

Coding and Billing Handbook

A Guide for Program Directors and Preceptors



Table of Contents

Introduction	4
Insurance 101	6
Telehealth.....	9
Value Based Payment.....	12
Resources	13
Terminology	14
Decision Tree.....	19
Process for Third Party Reimbursement in Facilities Setting	22
Chart of Third Party Payers for Facilities	26
Process for Third Party Reimbursement in the Private Practice Setting.....	27
Chart of Third Party Payers for Private Practice	31
Case Studies	32
Case Study 1a – Private Practice	33
Case Study 1b — Private Practice – Telehealth	36
Case Study 2 – Hospital Based Non-Medicare	38
Case Study 3a – Hospital-Based Medicare	39
Case Study 3b – Hospital-Based Medicare - Telehealth.....	40
Case Study 4 – Value-Based Payments	41
Handling Denied Claims	44
Answers and Discussion Notes.....	49
Case Study 1a – Private Practice	49
Case Study 1b – Private Practice - Telehealth.....	53
Case Study 2 – Hospital-Based Non-Medicare.....	55
Case Study 3a – Hospital-Based Medicare	56
Case Study 3b – Hospital-Based Medicare – Telehealth.....	57
Case Study 4 – Value-Based Payments	58

Acknowledgments

We are deeply grateful to the registered dietitian nutritionists who have generously shared their expertise and time to create and review this handbook over the course of its editions and revisions. We also extend our thanks to the members of the Academy of Nutrition and Dietetics' Nutrition Services Payment Committees from 2013-14, 2014-15, and 2021-22, as well as former Academy staff for their invaluable assistance. A special thank you goes to the dietetics education program directors and preceptors who provided essential feedback and suggestions.

Fifth Edition

© 2024 Academy of Nutrition and Dietetics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means without the prior written consent of the publisher. Printed in the United States of America.

The views expressed in this publication are those of the authors and do not necessarily reflect policies and/or official positions of the Academy of Nutrition and Dietetics. Mention of product names in this publication does not constitute endorsement by the authors or the Academy of Nutrition and Dietetics. The information in this publication is for reference use only and does not constitute the rendering of legal, financial or other professional advice of the Academy of Nutrition and Dietetics. The Academy of Nutrition and Dietetics disclaims responsibility for the application of the information contained herein.

Introduction

Health care is a business and, like any business, relies on payment from external sources for its survival and growth. It is imperative for entry-level registered dietitian nutritionists re payment models are shifting from a focus on paying for individual procedures and services to a focus on paying for value and performance, fee-for-service payments will continue to exist. Ultimately, competency in this area translates into respect, remuneration and reward.

This handbook serves as a tool to help supervised practice programs meet the DI/CP standard:

Explain the process for coding and billing for nutrition and dietetics services to obtain reimbursement from public or private payers, fee-for-service and value-based payment systems.

Every facet of coding and billing will not be included but this resource provides foundational knowledge and terms along with suggested activities, including sample case studies, for use with dietetic interns to help them apply theoretical concepts into practice. The handbook is designed to be used in a wide variety of clinical practice settings.

In developing the materials, the authors recognize that not all clinical sites bill for outpatient MNT services. Therefore, program directors and (under their direction) their preceptors are encouraged to create assignments and case studies as needed to create an environment in which interns think through the entire coding and billing process in preparation for taking on the responsibilities of an entry level registered dietitian nutritionist as described below. In some situations, you will be able to provide real-life experiences to your interns. In these situations, we recommend you direct your intern to complete the assignments using actual clients. For situations where you are unable to provide real-life experiences, you should provide simulated experiences using the case studies included in this handbook. In the latter case, we have provided some ideas on how you might apply these materials and encourage you to use your own creativity and available resources to build on these suggestions.

To assist interns in completing the assignments, the handbook includes a list of common terminology as well as resources available related to the topic(s). Key terms are noted in **red font** the first time they appear in each section of the handbook with definitions provided in the terminology section.



Entry-level Scope of Responsibilities

The entry-level RDN should be able to code and bill for dietetic/nutrition services to obtain reimbursement from public or private insurers as:

1. The RDN in a variety of settings that could include (but not limited to) a physician's office, private practice, a consultant to long-term care and/or home health agency, as an employee in a hospital setting providing inpatient and/or outpatient MNT services, or as a public health nutritionist.
2. This RDN may be responsible for all stages of the coding and billing process or just providing documentation that will be used by others to code and bill for services.
3. This RDN may also provide consultation to **health care providers** within the setting regarding opportunities to code and bill for nutrition services and the steps/criteria for doing so.

The entry-level RDN should be aware of systems to monitor for changes by various insurance payers in the billing and/or reimbursement process.



Directions to Preceptors

1. All materials within the handbook, apart from the answer keys, should be shared with the intern at the beginning of the rotation.
2. Common terminology encountered in the coding and billing process are noted in red font the first time they appear in each section of the handbook. You should direct the intern to the terminology section to find definitions of these terms. In the course of completing assignments, the intern may come across additional terms with which she/he may not be familiar. You may direct them to the resources list for assistance in finding definitions of these terms.
3. To assist you in mentoring interns, you may find it helpful to review the resources highlighted for each set of assignments.
4. Assignments are included in the recommended sequence below. However, the order in which you present the material to the interns should be based upon what works best for you in your facility, within your curriculum. You may choose to incorporate assignments into clinical rotations, clinical management rotations, or a seminar component of your supervised practice program. As with other aspects of your supervised practice program, there is no one right way to design experiences to help interns meet the necessary competencies.
 - a. Coding and Billing Practices (Facility or Private Practice)
 - b. Case Studies
 - c. Handling Denied **Claims**
5. Evaluation and Grading: Use the same criteria and rating scale as used throughout your program.

Insurance 101

Understanding the basics of health insurance and why payment for nutrition related services is important is not only critical for an RDN's financial future, but it also enhances RDN presence and influence within an organization and the general population. Knowledge about the financial value of the services an RDN can provide will help secure their future and the future of the profession.

National Provider Identifier

The presence of an RDN as a health care provider needs to be accounted for, independent of whether they are billing for their services. One of the first steps to ensuring the RDN is noted as an important healthcare provider is by obtaining a **National Provider Identifier (NPI)**, a unique, 10-digit, identification number. The **NPI** is necessary for also becoming credentialed with a private insurer, **Medicare**, and **Medicaid**, submitting claims to insurers, and electronic health care information. It serves as a "digital footprint" that demonstrates the RDN as a viable workforce to external stakeholders, including the government and private payers, to document their value within the health care system. For more information on easily obtaining an NPI visit:

[Obtaining a National Provider Identifier \(eatrightpro.org\)](https://eatrightpro.org).

Health Insurance Basics

The basic facts about the types of health insurance, health insurance terminology, and how health care services can be accessed through health insurance is essential to understanding payment from health insurance payers for services provided by RDNs (e.g., MNT and other services). Health insurance can be obtained through a variety of means including government and private health and commercial insurance options (e.g., Blue Cross Blue Shield, United Healthcare). Examples of government health insurance programs for individuals meeting specific criteria include Medicare, Medicaid, and the **Children's Health Insurance Plan (CHIP)**.

Government Insurance Plans

- **Medicare** is the federal health insurance program provided by the government to people aged 65 and older, certain people with disabilities, and people with end-stage renal disease. Medicare **includes 4 parts: Medicare Part A** (hospital), **Medicare Part B** (outpatient services), Medicare Part C (**Medicare Advantage**) and **Medicare Part D** (Prescription drugs). Medicare **beneficiaries** can choose to get their Medicare coverage through traditional Medicare (Part A and Part B) or through a **Medicare Advantage** Plans (Part C). The latter are health coverage plans offered by **private insurance** companies or **managed care** organizations that contract with Medicare to provide Medicare Part A and B benefits to Medicare beneficiaries.
- **Medicare Part B beneficiaries have a benefit for MNT in the outpatient setting if they have diagnoses of diabetes, chronic kidney disease, and/or three years after a kidney transplant.** Learn more about MNT and Medicare: [Medicare \(eatrightpro.org\)](https://eatrightpro.org)
- **Medicaid** is a state-run health insurance program that provides health coverage to low-income adults, children, pregnant women, elderly adults, and people with disabilities. MNT/nutrition counseling is not a required benefit in Medicaid programs; however, numerous states have elected to add MNT/nutrition counseling benefits for Medicaid enrollees. Learn more about MNT and Medicaid: [Medicaid \(eatrightpro.org\)](https://eatrightpro.org)
- **Children's Health Insurance Program (CHIP)** serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. Eligibility and coverage under this program vary from state to state.

Private Health Insurance is any health insurance coverage that is offered by a private entity instead of a state or federal government. Examples are companies such as Blue Cross Blue Shield, United Health Care, Aetna, etc. Coverage and payment of RDN services can vary greatly from one insurer to the other. Even within the same insurer there is extreme variability of benefits that are offered under each plan including whether RDN services are considered a covered benefit. For more information regarding private insurers: [Private Insurance \(eatrightpro.org\)](https://eatrightpro.org).

The distinction between the terms **“benefits”** and **“coverage”** as it relates to payment for MNT are important to understand.

- **Benefits:** Health insurance policies include benefits for specific health care services and items. Nutrition counseling/medical nutrition therapy is an example of a specific health care service that may be included as a benefit through an individual’s health insurance policy.
- **Coverage:** The term “coverage” refers to the details under which an individual can access a particular benefit (e.g., MNT) and outlines when the benefit is “covered” (e.g., certain conditions or a set number of visits) under the individual under the policy.

The combination of a patient’s benefits and the details of the coverage help determine whether a payor may pay a claim submitted for MNT (RDN services). For more information on health insurance benefits and coverage, and the connection to payment for MNT visit: [The Difference Between Benefits and Coverage \(eatrightpro.org\)](https://eatrightpro.org).

Credentialing and Enrolling with Insurers

Credentialing is an important step in the billing and payment process. It allows health care organizations such as insurance companies and other groups to identify qualified health care providers and practitioners for their provider networks. When you are credentialed with a private payer, you agree to the terms and rules defined in a provider agreement, and the entire process may take several months to complete. Sometimes RDNs encounter challenges to becoming credentialed, such as networks being closed to new providers, or situations where a health plan or group does not credential RDNs. For more information on becoming credentialed and strategies for dealing with these challenges visit: [Private Insurance Credentialing \(eatrightpro.org\)](https://eatrightpro.org).

In addition to credentialing with private insurers, enrolling in Medicare as a provider can be easy and has a great deal of advantages, including providing a significant business opportunity for the RDN while supporting and caring for an at risk and large percentage of the population. For more information on enrollment and its advantages visit: [Becoming a Medicare Provider \(eatrightpro.org\)](https://eatrightpro.org).

