Cracking the Code
Alphabet Soup: Understanding the Use of Coding/Billing Terminology

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Session Objectives

• Identify procedure codes for nutrition and nutrition-related services that may be reimbursed by Medicare and/or commercial third party payers.
• Understand the terms found on a typical claims form and the proper procedure for submitting a “clean” claim.
• Recognize opportunities to expand nutrition practice to receive payment for nutrition and nutrition-related services in multiple settings.
• Recognize new tools and resources included on the Academy’s website to help educate RDNs on this topic.
• Recognize coding use and payment trends among RDNs across the country.

Academy Nutrition Services Payment Committee (NSPC)

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Lucille Beseler, MS, RD, CDE, LDN - Vice-Chair
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  • Marsha Schofield, MS, RD, LDN, FAND
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NSPC Purpose/Member Benefits

Member Education
Develop, implement and market a multi-faceted member education plan that addresses various practice settings, levels of member expertise and current and future payment models.

Advocacy
Increase RDN recognition and coverage for RDN services.

Code Creation/Valuation
Develop proposals to decision makers that expand the range of services that can be reimbursed and reported by RDNs.

Collaboration or Influence
Advise and collaborate with Academy organizational units to achieve Committee’s goals.

National/Grassroots
Public Payers/Private Payers

Disclosures

We have no commercial relationships to disclose relevant to the topic being presented.
**Introductory Terms & Acronyms**

**AMA:** American Medical Association

**CPT:** Current Procedural Terminology Panel
- Code Creation Panel → → Services Descriptors

**RUC:** RVS Update Committee
- Code Valuation Panel → → Payment

**RVS:** Resource-Based Relative Value System

**HCPCAC:** Health Care Professionals Advisory Committee (non-physician panel)

**NCPT:** Academy developed standardized language used to describe the Nutrition Care Process; used in the documentation of nutrition services provision
- does not replace ICD-9 diagnosis

**Basic Terms and Acronyms**

**CMS:** Centers for Medicare & Medicaid Services

**Medicare**
- **Part A:** Hospital services
- **Part B:** Outpatient professional services (MNT), Diagnostic tests/Lab, etc.
- **Part C:** MC Advantage Plans
- **Part D:** Prescription drugs

**HIPAA:** Health Insurance Portability & Accountability Act

**NPI:** National Provider Identifier

**Credentialed:** a systematic approach to the collection and verification of professional qualifications

**National Provider Identifier (NPI)**
- A 10-digit number used to recognize the provider on claims transactions.
- All providers who bill 3rd party payers must have one (HIPAA requirement)
- Lasts indefinitely; does NOT contain "intelligence"
- Each provider gets ONE NPI, regardless of the number of practice offices.
- Group practices, hospitals, and corporations get an NPI (see CMS Medlearn article: http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf)
- Contact the National Plan & Provider Enumeration System NOW!
  - Apply over the Web: https://nppes.cms.hhs.gov/NPPES/Welcome.do
  - Apply by phone: 1-800-465-3203 (NPI Toll-Free)

**Become a Qualified Provider**

**Medicare (few weeks)**
- Complete process online: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html

**Private payers (6-8 months)**
- Ask for provider relations or the credentialing department.
- Request a credentialing (enrollment) packet for RDs.
- Evaluate alternatives.
- Consider CAQH enrollment (Council for Affordable Quality Healthcare); http://www.caqh.org/ucd.php

**Medicare MNT**

[Image of brochure]


**More Basic Terms and Acronyms**

**Codes:** international/national numeric designations used to describe:
- **Diagnosis codes (ICD-9):** Describe an individual's disease or medical condition; physicians and trained billers determine these codes
- **CPT codes:** Current Procedural Terminology codes (procedure codes) that describe the service performed/provided to the patient by the healthcare professional
- **HCPCS codes:** Healthcare Common Procedure Coding System developed by payers (CMS) to describe services where no CPT code exists
- **PQRS codes:** Physician Quality Reporting System; "voluntary" quality-reporting system/codes; penalties incurred for non-participation or not meeting reporting requirements
ICD-9 Diagnosis Codes
(determined by MD)

