In Brief

What patients with diabetes want and need for the successful management of their disease is exactly what shared medical appointments (SMAs) can provide. Topping the list are increased access to care, quality time with the physician, an active role in medical and lifestyle decision-making, their unique needs individually addressed in a timely manner, and encouragement and support from other people with diabetes. For health care professionals, SMAs are a cost-effective way to provide both diabetes medical management and self-care education in the same visit in a manner consistent with highly interactive patient-centered care. This article offers an overview of Medicare and private insurance reimbursement for SMAs.

Reimbursement for Shared Medical Appointments Incorporating Diabetes Self-Management Education/ Training or Diabetes Medical Nutrition Therapy

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In today's highly competitive and challenging economic environment, physicians, health care professionals, and health care organizations are facing patient and payer demands for quality, access, service, and patient satisfaction with insufficient resources and ever-increasing workloads. It is more difficult than ever to meet these demands in a profitable way to sustain the practice entity. The old adage "do more with less" is now a reality.

The current U.S. health care system is beginning to shift to more cost-effective solutions in delivering quality patient care to meet these increasing demands. Ambulatory shared medical appointments (SMAs), also called group medical visits, have been recognized as an alternative to traditional one-on-one patient office visits. SMAs are designed to *1*) maximize the use of limited resources, *2*) better manage patient care workload, *3*) increase productivity without increasing work hours, *4*) manage busy physician practices more efficiently, *5*) effectively address the ongoing needs of patients with chronic conditions such as diabetes, *6*) increase face-to-face time between providers and patients with chronic conditions, and *7*) increase patients' involvement in their own care while improving patient satisfaction. For these reasons, providers are beginning to recognize the value of SMAs beyond the financial benefits.[1–4]

Brief Overview of SMAs

Patients in the same SMA generally share a common medical condition or chronic disease. SMAs have been used for medical management of chronic diseases such as type 2 diabetes, hypertension, asthma, and congestive heart failure. Patients may also benefit from SMAs for smoking cessation or the treatment of panic disorders. When homogenous patient groups share medical appointments, patient satisfaction, behavior goals, and clinical outcomes tend to improve.[1–4] This is because patients "share and compare" common disease challenges (e.g., diet, medications, exercise, and stress) and, more importantly, solutions to these challenges. This caring and connecting bonds patients together, helping them achieve enhanced psychological and health benefits.

The perception of many patients is that they are receiving more time with their provider in an SMA, even though providers typically spend less individual time with patients in this format. The average time spent per patient is 5–8 minutes in an SMA compared to 15–20 minutes in a traditional one-on-one office visit.[1,2,4,5] This phenomenon is the result of group homogeneity. When providers discuss treatment options for one patient's persistent hyperglycemia, other patients in the SMA who are experiencing the same issue may internalize the discussion and relate it to their own needs.

SMAs are typically 90–120 minutes in length and include established patients who are currently being seen by a physician or a qualified nonphysician practitioner (also called mid-level providers) such as a nurse practitioner, physician assistant, or clinical nurse specialists. Providers (physician or mid-level) often choose to furnish SMAs initially once per month for patients who are not at clinical targets and then quarterly for ongoing support.[4,5] Some models return patients to routine care after they meet clinical targets.

Evaluation and management (E&M) visits with providers may be offered in a separate room or behind a privacy screen. However, many providers adhere to the original concept of the SMA: sharing individual patient medical encounters with the other patients in the group.[1,2,4,5] Patients are required to sign a confidentiality statement before joining in an SMA in which they agree not to discuss what they have heard or seen during the appointment.

Group medical visits for patients with diabetes may consist of two distinct components: individual medical management and group diabetes self-management education/training (DSME/T) or group medical nutrition therapy (MNT). Group DSME/T instructors are typically registered nurses (RNs), registered dietitians (RDs), and/or pharmacists who may also be certified diabetes educators (CDEs); professionals from other disciplines may also teach. MNT is billable to Medicare Part B when provided by RDs or other qualified nutrition professionals.[6] For Medicare billing of DSME/T, programs must have accreditation status by either the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA).[7] Medicare does not allow billing for both benefits on the same day, although some private payers do.