Medicaid enrollment and coverage for RDN services varies from state to state. To better understand Medicaid in general and coverage for MNT visit: [Medicaid \(eatrightpro.org\)](https://eatrightpro.org)



Claim Submission

Once an RDN is credentialed and/or enrolled as a provider for an insurance plan and meets the terms of the provider policy for payment of services, billing for services rendered can occur. The term “billing” is commonly used, but the specific process of billing a payer is through claims submission. There are different processes and requirements for submitting claims depending on the situation. The **CMS-1500 claim** which appears in this handbook is used to submit non-institutional claims for health care services provided by physicians, other providers, and suppliers to Medicare. It can also be used for submitting claims to many private payers and Medicaid programs, as well as other government health insurance programs. For more information on filling out the 1500 claim form visit: [Filing Claims Using the CMS 1500 Form \(eatrightpro.org\)](#).

When a patient does not have benefits that include MNT, their diagnosis is not a covered benefit, or they do not have health insurance, the RDN can give the patient a **superbill**. The superbill is an itemized receipt for health care services provided, that is paid directly by the patient. For more information on the superbill visit: [What Is a Superbill \(eatrightpro.org\)](#).

Coding

Coding is an important component of completing a claim form. **Current Procedural Terminology (CPT®)** codes are five-digit procedure codes that describe the service rendered by the healthcare professional. The MNT codes 97802, 97803, and 97804 are CPT® codes that RDNs use on claims to report nutrition services provided by the RDN. In addition to the MNT codes, there are other codes that may be used by RDNs. [NULL](#)

Additionally, there is the Healthcare Common Procedure Coding System (HCPCS) which is overseen by the Centers for Medicare and Medicaid Services (CMS), HCPCS is a set of codes used to identify professional health care services, items and supplies that would otherwise be coded in CPT® but for which there are no CPT® codes. The HCPCS code set includes G codes for other services that RDNs may provide.

For more information on CPT® and HCPCS codes visit: [CPT Codes \(eatrightpro.org\)](#).

Diagnosis codes, such as the **ICD-10-CM**, are officially called the International Classification of Diseases, 10th Revision, Clinical Modification. They describe an individual's disease or medical condition, and physicians determine the patient's diagnosis and document this in the medical record. Trained billers then assign the diagnosis code numbers to the physician-documented diagnosis for use on claim forms. For more information on ICD-10-CM codes visit: [ICD Codes \(eatrightpro.org\)](#). The combination of CPT® codes and ICD-10-CM codes are what determines coverage and payment for RDN services.

RDNs who work as inpatient providers at a hospital or facility need to be familiar with malnutrition billing and coding. Hospital payment systems use set rates for different types of hospital visits, which depend on groups that describe the patients' conditions, called severity-adjusted diagnosis-related groups (MS-DRGs). Each group includes patients who are similar in how sick they are and how much care they need. Hospitals can also get extra payment for treating malnutrition if it is diagnosed and a treatment plan is put in place during the hospital stay. For information on coding for malnutrition visit: [Malnutrition Codes Characteristics and Sentinel Markers \(eatrightpro.org\)](#)

Claim Denial or Rejection

On occasion, a claim may be rejected or denied. For information on claim rejections and denial and how to manage them, refer to the [Handling Denied Claims](#) section of the handbook.

Telehealth

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.¹ It includes both the use of interactive, specialized equipment, for such purposes as health promotion, disease prevention, diagnosis, consultation, therapy, and/or nutrition intervention/plan of care, and non-interactive (or passive) communications, over the Internet, video-conferencing, e-mail or fax lines, and other methods of distance communications for communication of broad-based nutrition information.

Telehealth is not a separate service, it is a tool used to deliver MNT (RDN services).

Two types of telehealth technology include:

- **Synchronous:** a “real-time” interaction for patient health communication.

Examples include: video calls to share progress or check on healing; audio-only calls to confirm instructions; and text messaging to answer patient questions.²

- **Asynchronous:** communication between providers, patients, and caregivers stored for future reference or response.

Examples include: email or text messages with follow up instructions or confirmations; images for evaluation; and lab results or final statistics.³

Today, telehealth is a vastly growing care delivery modality for RDNs, and many other health care professionals. For more information on guidance, payment, policy, and regulations around providing nutrition care via telehealth visit: www.eatrightpro.org/telehealth

Payment and Reimbursement Models

Payments from Health Insurance

Health insurance payments from private/commercial and government sponsored insurance are one important source of revenue for MNT when consumers have health insurance benefits that include MNT and coverage for their condition(s) or other health status. Providers of health insurance, also referred to as “payers” or “**third party payers**” may compensate organizations or RDNs for providing MNT when it is provided outside of the hospital inpatient setting when specific conditions are met. There are other entities/organizations that may function as payers in addition to health insurance companies, such as third-party administrators (TPAs) for some employer groups, Independent Physician Associations, Managed Care Organizations, and or some medical groups.

¹ HealthIT.gov. What Is Telehealth? How Is Telehealth Different from Telemedicine? Accessed March 3, 2021. <https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine>

² 2021 National Consortium of Telehealth Resource Centers www.telehealthresourcecenter.org

³ 2021 National Consortium of Telehealth Resource Centers www.telehealthresourcecenter.org

Fee for Service and Reimbursement

The term “reimbursement” is associated with the fee for service (FFS) payment model, which is a method in which doctors and other health care providers are paid for each service performed.⁴ Examples of services include tests, doctor visits, as well as MNT. Fee for service has been the dominant payment model in the United States until recently.

In the FFS payment model, health care providers or suppliers are “reimbursed” for health care services without any regard for the quality of the service or the outcome of the care. It is important for entry level RDNs to recognize that FFS is not the only payment model, and reimbursement is not the only mechanism by which payments flow to organizations and RDNs when MNT is provided. When RDNs have a solid understanding of how payments for MNT work in the FFS context, it may be easier to grasp differences in how services provided by RDNs are paid for in specific settings (i.e., places of service) or when MNT is provided as a component of a set of specific health care services (e.g., home health, hospice services, cardiac rehabilitation) that have different payment methodologies, and do not include separate payments for each unique service or provider. The handbook provides general guidance that will help RDNs develop competency regarding the steps to securing payments from health insurance payers, including the assessment of individual patient/client benefits and coverage, use of ICD-10-CM and CPT® codes, and the process for submitting claims to payers in the context of the fee-for-service payments model when MNT is provided in common outpatient environments (non-inpatient).

Alternative Payment Models and Value-Based Payments

MNT has been demonstrated to be a cost-effective intervention for many conditions. However, not all healthcare services that are paid for by insurers are cost-effective. One potential drawback to the FFS payment model is that it can incentivize quantity over quality, prompting institutions and providers to prioritize high-paying care, tests, and procedures over more cost-effective options. To address this issue and reduce per capita healthcare costs in the United States, alternative payment models (APMs), also known as value-based payments (VBPs), are being proposed as a solution.

APMs are health care payments that are tied to outcomes, quality, and patient experience. VBPs are also tied to outcomes, quality, and the patient experience, but also achieve good care at a reasonable price. APM and VBP payments flow from payers to institutions, practices, and in some instances, individual providers; organizations then pay individual providers and other members of the health care team. In APM/VBP arrangements organizations (health systems, clinics, practices) maximize payments (from payers) by achieving agreed upon outcomes and performance benchmarks, and by also meeting cost targets set to achieve reductions in the total cost of care. APMs/VBPs should be adequate to cover the cost of providing the care required to achieve agreed upon outcomes and should not result in the rationing of care.

RDN awareness of the development and use of APMs/VBPs in their organizations is important. RDNs can take steps to help ensure that APM/VBP arrangements adequately factor the cost of providing evidence-based MNT, if MNT is not eligible for separate FFS payments. Such steps can help to improve consumer access to care as well as ensure that payments are adequate to employ RDNs. Furthermore, knowing the organization’s goals around quality and outcomes can help the RDN understand how to demonstrate value in the context of APMs/VBPs.

⁴ <https://www.healthcare.gov/glossary/fee-for-service/>



There are many different types of APMs and VBPs, which can be used simultaneously by organizations. Organizations may also be in arrangements with payers that include both FFS and APMs/VBPs. The resources section contains links to website content that introduce APMs/VBPs, explain a few different types of APMs/VBPs, and explore the value proposition of the RDN in value-based care. Most APM/VBP arrangements between organizations are unique, there is not one standard formula for APMs. It is not critically important to understand distinct differences in the different types of APMs/VBPs, but they should be aware that there are different types, which will affect how payments flow to organizations and practices.

An important goal for RDNs-in-training is that they understand the expectation to demonstrate value wherever they work. APM/VBP arrangements can enable greater flexibilities in how services are provided, enabling RDNs to consider more innovative delivery and scalability of services. RDNs can demonstrate value not only through achieving expected outcomes through evidence-based MNT, but possibly through performing other functions and taking on other roles as they garner additional competencies. Understanding of the following will help RDNs position themselves to advocate for the services they provide through the lens of others (consumers/patients, health care team, executives):

- Identifying the payment structure of your employer (office, hospital, home health agency, etc.).
- Strong knowledge of MNT outcomes data for target conditions and/or populations.
- Recognizing organizations key quality measures and the connections between MNT (outcomes) and the

work of the RDN with clinical quality measures and other organizational goals around improving care, outcomes and decreasing avoidable health care costs.

- How to translate the evidence into the cost of care (e.g., 4 visits of MNT = \$\$) and sell that the cost of MNT is less than the cost of avoidable care (e.g., ER visits, unplanned hospitalization, more medications).
- Population health management (community and clinical) paradigms.
- Knowledge of FFS payments (limitations as well as how to leverage).
- Understanding of what it means to work at the top of RDN Scope of Practice.
- Awareness of scope of practice beyond nutrition.

Alternative Payment Models

APMs are payment models that offer financial incentives for providing high-quality and cost-effective care. These models encourage health care providers to deliver efficient and coordinated care while meeting specific quality standards. Examples of APMs include accountable care organizations payment programs, such as:

- Bundled payments when health care providers are paid one fixed amount for all the care needed to treat a specific health condition.
- Shared savings arrangements, when health care providers are rewarded with a portion of the money saved by delivering high-quality care that helps keep patients healthy and avoid unnecessary treatments or hospitalizations.
- Capitated payments when healthcare providers are paid a fixed amount per patient per month, regardless of how many services or treatments they provide.

Value-Based Payment Models

VBP tie reimbursement to the quality and value of care delivered to patients. These models aim to improve patient outcomes, enhance patient experience, and reduce health care costs by rewarding providers for delivering high-quality, efficient care. VBPMs may involve pay-for-performance initiatives, shared savings programs, or penalties for poor performance on quality metrics. Examples of VBPMs include pay-for-performance programs like Medicare's Merit Based Incentive Program.

