
How clinics can help their patients avoid diabetes with National Diabetes Prevention Programs

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Rachel Burdon, MPH, Health Systems Policy Specialist, OHA

Kevin Ewanchyna, MD, President, Oregon Medical Association

Don Kain, MA, RD, CDCES, Harold Schnitzer Diabetes Health Center at OHSU



Presenters



Rachel Burdon, MPH,
Health Systems Policy
Specialist, OHA



Kevin Ewanchyna, MD,
President, Oregon Medical
Association



Don Kain, MA, RD, CDCES,
Harold Schnitzer Diabetes Health
Center at OHSU

Webinar objective

Increase knowledge of clinical staff on the effectiveness, benefit coverage and opportunities for partnership in Oregon for the Diabetes Prevention Program (DPP). Inform clinic practices on how to engage their patients in DPP.

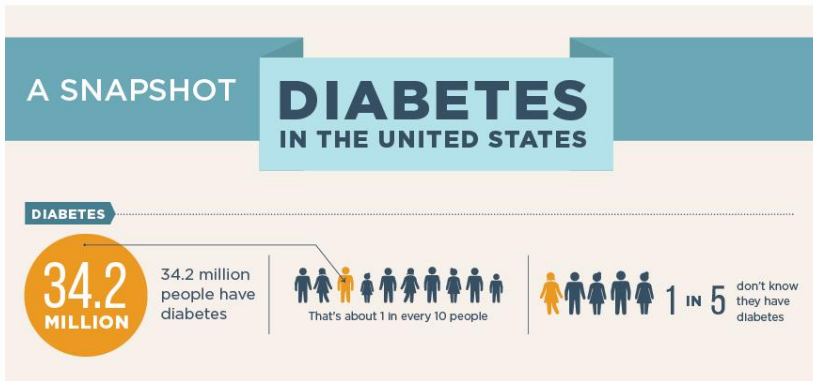
Webinar agenda

- **Why National DPP matters**
 - Diabetes: Problem and solution
 - How it works: Health system role in supporting the solution
 - Demonstration project lessons
- **What's covered in Oregon?**
- **Clinic role**
 - Screening and testing for prediabetes, overweight and obesity
 - Working with coordinated care and community-based organizations
- **Resources**

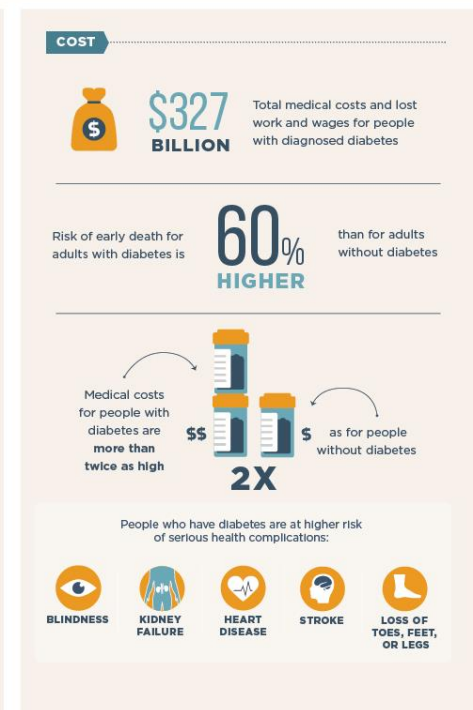
Why National DPP matters

Nationally and in Oregon

Diabetes – the “quiet epidemic”



- Diabetes is prevalent.
- Many people with diabetes are undiagnosed.
- Diabetes is costly for people and for our health care system.



Prediabetes


PREDIABETES

COULD IT BE YOU?

88 MILLION


88 million American adults — more than 1 in 3 — have prediabetes

1 IN 3






MORE THAN 8 IN 10

adults with prediabetes don't know they have it




With prediabetes, your blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes


Prediabetes increases your risk of:

TYPE 2 DIABETES HEART DISEASE STROKE

If you have prediabetes, losing weight by:







EATING HEALTHY & BEING MORE ACTIVE


can cut your risk of getting type 2 diabetes in


HALF





If you ignore prediabetes, your risk for type 2 diabetes goes up — type 2 diabetes increases your risk for serious health complications:


BLINDNESS


KIDNEY FAILURE



HEART DISEASE


STROKE



LOSS OF TOES, FEET, OR LEGS




YOU CAN PREVENT TYPE 2 DIABETES

FIND OUT IF YOU HAVE PREDIABETES —
See your doctor to get your blood sugar tested



JOIN A CDC-RECOGNIZED diabetes prevention program



- ✓ eat healthy
- ✓ be more active
- ✓ lose weight

LEARN MORE FROM CDC AND TAKE THE **PREDIABETES RISK TEST** AT www.cdc.gov/diabetes/basics/prediabetes.html

Without intervention, prediabetes can progress to type 2 diabetes within five years.

Source: *About Prediabetes & Type 2 Diabetes* (2019, April 4). Centers for Disease Control & Prevention

Impact of diabetes/prediabetes for individuals

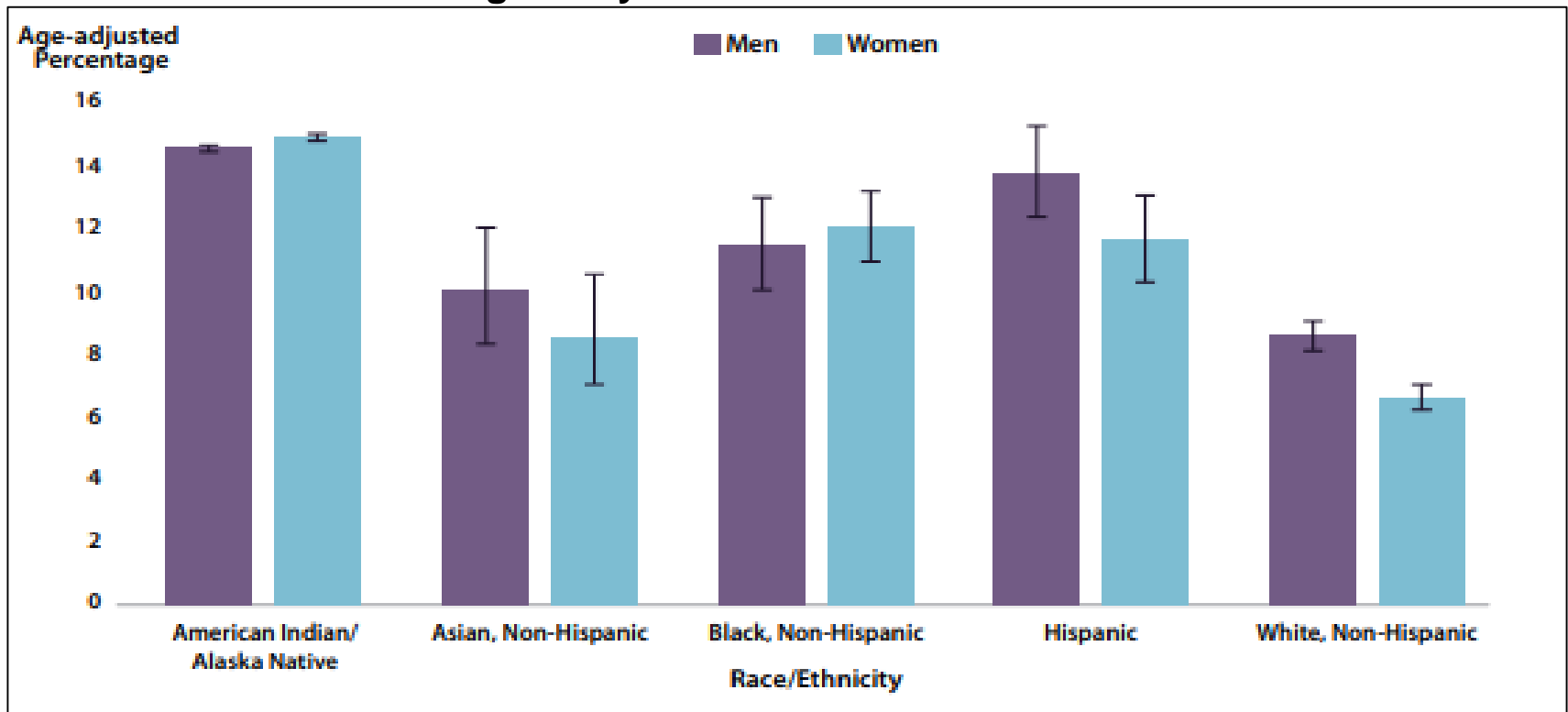
What prediabetes means for patients

- Diabetes is often associated with serious co-morbidities.
- 8.3% of Oregonians report having received a diabetes diagnosis.¹
Of them:
 - Nearly 71% also report **hypertension**²
 - About a third report **mobility limitations**³
 - More than 1 in 8 report **limitation to activities of daily living**⁴
 - One in 10 report **severe vision impairment or blindness**⁵
 - Nearly 1 in 4 report a diagnosis of **coronary heart disease**⁶
- Approximately 256,800 OHP adults may currently have prediabetes [calculated with OHA information & AMA DPP cost calculator].
- \$8,000 is the average medical expense for the first three years after transitioning from prediabetes to a diagnosis of type 2 diabetes [Prevent Diabetes STAT (2019), American Medical Association].

Diabetes disparities across groups

Need for focused improvement where the burden is heaviest

U.S. age-adjusted estimated prevalence of diagnosed diabetes for adults ages 18 years or older: 2017–2018