SMAs do not always include an education component, and some may provide nonbillable education. For example, a 30-minute foot care presentation provided by a podiatrist would not be considered billable education and would not allow a provider to increase the level of the E&M. In this SMA model, the provider would bill only for an individual, established-patient medical management encounter for each attendee. Billing Medicare for DSME/T using the procedure code G0109 (30 minutes of group DSME/T) for a podiatrist's presentation would be allowed if the following elements were in place: *1*) the session was provided through an accredited DSME/T program curriculum within the practice entity, *2*) the podiatrist was on the instructional staff of the accredited DSME/T program, *3*) all the patients were enrolled in the program, *4*) patients had not exceeded the utilization limit of the benefit, and *5*) all other Medicare DSME/T coverage guidelines were met.

A key element to the financial success of SMAs from the providers' perspective is the implementation of accurate reimbursement procedures. SMAs are a more cost-effective care delivery model than traditional one-on-one provider appointments.[1,2,4] Payers, including Medicare, now recognize the benefits of the group care approach. This has allowed providers to bill for individual E&M encounters furnished in this group format; thus, SMAs increase revenue capacity with less time on providers' part and without reducing the quality of care.[5,8]

For example, if there are 10 patients in an SMA that lasts for 2 hours, including 1 hour with a provider, the provider can bill for 10 individual follow-up E&M visits. If the fee is $100 per hour, the provider may bill for $1,000 (1 hour with each of the 10 patients). Compare that to seeing 10 patients one-on-one in a traditional office setting and spending about 20 minutes with each patient. It would take the provider more than 3 hours to bill for the same $1,000. In an SMA format, this 1 hour would translate to $17 per minute; the 3.3 hours in the office would translate to $5 per minute.

To maintain financial productivity, the number of patients seen in the SMA should justify the costs and effort associated with conducting the group visit. This is usually accomplished by setting the census at a level that roughly triples the number of patients a provider could see in the same amount of time in office visits. In other words, if a physician typically sees four patients in his or her office in 1 hour, an SMA should allow the physician to see ~12 patients in the same hour.

With private payers, it is important to address billing and any other system issues before starting an SMA program. Because of rapid changes in reimbursement from managed care organizations and government agencies, it is best to thoroughly explore all billing options. It is recommended that local insurers or contracted entities be contacted to identify any potential billing issues and to gain a clear understanding of the reimbursement policies and coverage guidelines involved in provision of SMAs.

Medicare Reimbursement for Services of Physicians or Qualified Nonphysician Practitioners in SMAs

It is important to note that at the time this article was written, Medicare had not issued any official payment or coding rules for SMAs.[6] In one instance, a group of physicians contacted the Center for Medicare and Medicaid Services (CMS) asking for an official response regarding "the most appropriate Current Procedural Terminology (CPT) code to sub-

mit when billing for a documented face-to-face evaluation and management (E&M) service performed in the course of a shared medical appointment, the context of which is educational." They also asked, "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room, or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?"[9]

The response from CMS was, " . . . under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E&M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary."[9] The response also stated that any activities of the patient group, including group counseling activities, should not affect the level of the CPT code reported by the physician or mid-level practitioner for the individual patient.[9] Therefore, the recommendation is that medically necessary visits by a physician or mid-level practitioner in an SMA may be billed the same as for a typical individual patient visit in an exam room based on the level of care delivered and documented in the patient's chart according to criteria for CPT code use.

There are five established patient E&M codes that represent different levels of care; the higher the last digit, the more complex the encounter and thus the higher the reimbursement rate: 99211, 99212, 99213, 99214, and 99215. Providers typically bill 99213, 99214, or 99215 (Table 1) for each patient in an SMA, represent-

Table 1. E&M CPT Codes for Provider Billing of Established Individual Patients in an SMA[10]

CPT Code	Description
99213	Office or other outpatient face-to-face visit for evaluation and management of an established patient, which requires at least two of three key components: expanded problem-focused history, expanded problem-focused examination, and medical decision-making of low complexity. Usually presenting problem(s) are of low to moderate severity.
99214	Office or other outpatient face-to-face visit for evaluation and management of an established patient, which requires at least two of three key components: detailed history, detailed examination, and medical decision-making of moderate complexity. Usually, presenting problem(s) are of moderate to high severity.
99215	Office or other outpatient face-to-face visit for evaluation and management of an established patient, which requires at least two or three key components: comprehensive history, comprehensive examination, and medical decision-making of high complexity. Usually, presenting problem(s) are of moderate to high severity.

