criteria can be denied.

- CO-96: Non-covered services
- CO-109: Claim service not covered by this health plan

Preauthorization or Referral Requirements: Many health plans require preauthorization or referrals for certain services. Failing to obtain these approvals before providing care can result in denials.

- CO-15: The authorization number is missing, invalid, or does not apply to the billed services

Timely Filing: Each health plan has specific deadlines for claim submission. Filing claims after the deadline can lead to automatic denials.

- CO-29: Timely filing expired

Coordination of Benefits (COB) Issues: When a participant has multiple insurance policies, COB issues can arise. Claims may be denied until the primary health plan processes the claim.

- CO-22: Care covered by another health plan through COB

Duplicate Claims: Submitting the same claim more than once can result in denials.

- CO-18: Duplicate claim

Policy Limitations: Some services or procedures may not be covered under a participant's health plan.

- CO-96: Non-covered services

Incorrect Provider Information: If a provider is not correctly enrolled with the health plan, claims may be denied. Verification of provider credentials and enrollment status is essential.

- CO-185: The rendering provider is not eligible to perform the service billed

Documentation Issues: Claims often require supporting medical documentation. Inadequate or missing documentation can lead to denials, as health plans need proof that the service was provided and necessary.

- CO-16: Claim lacks information or has errors
- CO-226: Information requested from the billing/rendering provider was not provided or not provided in a timely manner or was insufficient/incomplete

Billing Errors: Mistakes in calculating charges or mishandling modifiers can result in claims denials.

- CO-45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement



KEY TIPS

When in doubt, contact the health plan for additional detail on why a claim was denied or why a certain error code was used. Many of the common denial codes are generic and could mean many different things, so contacting the health plan directly can be beneficial.

Consider creating an internal standard operating procedure (SOP) document for each health plan that you work with. This can streamline adjudication and mitigate unnecessary errors and denials, since denial codes may be applied differently across health plans.



Revenue Cycle Management

Revenue cycle management (RCM) includes the process of correcting and resubmitting claims, reviewing and sending EOBs, and receiving reimbursement. MDPP suppliers will cycle through resubmission, remittances, and reconciliation until the claim processes for payment.

Working with a Billing Agent

The [billing agent](#) is the individual or company that provides billing services for the MDPP supplier. The billing agent could be in-house, but more often this role is performed by an external contractor. When working with a billing agent, a clear communication and reconciliation process should be in place to ensure that claims and payments are managed effectively. If an [ERA](#) has not been established or is not available, these communication procedures are even more critical.



KEY TIP

Establish a regular meeting cadence (e.g., monthly) with your billing agent to facilitate clear, ongoing communication and the sharing of key learnings.

To learn more, see the [MDPP Implementation Resources](#) page on the National DPP Coverage Toolkit.

Questions? Reach out to the [CMMI MDPP Support Center](#)



Working Denied Claims

When claims are denied, the MDPP supplier will need to work with their billing agent to address denial codes and resubmit corrected claims. Having access to the health plan's payer portal is extremely helpful in this stage, as additional information can be found directly on the claim that is not included on the [ERA](#) or EOB. While working on denied claims, it is important to be aware of the timely filing rules for the health plan. For traditional Medicare, claims must be submitted within one year from the date of the MDPP session, and 180 days are allowed for corrected claims to be resubmitted. For state Medicaid, managed care organizations (MCOs), and commercial health plans, timely filing limits vary.



KEY TIP

Read and understand the provider manual for each of the health plans that you are billing for MDPP services. These manuals provide plan-specific information, including timely filing requirements, that can be useful throughout the lifecycle of an MDPP claim.

Remittance/Payments

MDPP claim payments can fall into several different categories based on the participant's health plan and the accuracy of the submitted claims. It is important to understand these different payment scenarios as they influence MDPP suppliers' ongoing financial sustainability.

Most Common Payment Scenarios for MDPP Suppliers

- **Payment in Full:** In this ideal scenario, the health plan covers the entire cost of the service.
- **Payment with Adjustments:** The health plan may pay the claim but with adjustments, such as reducing the payment amount based on negotiated rates or contract terms.
- **Partial Payment:** A partial payment occurs when the health plan does not cover the entire billed amount.
- **Zero Payment:** The health plan may issue an EOB or Explanation of Payment (EOP) indicating that the claim has been processed but results in a payment amount of \$0.
- **Rejected Claims:** Claims that are outright rejected do not result in any payment.

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Key MDPP Claim Terminology

Billing Agent: An entity or individual authorized to submit claims on behalf of health care providers, offering services related to claims processing, coding, and billing.

Claim Adjustment Reason Code (CARC): A standardized code used to explain why a claim or service was adjusted, denied, or rejected during the claims processing.

Clean Claim: A medical claim that is complete, accurate, and free from errors, making it more likely to be processed and paid promptly by health plans.

Clearinghouse: An intermediary organization that receives, validates, and routes electronic claims and other health care transactions between providers and health plans, helping to ensure data accuracy and compliance.

Centers for Medicare & Medicaid Services (CMS) 1500: A standard paper claim form used for submitting medical claims for services and procedures to health plans, including Medicare and Medicaid.

Electronic Data Interchange (EDI): A digital system that enables the secure and standardized exchange of health care-related information and transactions between health care providers and plans. It streamlines the process of submitting, processing, and reconciling medical claims, improving efficiency and reducing manual paperwork.

Electronic Funds Transfer (EFT): A secure electronic method used to transfer funds directly from a health plan to a health care provider's bank account, often used for claim payments.

Electronic Remittance Advice (ERA): A digital document that provides health care providers with explanations and details about payments and adjustments made for claims, facilitating payment reconciliation.

Internal Control Number (ICN): A unique reference number assigned to each processed Medicare claim, allowing providers to track and reconcile individual claim payments.

Medicare Administrative Contractors (MACs): Organizations authorized by CMS to process and pay Medicare claims on behalf of the government.

Medicare Provider Enrollment, Chain, and Ownership System (CMS PECOS): An online portal provided by CMS that allows health care providers and suppliers to manage their enrollment information with Medicare. It is a critical tool for providers to maintain their Medicare billing privileges, update their credentials, and ensure compliance with Medicare enrollment requirements.

National Provider Identifier (NPI): A unique 10-digit identification number assigned to health care providers, used for claim submissions, health care transactions, and provider identification.

Provider Transaction Access Number (PTAN): A unique identifier assigned to health care providers, specifically those who bill Medicare.

Remittance Advice Remark Code (RARC): A code used to provide additional information or clarification related to a claim adjustment, often accompanying a CARC.

Revenue Cycle Management: The process of managing a health care provider's financial operations, including claim submission, payment collection, and revenue optimization.

Tax Identification Number (TIN): An identification number used by businesses, including medical practices, for tax purposes and often required for claims and billing.

To see the current PFS MDPP Payment Rates visit the [CMS MDPP Webpage](#)

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The National Association of Chronic Disease Directors (NACDD) and its more than 7,000 Members seek to strengthen state-based leadership and expertise for chronic disease prevention and control in states and nationally. Established in 1988, in partnership with the U.S. Centers for Disease Control and Prevention, NACDD is the only membership association of its kind to serve and represent every chronic disease division in all states and U.S. territories. For more information, visit chronicdisease.org.

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