Chronic Kidney Disease (CKD) - 585.X
include a 4th digit which describes the stage of kidney disease
• 585.4; chronic kidney disease, Stage IV (severe)

Diabetes Mellitus – 250.XX
include a 4th digit which indicates the type of complication, and
include a 5th digit which indicates the diabetes type and control
• 250.00 - type II or unspecified type, without mention of complication, not stated as uncontrolled
• 250.52 - type II or unspecified type, with ophthalmic manifestations, uncontrolled

Coming 10/15: ICD-10CM & ICD-10-PCS
Transition to ICD-10 will impact all billing software, forms, and billing procedures

Codes are alpha-numeric, up to seven characters. For example:
• diabetes, type 2... With complication E11.8
• chronic kidney disease, stage III N18.3

Includes about 8,000 categories
More at: www.eatrightpro.org/resources/practice/getting-paid

Components of CPT Code Values

3 components are reviewed to establish a code value:

1) Work - describes the service provided (48.3%)
• Pre-service work
  • Review (medical) records, lab work, obtain vitals, room set up, informed consent, etc.
• Intra-service work
  • History and presenting problem, review of systems, treatment options, create &/or distribute educational materials, arrange follow-up and/or referral as needed
• Post-service work
  • Documentation, communication with referring physician, care coordination, short-term (7d) communication with patient as needed

2) Practice expense (47.4%)
includes items such as clinical labor (other than RDN work), equipment (scales, food models, nutrient analysis software, laptop, etc.), patient education materials, office rent, utilities, personnel, etc.

3) Practice liability expense (4.3%)
Malpractice insurance – we pay the lowest rates of any specialty - $$ hundreds versus thousands

Definition of Work

• Time
  length of service
• Mental Effort/Judgment
  synthesis of data/complexity of decision making
• Technical Skill
  knowledge/skills set, experience
• Physical Effort
  physical nature of work involved
• Psychological Stress
  pressure to produce the desired outcome and likelihood/risk of adverse effects that may result irrespective of the level of knowledge/skill/experience of the provider

Components of CPT Code Values
**MNT CPT Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>MNT initial assessment and intervention, individual, face-to-face, each 15 minutes</td>
</tr>
<tr>
<td>97803</td>
<td>MNT, reassessment and intervention, individual, individual, face-to-face, each 15 minutes</td>
</tr>
<tr>
<td>97804</td>
<td>MNT, group, 2 or more individuals, each 30 minutes</td>
</tr>
</tbody>
</table>

CPT codes, descriptions and material only are ©2015 American Medical Association. All Rights Reserved.
(search: cpt® Code/Relative Value Search)

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**Face-to-Face Time/Unit Billed**

For any single "15 minute face-to-face" CPT code:

<table>
<thead>
<tr>
<th>Face to face actual time spent:</th>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 unit &gt; 8 minutes to &lt; 23 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>2 units &gt; 23 minutes to &lt; 38 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>3 units &gt; 38 minutes to &lt; 53 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>4 units &gt; 53 minutes to &lt; 68 minutes</td>
<td>60 minutes / 1 hour</td>
</tr>
<tr>
<td>5 units &gt; 68 minutes to &lt; 83 minutes</td>
<td>75 minutes</td>
</tr>
<tr>
<td>6 units &gt; 83 minutes to &lt; 98 minutes</td>
<td>90 minutes / 1.5 hours</td>
</tr>
<tr>
<td>7 units &gt; 98 minutes to &lt; 113 minutes</td>
<td>105 minutes</td>
</tr>
<tr>
<td>8 units &gt; 113 minutes to &lt; 128 minutes</td>
<td>120 minutes / 2 hours</td>
</tr>
</tbody>
</table>