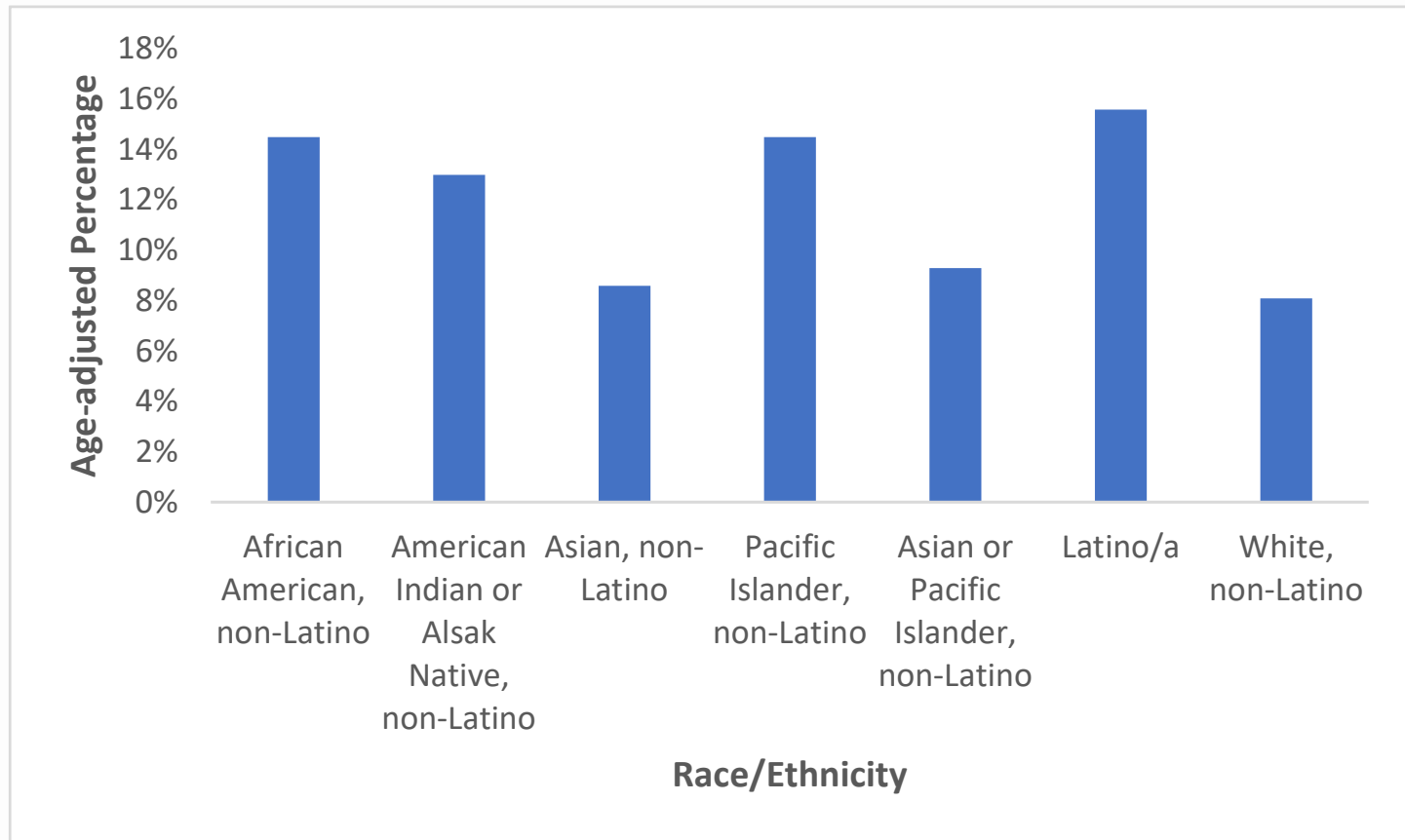


Source: Graphic from the CDC's National Diabetes Statistics Report 2020.

Note: Error bars represent upper and lower bounds of the 95% confidence interval. Data sources: 2017–2018 National Health Interview Survey; 2017 Indian Health Service National Data Warehouse (for American Indian/ Alaska Native group only).

Diabetes disparities in Oregon

Age-adjusted diabetes among Oregon adults by race and ethnicity, 2015-2017



Data source:

https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORRaceEthnicity_diseases.pdf

COVID-19 and diabetes/prediabetes

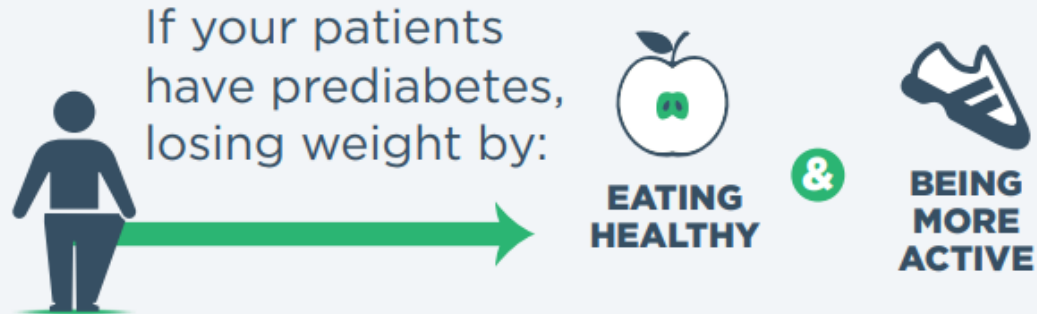
COVID-19 pandemic⁷

- As of May 30, 2020, among COVID-19 cases, the most common underlying health conditions were cardiovascular disease (32%), diabetes (30%), and chronic lung disease (18%).⁸
- Persons with diabetes are at higher risk for severe illness from COVID-19.
- COVID-19 impact on prediabetes and diabetes
 - Rates of pre/diabetes could increase due to response measures.
 - Longevity of economic downturn has impact on health outcomes/access.

Excess weight and diabetes: three interplays of comorbidity

#1

Weight loss reduces risk of type 2 diabetes onset



can cut their risk of getting type 2 diabetes in

HALF



Weight loss of 5 to 7% of body weight achieved by reducing calories and increasing physical activity to at least 150 minutes per week resulted in a 58% lower incidence of type 2 diabetes

#2 Type 2 diabetes and obesity share the same set of lifestyle risk factors

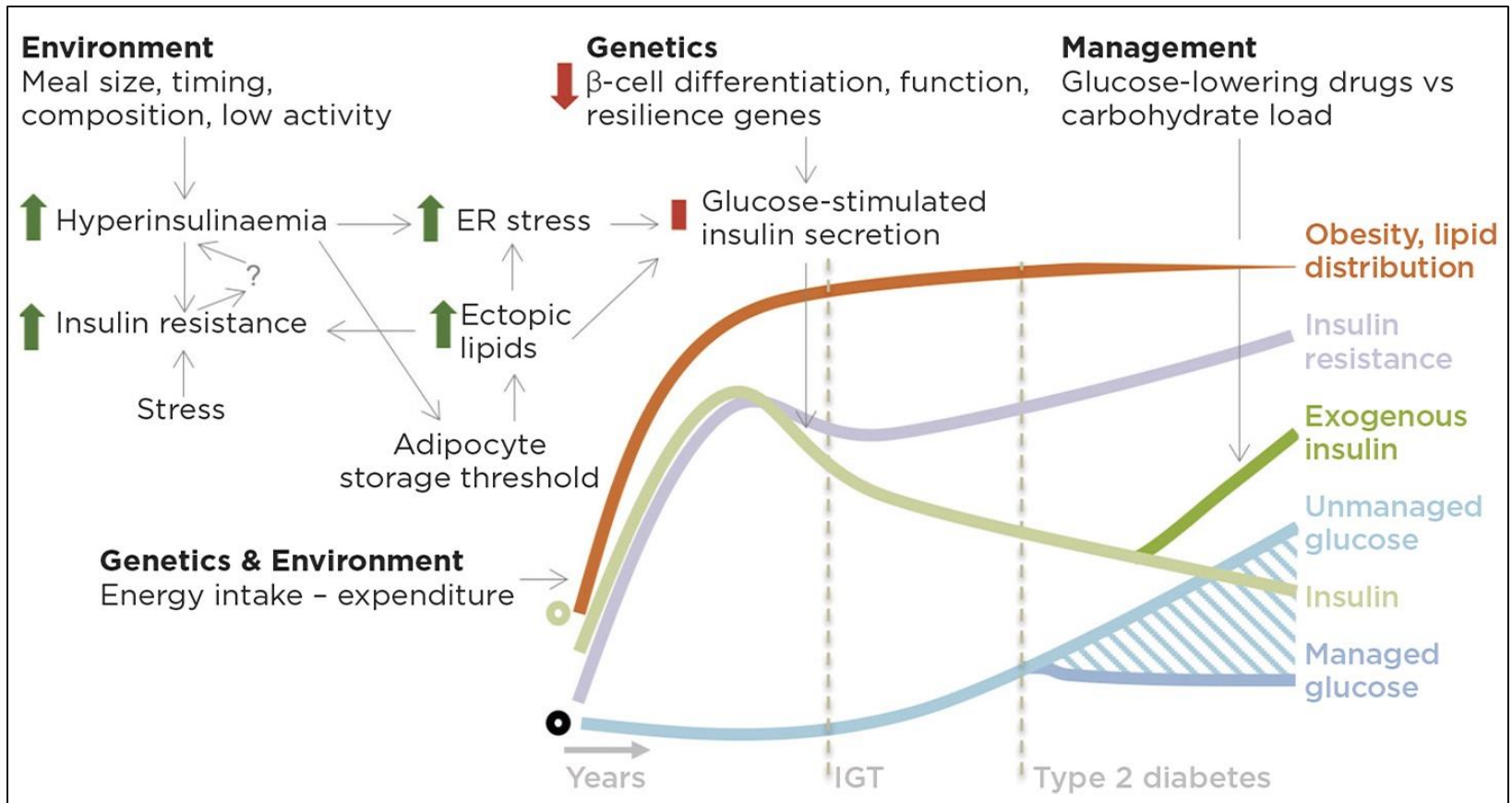
THE LEADING CAUSES OF DEATH AND DISABILITY
and Leading Drivers of the Nation's \$3.5 Trillion in Annual Health Care Costs



