NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Medicare DPP Supplier Learning Series

MDPP Billing Workshop: Part 1 and 2

FAQ Document

September 22, 2021 and November 10, 2021

On September 22, 2021 and November 10, 2021, the National Association of Chronic Disease Directors (NACDD), with support from the Centers for Disease Control and Prevention (CDC), hosted two MDPP Billing Workshops (Part 1 and 2) on behalf of the Centers for Medicare and Medicaid Services (CMS). Cassandra Stish from Welld Health was the featured guest presenter. The objective of the workshops was to discuss the various aspects of billing and claims submission associated with the Medicare Diabetes Prevention Program (MDPP). The workshop recordings and this FAQ document can be found on the MDPP Implementation and Resources page on the National DPP Coverage Toolkit.

This document organizes the questions generated from the workshops into two sections:

General Billing Questions and Claims Questions

Please note, CMS contributed to this FAQ document.

General Billing Questions

General

Should the name for billing be the organization name or the name of the department running the program?

- It should be the name of the entity that is on the MDPP enrollment application in PECOS.

How can you list a virtual workshop as a community site?

- The service facility location information in box 32 should be the physical location where the service was rendered (i.e., the location information of the MDPP supplier should be given in box 32). If you have additional questions, please contact your MAC. The MDPP supplier should use the most appropriate Place of Service (or, POS) code to indicate where the MDPP service was furnished, for example, "Office" (11), an outpatient facility code (19 or 22), or "Other" (99). We suggest using POS 99 for virtual make-up sessions. If you have additional questions, please contact your MAC.

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If a class begins in July 2020 and ends July 2021, is month 13 July 2021?

- The core services period is 12 months from the initial core session date. Note the date of the initial core session starts the MDPP clock for a participant, with the initial core session essentially registering the participant in MDPP. So, if the first core session started on July 15, 2020, then the core services period will end July 14, 2020, and Month 13 would start on July 15, 2021.

Are Medicare and Medicaid eligibility requirements the same?

- No. Please note that MDPP is a Medicare Part B service and a participant must be eligible for Medicare at the time the MDPP services are provided. So, if a participant is Medicaid only, they would not be eligible for MDPP.

  If the participant is dual eligible, meaning they currently have both Medicare and Medicaid, and they qualify for MDPP according to the criteria listed here, they may qualify to receive MDPP.

  Some state Medicaid programs may cover diabetes prevention programs similar to MDPP. We recommend checking with your state Medicaid program directly.

Where can I find the updated CMS MDPP billing codes and rates?

- Please see link to the finalized CY 2022 MDPP payment rates at https://innovation.cms.gov/media/document/mdpp-payment-rates-cy22

If a beneficiary is unable to make it to the 2nd session, would you be unable to bill for any classes in rest of the series?

- The sessions counted by how many attendances a person had and on what date… If the participant comes to class a 2nd time at any time during Core, that would be their 2nd session. Note, it's not advisable to let participants drop in and out as they will get out of sync with their cohort as the group moves into different phases of curricula, etc.

Is there a best practice for billing in certain cycles (i.e., having all the dates of service in one month be billed together)?

- MDPP suppliers should submit claims to the MAC when each payable performance goal is met. You must also include all associated non-payable claims as a separate line item using the code G9891 for each session attended that builds to a payable code on the claim form. For example, during the Core Sessions, when billing for the 1st session attendance goal, you will use payable code G9873. When billing for the 4th session attendance goal, you will use payable code G9874 AND you would also include code G9891 for sessions 2 and 3. When billing for the 9th session attendance goal you will use G9875 AND code G9891 for sessions, 5, 6, 7, and 8.

  Other than a claim for the first attendance goal (G9873), if G9891 is not included as a line item for each session attended by a beneficiary that counted toward the achievement of an attendance performance goal on a claim for a payable code, the claim will be denied. Suppliers are only required to submit claims containing G-codes associated with payment, but the non-payable code must be listed on that claims form for each session the beneficiary attended since the last claim was submitted.

