GLOSSARY OF TERMS

Advanced Beneficiary Notice (ABN)—Advanced Beneficiary Notice advises beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.

Carriers—organizations that administer Medicare Part B.

CMS—Centers for Medicare & Medicaid Services (formerly HCFA—Health Care Financing Administration); the Federal Agency that develops and pays for Medicare benefits. Some of the forms from Medicare are still referred to as HCFA.

CMS From 855B—Application for Health Care Suppliers that bill Medicare Carriers. Form used by dietitians and nutritionists who form a group practice to enroll in Medicare and bill Medicare as a single supplier. Single supplier includes individuals, partnerships, groups, organizations and and corporations. Individuals must enroll individually and may enroll as a member of an organization. When joining an organization, the individual reassigns their benefits. If the dietitian's or nutritionist's employer (ie, hospital) doesn't have a Part B billing number it must complete a CMS 855B to obtain a PIN.

CMS Form 855I—this is the Application for Individual Health Care Practitioners form that all dietitians and nutritionists wishing to bill Medicare for MNT must complete in order to receive a provider identification number (PIN).

CMS Form 855R—this is the application for Individual Health Care Practitioners to reassign Medicare Benefits form that allows individual reassignment of benefits to the organization which RD has an employment or independent contractor relationship. This form allows the dietitian or nutritionist to re-assign her/his Medicare reimbursement to the organization to whom the practitioner authorizes to bill Medicare on her/his behalf.

CPT—Physician's Current Procedural Terminology (CPT)codes published and copyrighted by the American Medical Association (AMA). The 2002 CPT book is available for a fee from the AMA and is updated annually.

DMERCS—Durable Medical Equipment Regional Carrier, pronounced "dee-merk". Medicare has four DMERCs that process claims for all durable medical equipment, prosthetics, orthotics, and supplies, including blood glucose monitors, test strips, and insulin pumps. For a complete list of all procedure codes billable to the DMERC, please write to your local Medicare carrier or local DMERC.

DSME—diabetes self-management education; this is the term used in the National Standards for Diabetes Self Management Education (See Selected Resource List); this term is synonymous with DSMT

DSMT—diabetes self-management training; CMS uses this term and references this acronym throughout their government documents related to Medicare diabetes benefits. This term is synonymous with DSME. DSMT includes nutrition as one component of the curriculum content.

ERP—Education Recognized Program; a programs that has been approved as meeting The National Standards for Diabetes Self-Management Education. CMS calls these programs "accredited" because American Diabetes Association is now recognized as an "accreditation organization".

Fiscal Intermediaries (FIs)—organizations that administer Medicare Part A.

HCFA—Health Care Financing Administration; this is the former term for what is now called CMS.

HCFA 1500—the standardized Medicare claim form required by Medicare for submission of claims to a Medicare carrier and most payors when a provider submits claims for reimbursement. This form is used by health care providers in MD office based settings, and must be used for Medicare MNT claims. NSF/ANSI837 is the electronic claims form that may be used in place of the HCFA 1500 paper claims form.

ICD-9—International Classification of Diseases, Ninth Revision; this is a system of classifying diseases using specific diagnoses code numbers to describe a patient's health care condition. ICD-9 codes are updated annually. Providers should purchase a new book each year. New, revised and discontinued codes can be accessed via the CMS website at: www.coms.hhhs.gov/medlearn/icd9code.asp

Medicare—the federal health program that provides medical coverage for people 65 or older, for certain disabled people and for some people with end-stage renal disease.

Medicare Beneficiary—any person whose medical care is covered by the Medicare program

Medicare Part A (also called hospital insurance)—part of the federal health program that helps to pay for (not limited to) inpatient hospital care; inpatient care in a skilled nursing facility following a covered hospital stay; home health care; and hospice care. Most people do not have to pay for Medicare Part A since they or their spouse paid Medicare taxes while they were working.

Medicare Part B (also called medical insurance)—part of the federal health program that helps to pay for doctor's services; outpatient hospital care, clinical laboratory and diagnostic services; surgical supplies and durable medical equipment; ambulance services; and other medical services that are not covered by Part A. The covered service or supply must be medically necessary. After age 65, individuals may choose to enroll in the program, and pay monthly premiums and an annual deductible for services covered by Medicare Part B.

MNT—medical nutrition therapy; this term was introduced by the American Dietetic Association in the early 1990s to describe the nutrition therapy process to payers & others; when implemented correctly, process includes assessment, goal setting, intervention and evaluation. This term is defined in the statute and Federal Register (42 CFR, Part 410.130, Vol 66, No. 212, November 1, 2001) as "nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or renal disease."

NCD—National Coverage Determination; this is the policy published in the "Coverage Issues Manual: (the CIM) on May 1, 2002. The decision memorandum published earlier is just a step in the policy development of the NCD. The Medicare benefit NCD serves three purposes: (1) gives the background for the development of this decision memorandum; (2) summarizes the clinical evidence and analyzes relevant clinical literature on the use of medical nutrition therapy (MNT) for both diabetes and renal disease; and (3) explains the coverage decision regarding the duration and frequency of MNT and the coordination of the benefit with the diabetes self-management training (DSMT) benefit.

Payor—an insurance company, third-party administrator, self-funded employer, managed care organization, or federal health benefit program (Medicare/Medicaid) that reimburses claims.

PIN—provider identification number; all RDs must apply for and receive a provider identification number from CMS in order to bill for MNT. As of January 1, 2002, RDs are allowed to establish DSMT accredited programs. PINs are required to bill for the DSMT program. In this case, the RD is the owner of the DSMT program and bills for the program. Providers may receive more than one PIN if their practice offices are located in different geographic payment areas of in different states.

QI—quality improvement; focuses on healthcare delivery systems to improve health outcomes. Plans for change based on data to improve outcomes of a particular service. For DSMT/DSME, outcome is defined in terms of lab tests or physical measures and reduced complications from diabetes.

RVU—relative value units; Medicare payment under the Physician Fee Schedule is based on national uniform relative value units that represent physician work, practice expense, and malpractice expense.

UB92--the standardized Medicare form that health care providers in hospital based settings must submit for DSMT when appropriate on each patient served to receive reimbursement. Same as HCFA-1450. This form is not used for Medicare MNT services, but is used in hospital based accredited DSMT programs. NSF/ANSI837 is the electronic claims form that may be used in place of the UB 92 paper claims form.

UPIN—Unique Physician/Practitioner Identification Number; a unique number assigned to each Medicare physician/practitioner to identify the referring or ordering physician on Medicare claims. This is different from a PIN, which is assigned to Medicare providers and reported on the claims form to identify who provided the service to the beneficiary.