By shifting from volume-based reimbursement to value-based payment models, health care systems are incentivized to prioritize patient outcomes and quality of care, ultimately leading to better health outcomes and more efficient use of healthcare resources.

An important goal for RDNs-in-training is that they understand the expectation to demonstrate value wherever they work. RDNs can demonstrate value not only through achieving expected outcomes through evidence-based MNT, but possibly through performing other functions and taking on other roles as they garner additional competencies. Understanding of the following will help RDNs position themselves to advocate for the services they provide through the lens of others (consumers/patients, health care team, executives):

- Identifying the payment structure of your employer (office, hospital, home health agency, etc.).
- Strong knowledge of MNT outcomes data for target conditions and/or populations.
- Understanding organizations key quality measures and the connections between MNT (outcomes) and the work of the RDN with clinical quality measures and other organizational goals around improving care, outcomes and decreasing avoidable health care costs.
- How to translate the evidence into the cost of care (e.g., 4 visits of MNT = \$\$) and sell that the cost of MNT is less than the cost of avoidable care (e.g., ER visits, unplanned hospitalization, more medications).
- Population health management (community and clinical) paradigms.
- Knowledge of FFS payments (limitations as well as how to leverage).
- Understanding of what it means to work at the top of RDN Scope of Practice.
- Awareness of scope of practice beyond nutrition.

Suggested Resources for Value Based Payments

- [Quality Performance Program \(eatrightpro.org\)](http://eatrightpro.org)
- [MNT Works Toolkit \(eatrightpro.org\)](http://eatrightpro.org)

Resources

The following resources are recommended to help you build your knowledge of coding and billing for nutrition services. The list is more inclusive than what may be needed to complete the assignments and may be of use later when you enter practice. Resources from this list that may be of value in completing particular assignments are included as footnotes within each assignment.

Primary (Recommended) Resources

1. Payment Pages at www.eatrightpro.org/payment***
2. **Federal Employer Identification Number (EIN) Application: How to apply for an EIN.**
3. National Provider Identifier (NPI): [How to apply for an NPI.](#)
4. The **Council for Affordable Quality Healthcare (CAQH)** is a non-profit alliance of health care plans that provides health care professionals with a centralized platform for managing and verifying their practice information, aiming to streamline administrative health care processes like credentialing.
5. CMS.gov—[About ICD-10](#)
6. CMS.gov-Internet Based [Provider Enrollment, Chain and Ownership System \(PECOS\)](#). is the online resource for making changes to your Medicare-enrolled provider status.

Additional Resources

1. [States with Laws that Regulate the Practice of Dietetics](#).NULL ***
2. Telehealth www.eatrightpro.org/telehealth ***
3. Medicare.gov – [Nutrition Therapy Services](#) (Medicare coverage of MNT).
4. CMS.gov – [MNT Services for Beneficiaries with Diabetes or Renal Disease](#).
5. Setting Fees - www.eatrightpro.org/payment/business-practice-management/services-fees-and-management-resources/setting-fees ***
6. [RDNs Complete Guide to Credentialing and Billing: The Private Payer Market](#)***
[Medical Nutrition Therapy MNTWorks® Toolkit](#) *****
7. Malpractice insurance (Resource for rationale and process for obtaining malpractice insurance):
[Dietetic Practitioners Professional Liability Insurance \(proliability.com\)](#).
8. CMS.gov – [Fee for Service-Advanced Beneficiary Notice of Non-coverage \(ABN\) Form CMS-R-131](#)
(Resource for ABN form and instructions).

***Requires Academy membership for access

Terminology

Coding and billing has a language of its own. The below list of terms will be helpful in answering the assignments and provide an overview of the language of coding and reimbursement. Terms in this list that are included in this handbook are noted in red font the first time they appear in each section of the document.

- Note: While this list is not inclusive, it may include more terms than you will encounter while completing the learning activities.

VOCABULARY	DEFINITION
Accept Assignment	Health care provider or supplier agrees (or is required by law) to accept the third party payer-approved amount as full payment for covered services and not to bill the client for any more than the deductible and coinsurance.
Accountable Care Organization (ACO)	A group of health care providers who give coordinated care and chronic disease management, and thereby improve the quality of care patients receive. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.
Actual charge	The amount of money charged by the health care provider or supplier for a certain medical service or supply. This amount is often more than the amount Medicare or third party payers approve.
Advance Beneficiary Notice (ABN)	May also be known as a <i>waiver of liability</i> . A notice health care providers and suppliers are required to give and have signed by an insured by Original Medicare when they believe that Medicare will not cover the services or items and the person has no reason to know that Medicare will not cover these services or items. If a provider does not provide an ABN to sign and the procedure is not covered, then the Medicare insured does not have to pay. A Medicare insured is financially responsible when he or she has signed an ABN for the service or item and Medicare does not pay for it. Providers are not required to give the insured an ABN for services or items Medicare never covers, although it may be a good idea to do so for the purposes of informed consent and to protect the provider.
Allowable charge	Generic term referring to the maximum fee that a third party will use to reimburse a provider for a given service.
Appeal	A request by a beneficiary or a provider to have a review when health care services are denied based on medical necessity or appropriateness, or improperly paid.
Authorization	A referral that has been submitted to the patient's insurance company for approval for the services requested to be performed.
Balance Billing	Balance billing is the practice of billing a patient for charges not paid by his/her insurance plan because the charges are in excess of covered amounts. Balance billing amount will often be charges that are beyond the fee schedule or contract rate.
Beneficiary	A person who is covered by the third party payer.
Benefit Period	The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by a third party payer.
Bundled Payment	The reimbursement of health care providers (such as hospitals and physicians) on the basis of expected costs for clinically defined episodes of care. It has been described as a "middle ground" between fee for service reimbursement (in which providers are paid for each service rendered to a patient) and capitation (in which providers are paid a "lump sum" per patient regardless of how many services the patient receives). Bundled payments have been proposed in the health care reform debate in the United States as a strategy for reducing health care costs.
Capitation	A payment arrangement for health care service providers based on a set amount for enrolled persons assigned to them rather than a payment per service provided. The provider is paid whether or not the enrolled persons seek care.
Case Mix Reimbursement System	A payment system that measures the intensity of care and services required for each patient and translates these measures into the amount of reimbursement given to the facility for care of a patient. Payment is linked to the intensity of resource use.
Charge Master	An electronic list of a facility's services and supplies, billing codes and the associated charges. The charge master must be kept updated to the latest codes and government billing regulations for health claims.
Claim	A request for payment for service(s) provided by a health care provider.
1500 Claim Form	The 1500 claim form is the universal insurance claim form developed and approved by the American Medical Association and the Centers for Medicare and Medicaid Services. This form is used by non-institutional providers or suppliers to bill Medicare carriers, commercial/private insurance and billing of some Medicaid State Agencies.
Centers for Medicare & Medicaid Services (CMS)	CMS, formerly known as HCFA (Health Care Financing Administration), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

VOCABULARY	DEFINITION
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage.
Coordination of Benefits (COB)	The sharing of costs by two or more health plans, based on their respective financial responsibilities for medical claims. A primary insurance and secondary insurance must coordinate benefits to pay claims. If one of the plans is Medicare, federal law may decide who pays first.
Copayment (or Copay)	A set amount determined by the third party payer that the insured pays to a provider for the treatment or service.
Corporate integrity	The degree to which a corporation adheres to a code of ethics and to established laws and regulations in conducting its business.
Council for Affordable Quality Healthcare (CAQH)	A nonprofit alliance of health plans and trade associations which allows for industry collaboration and simplifies health care administration by facilitating cooperation on public-private initiatives. A single location for providers to submit an initial enrollment application to become a participating provider, re-credential and update provider information to participating health care plans of CAQH.
Covered Services	A service or supply, specified in a contract, for which benefits will be provided pursuant to terms of the contract.
Current Procedural Terminology (CPT code)	A comprehensive, descriptive list of terms and numeric codes used for reporting diagnostic and therapeutic procedures and other medical services performed by dietitians and other health care providers; published and updated annually by the American Medical Association. Some of the frequently used MNT CPT® codes used by third party payers, including Medicare that best describe the MNT services that RDNs provide to patients are: <ul style="list-style-type: none"> • 97802: Medical nutrition therapy*; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. • 97803: Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes. • 97804: Group [2 or more individual(s)], each 30 minutes. • G0270: 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. • G0271: 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.
Date of Service (DOS)	The date the service is provided.
Deductible	The amount of money that is required to be paid by the insured under the insurance contract before any payment is made by the insurer. Deductible amounts can change every year.
Demand Bill	When a client receives an Advance Beneficiary Notice (ABN), a Home Health Advance Beneficiary Notice (HHABN), or Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) from a health care provider, a demand that the provider continue to bill Medicare for the –services is given, even though the provider does not think that Medicare will cover them. To demand bill, the client must sign the ABN and agree to pay for the services in full if Medicare denies coverage.
Diagnostic Related Group (DRG)	DRG is a patient classification system used by hospitals to bill and be paid by third party payers. The payment is based on the average cost for the patient's DRG. Patients are assigned to a DRG based upon the patient's diagnosis, gender, age, sex, treatment procedure, discharge status, and the presence of complications and co-morbidities. Today, there are several different DRG systems that have been developed in the United States, including: <ul style="list-style-type: none"> • Medicare DRG (CMS-DRG & MS-DRG) • Refined DRGs (R-DRG) • All Patient DRGs (AP-DRG) • Severity DRGs (S-DRG) • All Patient, Severity-Adjusted DRGs (APS-DRG) • All Patient Refined DRGs (APR-DRG) • International-Refined DRGs (IR-DRG)
Dual-eligible	A person who has both Medicare and Medicaid.
Employer Identification Number (EIN)	An EIN is also known as a Federal Tax Identification Number and is used to identify a business entity. Generally, businesses need an EIN. RDs use an EIN instead of their Social Security number to protect against identity theft. EINs may be applied for in various ways including online at irs.gov. This is a free service offered by the Internal Revenue Service. Applicants must check with the state to make sure if they need a state number or charter.
Exclusive Provider Organization (EPO)	A managed care plan where services are covered only by doctors, specialists, or hospitals in the plan's network (except in an emergency).
Explanation of Benefits (EOB)/Explanation of Medical Benefits (EOMB)	A statement issued to the insured and the health care provider by an insurer to explain the services provided, amounts billed, and payments made by a health plan.
Fee for Service	A method of payment for health services and procedures (CPT/HCPCS codes) in which a health care provider is paid for each service.
Fee Schedule	A set payment of reimbursement developed by a third-party payer to be paid for specific health care services and procedures based on CPT/HCPCS codes.