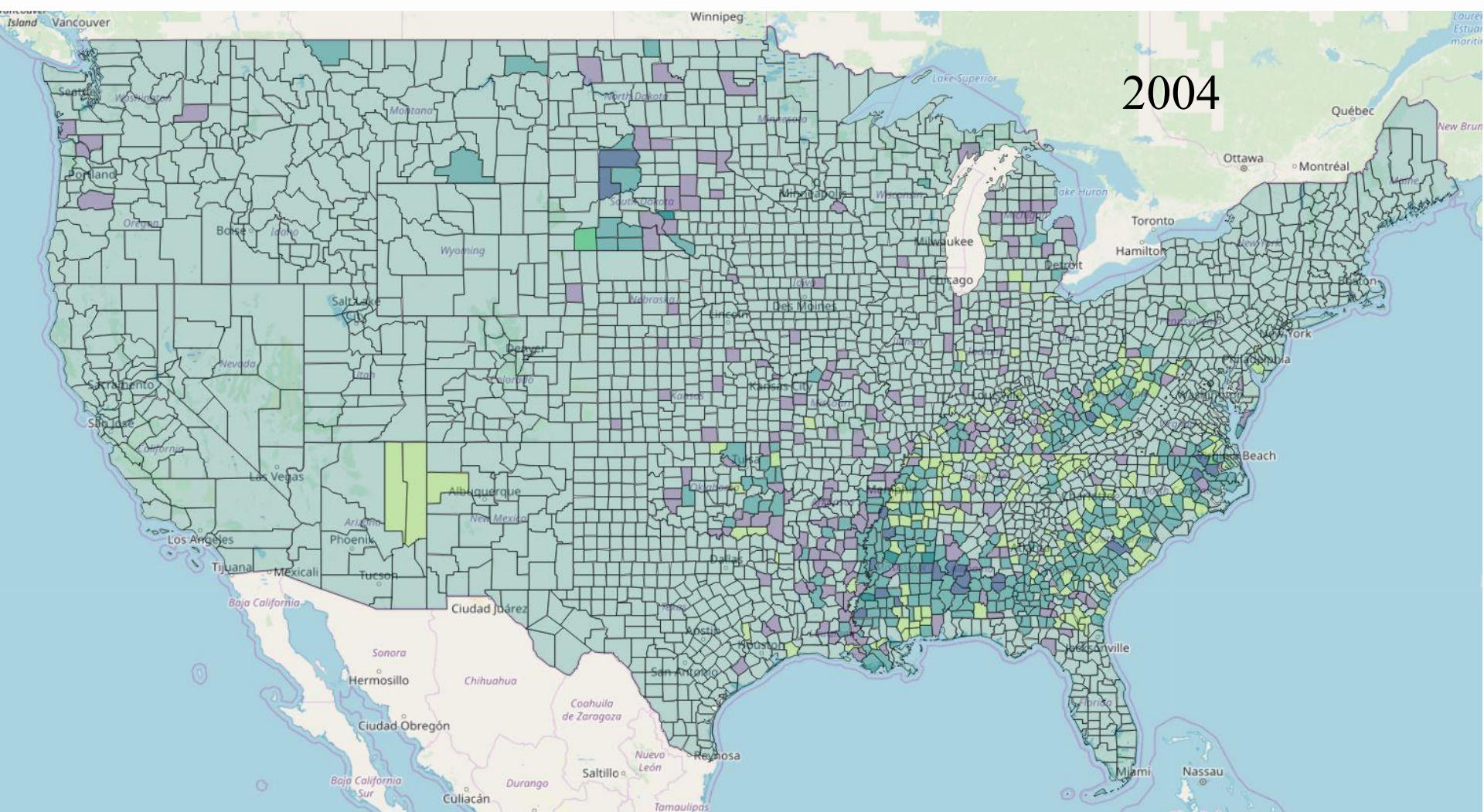
THE KEY LIFESTYLE RISKS FOR CHRONIC DISEASE



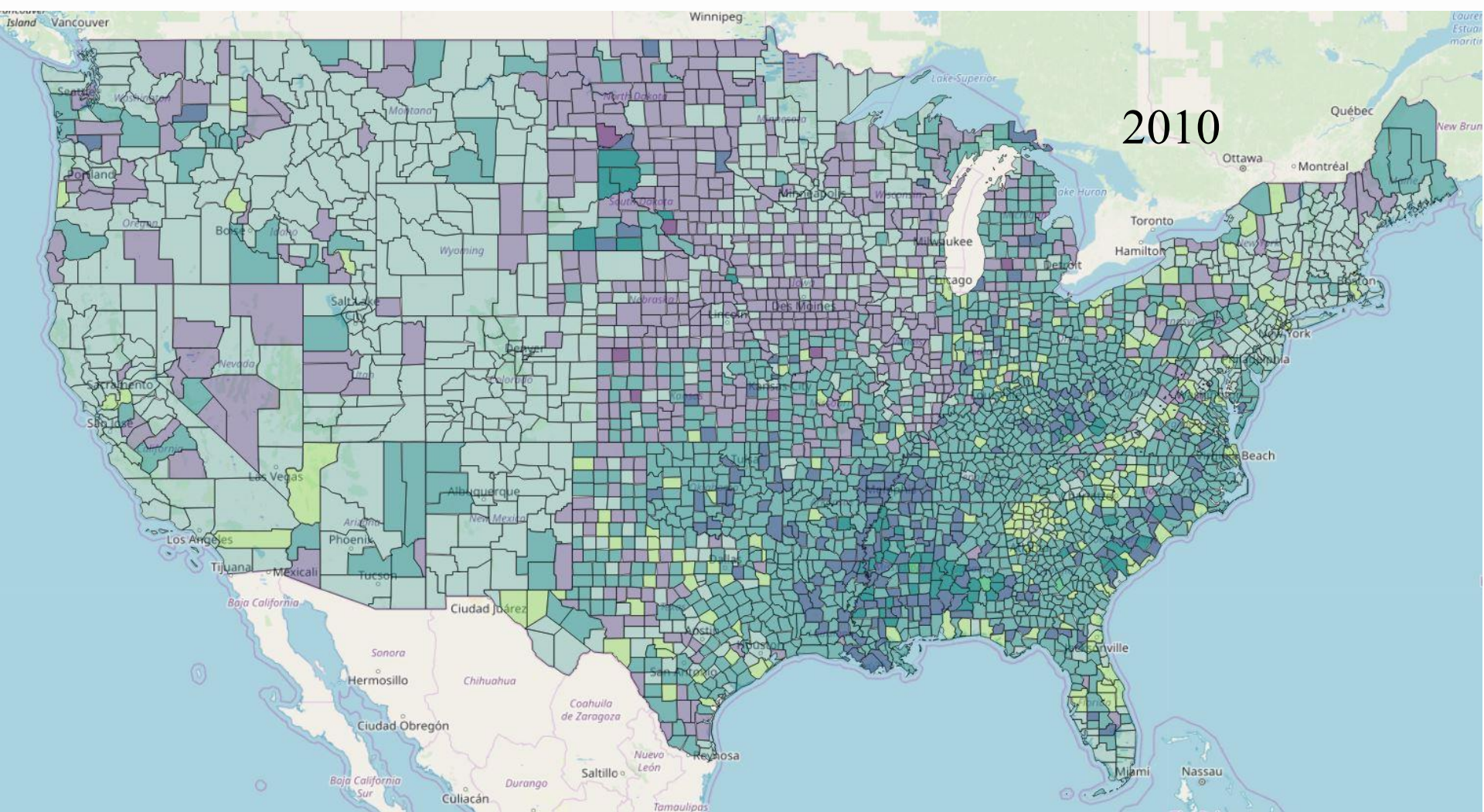
#3 Similar metabolic pathways contribute to obesity and type 2 diabetes



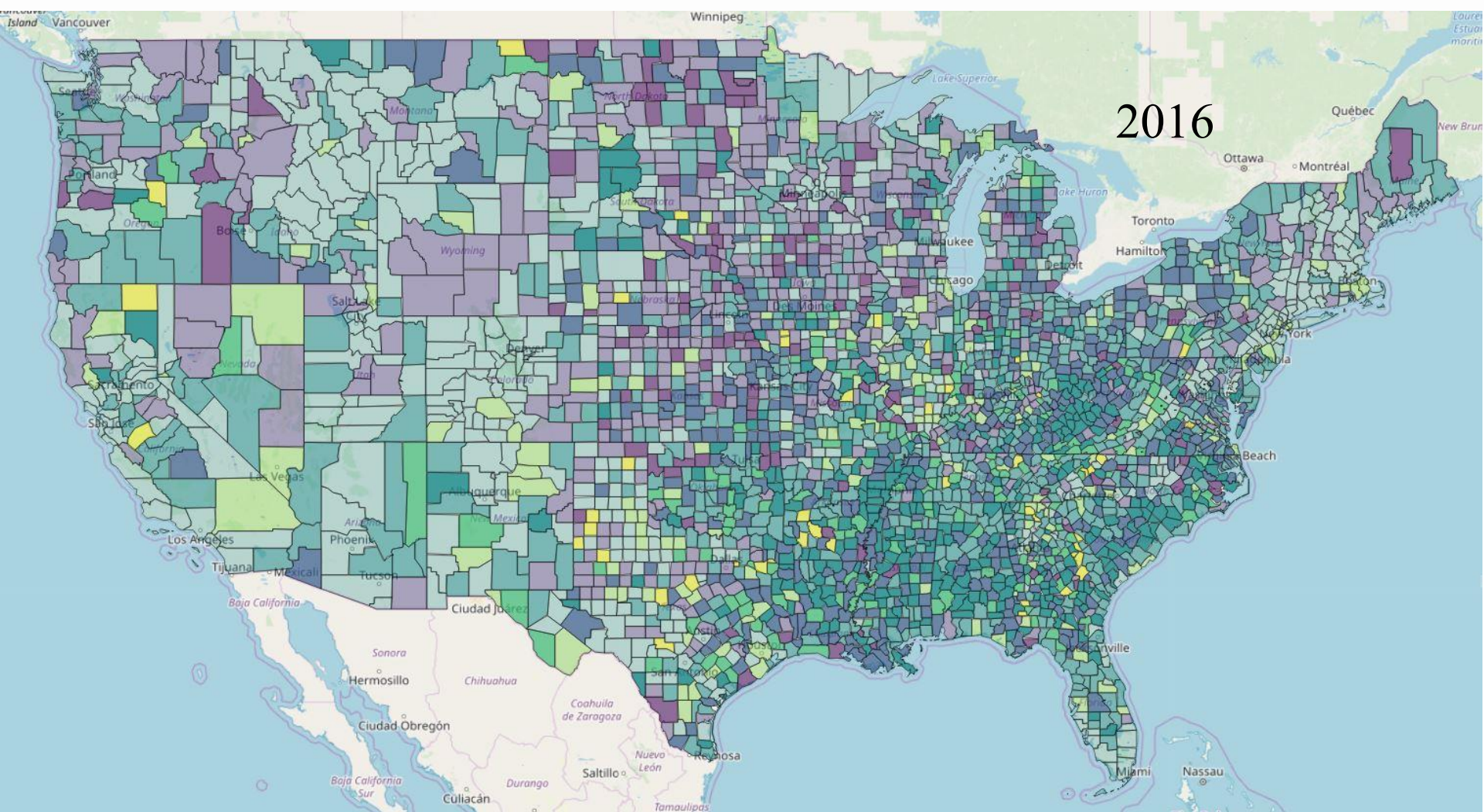
Prevalence mapping: obesity and diagnosed diabetes



Prevalence mapping: obesity and diagnosed diabetes



Prevalence mapping: obesity and diagnosed diabetes



Diabetes Prevention Programs

A national effort to mobilize and bring effective lifestyle change programs to communities across the country

REDUCING THE IMPACT OF DIABETES

It brings together:

- HEALTH CARE ORGANIZATIONS
- EMPLOYERS
- PRIVATE INSURERS
- COMMUNITY ORGANIZATIONS
- FAITH-BASED ORGANIZATIONS
- GOVERNMENT AGENCIES

Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in **HALF**

to achieve a greater combined impact on reducing type 2 diabetes

(Note: The infographic includes a circular seal on the left and a pair of scissors icon at the bottom right of the central graphic area.)

Diabetes Prevention Programs

THE GOOD NEWS!

- Prediabetes can usually be reversed.
- Initiatives like the **National Diabetes Prevention Program** lifestyle change program help significantly lower the risk of developing type 2 diabetes.
- Opportunities for diabetes prevention
 - Strengthen public health and Medicaid relationships
 - Increase virtual delivery
 - Eliminate prior approvals
 - Extend beneficiary eligibility
 - Improve community resilience
 - Improve health equity

New CCO medical director “makes the case” for National DPP video!

