Cracking the Code – Billing Beyond MNT
ADA Coding and Coverage Committee

Billing Primer
To successfully bill for nutrition services provided by RDs, practitioners need to become familiar with certain terms and procedures used on claims forms.

Definitions
Codes – The standardized “language” used to describe the particular service provided (e.g. MNT) and the reason the service was necessary (e.g. the disease/condition addressed). Both the procedure and diagnosis codes are used on claims so that a decision can be made for reimbursement of the service.

Current Procedural Terminology (CPT) codes- A medical code set used to identify and describe the services offered by all health care providers to the public. The CPT codes provide a uniform language to accurately describe medical, surgical and diagnostic services and allow nationwide communication among providers, patients and third party payers. Each code is comprised of five-digit numbers, eg. 97802. These codes are categorized into one of six major sections (i.e. Evaluation & Management, Anesthesiology, Surgery, Radiology, Pathology and Lab, or Medicine.) The MNT CPT codes are listed in the Medicine section. Within each of the six sections, the codes are divided into further subsections such as body systems (musculoskeletal, respiratory, etc), place of service (office visit or hospital visit) and the patient’s status (new or established patient). The CPT code set is maintained and copyrighted by the American Medical Association (AMA), and has been adopted by the Secretary of Health and Human Services as the standard (under the Health Insurance Portability and Accountability Act-HIPAA) for reporting health care services in the US. They are revised annually.

Healthcare Common Procedure Coding System (HCPCS)- Medicare’s National Level II Codes- A medical code set, accepted under HIPAA, that identifies health care procedures, equipment, and supplies for claim submission purposes. HCPCS Level II codes are alphanumeric codes, eg. G0270, used to identify various items and services that are not included in the CPT code set. CMS annually maintains the codes with input from other payer groups. HCPCS codes include two G codes used with Medicare Part B Medical Nutrition Therapy (G0270 and G0271) and codes for Medicare diabetes self-management training programs (G0108 and G0109).

ICD-9-CM codes (International Classification of Diseases - 9- Clinical Modification)
Often referred to as “diagnosis codes,” this code set is the official system for tracking disease/condition incidence in all health care settings in the US. The National Center for Health Statistics (NCHS) and CMS are the governmental agencies responsible for overseeing the ICD-9-CM. Diagnosis codes describe an individual’s medical condition that is determined by the treating physician. By law, CMS requires physicians to submit diagnosis codes for Medicare reimbursement. Physicians are the trained health care provider responsible for determining a medical diagnosis, so when listing the diagnosis code on a claim form for nutrition services provided by an RD, the RD should obtain the appropriate diagnosis code(s) from the patient/client’s physician. An example of a diagnosis code is 250.02- diabetes mellitus, type II or unspecified type, uncontrolled.

NPI- The National Provider Identifier (NPI) is a unique, government issued, standard identifier mandated by HIPAA that replaces providers’ other provider numbers from Medicare and other private payers. Once assigned, the 10 digit numeric NPI stays with a provider for life. For more information go to ADA’s Web page at: www.eatright.org/advocacy/mnt.
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CPT and HCPCS Codes Relevant to Nutrition Services

Medical Nutrition Therapy CPT and HCPCS codes
Compared with other CPT codes, the following MNT CPT codes best describe the services that RDs provide to patients/clients receiving medical nutrition therapy services for a particular disease or condition. The codes can be used among private insurance companies, depending on the coding and billing details listed in the RD’s contract with the payer. CMS requires use of these codes for the Medicare Part B MNT benefit by enrolled RD providers who perform MNT services for diabetes and non-dialysis kidney disease.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>97802</td>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
</tr>
<tr>
<td>97803</td>
<td>re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
</tr>
<tr>
<td>97804</td>
<td>group (2 or more individual(s)), each 30 minutes</td>
</tr>
</tbody>
</table>

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CMS also established HCPCS codes for use with Medicare covered services, effective for dates of service on or after January 1, 2003. These new G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.