The non-payable code is not required for non-attendance weight loss performance goals 5% WL achieved G9880, 9% WL achieved G9881, or a Bridge Payment G9890.

The 12-month timely filing limit starts on the date on which the service is furnished. For example, if a beneficiary attends the first Core Session on October 1, 2018, the MDPP supplier must submit the claim for payment no later than one year later: October 1, 2019. While not required, we encourage suppliers to submit claims as soon as possible following the service to avoid delays in payment and timely filing issues.
Operationally, there may be some benefit to creating and submitting claims every week or every two weeks. Waiting a full month may be a bit long.

Please visit the MDPP website for more information https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/.

Is there a difference between billing for the National DPP lifestyle change program and MDPP?

- Yes. MDPP is for Medicare beneficiaries only. DPP is for non-Medicare participants or Medicare participants who are not eligible for MDPP. DPP may be self-pay or covered by other health plans or payers.

Can we have a cohort that includes both MDPP and National DPP lifestyle change program participants if we bill for each participant appropriately (i.e., through CMS or regular insurance)?

- Yes, you can have mixed cohorts that include both MDPP and DPP participants. 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 who are not eligible for MDPP, but attend DPP services, suppliers should seek their own legal counsel regarding charging for the delivery of these services.

Can we bill for a beneficiary who became eligible for the MDPP after the enrollment date?

- No, beneficiaries cannot enroll in MDPP mid-cohort. If a beneficiary has received National DPP services prior to enrolling in Medicare, they remain eligible for MDPP because they have not yet received specific MDPP services. The MDPP services period begins once a beneficiary attends their first core session, activating that beneficiary's once per lifetime limit on MDPP services.

Are there special enrollment requirements for an FQHC?

- No -- there are no special enrollment requirements for FQHCs. Any provider with an existing enrollment type (including FQHCs), qualifying CDC DPRP full or preliminary recognition status and meets MDPP Supplier standards must re-enroll as an MDPP supplier and bill using the CMS-1500 paper claim form or its electronic equivalent in order to bill Medicare for MDPP services. Once enrolled as an MDPP supplier, the FQHC may bill Medicare for MDPP services, but only using the MDPP HCPCS G-codes that were finalized in the CY2018 Physician Fee Schedule final rule. MDPP services would be billed using a separate NPI on a

CMS-1500 paper claim form or its electronic equivalent. FQHCs must ensure that there is no co-mingling of MDPP services with RHC or FQHC services, and any costs related to furnishing MDPP services must be reported as non-reimbursable costs on the RHC or FQHC cost report.

Organizations should obtain a separate NPI to be used for MDPP enrollment in order to reduce claim rejections and denials that may occur if multiple enrollments are associated with a single NPI. Any currently enrolled MDPP supplier that elects to obtain a separate NPI to be used for its MDPP enrollment can update its current enrollment with the new NPI in PECOS. In the event that an organization is unable to obtain a separate NPI or continues to encounter issues related to claims submission and processing after updating its enrollment with the new NPI, please contact your MAC for assistance.

For more information on enrolling as an MDPP supplier, please review the MDPP Enrollment Checklist at https://innovation.cms.gov/Files/x/mdpp-enrollmentcl.pdf

Provider Enrollment, Chain, and Ownership System (PECOS)

What do we do if a coach changes?

- Organizations are required to report any changes of ownership, changes to the coach roster, or new final adverse action history of any individual or entity on the enrollment application within 30 days of the change. You may log in to PECOS at https://pecos.cms.hhs.gov/pecos/ to make changes to your enrollment application.

  To add, remove, or modify information related to your coach roster, an MDPP supplier must submit a change of information request through PECOS or via a paper application, using the CMS-20134 form. Your organization should indicate that the reason for submitting the application is to "change your Medicare information", note the section of the MDPP enrollment application you are seeking to change--in this case, "MDPP coach information" -- and then modify the appropriate information under the "MDPP coach information section."