Check it out: <https://www.youtube.com/watch?v=EwH-qeCBgnY&t=3s>

National DPP: how it works

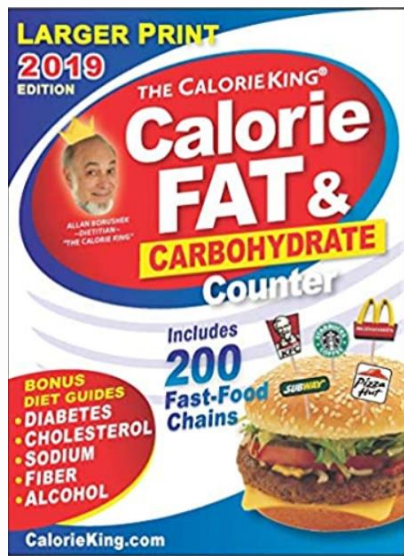
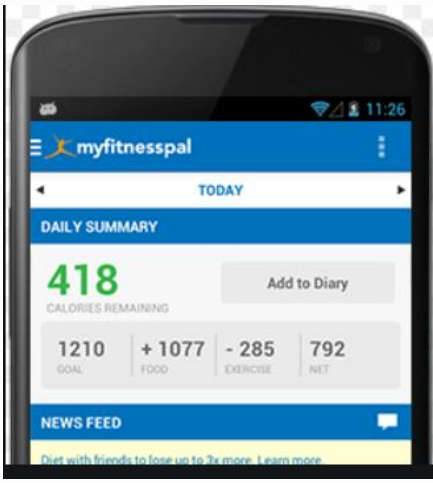
- Lifestyle Coach works with groups of participants to reduce their risk by:
 - Losing weight through healthy eating (5-7% of starting weight)
 - Increasing physical activity (target = 150 minutes per week)
 - Learning to identify and address barriers to healthy eating and physical activity
- Relies on self-monitoring, goal setting, group process
- 2-year program
 - **Months 1–6:** 16 sessions, usually held weekly
 - **Months 7–12:** Biweekly sessions for the balance of year 1
 - **Months 13–24:** Biweekly sessions for year 2




Sample topics covered during one-hour sessions

National DPP Topics	
Skill development	Eating well to prevent diabetes Getting active to prevent diabetes Tracking food and activity Problem solving
Dealing with external environment	Shop and cook to prevent diabetes Eating well away from home
Dealing with emotions	Manage stress Get support Take charge of your thoughts Cope with triggers Stay motivated
Health and wellness	Keep your heart healthy Get enough sleep

National DPP activities: food and activity tracking



Goals			
	Fat Grams	Calories	Minutes of Activity
Daily			
Weekly Average			



Food and Activity Tracker

Name: _____

Starting Date: _____

My To-Do this week:

Totals				
	Fat Grams	Calories	Minutes of Activity	Weight
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				
Total				



Steering Toward Health is a multi-year initiative that focuses on the prevention of chronic diseases, starting with type 2 diabetes. Its aim is to save physicians and their care teams valuable clinic time, while connecting their at-risk patients to evidence-based, behavioral-change programs.

Below, you'll find a toolkit with resources that help to identify and refer patients with prediabetes to National Diabetes Prevention Programs (National DPPs) recognized by the Centers for Disease Control and Prevention (CDC). Now covered by the Oregon Health Plan (OHP), Medicare, and some private insurance plans, National DPPs have been shown to reduce participants' risk of diabetes and other lifestyle-related diseases by promoting modest weight loss, regular exercise, and self-management of health habits over the long term.

The Steering Toward Health Diabetes Prevention Toolkit:

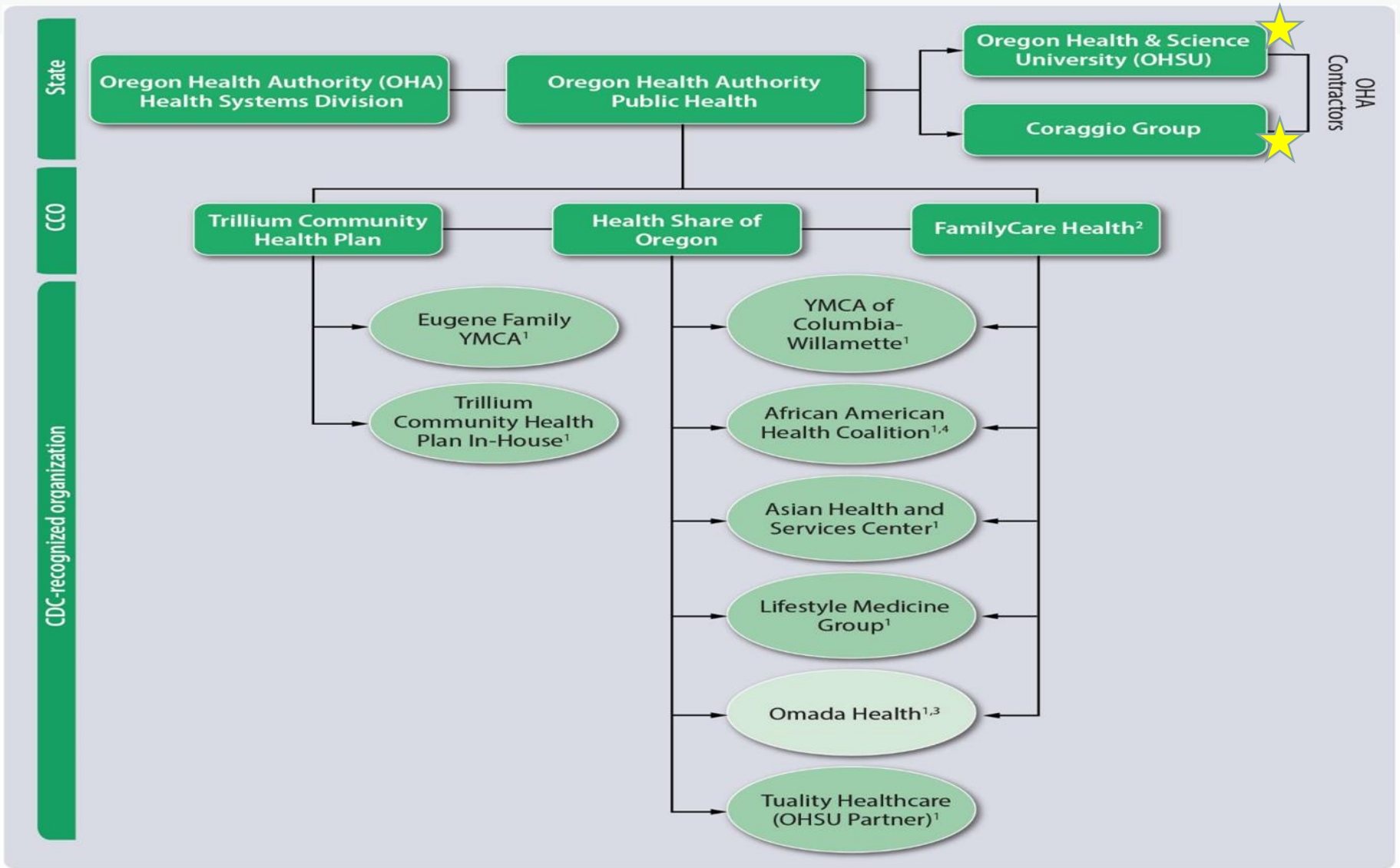
<https://www.theoma.org/OMA/Learn-content/Public-Health-Library/Diabetes.aspx>



Demonstration lessons learned

Oregon's approach to DPP demonstration

- Demonstration 2016–2018
 - Demonstration to study National DPP implementation for Medicaid pilot population in two states: Maryland and Oregon
- Demonstration project structure
 - National Association of Chronic Disease Directors (NACDD) funding agency with CDC as key partner
 - OHA Public Health served as project lead
 - Medicaid office served as liaison to CCOs for decision making
- CCO demo partners were the primary organizations for delivery of the demonstration
- DPP providers: in-house, CBOs, online



CDC-Recognized Organization Type: In-person Online

DPP demonstration project highlights

Stats

- Health Share, FamilyCare and Trillium completed demonstration projects for program delivery 2016–18
- 351 people enrolled!
- Lead with equity

Outcomes

- Medicaid coverage achieved
- Informing Medicaid pathways
- Closed-loop referrals
- Contracts with CBOs
- Online programs popular
- In-house programs

Demonstration evaluation results

Weight loss

- ↓4.5% among demonstration participants (meeting certain criteria)
- Total # of sessions attended significantly associated with weight loss

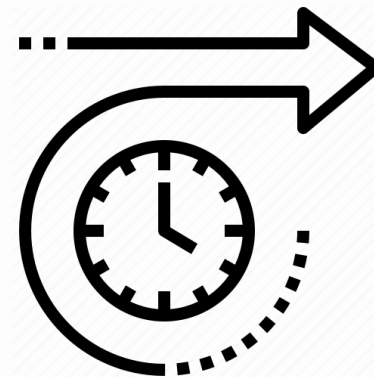
Likelihood of physical activity improved

Online vs. in-person

- Satisfaction greater among in-person program participants
- Online participants attended fewer sessions on average but achieved greater weight loss

Lessons learned: contracting

- Contracting takes time
- Community-based organizations, non-traditional medical billing providers, benefit from support and technical assistance in contracting phase
- Design of the contracts, including payment structures with CBOs provided for necessary support for implementation of DPP for the demonstration
 - Payment structures for startup
 - Grant-based payments
 - Outcomes-based payments



DPP and equity opportunities

Importance of cultural competence/equity:

- Address disparities
- Identify and **prioritize** groups with disparities
- **Partner** with CBOs that serve priority populations
- Provide **culturally specific** services
- **Engage community health workers**
- **Tribal Health** DPP programs

What's covered in Oregon




The Medicaid benefit – “ins and outs”

National DPP coverage in Oregon

Coverage across several payer types:

- Oregon Health Plan/Medicaid – effective January 2019
- Medicare – effective April 2018
- Public Employees Benefit Board (PEBB)
 - Providence Plans – effective 2017
 - Kaiser – effective 2016
- Oregon Educators Benefit Board (OEBB) – various plans effective 2017

Oregon Medicaid National DPP coverage

 Who is Covered? Eligibility Criteria	 What is Covered? The Covered Benefit	 How is coverage provided? DPP Service Provision
Screening and Diagnosis <ul style="list-style-type: none"> • Prediabetes (R73.03) when confirmed via blood test within past year • Previous gestational diabetes (Z86.32) • As a high intensity intervention for obesity or overweight (E66.01-E66.9) 	Funding, Billing & Referral <ul style="list-style-type: none"> • Two years of the national DPP program • Up to 52 sessions over two years • All CDC recognized National DPP curriculums; including Native Lifestyle Balance • Multiple modalities covered: in-person, distance learning, online programs 	Provider Requirements <ul style="list-style-type: none"> • National DPP must be provided by a CDC-recognized organization • National DPP provider or supplier must collect and report data to CDC • Two types of payment sources: Medicaid/Medicare reimbursement, Health-related services funds.

Note: Up to 52 sessions or 24 months over two years is based on two separate billing processes.

OHP: Who is covered to receive the National DPP?

In addition, under OHP:

- Participation in the National DPP **requires** a primary diagnosis of prediabetes (R73.03) or
 - gestational diabetes history (Z86.32) or
 - overweight/obesity (E66.01–E66.9)*
- Patients **do not qualify** if they have type 1 or type 2 diabetes or end stage kidney disease
- Note: Health Evidence Review Commission (HERC) guidelines **require a blood test** confirming the prediabetes diagnosis. Prediabetes Risk Test* results will not be accepted.

*Additional information on how to meet CDC criteria provided later in this slide deck

*Prediabetes/Gestational Diabetes effective January 1, 2019, Overweight/Obesity added October 1, 2019.