**MNT “G” Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0270</td>
<td>MNT re-assessment and subsequent intervention(s) following 2nd referral in the same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease); individual; face-to-face; each 15 minutes</td>
</tr>
<tr>
<td>G0271</td>
<td>MNT re-assessment and subsequent intervention(s), group (2 or more individuals), each 30 minutes</td>
</tr>
</tbody>
</table>

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**Procedure Codes Applicable to RDNs**

**Intensive Behavioral Therapy (IBT) for Obesity**

- G0447: Face-to-Face Behavioral Counseling for Obesity, 15 Minutes
- G0443: Face-to-Face Behavioral Counseling for Obesity, Group (2-10), 30 Minutes

ICD-9 diagnosis codes for BMI 30.0 kg/m² or over (V85.30-V85.39, V85.41-85.45)

Service can be provided up to 22 times in a 12-month period per CMS schedule

RDNs can provide IBT as auxiliary personnel in primary care settings

RDNs must bill as “incident to” physician services (guidelines differ for office-based vs. hospital outpatient clinics)

Billable to Medicare; check private payer policies for use of code


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**Medicare Annual Wellness Visit (AWV)**

- G0438: Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
- G0439: Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit

No specific diagnosis codes are required, but one must be included on the claim.

RDNs can provide the AWV under direct supervision of a physician (bill as “incident to” physician services)

Learn more at: [www.eatrightpro.org/resource/practice/getting-paid/who-pays-for-nutrition-services/annual-wellness-visit-in-medicare](http://www.eatrightpro.org/resource/practice/getting-paid/who-pays-for-nutrition-services/annual-wellness-visit-in-medicare)
Telehealth Services Under Medicare

Individual Medicare MNT can be provided via telehealth

Use the MNT code 97802 and modifier "GT"

- Must use an interactive audio and video telecommunications system that permits real-time communication between RDN and patient

Procedure Codes Applicable to RDNs

Chronic Care Management

- **99450** Chronic care management services; at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/compensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored.

Complex Chronic Care Coordination Services

- **99487** Complex care coordination services; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
- **99489** Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Cannot report if care plan is unchanged or requires minimal change

- Requires medical decision making of moderate or high complexity
  (Not billable to Medicare; check payer policies to determine use of codes)

CPT Code Resources
Medicare Performance Measures: PQRS Codes

• RDN Medicare providers can avoid a downward payment adjustment if report on at least 9 measures across 3 National Quality Domains for at least 50% of Medicare FFS patients.

• If provider sees at least 1 Medicare patient in a face-to-face encounter, must report at least 1 cross-cutting measure (as part of the 9).

• 2015 reporting data determines the downward payment adjustment (-2%) to be applied in 2017
  • Payment in 2015 based on 2013 reporting (potential -1.5% downward adjustment)
  • Payment in 2016 based on 2014 reporting (potential -2% downward adjustment)


Medicare 2015 PQRS RDN Measures

2015 PQRS Measures Applicable to RDNs:

PQRS #1: Diabetes Mellitus: Hemoglobin A1c Poor Control
PQRS #128: Preventive Care and Screening: BMI Screening and Follow-up*
PQRS #130: Documentation of Current Medications in Medical Record*
PQRS #181: Elder Maltreatment Screen and Follow-up Plan

Onetsupport@sdps.com

* Denotes a “cross-cutting” measure

The 2013 Academy Coding Survey Results

Email Invitation:
Provision of MNT in Ambulatory Care (Billable) Settings (ACS):

• All member/non-member RDNs in Academy/CDR database;
  - Not retired
  - Email address
  - US residence
  - Total Emailed n = 82,262
  - Total Respondents n = 5,840
• Provide &/or manage provision of MNT in ACS n = 3,628
  - Completed entire survey n = 3015 (~83%)

Coding Survey Demographics

Coding Survey Demographics: Response by Practitioner Type

Practitioner Type

- Provider 83%
- Manage/Prov 12%
- Manager 5%
Employment Status:
Response by Practitioner Type