  For more information on how to make changes within your Medicare enrollment, please see this YouTube video: https://www.youtube.com/embed/U0fJnhQ0egk?rel=0&autoplay=0. It can also be found on the PECOS website under "Enrollment Tutorials."

If you update the coach info within the 30-day window will the bill be paid within that 30 days? Can the billing and PECOS update cross in the mail?

- PECOS is updated online in real-time. There shouldn't be anything in the mail. Claims that are sent in for processing should only be sent if the coach information on the claim is correct and matches the information in PECOS.

How do you verify that your coach is updated in PECOS?

- You will receive a verification notice from your MAC or PECOS if the update is approved. You can also reach out to your MAC. Remember that every MDPP coach delivering MDPP services for your organization **MUST** be added to your Coach Roster within 30 days of furnishing MDPP services.

Medicare Administrative Contractors (MACs)

What are some examples of situations when we should be contacting a MAC?

- We recommend that you contact your MAC anytime you have a question about Medicare billing or enrollment (i.e., claims submissions, new enrollments or updating a Medicare enrollment application in PECOS).

  For an example, keeping your MDPP enrollment application current in PECOS is important and will help make sure that you stay in compliance with the program, can submit claims, and get support when you need it. Keep in mind that MDPP suppliers must update their PECOS enrollment application under the following circumstances:

  Within 30 days when changes are made to:
  • Ownership
  • The coach roster
  • Final adverse action history

  Within 90 days when changes are made to:
  • Administrative location(s)
  • Community settings
  • Authorizing Officials
  • Any other reportable event.

  Get to know your MAC and contact them often. You can find your MAC here: https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html

Medicare Advantage (MA)

Does a Medicare supplier also suffice for MA plans? Do we need to fill out other work for MA and are there other codes for MA to get payment?

- Organizations are required to be approved MDPP suppliers to provider MDPP set of services under MA Plans. If your organization needs information or assistance with MDPP payment policy or MA billing processes (such as determinations and appeals), you can submit your question(s) to CMS's MDPP Supplier Support Center page at https://cmmi.my.site.com/mdpp/ and follow the steps provided to "Start a New Inquiry."

  Please refer to our website for additional MA resources:
  - MDPP guidance for Medicare Advantage plans, please refer to the resource available on our website at https://innovation.cms.gov/Files/x/mdpp-maguidance.pdf.
  - Fact Sheet - Medicare Advantage at https://innovation.cms.gov/Files/fact-sheet/mdpp-ma-fs.pdf
  - MA section of the FAQs at https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/faq.html#medicare

Does MA and commercial insurance recognize the same NPI numbers for organization and coaches? Does MA and commercial use the same billing codes as traditional Medicare?

- Yes. MA and commercial insurance recognize the same NPI numbers for organization and coaches. Yes, MDPP services would be billed using a separate NPI on a CMS-1500 paper

claim form or its electronic equivalent. For more information on MDPP billing and claims, please review:

"Billing and Claims Fact Sheet" at https://innovation.cms.gov/Files/fact-sheet/mdpp-billingclaims-fs.pdf. This resource provides the steps MDPP suppliers should take to bill for MDPP services and includes tips to prepare for billing and where to get help along the way.

"Billing and Payment Quick Reference Guide" at https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf. This resource provides helpful guidance on the MDPP payment structure and when to use the HCPCS G-Codes to bill for MDPP services.

With Self-Submit, how do we submit for Medicare Advantage plans?

- Each plan has a website and instructions on how to submit claims to them. You'll need to use each plan's processes and tools.

National Provider Identifier (NPI) Number

Do you suggest we bill to the new NPI number we have set up, rather than the old one?

- How your organization gets reimbursed for MDPP set of services is established through your organization's MDPP enrollment application in PECOS. So, if your organization has established a different NPI for MDPP, then that NPI should be used as the supplier NPI for MDPP-related claims.