<https://www.oregon.gov/oha/hpa/dsi-herc/Pages/index.aspx>



Referral for Diabetes Prevention Program

Primary and secondary diagnoses:

Primary diagnosis of pre-diabetes (R73.03) or gestational diabetes history (Z86.32) diagnosis code, or obesity/overweight diagnosis (E66.01–E66.9) required

HERC criteria require BMI as a secondary diagnosis for payment processing on claims

Qualifying BMI codes below:

Z68.23 Body mass index (BMI) 23.0-23.9, adult	Z68.34 Body mass index (BMI) 34.0-34.9, adult
Z68.24 Body mass index (BMI) 24.0-24.9, adult	Z68.35 Body mass index (BMI) 35.0-35.9, adult
Z68.25 Body mass index (BMI) 25.0-25.9, adult	Z68.36 Body mass index (BMI) 36.0-36.9, adult
Z68.26 Body mass index (BMI) 26.0-26.9, adult	Z68.37 Body mass index (BMI) 37.0-37.9, adult
Z68.27 Body mass index (BMI) 27.0-27.9, adult	Z68.38 Body mass index (BMI) 38.0-38.9, adult
Z68.28 Body mass index (BMI) 28.0-28.9, adult	Z68.39 Body mass index (BMI) 39.0-39.9, adult
Z68.29 Body mass index (BMI) 29.0-29.9, adult	Z68.41 Body mass index (BMI) 40.0-44.9, adult
Z68.30 Body mass index (BMI) 30.0-30.9, adult	Z68.42 Body mass index (BMI) 45.0-49.9, adult
Z68.31 Body mass index (BMI) 31.0-31.9, adult	Z68.43 Body mass index (BMI) 50-59.9, adult
Z68.32 Body mass index (BMI) 32.0-32.9, adult	Z68.44 Body mass index (BMI) 60.0-69.9, adult
Z68.33 Body mass index (BMI) 33.0-33.9, adult	Z68.45 Body mass index (BMI) 70 or greater, adult

Z68.53 Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age*

Z68.54 Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age*

*The DPP benefit only applies to those OHP clients at least 18 years of age

**HERC
required
diagnosis
codes**

Pathways to Implement National DPP in Oregon

Pathway #1

CCO implements National DPP via contract with CDC-recognized delivery organization for in-person, distance learning, or combination (on-line, in-person & distance)

Clinics with trained lifestyle coaches and CDC-recognized programs deliver DPP

Clinics with OHP enrolled providers utilize reimbursement methodology for Medicaid (and Medicare) billing for DPP

Pathway #2

CCO contracts with CDC-recognized provider for on-line delivery of DPP

CBOs with trained lifestyle coaches and CDC-recognized programs deliver DPP **New Provider Type**

CBOs (or other DPP provider) collaborate with CCOs and/or clinics to determine reimbursement methodology for Medicaid (and Medicare) billing for DPP

CDC-recognized provider delivers DPP on-line from in-state or out-of-state **New Provider Type**

CCOs and CBOs determine contractual agreement for use of Medicaid/CCO Health-related services (HRS) funding to support DPP.

Pathway #3

CCO delivers DPP "in house" by building internal infrastructure

CCO must:

- Obtain CDC recognition
- Employ trained lifestyle coaches
- Adhere to DPRP standards
- Collect and report data to CDC

Payment for DPP is supported via CCO administrative budget

APM/VbP model

CCO funding options

Medical CPT Coding

- Traditional medical billing model. Similar to FFS model for OHP.
- 87% of Oregon's current CDC recognized programs were within organizations that are currently Medicaid enrolled.
- CCOs may choose to use DPP provider type for medical billing model.

Health-Related Services (HRS)

- DPP services that are not covered for an individual OHP member may be considered HRS as Flexible Services
- DPP programs provided by community-based organizations may be considered HRS as a Community Benefit Initiative.

In House

- CCO seeks CDC recognition and delivers National DPP in house.
- CCOs may choose to deliver the National DPP with in-house community health workers or lifestyle coaches.

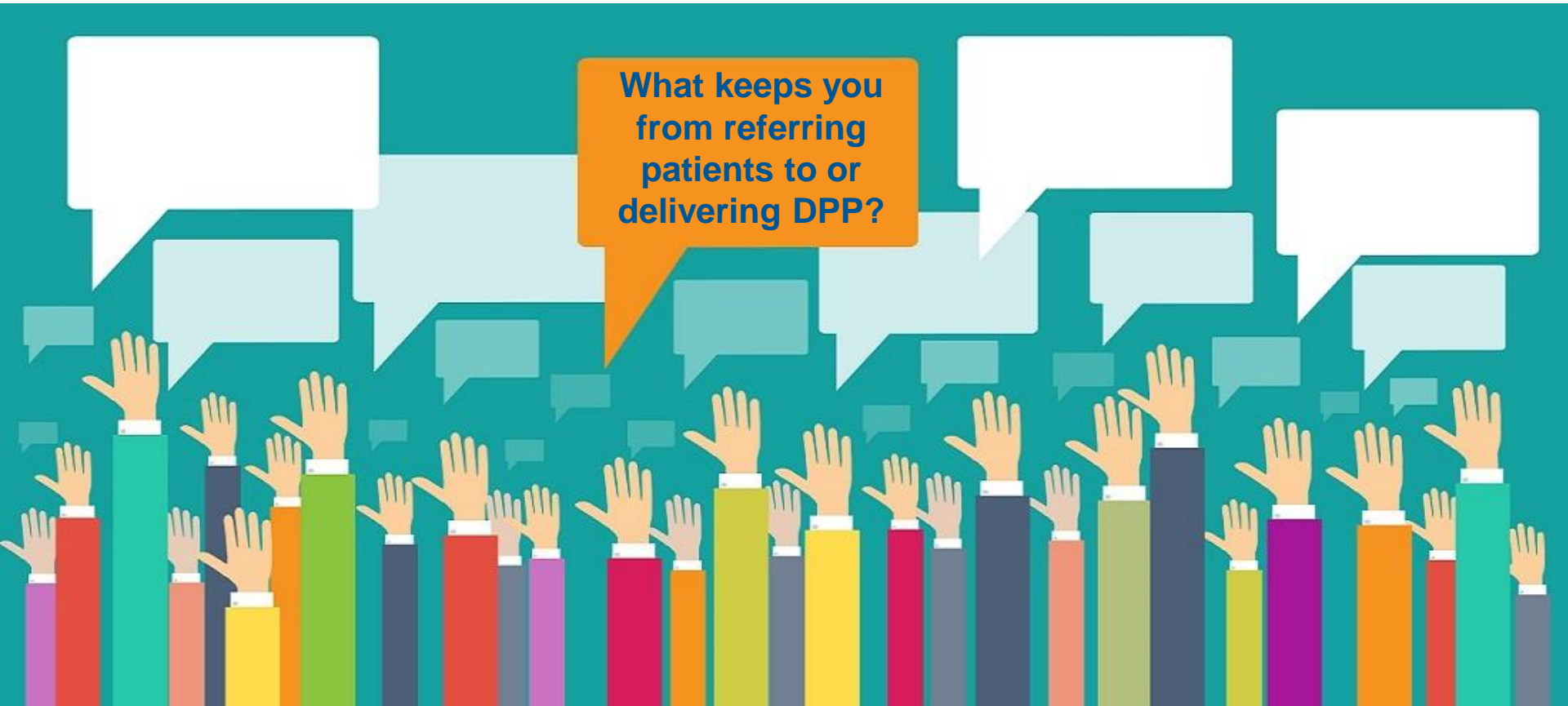
APM or VbP Model

- CCO to CDC-recognized National DPP organization
- CCOs may find alternative payment (APM) or Value-based Payment (VbP) models useful. Plans may have a APM/VBP provider contract that could be modified to include the National DPP
- APM/VbP model option can enhance a CPT coding

Clinic role in National DPP delivery

Overview

Clinic poll: pain points



Screening, testing and referral

The AMA and CDC urge you to: prevent diabetes STAT



SCREEN

patients for prediabetes using the CDC Prediabetes Screening Test (or the American Diabetes Association Diabetes Risk Test)



TEST

patients for prediabetes using one of three blood tests



ACT TODAY

to help prevent diabetes by referring patients with prediabetes to a [diabetes prevention program](#)

<https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/point-of-care-prediabetes-identification-algorithm.pdf>

Pre-diabetes Risk Test

Prediabetes Risk Test



Note: The Pre-diabetes Risk Test may not be used to determine eligibility for a DPP for patients covered by Medicaid.

1. How old are you? Write your score in the boxes below

Younger than 40 years (0 points)

40–49 years (1 point)

50–59 years (2 points)

60 years or older (3 points)

2. Are you a man or a woman?

Man (1 point) Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?

Yes (1 point) No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?

Yes (1 point) No (0 points)

5. Have you ever been diagnosed with high blood pressure?

Yes (1 point) No (0 points)

6. Are you physically active?

Yes (0 points) No (1 point)

Height	Weight (lbs.)		
4'10"	119-142	143-190	191+
4'11"	124-147	148-197	198+
5'0"	128-152	153-203	204+
5'1"	132-157	158-210	211+
5'2"	136-163	164-217	218+
5'3"	141-168	169-224	225+
5'4"	145-173	174-231	232+
5'5"	150-179	180-239	240+
5'6"	154-184	185-246	247+
5'7"	158-188	189-251	252+
5'8"	162-192	193-256	257+
5'9"	166-196	197-261	262+
5'10"	170-200	201-266	267+
5'11"	174-204	205-271	272+
6'0"	178-208	209-276	277+
6'1"	182-212	213-281	282+
6'2"	186-216	217-286	287+
6'3"	190-220	221-291	292+
6'4"	194-224	225-296	297+

7. What is your weight category?

(See chart at right)

1 Point **2 Points** **3 Points**

You weigh less than the 1 Point column (0 points)

Total score:

If you scored 5 or higher

You are at increased risk for having prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition in which blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes. **Talk to your doctor to see if additional testing is needed.**

If you are African American, Hispanic/Latino American, American Indian/Alaska Native, Asian American, or Pacific Islander, you are at higher risk for prediabetes and type 2 diabetes. Also, if you are Asian American, you are at increased risk for type 2 diabetes at a lower weight (about 15 pounds lower than weights in the 1 Point column). Talk to your doctor to see if you should have your blood sugar tested.

You can reduce your risk for type 2 diabetes

Find out how you can reverse prediabetes and prevent or delay type 2 diabetes through a **CDC-recognized lifestyle change program** at <https://www.cdc.gov/diabetes/prevention/lifestyle-program>.