VOCABULARY	DEFINITION
Fiscal Intermediary	A private company that has a contract with Medicare to process Medicare Part A claims.
Federally Qualified Health Center (FQHC)	Federally funded nonprofit health centers or clinics that provide primary care services to medically underserved areas and populations. Services are provided on a sliding scale fee based on ability to pay.
Healthcare Common Procedural Coding System (HCPCS codes)	An alphanumeric classification system that identifies and describes the healthcare services, procedures, equipment, and supplies rendered for reimbursement/payment. These codes are used for claim submissions on an insurance form.
Health Maintenance Organization (HMO)	A type of managed care plan that generally covers only the care from providers in the HMO's network. HMO members must choose a primary care physician (PCP) who coordinates their care. The PCP acts as a gatekeeper to their care and provides a referral through the HMO to see specialists, including RDNs. People with Medicare can choose to obtain their Medicare benefits through a commercial or private HMO that contracts with Medicare Part C.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	HIPAA provides consumers with greater access to health care insurance, protects the privacy of health care data, and promotes more standardization and efficiency in the health care industry. Everyone covered by HIPAA is required to provide the same information—standard formats for processing claims and payments; as well as for the maintenance and transmission of electronic health care information and data.
Health Savings Account (HSA)	An account available to employees where they have made monetary contributions, usually through payroll deduction, to help offset future health care costs. Members can use this fund to pay for copayments, deductibles, coinsurance, or fees for non-covered services.
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	A classification system by the World Health Organization used to report morbidity and mortality information. The ICD-10 codes are specific for diseases, injuries and signs and symptoms. Example: Diabetes, type 2 = E11.9.
In Network	A provider or group of providers under contractual agreement with a health plan to provide services to their beneficiaries. Can also be referred to as a participating provider.
Managed Care	Any arrangement for health care in which an organization, such as a third party payer, acts as an intermediary between the person seeking care and the medical care provider.
Medicaid	Medicaid is the United States health program for U.S. citizens or legal permanent residents, including low-income adults, their children, and people with certain disabilities. It is jointly funded by the state and federal governments and is managed by the states. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States.
Medicaid Waiver	An authorization obtained by a service coordinator for Medicaid to cover certain services that are not typically covered by policy guidelines. Waivers must state specifically what services are covered, how many visits are authorized, and for what time frame.
Medicare	The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
Medicare Administrative Contractor (MAC)	Medicare administrative contractors (MACs) are regionally contracted Medicare agencies to process provider enrollment, training and claims processing for both Medicare Part A and Part B. The MAC covering a specific area in the United States can be found at cms.gov.
Medicare Advantage Plans	A Medicare program that gives patients more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare advantage plans used to be called Medicare + Choice Plans.
Medicare Explanation of Benefits (EOMB)	A Medicare explanation of benefits (EOB) is a form or document sent by Medicare to explain a health care service that was paid by your Medicare benefit.
Medicare Form 8551	Also known as the Medicare Enrollment Application Form for individual physicians and non-physician practitioners including registered dietitians to become a Medicare provider. This form is completed in order to bill Medicare or make a change to enrollment. The practitioner must meet one of the following: <ul style="list-style-type: none"> • An individual practitioner who will provide services in a private setting. • An individual practitioner who will provide services in a group setting. • Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction (e.g., practitioner has opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor). • Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., practitioner has added or changed a practice location). • An individual who has formed a professional corporation, professional association, limited liability company, etc., of which the practitioner is the sole owner.
Medicare Assignment	Accepting Medicare assignment for RDNs means accepting payment in full a set amount of money for a service determined by the federal government. The patient/Medicare beneficiary cannot be billed the difference between what was billed and paid.
Medicare Part A	Part A is often considered "hospital insurance" as it covers most medically necessary hospital, skilled nursing facility, home health and hospice care. It is free if the recipient has worked and paid Social Security taxes for at least 40 calendar quarters (10 years); if this is not the case the person will pay a monthly premium if they have worked and paid taxes for less time.
Medicare Participation	The status in which the provider signs a participation agreement with Medicare and agrees to accept the allowable fee as payment in full and the patient pays any remaining balance, up to the allowed fee.

VOCABULARY	DEFINITION
Medicare Part B	Part B is synonymous with medical insurance and covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. Recipients pay a monthly premium for this coverage. RDN services fall under Part B.
Medicare Part C/ Medicare Advantage Plans	A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide the person with all Part A and Part B benefits. Medicare advantage plans include HMOs, PPOs, Private Fee for Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare advantage plans offer prescription drug coverage.
Medicare Part D	An optional benefit for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.
National Committee for Quality Assurance (NCQA)	An independent, non-profit institution that reviews and accredits managed care, behavioral health, preferred provider and credentialing verification organizations on a voluntary basis.
National Provider Identifier (NPI)	A universal number assigned to a provider that identifies them as the provider of service to the patient. The NPI is a unique, government issued, standard identifier mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Non-Participating Provider	A professional provider who has not signed a participating provider agreement with a third party payer and is considered out-of-network.
Open Access	Insurance that usually will not require referrals to a specialist, but certain services such as nutrition services considered ancillary services do need to be authorized. Typically has a co-payment.
Out of Network	Benefits accessible to an insured patient to utilize but who are not contracted with the insurance plan. These benefits are available at a higher financial responsibility to the insured patient.
Participating Provider	A professional provider, who has entered into a contractual agreement with a third party payer for the provision of services to members on an agreed-upon basis, has satisfied credentialing criteria and has been accepted as such by the third party payer.
Patient-Centered Medical Home (PCMH) or Medical Home	The PCMH is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians.
Provider Enrollment, Chain and Ownership System (PECOS)	Provider Enrollment, Chain and Ownership System is an Internet-based electronic Medicare enrollment system through which providers and suppliers can: submit Medicare enrollment applications; view and print enrollment information; update enrollment information; complete the revalidation process; voluntarily withdraw from the Medicare Program; and track the status of a submitted Medicare enrollment application.
Point of Service Plan (POS)	A POS plan is a type of managed care health insurance system which combines characteristics of both the HMO and the PPO. Members of a POS plan do not make a choice about which system to use until the point at which the service is being used. The POS is based on the basic managed care foundation: lower medical costs in exchange for more limited choice. But POS health insurance does differ from other managed care plans. When the patient enrolls in a POS plan, they are required to choose a primary care physician to monitor the patient's health care. This primary care physician must be chosen from within the health care network and becomes their "point of service." The primary POS physician may then make referrals outside the network, but then only some compensation will be offered by the patient's health insurance company.
Preferred Provider Organization (PPO)	A type of managed care plan. Insured receive full coverage at minimal cost when they use in-network providers in their health care plan but can opt to receive services from out-of-network providers at a higher cost.
Primary Care Physician (PCP)	The PCP is the responsible physician to oversee all aspects of care for a patient. This can be a family practitioner, internist or pediatrician. The PCP will refer to specialist as necessary and complete the insurance forms for the referral if needed by a patient's health care plan.
Primary Insurance Coverage	Health insurance that pays first on a claim for medical and hospital care.
Prior Authorization or Pre-authorization	Prior authorization: Also called "pre-authorization" or "pre-approval." A restriction placed on coverage by private health plans and Medicare private drug plans. If a service or medication is covered with "prior authorization," the doctor or provider must get special permission from the plan to prescribe the service or medication before it will be covered. Failure to get prior authorization before a service can deny coverage for the service.
Private Insurance	Insurance provided through either a for-profit or not-for-profit company rather than by the federal or state government.
Prospective Payment System (PPS)	A payment system, developed for Medicare facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
Protected Health Information (PHI)	Any information that may be used to identify a patient, including but not limited to name, date of birth, address, phone number or account number.
Provider or Health Care Provider	A doctor, hospital, health care professional or health care facility.