Can you use your NPI number if you are a nurse, or do you still need to obtain a new one?

- MDPP coaches are considered rendering providers on the MDPP claim. If coaches already have an NPI number they do not need to obtain another in order to furnish MDPP services. If an individual or organization has an existing NPI for a non-MDPP purpose, then they may choose to use that NPI for their MDPP enrollment or obtain a separate NPI.

Will individual NPIs be required for lifestyle coaches offering the program as an umbrella hub subsidiary?

- Yes. Individual NPIs are required for all lifestyle coaches offering MDPP, including those working as part of a CDC Hub subsidiary. Coaches are required to have a National Provider Identifier (NPI) to furnish services on behalf of the MDPP supplier. MDPP coaches must be trained per the CDC Diabetes Prevention Program (DPRP) requirements as listed in the DPRP standards, but are not required to have any additional training, credentialing, or licensing by CMS. Organizations and individuals can apply for NPI numbers using the NPPES website at https://nppes.cms.hhs.gov/.

  CMS requires coaches to obtain a National Provider Identifier (NPI) to help ensure the coaches meet CMS program integrity standards. **MDPP suppliers are required to submit the active and valid NPIs of all coaches who would furnish MDPP services on behalf of the MDPP supplier through a roster of coach identifying information.** If MDPP suppliers fail to provide active and valid NPIs of their coaches, or if the coaches fail to obtain or lose their active and valid NPIs, the MDPP supplier may be subject to compliance action or revocation of MDPP supplier status.

  MDPP suppliers are required to report the NPI of the coach who furnished the session as Item 24J on the line-item for each session reported on claims for performance payments for

MDPP services. The coach who furnished the session would be the rendering provider for purposes of reporting on the CMS–1500 claim form.
Interested organizations can make use of supplier support materials on the MDPP website, http://go.cms.gov/mdpp.

Do we use the coach specific NPI or our facility NPI?

- Both - the TYPE 2 NPI is for the billing entity and the coach's TYPE 1 NPI is the "rendering provider"

Will I need an extra Type 1 NPI if I have one for MNT and will also be a coach?

- No, if a coach already has an NPI number they do not need to obtain another in order to furnish MDPP services.

Can there be 2 NPIs in Box 24J?

- No.

If one coach leads for Session 2 but a different coach leads for 3 or 4, which NPI number should we use?

- Apply the appropriate "Rendering Provider NPI" on Box 24 J for the date of service that each coach performed. The coach that performed the services for the 4th session (the actual billable service) is the coach name that should appear on the bottom of the claim in Box 31.

Reimbursement

What causes a denial that says, "payment is denied when performed/billed by this type of facility"?

- Please reach out to your MAC for further information.

Is it a good practice to set up billing so all payers reimburse in the same manner as Medicare?

- Welld recommends doing as much as can be done to keep the billing processes similar regardless of the payer.

Will Medicare reimburse for distance learning sessions?

- Per MDPP's Emergency Policy, any MDPP session may be delivered virtually, including the first core session, during an 1135 waiver event. As of November 2, 2021, we are in an 1135 waiver event due to the COVID-19 public health emergency. Please use the virtual modifier (VM) when submitting your claims. The place of service should be the location listed on your Medicare enrollment application.

  Please see the MDPP emergency policies finalized in the CY21 Physician Fee Schedule. https://www.cms.gov/newsroom/fact-sheets/final-policies-medicare-diabetes-prevention-program-mdpp-expanded-model-calendar-year-2021-medicare.

When payment comes in, do we have to locate the claim in our internal system by name?

- There will be a check or EFT number associated with a remittance. You can use this number to reconcile claims with payments. There may be more than one claim paid on a single EFT transaction. It will be necessary to review the accompanying EOB to know which claims were paid on that check.

Claims Questions

Codes and Rates

What is the significance of the Z71.89 versus R73.3? Are those the only two codes that will be approved by Medicare if we do not have a referral that states another diagnosis code?