Note: *Some, but not all, private payers may require Healthcare Common Procedure Coding System II modifier TT to be appended to the E&M code on the claim form. This modifier indicates that individualized services were furnished with multiple patients present. Medicare does not recognize this modifier.*

Table 2. Medicare Coding and Coverage Guidelines and Tips for SMAs for Patients With Diabetes[3,4,6,7,9–11]

S	Submit claim forms with HCPCS code G0109 (group DSME/T) or CPT code 97804 (group MNT) for each patient if DSME/T or MNT is furnished.
U	Understand that only certain types of providers can bill Medicare for DSME/T, MNT, and E&M services.
S	Submit claim forms with CPT code 99212–99215 (E&M for established individual patient visit) for each patient; select the code for the level of individual E&M furnished and documented.
T	Track status of claims to identify those paid, denied, or rejected; take appropriate action on denied and rejected claims in a timely manner.
A	Ask each Medicare patient to sign an attendance sheet if group DSME/T is furnished. (Note: "group" is defined as 2–20 patients, not all of whom must be Medicare beneficiaries.)
I	Implement accreditation status of the DSME/T program by either AADE or ADA.
N	Note the importance of entering the NPI number of the rendering provider in the rendering provider locator field on the claim form; this may be different from the billing provider.
I	Identify established (not new) patients in physician's or qualified nonphysician practitioner's practice for receipt of E&M service.
N	Never furnish group DSME/T and group MNT on same day to the same Medicare beneficiaries.
G	Generate documentation forms or electronic medical record templates that simplify documentation of required information.

ing individual visits for established patients with a physician or qualified nonphysician practitioner.

It is important to note that providers' documentation of these encounters must match the level of the E&M code used; thus, each patient care encounter in the SMA is to be viewed as a unique procedure that requires specific and detailed documentation. To improve the efficiency of this documentation, scribes (e.g., medical assistants) are often used to document providers' care on a concurrent basis in the SMA. Charting in an electronic medical record during the visit is another way to optimize the face-to-face time with each patient.

Providers may not select an E&M code based solely on the time spent with each patient. The length of the visit can be the criterion for code selection only when counseling or coordination of care accounts for ≥ 50% of the time spent with a patient. In an SMA, the service delivered by a provider is medical E&M, not counseling or coordination of care.

Medicare Reimbursement for Group MNT and Group DSME/T

When all coverage criteria are met, Medicare allows for reimbursement of the E&M service and group MNT or group DSME/T that each beneficiary receives in the SMA on the same day. The group MNT or group DSME/T must be billed under a national provider identification (NPI) number that is different from the NPI number of the E&M provider (i.e., MNT or DSME/T must be rendered by a different provider).

Table 2 provides guidelines and tips for Medicare coding and coverage of SMAs for people with diabetes. Table 3 summarizes the required Healthcare Common Procedure Coding System (HCPCS) and CPT codes required for Medicare billing. Table 4 summarizes Medicare's key coverage criteria for these two benefits, and Table 5 offers an example of billing for MNT.

Payer and Medicaid Reimbursement for SMAs, Group DSME/T, and Group MNT

As with many services, billing for SMAs, group DSME/T, and group MNT requires that the billing/coding staff do preliminary work with private payers and state Medicaid plans to find out whether these services are payable benefits, and, if so, to learn their specific coverage guidelines. Many payers adhere to Medicare's coverage policies, but others do not. If these services are covered, each payer (including each state's Medicaid plan) will have its own coverage regulations, including the appropriate billing codes, utilization limits, and patient and provider eligibility requirements.