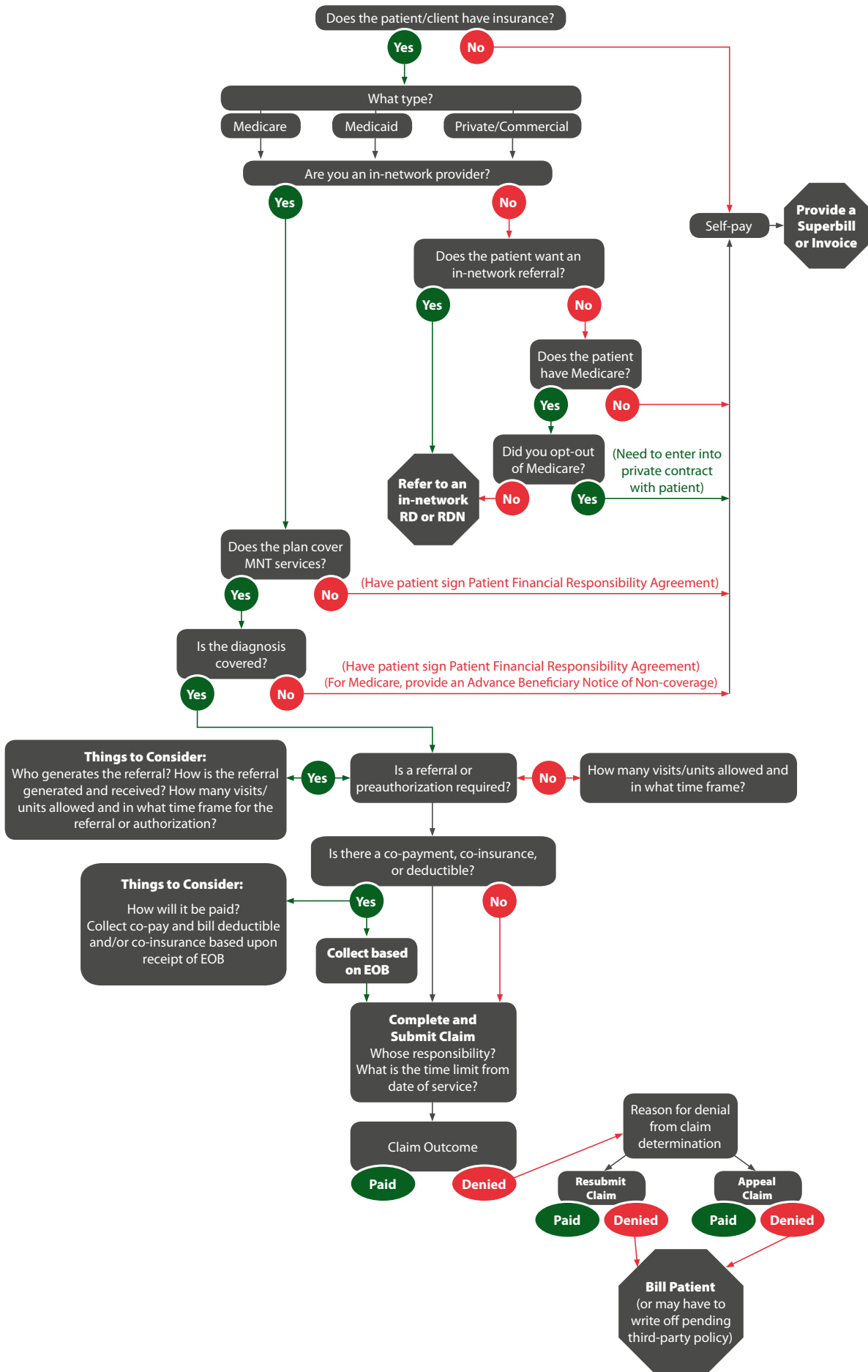
VOCABULARY	DEFINITION
Provider-Based Billing	Provider-based billing is the practice of charging for professional or physician services separately from building/facility overhead. A hospital outpatient clinic must meet specific requirements set forth by CMS before it can use this method of billing for services. In the provider-based billing model, also commonly referred to as hospital outpatient billing, patients may receive two charges on their combined patient bill for services provided within a clinic. One charge represents the facility or hospital charge and one charge represents the professional or physician fee.
Quality Payment Program (QPP)	The Quality Payment Program (QPP), effective January 1, 2017, is a system for paying Medicare Part B providers based on quality and cost of care. The QPP consists of 2 different payment tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models. MIPS consolidates several reporting programs - the Medicare EHR Incentive Program, the Value-based Payment Modifier, and the Physician Quality Reporting System (PQRS) - into a single payment system. https://qpp.cms.gov/
Recovery Audit Contractors (RAC)	The RAC Program detects and corrects past improper payments so that CMS, claim s processing contractors, and providers can implement actions that will prevent future improper payments. Fee-for-service programs' claim s will be subject to review by the RACs.
Remittance Advice	Same as EOB.
Resource Utilization Group (RUG)	A category-based classification system in which nursing facility residents classify into one of 66 or 57 or 47 RUG-OV groups. Residents in each group utilize similar quantities and patterns of resources. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0. Medicare Part A uses the 66-group classification.
Rural Health Clinics (RHC)	The rural health clinics (RHC) program is intended to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, private or non-profit. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, under-served areas and must use one or more physician assistants or nurse practitioners.
Secondary Insurance Coverage	Health insurance that covers health care after the primary insurance has been made on a claim for medical or hospital care. The secondary insurer usually pays for all or some of the costs that the primary insurer did not cover but may not cover services not covered by the primary insurer. Can also be called Supplemental Insurance.
Self-insured/Self-funded	A type of health care plan used by companies. The company contracts with a third party administrator (can be a commercial or private insurer) or self-administers the health care plan. The employer decides the premiums from enrollees, the coverage for services and takes on the responsibility of paying employees' and dependents' medical claims.
Self-pay	A patient with no insurance coverage and is responsible for all health care expenses.
Skilled Nursing Facility (SNF)	A Medicare-approved facility that provides short-term post-hospital extended care services, at a lower level of care than provided in a hospital.
Systematized Nomenclature of Medicine—Clinical Terms (SNOMED)	SNOMED is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP). It is one of a suite of designated standards for use in U.S. federal government systems for the electronic exchange of clinical health information and is also a required standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel.
State Health Insurance Assistance Program (SHIP)	A federally-funded program in each state that provides free counseling about Medicare to Medicare beneficiaries.
Superbill	A superbill contains vital information about the professional providing the health care service—name, address, registration and licensing/certification. The superbill also contains codes and charges for the service. A client can submit the bill directly to the health care insurer for payment to the insured.
Taxonomy Code	Identifies the specialty the provider was credentialed for with an insurer. The payer tells the provider what taxonomy code to use when billing the insurer.
Telehealth	The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth will include both the use of interactive, specialized equipment, for such purposes as health promotion, disease prevention, diagnosis, consultation, therapy, and/or nutrition intervention/plan of care, and non-interactive (or passive) communications, over the Internet, video-conferencing, e-mail or fax lines, and other methods of distance communications, for communication of broad-based nutrition information.
Telemedicine	Is applicable to physicians and other practitioners, and is the use of medical information exchanged from one site to another via electronic information and telecommunications technologies to improve patients' health status, to engage in the diagnosis and treatment of medical conditions, to support clinical care, or to provide health services or aid health care personnel at distant sites.
Third Party Payer	A term used to refer to any company that acts as the payer under coverage provided by a health care plan, for example, Medicare or Blue Cross/Blue Shield. An organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services.
UB-04	The UB-04, also known as the Form CMS-1450, is the uniform institutional provider hardcopy claim form suitable for use in billing multiple third party payers. Unique to Medicare is that the Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies for initial claims that a provider did not bill electronically. The UB-04 is the only hardcopy claim form that the Centers for Medicare & Medicaid Services (CMS) accepts from institutional providers (e.g., hospitals, Skilled Nursing Facilities, Home Health Agencies, etc.) which meet the ASCA exceptions or which have been granted a waiver.
Unit of Service	Refers to the number of minutes of service based upon the face-to-face time spent with the client.
Value-based Purchasing	Links provider payments to improved performance.
Whistleblower	A person who reveals wrongdoing within an organization to the public or to those in positions of authority.

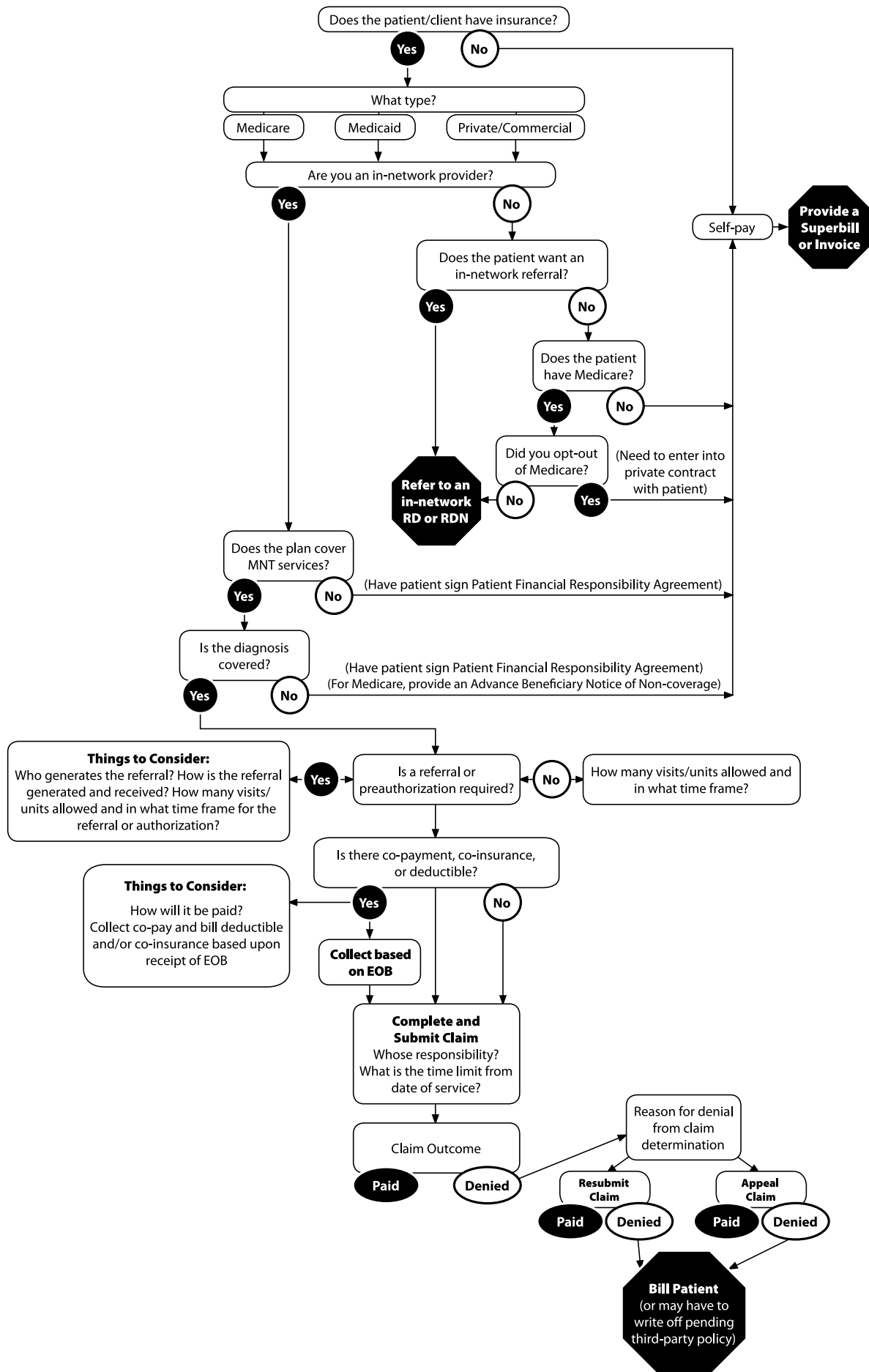


Decision Tree

The decision tree below is meant to assist you with understanding the big picture of coding and billing. The assignments and case studies are meant to provide further insight into the decisions that are depicted in the diagram.

The decision tree is provided in both a color and black and white version to accommodate your printing capabilities should you need a hard copy.





Process for Third Party Reimbursement in Facilities Setting

Preceptor Tips:

- If the facility does not bill **third party payers** for MNT services, identify another facility that does and allow the intern the opportunity to interview the clinical nutrition manager from that facility. Alternatively, consider connecting the intern with an RDN in private practice within the community to complete the alternate assignment.
- This assignment could also be completed by inviting a guest lecturer to speak to the class of interns and having the interns subsequently write up a report or answer some questions related to the presentation.
- If an intern is completing this assignment within a long-term care facility, instruct them to interview the appropriate personnel within the facility to learn how the RDNs' involvement in the Minimum Data Set (MDS) process translates into payment to the facility.
- If an intern is completing this assignment in an acute care facility that does not provide outpatient services, instruct them to interview the appropriate personnel within the facility to learn how documenting and coding for malnutrition impacts the facility's revenues. Alternatively, instruct the intern to interview the clinical nutrition manager or department director to learn the source of funding for RDN positions and how the department generates revenue.

Preceptor directions

- Please reproduce the next five pages and give it to your intern with a specified time limit in which the intern should complete the assignment.
- Please schedule a discussion period following the intern's submission of the assignment.

The intern should follow these steps to develop a report that describes the process used at the facility at which they are completing their MNT rotation(s). If the intern is completing a rotation in a private practice/office setting, he/she should follow the steps in the [*Process for Third Party Reimbursement in the Private Practice Setting*](#) section.