- If you don't have a referral that states a diagnosis code do not put anything in the indicated section. The only exception is Z71.89 as it is a special case that can be used without a physician referral. All other codes would need a physician referral to be entered.

For Box 21, entering default code (DX Z71.89) and other applicable codes, we would use both codes?

- Yes, it is recommended to use both codes, the more data there is documented the better.

What is the VM modifier?

- VM stands for "virtual modifier". You can use this modifier when you hold a virtual class in place of an in-person class. Virtual make up sessions require a "VM" at the end of the appropriate HCPCs G-code (e.g. G9894VM). You can use the non-payable G-code (G9891) to report attendance at sessions that are not associated with a performance goal. A list of HCPCs G-codes can be found in the Billing and Payment Quick Reference Guide at https://innovation.cms.gov/files/fact-sheet/mdpp-billpymnfs-2020.pdf. Note that in-person classes are the only reimbursable session type outside of the PHE for Medicare, if you are only conduct in-person classes you will not worry about the VM modifier. You should be appended to the HCPCS G-code on each claim line item that represents a virtual session.

Is there a list of possible modifiers?

- VM is the only modifier for MDPP

My MAC has modifier 95 to use for MNT. Do I need to check with my MAC of whether to use VM?

- Medical Nutrition Therapy (MNT) is a separate program from MDPP. Please check with you MAC regarding how to provide a virtual modifier for MNT. Note that your organization should not bill non-MDPP codes (e.g., MNT) on the same claim as MDPP-related claims. For MDPP-related claims, please use the VM for virtual makeup sessions. Virtual make up sessions require a "VM" (virtual modifier) at the end of the appropriate HCPCs G-code (e.g. G9891VM).

Is the Attending Taxonomy Code a required field on a MDPP claim?

- No, it's not required for FFS MDPP claims. It may be required for some Medicare Advantage claims.

When you bill for the initial session do you only bill for G9873 on the claim by itself or can you bill that code with more sessions?

- You must bill either attendance at the first core session (G9873) or the bridge payment (G9890) **before** billing for any other MDPP services. That being said, you can submit more than one service line on a single claim form. Be sure that the dates of service (DOS) are in order and that the first Core session is listed first.

I have been directed not to log G-Code G9891 alone because there is no charge. Is that something I should discuss with my MAC?

- Only submit a claim with a positive dollar charge and one of the billable milestones and include the G9891 to support that claim: for example, 4th session attended should be billed with dates of service for 2nd and 3rd sessions. You would not submit a claim just for the 2nd session attendance as it is not a billable milestone.

When we submit a claim for sessions 2-3 do we just code as reporting codes or do we need to wait to submit at specific milestones for classes?

- You can only submit a claim that has a positive dollar amount. You can submit an attendance only code but it must go with the next billable claim, it cannot be submitted by itself. It is recommended that you bundle claims. We encourage you to review the MDPP Billing and Claims Cheat Sheet at https://innovation.cms.gov/files/fact-sheet/mdpp-billpymnfs-2020.pdf.

General Claims Questions

If you are a hospital-based program, is this program primarily set up for freestanding clinics? Is the 855-form filled out and 855B or 855A?

- No. MDPP can be delivered in many types of settings, including: hospitals, community organizations, churches, clinics, and other kinds of organizations. MDPP services would be billed using a separate NPI on a CMS-1500 paper claim form or its electronic equivalent. For more information on MDPP billing and claims, please review:

  "Billing and Claims Fact Sheet" at https://innovation.cms.gov/Files/fact-sheet/mdpp-billingclaims-fs.pdf. This resource provides the steps MDPP suppliers should take to bill for MDPP services and includes tips to prepare for billing and where to get help along the way.

  "Billing and Payment Quick Reference Guide" at https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf. This resource provides helpful guidance on the MDPP payment structure and when to use the HCPCS G-Codes to bill for MDPP services.