Primary Work Setting
Response by Practitioner Type

Malpractice Insurance Coverage
Response by Practitioner Type

Medicare Provider Status
Response by Practitioner Type

Average Time Spent Providing MNT:
Basic Services

Average Time Spent Providing MNT:
Added Visits/Change of Condition

22.8% of total respondents don't carry or don't know if they carry malpractice insurance
Selected Diseases/Conditions Reimbursed

Case Study
A 66 year old female has been newly diagnosed with Type 2 DM.
MD Progress Note:
Type 2 DM, uncontrolled; 250.02
Patient reluctant to start another medication.
Referral for MNT, 3 visits
Weight: 155 lbs, trace edema
BP 135/72
HbA1c: 8.4
LDL: 150mg/dl, TG: 275 mg/dl

Case Study
Key items biller lists on CMS 1500 claims form
Even if RDN doesn’t bill themselves, you should/may need to provide codes and information included on claim – YOU are responsible for all services billed under your name
1. Complete patient contact /demographic information & visit documentation (EBPGs)
2. Enter ICD-9 code 250.02 on line 21
Use diagnosis code from the referring physician (PCP); review referral form, MD prescription, or call MD office for diagnostic (ICD-9) code.
(see handout for sample claims form)

Case Study

Reimbursement:
An ALL Member Imperative

Sandi Morris, RD,CD
Indiana University Health-Goshen
Hospital Clinical Nutrition Manager
IAND Reimbursement Representative

Your “To Do” List: 1.0
✓ Provide/Bill for Nutrition Services
✓ Malpractice Insurance Coverage: www.academypersonalinsurance.com/
✓ Establish a Usual & Customary Fee
✓ Compliance with current regulations:
  • NPI → HIPPA required
  • Correct coding
  • PQRS Incentives → Penalties
Your “To Do” List: 1.0 (con’t)
Questions for Hospital/Clinic Billing Department

- Are we billing for MNT or nutrition services?
- What insurances are we in-network for?
- Are you aware that RDNs can bill directly for MNT services?
- Are you aware that RDNs can bill in clinic/office settings?
- Can we expand our services to other areas (office, outpatient, DSMT, clinics, specialty practices)?

Your “To Do” List: 2.0

Drive future EBNP (practice)
- Track Outcomes
  - Health Improvement
  - Reimbursement
    - Payment rates per Public/Private Payer Billed
    - Diseases/Conditions Covered
    - Use of G-codes to provide additional service (MC only)
- Track New Services Requests
- Improve Contracts Negotiation
  - Reimbursement Rates
  - Expand Diseases/Conditions Covered
  - Establish RDNs as preferred providers of Nutrition Services

Your “To Do” List: 3.0

✓ Advocate for expansion of MNT benefit
✓ Grassroots marketing essential
  - Does YOUR health plan cover MNT/RDN services?
  - Contact your personal insurance carrier to determine nutrition services coverage
  - Communicate with your facility to see if you are billing for outpatient nutrition services (MNT)
  - Medical professionals asking for RDN services but unaware of how to pay for services
  - Many facilities < DSMT or other outpatient services
  - Enroll/credential/bill – YOURSELF / your peers

Your “To Do” List: 3.0 (con’t)

Call your insurance plan to ID your MNT benefits. ASK the following:
1. If I had _____ (need dx code) and was treated by _____ (need procedure code), is MNT covered?
2. What is my deductible?
3. What is my share of the cost after the deductible?
4. How many MNT visits are allowed?
5. Who can provide the care?
6. Are there RDNs in your provider network?
7. Does MNT come under preventive care in the plan?
8. Is there a yearly/lifetime maximum on MNT coverage?
9. Any other coverage guidelines, exclusions, or limitations?

Academy Resources

www.eatrightpro.org/resources/practice/getting-paid
www.eatrightpro.org/resources/practice/getting-paid-in-the-future
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, annually updated 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. (Source: The AMA CPT 2012, and CMS Glossary accessed from [http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English](http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English).)