Process for Third Party Reimbursement in Facilities Setting

Background information on this process

The purpose of learning about the process of third party reimbursement in a facility setting is to gain knowledge and understanding of revenue generated from third party payers for MNT. Funding for the RDN position to provide MNT may be dependent on third party reimbursement.

Directions

Follow these steps to develop a report that describes the process used at the facility at which you are completing your MNT rotation(s).

Step 1. Identify/determine the department/persons who oversee and/or are responsible for third party billing within the facility.

Purpose: To explain the chain of command within the facility for reimbursement and where to go when the RDN needs assistance on reimbursement.

Note:

- This will vary from facility to facility.
- The facility's Organizational Chart may assist.
- Ask which department or persons in the facility are responsible for completing the paperwork/insurance forms. Once the persons are identified, the RDN can then direct some of the questions below to them as necessary.

Step 2. Identify and, where possible, obtain resources for the facility's policies and procedures pertaining to third party reimbursement, specifically for MNT and/or nutrition services, including the Policy and Procedures manual.

Purpose: To describe what the procedures are within the facility to complete the paperwork to submit a **claim** for MNT and/or nutrition services and be paid; to ensure compliance with the facility's Policy and Procedures Manual.

Note:

- Information may be obtained from the billing, accounting and/or nutrition departments.
- Policies and procedures may not be specific to MNT but can apply.
- Identify all forms within the facility to assist in completing the insurance form for a claim.
- Specify the insurance claim form submitted to the third party payer.
 - Is it the **UB-04/CMS-1450** form⁵?
 - Is it the **1500 claim form**⁶?
 - Is it a **superbill**?

⁵ Medicare Billing: 837I and Form CMS-1450: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf>

⁶ Medicare Billing: 837P and Form CMS-1500: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/837p-cms-1500.pdf>

- Once the required insurance forms for the claim are completed and submitted by the facility⁷...
 - How long after submission does the facility usually receive the **EOB** or notification about the claim?
 - As the **provider** of services, will/can the RDN be informed if the claim was paid or denied?

Note: Tracking this information can be helpful when seeing other patients with the same insurance, same policy and same diagnosis.

 - Will/can the RDN read the EOB or notification about the claim received by the facility?
 - If the claim is paid, will/can the RDN be informed what the facility was paid for nutrition services?
 - If the claim was denied, will/can the RDN be informed of the reason⁸ as the provider of services?

Note: Possible reasons for denial can include patient did not have coverage, the diagnosis was not covered, there was no referral, coverage was exhausted, incorrect completion of forms to submitted for the insurance form, and inaccurate/incomplete medical record charting. There are other reasons for denials that may require additional research.

 - Will the RDN play a role when the denial can be resubmitted for claim errors on the part of the third party payer?
 - What are the steps for resubmitting the claim?
 - Is there a time limit to resubmit the claim?
 - What will be the RDN involvement for denials when an **appeal** to the third party payer is necessary?
 - What are the steps for appealing to the third party payer? This can vary among third party payers.

Step 3. Identify who within the facility handles credentialing and the credentials and/or third party payer paperwork required to provide MNT and/or nutrition services for the facility to be reimbursed⁹.

Purpose: To determine if additional credentials and/or third party payer paperwork are required by the facility and or payers to be reimbursed.

Note:

- RDNs may be covered under existing credentialing contracts within a facility.
- Credential and third party payer paperwork requirements may vary among third party payers.
- This may include **NPI**, **Medicare** provider number, state licensing, and other possible credentials such as a CDE.

Step 4. Identify and list the top three (by volume of claims) third party payers with whom the facility participates and has contracts¹⁰.

Purpose: To recognize the major **in-network** or participating third party payers for the facility.

⁷ RDN's Complete Guide to Credentialing and Billing: The Private Payer Market <https://www.eatrightstore.org/product-type/toolkits/rdns-complete-guide-to-credentialing-and-billing>

⁸ Appealing private insurance companies' allegations related to code use" http://www.eatrightpro.org/~/_media/eatrightpro%20files/practice/coding%20coverage%20compliance/claims_disputes.ashx

⁹ Obtaining an Employer Identification Number (EIN). https://tax-ein-forms.com/?gclid=EAlalQobChMlu-qHps2K7gIVivOzCh03KQj3EAAYAiAAEgIAafD_BwE

¹⁰ Medicare MNT information. <http://www.eatright.org/mnt/>

Step 5. For each third party payer identify coverage for MNT and/or nutrition services:

Purpose: To recognize the billing and coding requirements for each third party payer.

Complete separate chart with this information.

- Which diagnoses (ICD-10-CM^{11,12}) for MNT are covered?
Note: Coverage for diagnoses differs among third party payers. It can even vary from policy to policy within the same third party payer. The Nutrition Care Process Terminology (NCPT) is used to document the Nutrition Care Process and is not recognized by third party payers for billing and/or payment purposes.
- Which CPT codes are covered for MNT¹³?
- How many visits or number of units allowed or authorized for MNT¹⁴?
 - Are the visits or numbers of units allowed per year, per diagnosis, per lifetime or are there other limitations of coverage for MNT?
 - Is there a time limit for each visit?
- Is a referral or **preauthorization** required¹⁵?
 - Who generates the referral or preauthorization? How is the referral or preauthorization generated?
 - Paper or electronically?
 - How will the RDN be notified of the referral or preauthorization?
 - Is there a time limit for the referral or preauthorization?
- How does the RDN determine if there is a **copayment**, **deductible** or coinsurance?
 - Who is responsible for this?

Step 6. Identify criteria and documentation required for MNT and/or nutrition services within the facility.

Purpose: To recognize paperwork needed for documentation for the facility to be reimbursed for MNT and/or nutrition services.

Note:

- Are there billing forms within the facility the RDN will complete for MNT and/or nutrition services?
- Who within the facility obtains the patient's insurance information?
- Who within the facility confirms the patient's coverage for MNT and/or nutrition services?
- Who will obtain the referral or preauthorization?
- If MNT and/or nutrition services are not covered who will generate a superbill for the patient? What if a patient, for their records, wants a superbill? Who will provide it?
- If Medicare insures the patient and the diagnosis is not covered who will provide the Medicare **Advance Beneficiary Notice** of Non-coverage (ABN)?
- Explain documentation criteria/charting required in the patient's medical record for MNT and/or nutrition services.
- Identify required forms to be submitted to the facility's responsible department for completing insurance form to be sent to third party payer. This will include the ICD-10-CM- and CPT® codes and other pertinent information.

¹¹ ICD-10-CM <https://www.eatrightpro.org/payment/coding-and-billing/diagnosis-and-procedure-codes/icd-10-cm>

¹² Resource for transition to ICD-10 codes. <http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10>

¹³ CPT and G Codes for RDNs. <https://www.eatrightpro.org/payment/coding-and-billing/diagnosis-and-procedure-codes/cpt-and-g-codes-for-rdns>

¹⁴ Medicare MNT <https://www.eatrightpro.org/payment/medicare/mnt>

¹⁵ Sample Nutrition Coverage Referral Forms and Patient Policies <https://www.eatrightpro.org/payment/medicare/mnt/mnt-forms-and-resources>

Step 7. Identify the steps within the facility the RDN will follow prior to and after providing MNT and/or nutrition services to a patient in order for the facility to properly submit a claim and receive payment from the third party.

Purpose: To follow the facility's policy and procedure when providing MNT and/or nutrition services for the facility to be reimbursed for the RDN services.

- What are the steps that must be completed prior to providing MNT and/or nutrition services to a patient?
 - Specify all information the RDN needs. (Refer to [Decision Tree](#) for assistance if necessary).

- What steps must the RDN take while meeting with the patient to facilitate coding and billing for the MNT services?
 - This may include verifying payment information, etc. from the patient.
- After the RDN provides MNT and/or nutrition services, what are the RDN responsibilities (in sequence) for the claim to be submitted by the facility?
- Once the claim is submitted what are steps to determine the outcome of the claim?
 - Include the RDN's responsibility when the claim is paid.
 - Identify the RDN's responsibility when the claim is denied.

Chart of Third Party Payers for Facilities

Step 5. For each third party payer identify coverage for MNT and/or nutrition services.

Third party payer	ICD-10-CM	CPT®	# of visits or units/criteria (Include time limit for visits/units or other limitation)	Referral or preauthorization required (Include who and how referrals are generated and how referral notification is received.)	Copayment, deductible, coinsurance	Time limit for claim submission

Process for Third Party Reimbursement in the Private Practice Setting

Note: This assignment should only be completed if the intern is completing an experience within a private practice setting. Interns who are only completing rotations within health care facilities do not need to complete this assignment. They should complete the [“Process for Third Party Reimbursement in the Facilities Setting”](#) assignment.

Preceptor directions

- Please reproduce the following five pages and give it to your intern with a specified time limit in which the intern should complete the assignment.
- Please schedule a discussion period following the intern’s submission of the assignment.

The intern should follow these steps to develop a report that describes the process used within the private practice to code and bill for MNT services.

Process for Third Party Reimbursement in the Private Practice Setting

Background information on this process

The purpose of learning about the process of third party reimbursement in a private practice setting is to gain knowledge and understanding of revenue generated from third party payers for MNT.

Directions

Follow these steps to develop a report that describes the process used at the facility at which you are completing your MNT rotation(s).

Step 1. Determine licensure, certification, credentials and other information required and/or recommended by **third party payers** to provide MNT and/or nutrition services as a **participating provider**.

Purpose: To identify credentials and other requirements needed to complete an application to third party payers.

Note:

- Licensure, certification, credentials and other requirements may vary among states and third party payers.
- Some credentials may not be obtained until after becoming a participating provider, for example **CAQH**.
- Credentials to explore:
 - State license/credentials to practice¹⁶.
 - **NPI** via **PECOS**¹⁷.
 - **EIN**¹⁸.
 - Liability insurance
 - Malpractice insurance¹⁹.
 - CAQH- Universal Provider Data²⁰.

Step 2. Identify and list the top three third party payers in the private practice's payer mix.

Purpose: To enroll as an in-network provider with third party payers in the practice area. As an in-network provider with third party payers, the RDN is listed in provider directories, which can lead to increased business through referrals from other participating providers and self-referral from clients/patients participating in the health plan.

Note:

- Applications and enrollment processes vary for each third party payer.
- Government Plans:
 - Explain how to obtain and complete enrollment for:
 - **Medicare**²¹
 - Enrollment is managed by **Medicare administrative contractors (MACs)**.
 - **Medicaid/CHIP**²²
- Commercial/Private Plans
 - Identify how to determine what commercial/private plans are in the area of the private practice.
 - Explain ways to obtain an application and enrollment from commercial/private plans.