Clinic/CBO testing and referral process: clinic initiation

Clinic Step 1: Screen and Test

- Measure patient height and weight; calculate BMI
- Screen patient for history of gestational diabetes and/or draw blood to test for prediabetes (fasting plasma glucose or A1C)

Clinic Step 2: Diagnose and Refer

- Patient's blood test shows prediabetes and/or patient's BMI shows overweight or obese
- Make referral to affiliated CBO with CDC recognition to deliver National DPP

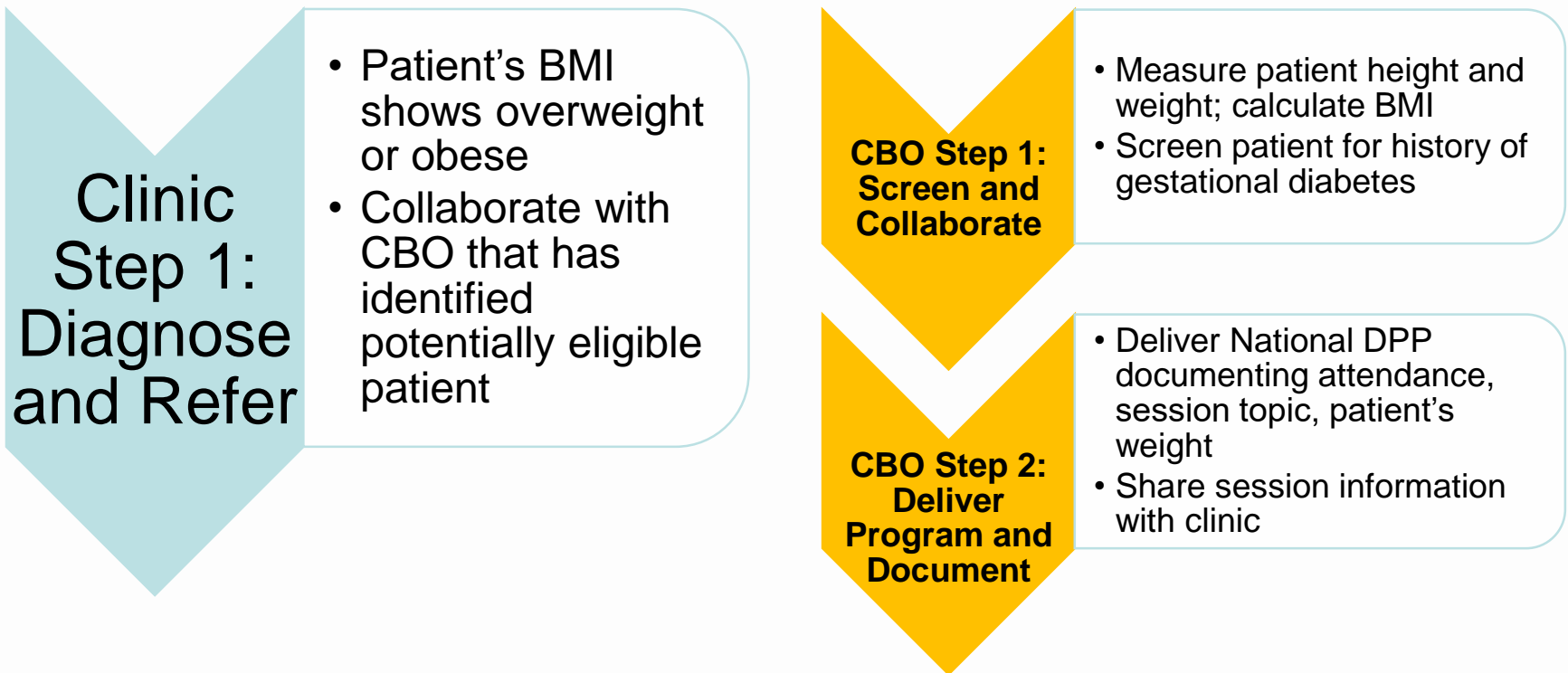
CBO Step 1: Accept Referral and Schedule

- Receive National DPP referral
- Schedule patient into upcoming National DPP

CBO Step 2: Deliver Program and Document

- Deliver National DPP documenting attendance, session topic, patient's weight
- Share session information with clinic

Clinic/CBO testing and referral process: CBO initiation



Clinic/CBO testing and referral process: either initiates

Clinic Step 2 or 3: Document and Bill

- Document class attendance and bill for DPP delivery
- Identify affiliated CBO as provider of National DPP class

Clinic Step 3 or 4: Pay CBO

- CCO or FFS OHP reimburses clinic for National DPP delivery
- Clinic pays CBO for delivery of National DPP

Provider and DPP program roles

Medical Billing Provider	CDC-Recognized DPP Program+
<p>Diagnosis & Referral in Medical Record</p> <p>--If prediabetes referral, share that member has had qualifying blood test</p> <p>--If obesity referral, share BMI and if completed at your office, CDC/ADA Prediabetes Risk Test</p>	<p>Receive and track referrals (per CDC requirements)</p> <p>% Participants Qualifying with Blood Test –35% minimum</p> <p>--referred prediabetes</p> <p>% Participants Qualifying CDC or ADA Screening –up to 65%</p> <p>--referred obesity/BMI –keep documentation of completed risk/screening tests. If provider did not administer, complete CDC/ADA Prediabetes Risk Test (Qualifying Score 5 or higher on the CDC/ADA Prediabetes Risk Test)</p>
<p>Attendance/Participation: Keep attendance in member record to submit accurate billing</p>	<p>Attendance/Participation/Completion</p> <p>Following CDC tracking expectations</p> <p>Complete loop by providing attendance/participation back to billing provider</p>
<p>Reports on completion from DPP program/DPP instructor</p>	<p>Record weight and physical activity minutes</p> <p>Submit data to CDC as required for tracking</p>
<p>Additional Online Expectations: Address expectations for online DPP program documentation (properly recording and tracking individual participant participation and completion in case of audits).</p>	<p>Additional Online Expectations: Online programs should maintain a participation record that can demonstrate (1) how CDC content is being delivered and (2) include by participant record demonstrating online completion of content as verification for potential audit.</p> <p><i>Members must be actively participating during the month for provider to bill for any full month of DPP service.</i></p>

+ Details for data requirements for maintaining CDC recognition can be found in the CDC Diabetes Program Recognition Standards <https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf>

Clinic/CBO partnership: Who's involved in each step of the billing process



Collaborating to recruit participants

Responsibility for participant recruitment does not reside with a single entity

Entity	Responsibility/Contribution
CBO/DPP Program	<ul style="list-style-type: none">• Promotion within community• Might be delivering program• May be able to help identify OHP members eligible for medical coverage
Clinic	<ul style="list-style-type: none">• Screening and testing for prediabetes• Referral to culturally appropriate DPP
CCO	<ul style="list-style-type: none">• Develop creative, inclusive reimbursement infrastructure for National DPP delivery• Promote program to CCO members

Partnership



Community-based organizations/community clinics

Ideally would like to see National DPP delivered by trained Lifestyle Coaches from the communities they serve

- CBOs have the trained coaches, but may not be OHP providers
- Community clinics are OHP providers, but may not have trained National DPP Lifestyle Coaches

Pilot partnership between Neighborhood Health Center and Familias en Accion

Clinic poll: gaps



Questions?



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Additional trainings

On-demand, recorded webinars with no-cost CME available

- [Patient education and engagement in diabetes care](#) (no-cost CME available): On-demand, recorded webinar
- [Working with pharmacists on a diabetes care team](#) (no-cost CME available): On-demand, recorded webinar

Presenter contacts

- **Lisa Bui:** Lisa.T.Bui@dhsosha.state.or.us
- **Rachel Burdon:** Rachel.E.Burdon@dhsosha.state.or.us
- **Dr. Kevin Ewanchyna:** KEwanchy@samhealth.org
- **Don Kain:** kaind@ohsu.edu

Thank you!

This webinar is hosted by the
Oregon Health Authority Transformation Center.

- For more information about this presentation, contact Transformation.Center@state.or.us
- Find more resources for diabetes care here: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Diabetes.aspx>
- Sign up for the Transformation Center's technical assistance newsletter: <https://www.surveymonkey.com/r/OHATransformationCenterTA>

Sources

Endnotes

- ¹ <https://nccd.cdc.gov/Toolkit/DiabetesBurden/Prevalence>
- ² <https://nccd.cdc.gov/Toolkit/DiabetesBurden/SelfReported/Hy>
- ³ <https://nccd.cdc.gov/Toolkit/DiabetesBurden/SelfReported/Mi>
- ⁴ <https://nccd.cdc.gov/Toolkit/DiabetesBurden/SelfReported/Iadl>
- ⁵ <https://nccd.cdc.gov/Toolkit/DiabetesBurden/SelfReported/Bl>
- ⁶ <https://nccd.cdc.gov/Toolkit/DiabetesBurden/SelfReported/Chd>
- ⁷ https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/website-2020/covid/covid_slides_prediabetes_and.pdf
- ⁸ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm>

Resources

AMA Tools for Providers

- Sample AMA Referral Form to DPP Program
 - https://amapreventdiabetes.org/sites/default/files/uploaded-files/amapreventdiabetes_Referral%20Form.pdf
- CDC/AMA Stat Patient Education & Referral Form
 - <https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/why-participate-in-dpp.pdf>
- Pre-Diabetes Patient Awareness Flyers (English & Spanish)
 - <https://amapreventdiabetes.org/tools-resources>
- Optimizing Your EHR to Prevent Type 2 Diabetes
 - <https://amapreventdiabetes.org/sites/default/files/uploaded-files/18-300622%20-IHO-STAT%202.0%20Optimize-ehr.pdf>
- Oregon OMA Steering Toward Health Resources
 - <https://www.theoma.org/OMA/Learn-content/Public-Health-Library/Diabetes.aspx>

Additional health care provider links

- [Steering Toward Health](#) – Online toolkit for the OHA and Oregon Medical Association multiyear initiative to connect adults with prediabetes to evidence-based lifestyle change programs.
- [Screen and Refer Patients to a Lifestyle Change Program](#) – Resources including the [Prevent Diabetes STAT toolkit](#) developed by the AMA and CDC
- [CDC-recognized National Diabetes Prevention Programs in Oregon \(find a workshop\)](#)
- [Guideline Note 179](#) – Outlines National DPP eligibility criteria for Medicaid members in Oregon, per the Prioritized List of Health Care Services
- [Guideline Note 5](#): High-intensity intervention for obesity or overweight diagnoses.

Encouraging member participation

- Encourage members to participate! Your encouragement goes a long way to helping members take the next step.
- Remember stages of change, and patient activation models and motivational interviewing techniques. Not everyone may be ready when you first mention the program, but don't give up on telling your patients how important the program can be in helping them stay healthy.
- Arrange for NEMT if needed! Help make the connection for setting up NEMT for those who need it to attend.
- Reminder that you can also bill OHP for encouraging and supporting participant engagement, for example, via existing Chronic Care Management or prevention counseling codes:
 - CPT® code 99490 for providing non-face-to-face care coordination services. (such as outreach to member by clinic staff)
 - Prevention Counseling Codes: CPT® 99401-99404
- If you have community health workers on your team, consider how they can support and encourage member participation. Some clinics are training CHWs to deliver the program, others engaging in member follow-up through contacts made by the CHWs.

How to become a National DPP provider

How to become a National DPP provider

To become a National DPP Provider, organizations must be willing to follow these steps:

- Have program leaders trained as DPP Lifestyle Coaches
- Agree to use a CDC-approved curriculum to deliver the program
- Deliver the program within 6 months of receiving CDC approval to do so
- Submit data to the CDC on participant attendance, weight loss and physical activity every 6 months

Not yet a National DPP provider?

Contact the OHA Public Health Division to learn how you can get trained:

Kaitlyn Lyle, Diabetes Program Coordinator

Kaitlyn.E.Lyle@dhsoha.state.or.us

CDC program registry:

https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

Additional Resources:

[Standards for CDC Diabetes Prevention Program Recognition](#)

[Staffing Your National DPP Lifestyle Change Program](#)

Resources on NDPP

- [National DPP Coverage Toolkit](#) – Information on contracting, delivery, billing and coding, and data and reporting to support health insurance plans, employers, and state Medicaid agencies in making the decision to cover the National DPP lifestyle change program
- [Implement a Lifestyle Change Program](#) – Resources and guidance on offering a program, including staffing, participant recruitment and training, and data reporting
- [Interested in offering the DPP in Oregon? \(PDF\)](#)
- [CDC Diabetes Prevention Recognition Program Standards and Operating Procedures Handbook](#)
- [National Diabetes Prevention Program reimbursement for Oregon Health Plan members](#)
- [Diabetes Prevention Program OHP benefit coverage and billing guidance](#)

Billing FAQs

When can current enrolled providers supervise and bill for a DPP program?