  Please note any organization (including hospitals) that has an existing enrollment with Medicare must re-enroll as an MDPP supplier. Please note, organizations must be enrolled into Medicare as MDPP suppliers in order to furnish MDPP services to Medicare beneficiaries and receive payment from Medicare for those services.

We have been using R73.03 but not the Z71.89 and they have not had a provider referral and our coach is not a clinician, could this be a reason for a denied claim?

- It's possible but not likely. Without looking at the claim, it's hard to say why it's been denied. Only physicians are permitted to provide diagnosis codes.

Can we submit these services via UB format, or should we bill them on HCFA?

- MDPP Services are considered "professional services" and as such are billed on the HCFA or CMS 1500 not the UB 1450 which is reserved for institutional claims.

Can you bill multiple months together?

- Yes, so long as the 1st Session claim is first by date.

Is there a template for the informed consent form?

- No, there is no specific informed consent template. MDPP suppliers are free to determine their own documentation methods so long as they comply with MDPP-specific guidance on data collection, documentation, and recordkeeping requirements. You can find more information on these requirements in our MDPP Supplier Requirements Checklist (https://innovation.cms.gov/files/x/mdpp-supplierreq-checklist.pdf) and Crosswalk Guidance.

  Please note, MDPP suppliers are required to maintain and handle PHI and PII in compliance with HIPAA, applicable and federal privacy laws. For additional resources regarding HIPAA, see the following resources: https://www.healthit.gov/topic/privacy-security-and-hipaa/hipaa-basics

Why do you not put in the DPP actual charge for service when it is the 'actual' charge?

- When billing for Medicare beneficiaries, MDPP suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect any amount from an eligible beneficiary. Please see the CY22 Payment rates for the current rates (https://innovation.cms.gov/media/document/mdpp-payment-rates-cy22). MDPP suppliers may not deviate from the MDPP Fee Schedule with the outcomes-based benchmarks when billing Medicare for MDPP services provided to fee-for-service (Original Medicare) beneficiaries. If an MDPP supplier contracts with a Medicare Advantage (MA) plan to provide MDPP services to plan enrollees who receive their Medicare coverage via Medicare Part C, the MA plan is not required to utilize the MDPP fee schedule and the two parties may determine their own payment structure. MDPP suppliers would then request reimbursement in accordance with their agreement with the MA plan from the MA plan directly for any MA plan enrollees. Regardless of Medicare coverage (i.e. fee for service or Medicare Advantage), under no circumstance may an eligible Medicare beneficiary be charged for MDPP services. Where an MDPP supplier provides both MDPP and National DPP services, the MDPP supplier is not bound to the Medicare fee schedule for National DPP services provided to non-Medicare beneficiaries and Medicare beneficiaries who do not meet the eligibility criteria to receive MDPP services.

  Additionally, please note that only Medicare beneficiaries are covered 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.

  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 counsel regarding the amount you charge for the delivery of services. CMS does not provide regulations on the payment rate organizations can charge for the National DPP to non-Medicare participants.

How do you fill out the date for boxes 12 and 13?

- You put the date that the claim is being prepared on, this follows any software that would fill out a claim.

Do you have to type in all caps, or can it be mixed?

- It can be mixed but it should not have any extra punctuation.

Do sessions 2, 3, and 4 need to be on the same claim?

- Yes. 4th Session cannot be billed without verification of the 2nd and 3rd session attendances.

Will we be able to status these claims through FSS0 or ConneX?

- Your MAC website has tools like ConneX or FSSO to help you see the current status of all of your claims.

As a FQHC would we use the FQHC pos 50?