**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). (Source: CMS’ Web page: [http://www.cms.hhs.gov/apps/glossary/](http://www.cms.hhs.gov/apps/glossary/).)

**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. Note: A new code set, ICD-10-CM, will replace the current ICD-9-CM codes effective October 1, 2013. (Source: AMA International Classification of Diseases; Physician ICD-9-CM 2012 & CMS Glossary: [http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=I&Language=English#Content](http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=I&Language=English#Content).)

**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 the Academy’s Web page at: [www.eatright.org/coverage](http://www.eatright.org/coverage).
Medical Nutrition Therapy (MNT) 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, non-dialysis kidney disease and kidney transplants.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<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>

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.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<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 (98966-68); and On-line Medical Evaluation – (98969). 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” details go to “providing the service & billing” at www.eatright.org/mnt; for other code details go to www.eatright.org/coverage.

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>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

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-CM 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 Information” resources on the Academy’s Web page: www.eatright.org/coverage), 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 (UB-04) 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 on the CMS1500 form, go to the Academy’s Web page at www.eatright.org/mnt, then click on “providing the service & billing” and then “forms”.

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. A Superbill is a pre-printed, or created form that itemizes and describes the services and fees provided to the patient/client. For information on Superbills go to www.eatright.org/coverage, then “presentations.”

What other resources does the Academy have 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, check their web page for information. For example, the Nutrition Entrepreneurs (NE) DPG 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.


Access Medicare and other Coding and Coverage Information in the Members Section of the Academy’s Web site; www.eatright.org/mnt and www.eatright.org/coverage.
- Medicare MNT Resources
- HIPAA and Compliance Resources
• Private Insurance & Employers Resources  • The MNT Works Kit & List of Educational Sessions
• Academy Reimbursement Representatives’ Contact Information (for the affiliates and DPGs)
Medical Nutrition Therapy

MNTWorks

Frequently Used Codes for Nutrition Services

The medical nutrition therapy (MNT) CPT codes are used by many third party payers, including Medicare. These codes best describe the MNT services that registered dietitians provide to patients.

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803 reassessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97804 group (2 or more individual(s)), each 30 minutes.

Additional Codes Used by RDs (refer to CPT book for full code description):

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, individual, face-to-face with the patient, each 15 minutes.
G0271 group (2 or more individual(s)), each 30 minutes.
G0108 Diabetes outpatient self-management training services, individual, per 30 minutes.
G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.
98960–98962 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family).
98966–98968 Telephone assessment and management service provided by a qualified nonphysician health care professional.
98969 Online assessment and management service provided by a qualified nonphysician health care professional, internet or electronic communications.
99071 Educational supplies, such as books, tapes, and pamphlets, provided by the physician (or other qualified health care professional) for the patient’s education at cost to physician.
99366 and 99368 Medical team conference, with and without the patient and/or family.

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HEALTH INSURANCE CLAIM FORM

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ]
   [ ] GROUP HEALTH PLAN [ ] FECA [ ] HEALTH INSURANCE
   PERSONAL PLAN [ ] OTHER [ ]
   1a. INSURED'S I.D. NUMBER 123 45 6789 A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Doe, Jane B

3. PATIENT'S BIRTH DATE MM DD YY
   04 15 48

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
   Same

5. PATIENT'S ADDRESS (No., Street)
   123 Main St

6. PATIENT RELATIONSHIP TO INSURED
   Same

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       [ ] YES [ ] NO
    b. AUTO ACCIDENT?
       [ ] YES [ ] NO
    c. OTHER ACCIDENT?
       [ ] YES [ ] NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES
    [ ] YES [ ] NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    Relate A-L to service line below (24E)

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE
   From MM DD YY To MM DD YY
   01 05 15 01 05 15 11
   01 05 15 01 05 15 11

25. FEDERAL TAX I.D. NUMBER 454545454

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? [ ] YES [ ] NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. Reserved for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # 555-606

NNUC Instruction Manual available at: www.nuuc.org

PLEASE PRINT OR TYPE

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