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<tbody>
<tr>
<td>G0270</td>
<td>Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.</td>
</tr>
<tr>
<td>G0271</td>
<td>Medical Nutrition Therapy; reassessment and subsequent interventions(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes.</td>
</tr>
</tbody>
</table>

Other CPT codes for RDs-
Private insurance payers, but not Medicare, may accept other CPT codes, such as the Education and Training codes (98960-62); Medical Team Conference (99366 and 99368); Telephone Services (99441-99444); and On-line Medical Evaluation – (99444- Internet or similar electronic communications network; not related to [E/M] service within the last 7 days). Check your payer contract, policies or call the payer provider relations for more code policies. Physicians who offer RD provided nutrition services at their clinics may be able to bill certain third private insurance companies (NOT Medicare Part B) as “incident to” physician’s services. For additional “incident to” or other code details go to ADA’s Web page at: www.eatright.org/advocacy/mnt.

Diabetes Self-Management Training (DSMT).
Medicare Part B covers diabetes self-management training (DSMT) services when these services are furnished by a certified provider at an accredited program. Other private payers may also cover DSMT. This program is intended to educate beneficiaries in the successful self-management of diabetes and includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan (as indicated); and motivation for patients to use the skills for self-management. The following HCPCS codes are used for DSMT:

<table>
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<tbody>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes.</td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.</td>
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Cracking the Code – Billing Beyond MNT, ADA Coding and Coverage Committee
ADA Billing Primer – Frequently Asked Billing Questions

What information is typically included on the claims form?
- The name of the insured policy holder, and the patient/client name, gender, address, phone number, date of birth, social security number
- Name of the patient’s insurance, the individual insurance number and group number
- CPT code and number of code units for the provider’s service, eg. RD uses MNT codes
- ICD-9 code (from referring physician)
- Referring MD name and NPI; and RD provider name and NPI
- Date of service and charge for the service
- Signature date (Signature on File)

What is involved with hiring a biller to handle claims for nutrition services?
RDs may find it helpful and time/cost-effective to hire a biller to handle claims for nutrition services. Billers are familiar with the various claims forms, codes and billing procedures for third party payers. Billers usually are paid based on the volume of the practice, so a biller can get anywhere from 4 to 7% of the RD’s payments. Although there are several national groups that provide billing services and resources (see “Billing Resources” handout on ADA’s Web page: www.eatright.org/advocacy/mnt), talking to local private practice RDs or physicians can be a great source for identifying a local biller. Or, consult your local Yellow Pages (look up “Medical Billers”) or conduct your own Internet search (query “medical billing”) to identify billers in your area.

What claims forms are used to bill for nutrition services?
The CMS1500 and CMS1450 (UB92) forms are accepted by Medicare, however for Part B (outpatient) services, claims for MNT provided by enrolled RDs are usually submitted on the CMS1500 form. Some hospitals may only have access to the CMS1450, typically used to bill for Medicare Part A (inpatient) services, however in these cases, CMS will accept the CMS1450 form for Medicare Part B outpatient MNT services. Many private insurance companies use the CMS1500 form. For more information, go to ADA’s Web page at www.eatright.org and search for CMS1500 form.

If the client/patient is self-paying for the nutrition services, and the RD is not filing a claim with an insurance company, a Superbill is manually completed by the RD and provided to the client/patient. The Superbill is a pre-printed, or created form that itemizes and describes the services and fees provided to the patient/client.

What other resources does ADA to help me successfully code and bill for nutrition services?
Articles on setting fees:

Dietetic Practice Group (DPG) resources: Many DPGs have resources available to their members: The Nutrition Entrepreneurs (NE) has a mentoring program where RD members can contact another DPG member for discussion/networking etc. For more information visit the NE web site at www.nedpg.org.

ADA Guide to Private Practice: An Introduction to Starting Your Own Business; Ann S. Litt, MS, RD and Faye Berger Mitchell, RD This introductory guide incorporates checklists, self-assessments, sample forms and real-life examples from successful private practice RDs. Purchase from ADA’s Catalog, item #3479.