¹⁶ <https://www.cdrnet.org/state-licensure>

¹⁷ <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>

¹⁸ https://tax-ein-forms.com/?gclid=EAlaIqObChMlu-qHps2K7glVivOzCh03KQj3EAAYAiAAEgIAafD_BwE

¹⁹ http://www.proliability.com/professional-liability-insurance/dietetic-practitioners?prof=DieteticNutritionists_professionlist

²⁰ <http://www.caqh.org/overview.php>

²¹ Enrollment application is available from www.cms.gov. Instructions for completing the application is available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf> (Accessed December 2018)

²² Coverage for MNT varies from state to state. For information go to www.medicaid.gov

Step 3. For each of the above third party payers, identify coverage for MNT and/or nutrition services including nutrition preventative services.

Purpose: To recognize the billing and coding requirements for each third party payer to submit a **claim** for MNT and be paid.

Note:

- Information can be obtained from the contract signed with the third party, third party payer website, update received from the third party payer including emails, bulletins and newsletters. Staying up-to-date is imperative.

Complete the [separate chart](#) with this information.

- Which diagnoses (**ICD-10-CM**) for MNT are covered?
Note: Coverage for diagnoses differs among third party payers. It can even vary from policy to policy within the same third party payer.
 - When is an **ABN** used for Medicare?
- Which **CPT** codes are covered for MNT?
- How many visits or number of units allowed (authorized) for MNT?
 - Are the visits or numbers of units allowed per year, per diagnosis, per lifetime or are there other limitations of coverage for MNT?
 - Is there a time limit for each visit?
- Is a referral or **preauthorization** required?
 - Who generates the referral or preauthorization? MD, DO, PA, NP?
 - How is the referral or preauthorization generated?
 - Paper or electronically?
 - How will the RDN be notified of the referral or preauthorization?
 - Is there a time limit for the referral or preauthorization?
- How does the RDN determine if there is a **copayment**, **deductible** or coinsurance?
 - Will it be identified on the insurance card or determined when the claim is processed?
- What is the time limit from **date of service** for claim submission?

Step 4. Specify the client/patient information required in private practice to obtain third party payment.

Purpose: To obtain necessary client/patient information to ensure reimbursement for MNT.

Note: Step 5 may assist with this.

- What information is needed prior to rendering MNT and/or nutrition services to a patient?
 - Specify the information the RDN needs including how and when it will be obtained from the: (include information about use of the ABN)
 - Client/patient
 - Referring **health care provider**
 - Third party payer
- What information is required after the RDN has provided MNT to the client/patient?
 - Identify documentation criteria/charting required in the patient's medical record for MNT.
 - Include information and payment from the client/patient.
 - Specify when to use a **superbill**.

Step 5. Complete and submit a claim to the third party for payment of MNT.

Purpose: To recognize the information to properly complete the 1500 claim form for MNT reimbursement.

Note:

- 1500 claim form
 - Identify how to complete the 1500 claim form.
 - Who will complete the form?
 - How will the 1500 claim form be submitted to the third party?
- Superbill Form.
 - Explain the purpose of the superbill.
 - When would a superbill be provided?
 - What information is on a superbill?
- Advance Beneficiary Notice of Non-coverage (ABN)
 - Explain the purpose of an ABN
 - Under what circumstances would an ABN be provided?
 - Who completes the ABN?
 - How is the ABN completed?

Step 6. Determine claims outcome submitted to third party payers.

Purpose: To ensure payment is received for MNT.

- Track the outcome of claims.
 - Explain why tracking claims is important.
 - How long after submission is the EOB or notification about the claim determined?
 - Is the EOB or notification paper or electronic?

Note: Tracking this information can be helpful when seeing other patients with the same insurance, same policy and same diagnosis. The success of a private practice is dependent on being paid for MNT including third party reimbursement.

- The claim is paid.
 - Is payment in compliance with the fee schedule?
 - Is there a client/patient financial responsibility?
- The claim is denied.
 - Why?

Note: Possible reasons for denial can include patient did not have coverage, the diagnosis was not covered, there was no referral, coverage was exhausted, incorrect completion of submitted insurance forms and inaccurate/incomplete medical record charting.

- What action can be taken when a claim is denied?
 - Explain resubmitting the claim
 - Appealing the claim
 - Billing the client/patient
 - Writing off the claim

Chart of Third Party Payers for Private Practice

Step 3. For each third party payer identify coverage for MNT and/or nutrition services.

Third party payer	ICD-10-CM	CPT®	# of visits or units/criteria (Include time limit for visits/units or other limitation)	Referral or preauthorization required (Include who and how referrals are generated and how referral notification is received.)	Copayment, deductible, coinsurance	Time limit for claim submission



Case Studies

Preceptor Tips

The following case studies are included to provide a simulated experience with coding and billing for nutrition services for use in situations when experiences with actual patients are not available. Similar experiences with real patients might include:

- Ask the intern to select two to three patients for whom they are providing outpatient MNT services (facility-based or private practice). One of these patients should have **Medicare** coverage and one should have private health insurance coverage. For these patients, the intern should walk through the process of **third party payer** reimbursement, from identifying and verifying coverage for MNT services through completing a sample **claim** submission form or **superbill**. Questions from the case studies should be used to guide the intern's assignment. Schedule a discussion period following the intern's submission of the assignment.
- For any assigned case studies during the MNT rotations, ask the intern to address the topic of coding and billing for services. Questions to address would include whether or not the facility/practice can bill a **third party payer** for the MNT services provided by the RDN. If so, explain the steps necessary for doing so and complete a sample claim submission form.
- Print out copies of **NPI** enrollment form and Medicare **provider** enrollment form. Ask intern to complete applications.

Preceptor directions

- Please reproduce the following pages (up until you get to the [Answers and Discussion Notes](#) section) and give it to your intern with a specified time limit in which the intern should complete the assignment.
- Please schedule a discussion period following the intern's submission of the assignment.

Case Studies

Case Study 1a – Private Practice

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

The scenario: You are in private practice in your own office. You are newly starting out and have no staff yet. You are a provider with a number of third party payers.

The phone rings and you answer it. The person on the phone is John Doe. He explains he was told to call you by his doctor and make an appointment. He was recently diagnosed with type 2 diabetes. His doctor wants him to lose weight.

1. **What questions do you have or information do you need to obtain from Mr. Doe concerning his insurance while he is on the phone?**

Mr. Doe says he has Blue Cross Blue Shield (BCBS) through his work and has the written referral from his doctor.

2. **Now that you know Mr. Doe's insurance carrier and he says he has a referral, what additional information do you need about Mr. Doe's insurance and referral?**

You call Mr. Doe's BCBS.

3. **What information do you need to have to speak or check online with his insurance?**
4. **What questions do you need to ask Mr. Doe's insurance company in order to determine if your MNT will be covered for Mr. Doe?**

Mr. Doe was approved by BCBS for 24 units of MNT for 180 days starting on December 15, 2020. The first appointment is made for Mr. Doe for January 2, 2021 at 1:00 p.m. It is January 2 at 1:00 p.m. Mr. Doe has arrived to your office for his MNT.

5. **What must you obtain from him at the appointment?**

After the appointment you will need to submit an insurance claim form for Mr. Doe's service.

6. **What is the name of the insurance form to complete in private practice?**
7. **On the attached insurance form, complete the information for it to be submitted to Mr. Doe's insurance company.**

Here is Mr. Doe's registration information.

Mary Smith, RDN

456 Central Avenue
 Any, ZZ 11111
 222-555-6666 office phone
 NPI#: 9987654321
 EIN#: 11-1234567

Patient Registration

Patient name: John A. Doe	Date: 01/02/2021			
Street address: 123 Main Street	Town: Any	State: ZZ	Zip code: 11111	Home phone: (222) 333-4444
Date of birth: 01/01/1960	Sex: Male	Marital status: Single		
Referring PCP: John Friendly, MD	Referring PCP NPI: 1234567899	ICD-10-CM E11.9 E66.3	Referral #: 98765-432	
Date of service: 01/02/2021	Amount of time for MNT: 63 minutes	Fee: \$XXX.00		
<p>I, John A. Doe gives Mary Smith, RDN permission to bill my insurance company, Blue Cross Blue Shield.</p> <p>John Doe 01/02/2021 Signature Date</p>				



8. As a result of not receiving an **EOB** or any communiqué on the claim by March 1, what should you do?
9. Explain why you want to follow up on the claim.

You receive the EOB and the claim was paid.

If the claim was denied, what can you learn from the EOB?



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					8. RESERVED FOR NUCC USE					7. INSURED'S ADDRESS (No., Street)				
ZIP CODE					TELEPHONE (Include Area Code) () ()					CITY					STATE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER:										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
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.									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Inc.										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										23. PRIOR AUTHORIZATION NUMBER _____									
F. \$ CHARGES										G. DAYS OR UNITS H. EP907 Family Plan I. ID QUAL J. RENDERING PROVIDER ID. #									
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NP									
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. _____									
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.)										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
SIGNED _____ DATE _____										28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. Rsvd for NUCC Use _____									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()									
a. NPI										b. NPI									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Case Studies

Case Study 1b — Private Practice – Telehealth

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

The scenario: You are in private practice in your own office. You are newly starting out and have no staff yet. You are a provider with a number of third-party payers. You provide services in-person as well as via telehealth.

The phone rings and you answer it. The person on the phone is John Doe. He explains he was told to call you by his doctor and make an appointment. He was recently diagnosed with type 2 diabetes. His doctor wants him to lose weight. He would like to have the appointment via telehealth.

- 1. What questions do you have, or information do you need to obtain from Mr. Doe concerning his insurance while he is on the phone?**

Mr. Doe says he has Blue Cross Blue Shield (BCBS) through his work and has the written referral from his doctor.

- 2. Now that you know Mr. Doe's insurance carrier and he says he has a referral, what additional information do you need about Mr. Doe's insurance and referral?**

You call Mr. Doe's BCBS.

- 3. What information do you need to have to speak or check online with his insurance?**
- 4. What questions do you need to ask Mr. Doe's insurance company to determine if your MNT via telehealth will be covered for Mr. Doe?**

Mr. Doe's plan covers telehealth for the same number of visits as in-person visits (also known as coverage parity). He was approved by BCBS for 24 units of MNT for 180 days starting on December 15, 2020. The first appointment is made for Mr. Doe for January 2, 2021, at 1:00 p.m. It is January 2 at 1:00 p.m. and Mr. Doe has signed into his telehealth session.

- 5. What must you obtain from him at the appointment?**

After the appointment you will need to submit an insurance claim form for Mr. Doe's service.

- 6. What is the name of the insurance form to complete in private practice?**
- 7. On the attached insurance form, complete the information for it to be submitted to Mr. Doe's insurance company.**

Here is Mr. Doe's registration information.