- Oregon Licensing Boards provide guidance on supervision requirements and expectations such as scope of practice.
- OHP does not require supervising providers to be in the same office when auxiliary community health education and outreach are being performed.
- Programs that are within a health department, FQHC, or clinic that already has OHP enrollment can bill through the existing clinic/provider enrollment as for other services.
- Medicare “Incident-To” rules apply only to Medicare billing.
- OHP FFS DPP claims can be billed by the supervising provider; FFS doesn’t have a mechanism to directly enroll independent DPP suppliers like Medicare. CCOs can mirror this billing process.

Who is covered?



To be eligible for referral to a CDC-recognized lifestyle change program, patients must meet the following requirements:

- Be at least 18 years old and
- Be overweight (body mass index ≥ 25 ; ≥ 23 if Asian) and
- Have no previous diagnosis of type 1 or type 2 diabetes and
- Not have end-stage renal disease and
- For prediabetes diagnosis, have a blood test result in the prediabetes range within the past year:
 - Hemoglobin A1C: 5.7%–6.4% or
 - Fasting plasma glucose: 100–125 mg/dL or
 - Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL
- Or, be previously diagnosed with gestational diabetes

Coverage: What is covered for OHP?

In-person DPP program participation requirements and coverage limitations:

National DPP services can be provided

- In person; or
- Via remote two-way telehealth class (for medical billing use GT modifier).

	In-person DPP program	Total number of OHP-covered sessions
Year One	Months 1–6	16 core sessions (per CDC curriculum)
	Months 6–12	12 maintenance sessions (up to 2 per month)
Year Two	Months 1–12	24 maintenance sessions (up to 2 per month)
	Program Total	52 sessions over 24 months

Online National DPP coverage

Online program participation requirements and coverage limitations:

To qualify for reimbursement as an online program, the program must provide the OHP member

- an FDA-approved Bluetooth-enabled weight scale and
 - a web-based fitness tracker
- at the beginning of the program.

	Online DPP program	Total number of OHP-covered program months
Year One	Months 1–6	Up to 6 months (per CDC curriculum)
	Months 6–12	Up to 6 months (for each month the member actively participates in the program)
Year Two	Months 1–12	Up to 12 months (for each month the member actively participates in the program)
	Program Total	Up to 24 months

FFS claim detail

Example: Prediabetes diagnosis on claim

[Home](#) [Claims](#) [Financial](#) [Managed Care](#) [MAR](#) [POC](#) [Prior Authorization](#) [Provider](#) [EDI](#) [Recipient](#) [Reference](#) [TPL](#) [Site](#) [EDMS](#) [Help](#)
[home](#) [search](#) [information](#) [adjustments](#) [data corrections](#) [related data](#) [independent choices](#) [reports](#) [drug profile search](#)

Next Search By: ICN

Physician Claim Top Nav ? A ⬆ X

ICN [REDACTED]	Claim Type PROFESSIONAL CLAIM	Status* PAID	Details 1
Prev ICN [v]	Provider ID [REDACTED] MCD [Search]	FDOS* 05/22/2019	Billed [REDACTED]
Current ID* [REDACTED] [Search]	Ref Prov1 ID [Search]	TDOS* 05/22/2019	Net Billed [REDACTED]
Last Name [REDACTED]	Ref Prov2 ID [Search]	Hosp FDOS	Total TPL [REDACTED]
First Name [REDACTED]	Signature Yes	Hosp TDOS	TPL [REDACTED]
DOB [REDACTED]	Accident [v]	Date Billed* 09/03/2019	Spenddown [REDACTED]
Cert # [REDACTED]	Accident Date [REDACTED]	Date Paid 09/06/2019	Copay Amount [REDACTED]
Attachment No	ClaimDiagnosis 1 - R7303	TPL Rec Amt \$0.00	Paid [REDACTED]
RA Number [REDACTED]	PAN [REDACTED]	Reimbursed \$0.00	MRN [REDACTED]
MCO Billing Provider [REDACTED] NPI	Submitter ID [REDACTED]	Total Patient Liability \$0.00	TPR Code [REDACTED]
	Plan Payment [REDACTED]	TPL Non-Plan \$0.00	

List prediabetes (or gestational diabetes, or obesity) on ALL claims as primary diagnosis

Physician Claim Prefs Top Bot ? v
 Select an area to add or modify

Claim Detail Top Nav ? A v X

Diagnosis Top Nav ? A ⬆ X

Sequence	Diagnosis	Description	ICD Version	Present on Admission	Qualifier
2	Z6837	Body mass index (BMI) 37.0-37.9, adult	10		ABF
1	R7303	Prediabetes	10		ABK

List prediabetes (or gestational diabetes, or obesity) on ALL claims as primary diagnosis

On initial (1st) claim, include qualifying BMI as secondary diagnosis

FFS claim detail

Example: Billing Provider Submission

Claim Detail Top Nav ? A ↕ X

Detail Number	1	Status	PAID	FDOS	05/22/2019	Billed Amt	
Adjust Ind		Diagnosis Ind	1 2	TDOS	05/22/2019	Allowed Amt	
Procedure	0403T	POS		Units Billed		Copay Amt	
Modifier1		Ref Prov ID		Units Allowed		OI Amt	
Modifier2		Ref Prov1 ID		Emergency		System	
Modifier3		Ref Prov2 ID		EPSDT Ref		EPSDT/Fam Plan	
Modifier4		Patient Liability		Plan Payment		TPL Non-Plan	
NDC		NDC UOM		NDC Qty		NDC Qual	

Type changes below. goto

Detail #	1	Status	PAID	FDOS*	05/22/2019	Billed Amt	
Adjust Ind		Diagnosis Ind	1 2	TDOS*	05/22/2019	Allowed Amt	
Procedure*	0403T [Search]	POS		Units Billed	1.00	Copay Amt	
Modifier 1	[Search]	Rend Prov ID		Units Allowed	1.00	OI Amt	
Modifier 2	[Search]	Ref Prov1 ID		Emergency		System	No
Modifier 3	[Search]	Ref Prov2 ID		EPSDT Ref	None	EPSDT/Fam Plan	
Modifier 4	[Search]	Patient Liability	0	Plan Payment		TPL Non-Plan	
NDC	[Search]	NDC UOM		NDC Qty	0	NDC Qual	

Diagnosis Top Nav ? A ↕ X

Sequence	Diagnosis	Description	ICD Version	Present on Admission	Qualifier
2	Z6837	Body mass index (BMI) 37.0-37.9, adult	10		ABF
1	R7303	Prediabetes	10		ABK

Rendering Provider (in this case, a nutritionist) is the provider who attests that the patient attended the class conducted by the Lifestyle Coach

OHP provider billing guide

OHP NDPP billing guide:

<https://www.oregon.gov/oha/HSD/OHP/Tools/National%20DPP%20services%20for%20OHP%20members.pdf>

Questions?

- **Providing NDPP services to CCO members:** Contact your local CCO.
- **Providing NDPP services to OHP members not enrolled in a CCO:** Please email Jennifer Valentine at Jennifer.B.Valentine@dhsoha.state.or.us
- Submit FFS billing through the online provider portal for FFS <https://www.or-medicaid.gov/ProdPortal/>.

Medicaid FFS provider enrollment

For details on Oregon Medicaid provider enrollment go to:

<https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx>

- Information covered includes National Provider Identifier (NPI) requirements and OHA-specific requirements
- Additional information covered on this page regarding provider enrollment with CCOs or dental plans.

To find out if you or a provider at your organization is already enrolled with OHA, use OHA's verification tool by entering the NPI:

<https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx>
[https://www.oregon.gov/ProdPortal/Validate%20NPI/tabid/125/Default.aspx](https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx)

Email questions about provider enrollment to OHA Provider Services Unit: dmap.providerservices@state.or.us

New encounter-only provider type for DPP in CCOs:

When a CCO chooses a DPP provider who has no current other enrollable provider type, the CCO may want to use the new encounter-only provider type.

- MMIS Type 63 description on Form 3108 now is “National Diabetes Prevention Program Supplier”
- Type 63 specialty codes are:
 - (1) 497 for in-person program
 - (2) 498 for online program.
 - Form 3018 is available at:
<https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3108.pdf>
 - For information for DPP programs on how to get an NPI as a DPP supplier or instructor/coach, both CDC and Medicare provide instructions for DPP suppliers.
<https://innovation.cms.gov/Files/x/mdpp-enrollmentfs.pdf>
 - Many online-only DPP providers, especially larger national companies, are likely to already have Medicare DPP supplier enrollment which makes credentialing for you easier.

How to Use the Type 63 Encounter-Only “National Diabetes Prevention Program Supplier”

At the present time, our State Plan does not allow for DPP supplier enrollment in OHP FFS.

Creating a diagnosis and referral closed-loop system

- If you don't have your own in-house DPP program, develop a relationship with a local DPP program*. The DPP Program needs your patients to be referred with medical diagnosis and any testing completed.
- Start a conversation about working together. This might include conversations to establish specifics for referral, attendance, billing and payment. Decide if you need a Business Associate Agreement.
- Identify your patients who meet requirements, including (if necessary) completing blood testing, BMI measurements and diagnosis per the HERC Guideline note 179 or Guideline Note 5. [Consider prediabetes as you would for other chronic disease registry follow-up systems].
- Refer qualifying patients to a CDC recognized DPP program. Sample referral documentation form available from AMA. <https://amapreventdiabetes.org/tools-resources>
- DPP program monitors attendance for accurate billing by date of program participation and report back to provider for inclusion on billing. Record attendance in the patient record and submit billing as frequently as makes sense.
- Sample report templates available from Oregon AMA. <https://amapreventdiabetes.org/tools-resources>
- OHA receives billing from enrolled provider billing services for National DPP program who has pending, preliminary or full CDC recognition.

*For the most current list of CDC recognized DPP programs in Oregon:
https://nccd.cdc.gov/DDT_DPRP/Registry.aspx?STATE=ME

CMS credentialing requirements for CCOs and encounter-only DPP suppliers

- Each CCO is responsible for credentialing and ensuring encounter-only DPP supplier providers meet CMS network provider selection policies and procedures consistent with 42 CFR §438.12 (Specifically CMS requires MCEs to (a) not discriminate against particular providers that serve high-risk populations and (b) ensure providers are not CMS excluded per 42 CFR §438.214.)
- Given CMS credentialing requirements for CCOs, and since DPP suppliers have no Oregon licensure or licensing board, CCOs may choose to follow processes other states have been using to meet expectations around ensuring providers are not CMS excluded.
 - Other states are requiring CMS National DPP supplier enrollment process for credentialing via Medicare DPP supplier type providers/programs steps: <https://innovation.cms.gov/Files/x/mdpp-enrollmentcl.pdf>
 - An additional example of Maryland's credentialing process for National DPP suppliers that aligns with Medicare DPP supplier enrollments: <https://phpa.health.maryland.gov/ccdpc/diabetes/Documents/Medicare%20DPP%20Enrolling%20as%20Supplier%20Check%20List%201.pdf>
 - CMS DPP supplier enrollment exclusions could be monitored through the CMS PECOS system to address these federal MCE credentialing requirements.
 - CCOs can review currently enrolled CMS DPP suppliers in the CMS database: <https://data.cms.gov/Special-Programs-Initiatives/Medicare-Diabetes-Prevention-Program/vwz3-d6x2/data>.