ADA Web page
Access MNT Information in the Members Section of the ADA’s Web site; www.eatright.org.
Click on Advocacy & the Profession and then Medical Nutrition Therapy to access:
- Medicare MNT Resources
- HIPAA and Compliance Resources
- Private Insurance & Employers Resources
- The MNT Works Kit & List of Educational Sessions
- ADA Reimbursement Representatives’ Contact Information (for the affiliate & dietetic practice groups)

1/08 ADA Coding and Coverage Committee
### 10 Steps to Setting Up Private Practice Or Outpatient Nutrition Services for Reimbursement

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<tr>
<th><strong>Private Practice</strong></th>
<th><strong>Hospital-Based Practice</strong></th>
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<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td>Evaluate your readiness and abilities. Educate yourself on how to run a business. What resources do you need – financial, mentor, etc.</td>
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<td></td>
<td>Familiarize yourself on clinic reimbursement policies for nutrition services. Recall Medicare Part B covers MNT for diabetes and kidney disease, so that service can be provided as part of the facilities ‘conditions of participation’ under Medicare Part B. Understand Medicare Part B coverage to minimally include this as an outpatient nutrition billable service. Are other payer contracts in place that include outpatient nutrition services? Begin a discussion with your department supervisor to determine current contracts and analyze business potential. With your supervisor, determine a fee schedule for outpatient nutrition services (group and individual).</td>
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<tr>
<td><strong>Step 2</strong></td>
<td>Decide payer base. Will you implement a practice model where you select clients from all of these sources, or limit your clientele to certain payers? Practice model types: • Private self-pay • Insurance and Managed Care • Medicare • Medicaid</td>
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<tr>
<td></td>
<td>Identify and meet with the hospital staff who negotiate insurance contracts at your facility. Check hospital contracts to determine the extent that outpatient nutrition services are included and billable to payers. If nutrition is excluded, determine whether it can be added. Determine the procedures for RD credentialing (see step 3, 4&amp;5 in the Private Practice column).</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td>Identify major providers in your community. Talk to your state dietetic association reimbursement representative, or other private practitioners, for information about local coverage. Use the Internet, phone book, state insurance commission etc. to find provider contact numbers. (Reimbursement rep information is accessible from ADA’s Web page at <a href="http://www.eatright.org">www.eatright.org</a>. Search for Leadership Directory, then click on “Policy Initiatives &amp; Advocacy Committees/Task Forces.”)</td>
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<tr>
<td></td>
<td>Based on review of contract, discuss the process for including reimbursement for outpatient nutrition services policies with hospital administrators such as the Chief Financial Office (CFO), Billing Director, Compliance Officer.</td>
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<td><strong>Step 4</strong></td>
<td>Call provider relations or the credentialing department to ask about becoming a network provider. Request a credentialing packet for RDs. If the payer is not accepting RDs into their network at this time: • Ask when enrollment will be open for RDs • Evaluate alternatives</td>
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<td></td>
<td>Meet with Billing Department: • Contact the Charge Master Supervisor; add the MNT procedure codes to the Charge Master. (See “Billing Primer” handout for code examples.) • Review proposed outpatient nutrition services charges-hourly/per unit rate • Review which billing form will be used; CMS 1500 or CMS 1450 (UB-92) • Determine start date and billing staff training on outpatient nutrition services procedures. • Learn procedure for ‘charging’ the patient after a visit (initiate outpatient RD training)</td>
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**10 Steps to Setting Up Private Practice Or Outpatient Nutrition Services for Reimbursement, continued**