Table 3. Required HCPCS and CPT Codes for Medicare Billing of Group MNT and DSME/T[6,7]

CPT or HCPCS Code	Description	Utilization Limits in Initial Episode of Care and Provision of Hours	Utilization Limits in Follow-Up Episode of Care and Provision of Hours
G0109	Outpatient DSME/T; group session (2–20 individuals, not all of whom must be Medicare beneficiaries), face-to-face with the patient, each 30 minutes of training Program must be accredited by AADE or ADA as meeting the 10 national standards of DSME/T	10 hours in first consecutive 12 months with written referral by a physician or qualified nonphysician practitioner; 9 hours to be in group, unless: • Barriers that hinder group learning are documented by referring provider • No DSME/T program is scheduled within 2 months of referral date • Referring provider orders additional insulin training	2 hours in subsequent calendar years, starting the year after the year in which the beneficiary completed an initial 10 hours of DSME/T with another written referral by a physician or qualified nonphysician practitioner; 2 hours may be individual or group; documentation of learning barriers is not required to provide individual follow-up DSME/T
97804	MNT; initial assessment and intervention and re-assessment and intervention, group (≥ 2 individuals), each 30 minutes	3 hours in initial episode of care (initial assessment and intervention) in first calendar year with referral from treating physician	2 hours in follow-up episode of care (reassessment and intervention) in subsequent calendar years with another written referral by treating physician
G0271	MNT; reassessment and subsequent interventions after second referral in the same year for change in diagnosis, medical condition, or treatment regimen, group (≥ 2 individuals), each 30 minutes	At the time of this writing, no specified limit for additional hours > 3 initial hours and > 2 follow-up hours if RD obtains: • Documentation of medical necessity for specific number of additional hours • Another referral from physician for specific number of additional hours plus documentation of medical necessity	

Table 4. Summary of Medicare Coverage Guidelines for Group MNT and Group DSME/T[6,7,12]

Medicare Coverage Guidelines	Group MNT (Initial and Follow-Up Episodes of Care)	Group DSME/T (Initial and Follow-Up Episodes of Care)
Allowed Settings	Outpatient settings only, including hospital outpatient departments, private practices, federally qualified health centers, home health agencies, pharmacies, nursing homes, renal dialysis facilities, and rural health clinics	Outpatient settings only, including hospital outpatient departments, private practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes, and durable medical equipment companies
Excluded Settings	Hospital inpatient departments and skilled nursing homes	Hospital inpatient departments, nursing homes, renal dialysis facilities, and rural health clinics
Utilization Limits and Format	Initial: 3 hours in first calendar year; can be repeated every 3 years Follow-up: 2 hours in each subsequent calendar year; cannot extend unused initial or follow-up hours into next calendar year Format: group or individual; visit to be minimum of 30 minutes because CPT code 97804 is a 30-minute time-based code Additional hours may be reimbursed if the RD obtains documentation of medical necessity on another referral from treating physician and the number of extra hours is specified	Initial: 10 hours in 12 consecutive months, starting with referral date; once-in-a-lifetime benefit Follow-up: 2 hours in each year after the year in which initial DSME/T was completed Format of initial DSME/T: 9 of 10 hours must be provided in group, unless beneficiary meets criteria for individualized DSME/T; 1 hour may be used for individual visit Format of follow-up DSME/T: Group or individual
Billing Provider	Medicare provider RDs and qualified nutrition professionals; non-RD Medicare individual providers (e.g., physicians) and entity Medicare providers (e.g., clinics and physician's offices) may bill Medicare on behalf of Medicare provider RD and receive MNT reimbursement Only RD provider (or entity provider billing on behalf of RD) bills for MNT; benefit may not be subdivided for purposes of billing; cannot be billed as "incident to physician's services"	Individual providers: RDs, qualified nutrition professionals, physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and clinical psychologists Entity providers: outpatient hospital departments, private practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes, and durable medical equipment companies Must be billing for other Medicare Part B services and receiving reimbursement; only one individual or entity provider bills for entire program; benefit may not be subdivided for purposes of billing; cannot be billed as "incident to physician's services"
Reimbursement	RDs must accept assignment: • Must accept geographically adjusted assigned reimbursement rate set by Medicare as payment in full • Cannot bill beneficiary or secondary insurance for difference between RD's fee and Medicare payment. (See example in Table 5.)	Non-participating Medicare providers need not accept assignment; can bill beneficiary or secondary insurance for difference between fee and Medicare's assigned reimbursement rate Participating providers are required to accept assignment
Beneficiary Co-Payment	Effective 1 January 2011, beneficiaries no longer required to pay an MNT co-payment of 20%; Medicare pays 100% of the adjusted allowed reimbursement rate	Beneficiaries required to pay a 20% co-payment
Facility Fee	No Medicare facility fee allowed	No Medicare facility fee allowed