Dual Eligibles Coverage in OHP

Medicare–Medicaid Full Benefit Dual Eligible (FBDE)

Billing for OHP FBDE reminders:

- For the in-person program, **Medicare is primary payer** for OHP FBDE. OHP/CCO is responsible for cost-sharing.
 - Contact the member’s Medicare Advantage plan for billing instructions **or**
 - Bill Medicare FFS
- **Medicare does not cover the online program.** OHP/CCO is responsible as member’s primary coverage for the online program.



FBDE: OHP benefit packages BMM, BMD

Medicare (MDPP) FFS coverage and billing model: HCPCS G-codes and payment structure

This guide only applies to services furnished to beneficiaries receiving Medicare Part B coverage via Medicare Fee-for-Service (FFS). Contact a patient's Medicare Advantage plan to determine billing expectations.

MDPP Payment Structure							
Maximum possible payment per eligible beneficiary: \$670							
	CORE SESSIONS (16 SESSIONS) Months 0-6	CORE MAINTENANCE SESSIONS Months 7-12		ONGOING MAINTENANCE SESSIONS Months 13-24			
		INTERVAL 1 (3 SESSIONS)	INTERVAL 2 (3 SESSIONS)	INTERVAL 1 (3 SESSIONS)	INTERVAL 2 (3 SESSIONS)	INTERVAL 3 (3 SESSIONS)	INTERVAL 4 (3 SESSIONS)
Attendance only	Attend 1 session total: \$25 (G9873) Attend 4 sessions total: \$50 (G9874) Attend 9 sessions total: \$90 (G9875)	Attend 2 sessions (without at least 5% WL): \$15 (G9876)	Attend 2 sessions (without at least 5% WL): \$15 (G9877)	5% WL and attendance must be achieved to receive payment during ongoing maintenance sessions			
Attendance and Weight Loss (WL)	5% WL is not required to receive payment	Attend 2 sessions (with at least 5% WL): \$60 (G9878)	Attend 2 sessions (with at least 5% WL): \$60 (G9879)	Attend 2 sessions (with at least 5% WL): \$50 (G9882)	Attend 2 sessions (with at least 5% WL): \$50 (G9883)	Attend 2 sessions (with at least 5% WL): \$50 (G9884)	Attend 2 sessions (with at least 5% WL): \$50 (G9885)
Additional Codes	5% WL achieved: \$160 (G9880)						
				9% WL achieved: \$25 (G9881)			
				Bridge payment: \$25 (G9890)			
	Report attendance at sessions that are not associated with a performance goal. Non-payable codes should be listed on the same claim as the payable code with which they are associated: \$0 (G9891)						

• HCPCS G-codes and their payment amounts are bolded next to each payment description
 ★ Represents when a specific performance goal (i.e., attendance, weight loss) must be met for the beneficiary to be eligible to continue receiving services

Medicare DPP resources

- **Medicare Diabetes Prevention Program (MDPP) Quick Reference Guide to Payment and Billing Reference Guide**
 - <https://innovation.cms.gov/files/x/mdpp-billingpayment-refguide.pdf>
- **Medicare DPP Supplier Enrollment**
 - <https://innovation.cms.gov/Files/fact-sheet/mdpp-101-fs.pdf>
 - <https://innovation.cms.gov/Files/x/mdpp-enrollmentfs.pdf>
- **General Medicare DPP information:**
 - <https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>
- **Medicare Crosswalk Guidance** (required crosswalk file for CDC performance data and the corresponding Medicare identifiers):
 - <https://innovation.cms.gov/Files/x/mdpp-crosswalk-guidance.pdf>

Indian Health Service/Tribal/Urban Indian Programs

Connecting with I/T/U health programs to serve Tribal OHP members in CCOs

For OHP Tribal members, we strongly encourage you to connect with your local I/T/U Health Program, who may already be offering DPP.

- Some Tribal Health Programs in Oregon have been using CDC-recognized curriculum for many years and are now becoming CDC recognized DPP programs. These programs use a culturally adapted curriculum and often hold programs in places convenient to Tribal members.
- *Tribal Health Clinics are enrolled OHP providers and can bill for DPP programs through current enrollments.*

DPP programs in tribal settings can apply with CDC for a quick turnaround preliminary recognition approval of their already nationally recognized DPP culturally designed curriculum or decide to participate in a training in Oregon for the DPP curriculum.

How to apply for CDC recognition for DPP as a Tribal entity

Complete the CDC online registration form:

https://nccd.cdc.gov/ddt_dprp/applicationform.aspx

Select which CDC approved curriculum you are using in the drop-down menu of Question 17

NOTE: The full list of CDC Training entities are found here: <https://www.cdc.gov/diabetes/prevention/lifestyle-program/staffing-training.html>

17. Curriculum*

If you select **Other Curriculum**, you must submit your curriculum files.

- 2016 PreventT2 - English
- 2016 PreventT2 - Spanish
- 2016 PreventT2 - English and Spanish
- 2012 National DPP curriculum - English
- 2012 National DPP curriculum - Spanish
- 2012 National DPP curriculum - English and Spanish
- Native Lifestyle Balance-Preventing Diabetes in American Indian Communities
- Other Curriculum

How to apply for CDC recognition for DPP as a Tribal entity (continued)

You do not need to upload a copy of the curriculum you are using if it is one of the listed approved curricula for DPP programs such as Native Lifestyle Balance.

You should receive pending recognition within a few days as long as there aren't any questions about other information provided on the form.

To ensure CDC is aware of your application for recognition, please email Kirsten Aird at Oregon Public Health KIRSTEN.G.AIRD@state.or.us and copy the CDC contacts Pat Shea gzt0@cdc.gov and Beth Ely eke0@cdc.gov

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Additional resources

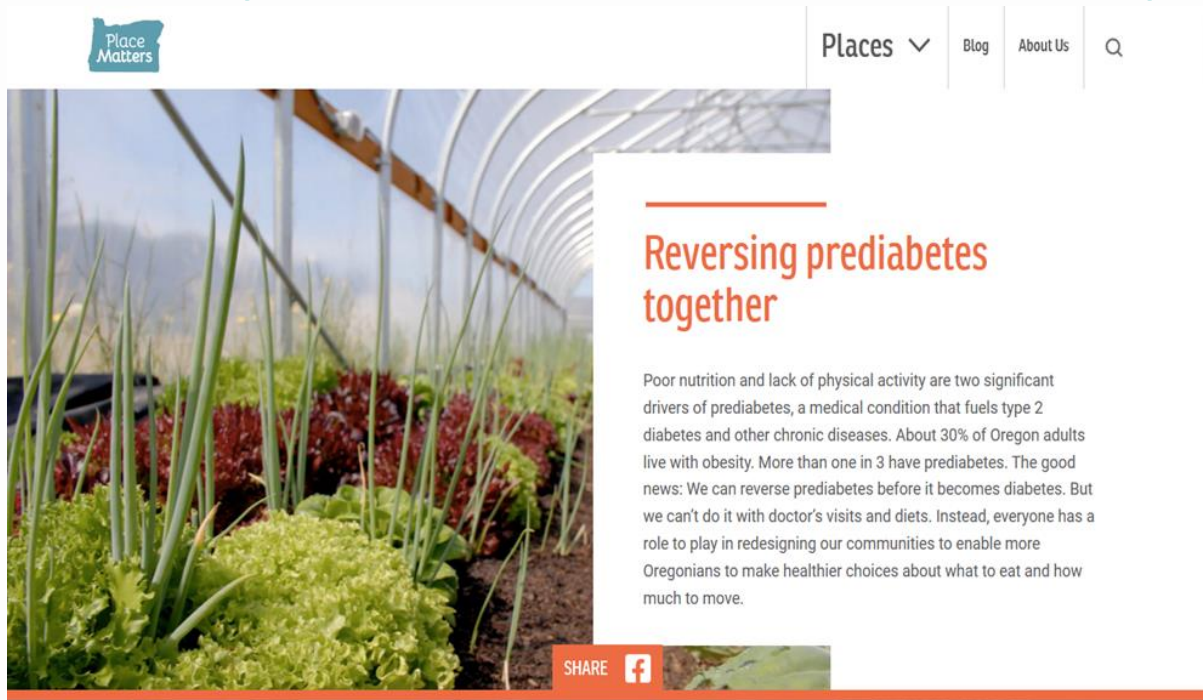
Web resources

For all audiences

- [Evaluation of the Medicaid Coverage for the National Diabetes Prevention Program Demonstration Project: Executive Summary](#)
- [Oregon Diabetes Report](#) (PDF) – Report to the 2015 Oregon Legislature on the burden of diabetes and progress on the 2009 diabetes strategic plan
- [Oregon Medical Association DPP platform](#) – Explore resources and training opportunities, connect with a DPP physician champion, and look for a communication campaign for providers and clinical teams launching June 2019
- [Comagine Health \(formerly HealthInsight\) DPP initiative](#) – Resources for clinicians, consumers, program delivery organizations and employers/health plans
- [CDC Prediabetes Screening Test](#)

For all audiences

- [Place Matters Oregon website](#)
- [Making the case for National DPP video \(short\)](#)
- [Making the case for National DPP video \(long\)](#)



<https://placemattersoregon.com/we-are/reversing-prediabetes-together/>

For employers and insurers

- [National DPP Coverage Toolkit](#) – Information on contracting, delivery, billing and coding, and data and reporting to support health insurance plans, employers, and state Medicaid agencies in making the decision to cover the National DPP lifestyle change program
- [Implementing Comprehensive Diabetes Prevention Programs: A Guide for CCOs](#) – Lessons from Oregon CCOs participating in the National DPP Medicaid Demonstration Project (2016–2018)
- [National Diabetes Prevention Program reimbursement for Oregon Health Plan members](#)
- [Diabetes Prevention Program OHP benefit coverage and billing guidance](#)
- [Health-related services FAQ guidance](#)
- [Covering a lifestyle change program as a health benefit \(CDC\)](#)

Medicare DPP resources

Medicare Diabetes Prevention Program (MDPP) Quick Reference Guide to Payment and Billing Reference Guide:

<https://innovation.cms.gov/files/x/mdpp-billingpayment-refguide.pdf>

Medicare DPP Supplier Enrollment

<https://innovation.cms.gov/Files/fact-sheet/mdpp-101-fs.pdf>

<https://innovation.cms.gov/Files/x/mdpp-enrollmentfs.pdf>

General Medicare DPP information:

<https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>

Medicare Crosswalk Guidance (required crosswalk file for CDC performance data and the corresponding Medicare identifiers):

<https://innovation.cms.gov/Files/x/mdpp-crosswalk-guidance.pdf>

For DPP providers

- [Implement a Lifestyle Change Program](#) – Resources and guidance on offering a program, including staffing, participant recruitment and training, and data reporting
- [Interested in offering the DPP in Oregon? \(PDF\)](#)
- [CDC Diabetes Prevention Recognition Program Standards and Operating Procedures Handbook](#)