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<tr>
<th>Step 5</th>
<th>Complete the credentialing (enrollment) packet and return to the insurance payer. (Note you may need letters of recommendation from physicians or others.) Keep a copy of the packet for your reference. Be patient – it can take 2 to 6 months to become credentialed. Note: in addition to submitting a packet to become credentialed as a recognized provider for the particular payer, RDs should also apply for a National Provider Identifier. For details go to ADA’s Web page at: <a href="http://www.eatright.org/advocacy/mnt">www.eatright.org/advocacy/mnt</a>.</th>
<th>Meet with Outpatient Registration •Alert them to your new program/service and the start date •Discuss procedures and forms necessary for signature, eg. signature on file form, ABNs for Medicare Part B covered services where it is uncertain if payment will be made. Note: For Medicare Part B MNT information, such as ABNs, go to ADA’s Web page at: <a href="http://www.eatright.org/advocacy/mnt">www.eatright.org/advocacy/mnt</a>. Scroll down to Medicare MNT section, click on “For Medicare RD Providers.”</th>
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<tr>
<td>Step 6</td>
<td>Find a contact in the company, perhaps your provider relations rep, to develop a professional relationship with.</td>
<td>Create a marketing plan: Meet with Community Relations department to create brochures, flyers etc. promoting outpatient nutrition services. Meet with medical director, others on the health care team (physician assistants, certified nurse practitioners) and area physicians to distribute promotional items.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Once credentialed with the payer, have an attorney review the payer’s contract, fee schedule and other printed materials with you. If needed, negotiate aspects of the contract, eg. the fee schedule, billable codes etc.</td>
<td>Review office set-up for scheduling: Identify phone line for incoming calls, messages etc., who will schedule clients/patients, determine mechanism for reminding clients about appointments, review policy for missed appointments etc.</td>
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<tr>
<td>Step 8</td>
<td>Carefully review and understand the payers’ rules for claims processing for nutrition services. Recognize the codes to include on the claims form; procedure (CPT) codes and diagnosis covered for nutrition services.</td>
<td>Prepare for first visits: Review documentation requirements, policy regulations such as the need for a physician referral (Medicare Part B), pre-authorization, laboratory data, etc.</td>
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<tr>
<td>Step 9</td>
<td>Determine if you will use a billing service, or submit claims yourself. In either case, make sure you have a billing system in place to track when the claim was sent, paid, denied, appealed etc. Create a marketing plan to promote your billable services; contact referring physicians, create brochures, flyers etc. promoting your nutrition services.</td>
<td>Follow the Claims Process: Make sure the hospital has a billing system in place to track when the claim was sent, paid, denied, appealed etc. Discuss with your supervisor or the billing department.</td>
</tr>
<tr>
<td>Step 10</td>
<td>Be persistent and keep educated!</td>
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**Additional considerations:**
- Network
- Keep your eyes and ears open at all times
- Be persistent
- Know the language
- Know your market
- Keep up-to-date on payer policies
## Points to consider for selecting a nutrition practice model (patient/client mix)

<table>
<thead>
<tr>
<th>Model</th>
<th>Pros</th>
<th>Cons</th>
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</table>
| Medicare clients                          | - Stable and predictable
   - Potential for large number of clientele and opportunity to increase client base
   - Minimal marketing
   - Opportunity for follow-up
   - Good systems development
   - Recognition as a Medicare provider
   - May open doors to other payers/providers | - Reimbursement rate may not meet salary expectations
   - Administrative duties/paperwork
   - Must follow regulations
   - Medicare clients limited to diabetes and renal |                                                                      |
| Blend of Medicare, third-party payers, self-pay and Medicaid clients | - Variety and professional satisfaction
   - Success with Medicare generates non-Medicare referrals
   - Maintains flow of clients
   - Builds skills and confidence with billing and negotiating systems
   - Benefit from economies of scale as a result of time and experience
   - Ability to negotiate fees
   - Marketing asset | - Requires up-front work to stay organized and efficient with time
   - Management of contracts and billing
   - Administrative duties/paperwork
   - May have set fees for reimbursement
| Blend of private pay, third-party payers, self-pay clients, and opting-out of Medicare | - Potential for higher payment rate
   - Broader range of clients
   - Provider status with private plans | - Requires marketing and negotiating skills
   - May be less stable
   - May reduce referrals from other Medicare providers
   - Requirements of opting-out. See ADA Web page at: [www.eatright.org](http://www.eatright.org); search for “opting out”
   - Ramifications of opting-out of Medicare |                                                                      |
| Self-pay clients                          | - Less paperwork
   - Fees set by RD; ability to negotiate fees | - May limit clients |