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Table 4. Summary of Medicare Coverage Guidelines for Group MNT and Group DSME/T,[6,7,12]
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Medicare Coverage Guidelines	Group MNT (Initial and Follow-Up Episodes of Care)	Group DSME/T (Initial and Follow-Up Episodes of Care)
Quality Standards	Regulations state: "RDs and nutritionists must use nationally recognized protocols, such as those developed by the ADA"; also known as evidence-based nutrition practice guidelines, these are available online from www.nutritioncaremanual.org	Program must have accreditation from ADA or AADE based on program meeting national standards for diabetes self-management education
Beneficiary Entitlement	Patients who have Medicare Part B insurance and have not received initial MNT in previous 3 years; Medicare carriers now in process of meeting new requirement to allow provider access to history of beneficiary's claims; beneficiary can also call Medicare to obtain their own history (1-800-MEDICARE)	Patients who have Medicare Part B insurance and have never received initial DSME/T
Allowed Referring Providers	Treating physicians with MD or DO degrees only; nonphysician practitioners (e.g., nurse practitioners, physician assistants, and clinical nurse specialists) cannot refer	Treating physicians with MD or DO degrees and qualified nonphysician practitioners (e.g., nurse practitioners, physician assistants, and clinical nurse specialists) can refer
Eligibility: Referral	Must establish medical necessity for MNT; accomplished by RD obtaining separate written referrals for MNT by provider for initial and follow-up MNT; referral must include diagnosis of diabetes or 5-digit diabetes CPT code and physician's NPI number.[9]	Must establish medical necessity for DSME/T; accomplished by program obtaining separate written referral for DSME/T by provider for initial and follow-up DSME/T; referral must include diagnosis of diabetes or 5-digit CPT code.[9]
Eligibility: Diabetes Diagnostic Laboratory Criteria	Documentation of one of the following three test results in chart: • Fasting blood glucose ≥ 126 mg/dl on two different occasions (cannot be obtained from home-based or inpatient [bedside] glucose meter) • Two-hour post-glucose challenge test ≥ 200 mg/dl on two different occasions • Random blood glucose test ≥ 200 mg/dl on one occasion for a person with symptoms of uncontrolled diabetes	Documentation of one of the following three test results in chart: • Fasting blood glucose ≥ 126 mg/dl on two different occasions (cannot be obtained from home-based or inpatient [bedside] glucose meter) • Two-hour post-glucose challenge test ≥ 200 mg/dl on two different occasions • Random blood glucose test ≥ 200 mg/dl on one occasion for a person with symptoms of uncontrolled diabetes

Table 5. Sample Medicare Billing for MNT

- An RD's usual and customary fee is $60 for one 30-minute unit of group MNT (CPT code 97804).
- Medicare's geographically adjusted reimbursement rate is $15 per one unit. The $15 is 100% of this adjusted rate because the beneficiary copayment amount of 20% has been waived as of 1 January 2011.[12]
- The RD must accept $15 as payment in full and cannot bill the beneficiary directly or bill the beneficiary's supplemental insurance for the difference between the usual $60 fee and Medicare's payment rate of $15.
- This does not mean, however, that the RD should adjust the usual and customary fee to match the Medicare reimbursement rate. Fees are determined by compiling and analyzing several factors, including Medicare reimbursement rates, but are not based solely on the Medicare rate.

A common misconception is that DSME/T provided in an SMA cannot be billed for at all if the program is not accredited. Following is an example of DSME/T billing by an unaccredited program. Assume an SMA includes as participants two Medicare beneficiaries plus six patients with private health care plans that do not require accreditation. DSME/T claims cannot be sent to Medicare for the two beneficiaries. These beneficiaries are to be given an advanced beneficiary notice (ABN) form before the SMA starts. The notice should explain that the DSME/T furnished in the SMA is a covered benefit, but that the program does not meet Medicare requirements, and thus it cannot be billed, and Medicare will not pay for it. On the ABN, the beneficiary can either agree to receive the DSME/T and be financially responsible for the full fee or decline the service. Claims for the six patients with private health care plans that do not require program accreditation can be sent to these

plans, adhering to each plan's coverage guidelines for DSME/T. If the private payers do not accept the G0109 code (for group DSME/T), or the 97804 code (for group MNT), other codes may be applicable, such as education and training by nonphysician practitioners for patient self-management using a standardized curriculum (CPT codes 98961 and 98962).[8,10]