- No --Any provider with an existing enrollment type (including FQHCs), qualifying CDC DPRP full or preliminary recognition status and meets MDPP Supplier standards must re-enroll as an MDPP supplier and bill using the CMS-1500 paper claim form or its electronic equivalent in order to bill Medicare for MDPP services. Once enrolled as an MDPP supplier, the FQHC may bill Medicare for MDPP services, but only using the MDPP HCPCS G-codes that were finalized in the CY2018 Physician Fee Schedule final rule. MDPP services would be billed using a separate NPI on a CMS-1500 paper claim form or its electronic equivalent. FQHCs must ensure that there is no co-mingling of MDPP services with RHC or FQHC services, and any costs related to furnishing MDPP services must be reported as non-reimbursable costs on the RHC or FQHC cost report.

  Information on the finalized CY 2022 MDPP payment rates can be found at https://innovation.cms.gov/media/document/mdpp-payment-rates-cy22.

Claims Submission

If you use a third-party biller, do you use their address for Box 33?

- No, your third-party billing agent is associated in PECOS. CMS and the Medicare Administrative Contractors (MACs) want to know who they are paying. Box 33 is the address for your claims. Note that many providers and suppliers use a billing agent to manage billing and payment processes on their behalf. If an MDPP supplier uses a billing agent, the billing agent's information
  must be listed on the MDPP Enrollment Application (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20134.pdf)

Should Boxes 32 and 33 be the same unless you have other offices?

- Yes.

Should Box 26 be our internal account number for the client or the Medicare policy number?

- Neither, Box 26 is for the patient account number (the account number that relates to the payer). It is not an MRN, rather the policy number that pertains to the health plan.

Is Box 26 for the participant ID we submitted to CDC?

- No, Box 26 is for the patient account number (the account number that relates to the payer). It is not an MRN, rather the policy number that pertains to the health plan.

Will a claim be rejected because we put the RD as the billing provider rather than the MDPP NPI in Box 33, like is done with DSMT?

- Box 33 is the Supplier/organization billing provider name, address, city, state, zip, and telephone.

If a rendering provider is in Box J, is the individual coach ID in there somewhere else? Is the NPI attached to the DPP itself as placed?

- Item 24J is the rendering provider. Use the Coach's NPI for each session. Item 33a is the supplier/organization NPI billing provider (specialty D1).

What is the difference between Box 32a and Box 33a?

- Box 33 is the Billing Provider (ENTITY or ORGANIZATION) name, address and NPI and must match what is on your MDPP application. Box 32 is the service location which may be the same as Box 33 or may be different if there are more than one service location listed on your MDPP application in PECOS. The Rendering Provider NPI or coach NPI is provided on each service line (Box 24J).

Why is Box 26 for the insurance policy number as opposed to the participants medical record number?

- The health plans have no need to see a patient's MRN. They only need to see the member's policy ID.

Would you ever put anything in Box 24?

- Box 24 A - J is the business end of the claim detail. It is where the services are listed out. All of the sections must be filled out.

Should a rejected claim be corrected and resubmitted as an original claim and not a corrected claim since it was not accepted by Medicare?

- Yes. If the rejected claim was never accepted into the adjudication system simply correct and resubmit. If there is an ICN (internal control number) that means it has been entered into the adjudication system and will need to be submitted as a corrected claim.

Other Questions

Is there a series for learning about the National DPP lifestyle change program like there is for the MDPP?

- No, but we would suggest learning from the CDC's Customer Service Center resources: https://nationaldppcsc.cdc.gov/s/

What is the best way to verify beneficiary eligibility for MDPP?

- There are 4 options for verifying a beneficiary's Medicare coverage: 1) Medicare Administrative Contractor (MAC) online provider portal; 2) MAC phone verification; 3) HIPAA Eligibility Transaction System (HETS), or 4) Billing Agency, Clearinghouse, or Software Vendor. For more information, see the "How to Verify an MDPP Beneficiary's Coverage Fact Sheet" at https://innovation.cms.gov/files/x/mdpp-verify-medicare-coverage.pdf

Where can I find the MDPP fee schedule?

- Information on the finalized CY 2022 MDPP payment rates can be found at https://innovation.cms.gov/media/document/mdpp-payment-rates-cy22.