Resources for SMAs

The following Web sites offer free, downloadable how-to guides that can help diabetes professionals implement SMAs:

- American Association of Clinical Endocrinologists: www.aace.org
- American Academy of Family Physicians: www.aafp.org
- VA Shared Medical Appointments for Patients with Diabetes: Maximizing Patient and Provider Expertise to Strengthen Care Management: Guide and Resources for Starting and Sustaining Successful SMAs: www.queri.research.va.gov/tools/diabetes/shared-med-appt.pdf

Summary

Advantages of diabetes-focused SMAs provide a triple win for clinics that utilize them:

- Providers win through more efficient use of their limited time and resources, thus improving their financial bottom line.
- Patients win through increased peer support and education, expanded time with their provider, and improved outcomes in terms of knowledge, behavior, clinical parameters, health status, cost-savings, and satisfaction.
- Payers win through reduced costs associated with patients whose outcomes improve.

SMAs are not suitable for every provider or every patient, but they offer a potential option for follow-up medical management visits. A careful review must be made of the practice entity's patient mix, along with an analysis of the availability of resources and staff necessary to furnish SMAs effectively and safely. If this care delivery model is selected, there are many benefits to be realized. The acronym MORE can be used to succinctly highlight the benefits of SMAs for diabetes care. Providers, patients, and payers get MORE (Maximization of Outcomes, Revenue, and Empowerment of patients).

References

[1]Weinger K: Group medical appointments in diabetes care: is there a future? *Diabetes Spectrum* 16:104–107, 2003

[2]Noffsinger EB: Physical shared medical appointments: a revolutionary access solution. *Group Pract J* 51:1–9, 2002

[3]American Academy of Family Physicians, Group visits (shared medical appointments [article online]. Available from http://www.aafp.org/online/en/home/practicemgt/quality/qitools/pracredesign/january05.html. Accessed 2 April 2011

[4]U.S. Department of Veeterans Affairs: VA shared medical appointments for patients with diabetes: maximizing patient and provider expertise to strengthen care management [article online]. Available from http://www.queri.research.va.gov/tools/diabetes/shared-med-appt.pdf. Accessed 2 April 2011

[5]American Association of Clinical Endocrinologists: Group visit starter kit: improving chronic illness care [article online]. Available from https://www.familydocs.org/files/Group%20Visit%20Starter%20Kit.doc. Accessed 2 April 2011

[6]Center for Medicare and Medicaid Services: Chapter 4: Part B hospital, section 300–300.6. In *Medicare Claims Processing Manual*. Available online from http://www.cms.gov/manuals/downloads/clm104c04.pdf. Accessed 2 April 2011

[7]Center for Medicare and Medicaid Services: Chapter 18: Preventive and screening services, section 120–120.3. In *Medicare Claims Processing Manual*. Available online from http://www.cms.gov/manuals/downloads/clm104c18.pdf. Accessed 11 February 2012

[8]American Association of Diabetes Educators: Diabetes education services: reimbursement tips for primary care practice [article online]. Available from http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/Reimbursement_Tips_2009.pdf. Accessed 2 April 2011

[9]American Association of Family Practice: Coding for group visits [article online]. Available from http://www.aafp.org/online/en/home/practicemgt/codingresources/groupvisitcoding.html. Accessed 2 April 2011

[10]American Medical Association: *Current Procedural Terminology*. Professional Edition. Milwaukee, Wisc., Wasserman Medical Publishers, 2011

[11]Buck CJ: *ICD-9-CM for Physicians*. Vols. 1 and 2, Standard Edition. Philadelphia, Pa., W.B. Saunders, 2010

[12]Centers for Medicare and Medicaid Services: Information for Medicare fee-for-service health care professionals, waiver of coinsurance and deductible for preventive services, section 4104 of the Affordable Care Act, removal of barriers to preventive services in Medicare [article online]. Available from http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf. Accessed 2 April 2011

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