Mary Smith, RDN
 456 Central Avenue
 Any, ZZ 11111
 222-555-6666 office phone
 NPI#: 9987654321
 EIN#: 11-1234567

Patient Registration

Patient name: John A. Doe	Date: 01/02/2021			
Street address: 123 Main Street	Town: Any	State: ZZ	Zip code: 11111	Home phone: (222) 333-4444
Date of birth: 01/01/1960	Sex: Male	Marital status: Single		
Referring PCP: John Friendly, MD	Referring PCP NPI: 1234567899	ICD-10-CM E11.9 E66.3	Referral #: 98765-432	
Date of service: 01/02/2021	Amount of time for MNT: 63 minutes	Fee: \$XXX.00		
<p>I, John A. Doe gives Mary Smith, RDN permission to bill my insurance company, Blue Cross Blue Shield.</p> <p>John Doe 01/02/2021 Signature Date</p>				

You submit the claims to BCBS on January 2. It is now March 1 and you have not received any information on the claim.

8. As a result of not receiving an EOB or any communiqué on the claim by March 1, what should you do?

9. Explain why you want to follow up on the claim.

You receive the EOB, and the claim was paid.

If the claim was denied, what can you learn from the EOB?

Case Studies

Case Study 2 — Hospital Based Non-Medicare

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

Scenario:

Adult ambulatory care dietitian receives a consult form the Family Medicine Clinic for Mr. Bobby Jones to receive Medical Nutrition Therapy for Diabetes. Mr. Jones is 40 years old.

1. **What information must the referring physician provide?**
2. **Before seeing the patient, what must you verify?**
3. **If you are not a provider for an insurance company, how do you become a provider?**
4. **If a patient was referred for MNT for a non-covered service, what form would the patient need to sign?**
5. **What CPT® codes are available for you to bill under?**
6. **What are the units of service for each of these codes?**
7. **What are the maximum hours/visits that you can bill the insurance company for each of these codes in the first year you see the patient? Subsequent years?**
8. **What if a patient needs more time due to the complexity of the disease, change in treatment, etc.? What do you do? What codes will you bill?**
9. **If your institution did not have electronic billing, which form would you use to bill for this service?**

Case Studies

Case Study 3a – Hospital-Based Medicare

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

Scenario:

Susie Jones is a newly hired dietitian in an ambulatory clinic in a hospital. As a new employee, specific criteria must be met and specific forms must be filled out before providing Medical Nutrition Therapy to Medicare patients.

1. **What qualifications must you meet and what paperwork must you complete to become a Medicare provider?**

Adult ambulatory care dietitian receives a consult from the Family Medicine Clinic for Ms. Betty Jo Smith to receive Medical Nutrition Therapy for her Chronic Kidney Disease. Ms. Smith is 65 years old and is a Medicare **beneficiary**.

2. **What information must the referring physician provide?**
3. **Before seeing the patient, what must you verify?**
4. **What MNT services are covered by Medicare part B?**
5. **If a patient was referred for MNT for a non-covered service, what form would the patient need to sign?**
6. **What three CPT codes are available for you to bill under?**
7. **What are the units of service for each of these codes?**
8. **What are the maximum hours that you can bill CMS for each of these codes in the first year you see the patient? Subsequent years?**
9. **What if a patient needs more time due to the complexity of the disease, change in treatment, etc.? What do you do? What codes will you bill?**
10. **If your institution did not have electronic billing, which form would you use to bill for this service?**
11. **Since you are working in a hospital, is the amount CMS will pay you per unit of service for MNT more or less than if you were in private practice? Why?**

(If you have already completed case study 3a, you can skip questions 1-4)

Case Studies

Case Study 3b – Hospital-Based Medicare - Telehealth

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

Scenario:

Jordan is a newly hired dietitian in an ambulatory clinic in a hospital. As a new employee, specific criteria must be met and specific forms must be filled out prior to providing Medical Nutrition Therapy to Medicare patients.

1. **What qualifications must you meet and what paperwork must you complete to become a Medicare Provider?**

Through the hospital's EMR, Jordan receives a consult from the Family Medicine Clinic for Ms. Garcia to receive Medical Nutrition Therapy. The referral indicates Ms. Garcia needs to be seen for chronic kidney disease.

2. **Ms. Garcia lives in a rural area. Does she meet the geographical requirements for Medicare to pay for her MNT visit to be provided via telehealth?**
3. **What must be included on the referral for it to be considered valid from Medicare?**
 - a. **Can the referral come from a mid-level provider (Physician Assistant, Nurse Practitioner, etc.) in the Family Medicine Clinic?**
4. **As part of your hospital's Electronic Medical Record, you see that Ms. Garcia has Medicare Part B coverage. Which 3 diagnoses are approved by Medicare part B to receive MNT services?**
5. **Before Jordan calls Ms. Garcia to schedule her appointment, s/he reviews the medical record and finds this is a new diagnosis. It does not appear that Ms. Garcia has been counseled on this condition before.**
 - a. **What is the maximum number of hours the patient can be seen for the approved Medicare conditions?**
 - b. **If this were not a new diagnosis, how would the number of hours allowed change?**
6. **Jordan calls Ms. Garcia to schedule the appointment. What needs to be confirmed for the visit to be able to happen?**

Jordan explains how Ms. Garcia will receive the meeting invite and notifies her that it is a secure platform. Through this platform, she will be able to e-sign all consents and forms and pay her co-pay.

Since this was an initial visit, you scheduled a 60-minute consult. Ms. Garcia was a few minutes late and you spent 49 minutes face-to-face with her.

7. **What should be added to your documentation since this visit was provided via Telehealth?**
8. **What CPT code should be used?**
9. **How many units of the CPT code should be charged?**
10. **What needs to be adjusted on the billing form?**
11. **Medicare will not adjust their reimbursement rate to the hospital due to payment parity. Please define parity as it relates to **telemedicine** payment.**

Case Studies

Case Study 4 – Value-Based Payments

Please write the procedural steps and options for this case study within ____ hours and submit it to your preceptor by _____.

Scenario:

You and three other RDNs provide MNT for adults at a large internal medicine (adult outpatient) practice with 15,000 patients. You also provide diabetes education in the practice's accredited

[Diabetes Self-Management Training/Education and Support \(DSMT/ES\)](#) program for adults with type 2 diabetes.

The way your practice will be paid by private and government health insurers (payers) is changing. Over the course of the next year, there will be a phasing out of most fee-for-service payments (i.e., reimbursement) where health care payments are paid to providers and organizations without any regard for outcomes, the quality of care, or the patient's experience. The organization will be paid through value-based payments, which are tied to patient outcomes, clinical quality, patient experience, improvements in population health* and reductions in avoidable health care costs.

Understanding value-based payments requires knowledge of several concepts as well as the integration of other information, not specific to nutrition, such as the cost of "avoidable care" (i.e., unplanned hospitalizations, emergency department visits, complications of disease). This case study will not cover the different types of value-based or alternative payment models, or all the elements. This case study will focus on two key "ingredients" of value-based payments: clinical quality and population health management, and the important connections with MNT and RDNs. This exercise is intended to help you position MNT and the RDN as indispensable in value-based models through improvements in patient care and clinical quality, and a population health management approach to delivering MNT and other services. These are not the only possible ways that RDNs can add value in the context of value-based payments. To learn more about value-based payments, see [Alternative Payment Models and Value-Based-Care](#).

Clinical Quality Measures (outpatient)

There are hundreds of validated quality measures that serve as signals for the quality of care for different populations. For example, there are several quality measures for diabetes care such as ones for glycemic control, blood pressure control, and health maintenance. Data, including results (e.g., laboratory A1c of 7.8%) and health care claims for other services (e.g., A1c test or a retinal examination occurred), are reported and attributed to practices and/or individual clinicians. There are validated quality measures for [malnutrition***](#) that are available for use by the [Centers for Medicare & Medicaid Services \(CMS\)](#) and other payers. CMS has added the [Global Malnutrition Composite Score](#) to its inventory of inpatient quality measures. Overall performance in clinical quality measures is often a component of a larger payment formula. There may be positive or negative adjustments (retrospective) in payments, depending on overall performance and the terms of the contracts with payers. RDNs need to know about quality measures that are relevant and of importance in their work environment to identify connections with the care and services they provide (e.g., MNT, DSMT/ES, remote physiologic monitoring, care coordination, food insecurity screening & referrals). Understanding quality measures is one way that RDNs can better connect their work with organizational priorities that are directly connected to payment.

There are various quality measures that have been adopted by different payers. One example is the Healthcare Effectiveness Data and Information Set (HEDIS) used by private payers to measure quality in commercially insured populations. [HEDIS](#) includes different domains (i.e., categories) of measures. For example, the [Effectiveness of Care](#) domain includes measures for diabetes and cardiovascular conditions. As of 2024, the diabetes measures assess adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c Control for Patients with Diabetes (HBD)

- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

CMS also uses quality measures that are connected to payment in different value-based programs for organizations, individual providers, and group practices. The names and participation criteria of CMS's various programs continues to evolve. The important take-away is that like HEDIS, CMS also has quality measures, including [diabetes measures](#) that are intended to measure quality in care provided to the Medicare and Medicaid populations. Similar measures might be used in managed care organizations. If your practice was a Health Resources & Services Administration (HRSA) health center that served geographically isolated and underserved populations, the health center would be required to provide data for the align with the CMS measures, but the populations (e.g., ages) might be different. The same is true for Medicaid programs. Your practice will report data, frequently the same type of data, for quality measures, for multiple populations (i.e., HEDIS measures for commercial insurance, CMS measures for Medicare, state Medicaid program measures, Medicaid Managed Care Organizations, [Medicare Advantage](#) (Medicare Part C)).

Understanding the effectiveness of MNT and/or DSMT/ES services (if applicable) can help RDNs articulate exactly how MNT will help the organization perform well in clinical quality, improve care and outcomes, and earn maximum payments (and avoid losing payment) in value-based arrangements. To learn more about the effectiveness of MNT for specific conditions, see the Academy's Evidence Analysis Library (EAL). Most importantly, if improvements in care translate into improved outcomes in the form of reductions in avoidable health care spending, the practice is likely to receive payments in the form of shared savings. This is a key element of many value-based payments.

To learn more about quality measurement outside of this exercise, a good resource is the [Partnership for Quality Measurement](#).

Population Health Management

Population health management** is also integral to value-based care programs and necessary to provide the most effective care for different populations, and to use resources effectively. Population health management interventions can occur in both clinical and community-based settings. Population health management is not public health, although there can be overlap in population health and public health. In this context, the focus is to improve the health of populations with diabetes (i.e., high risk, moderate risk, low risk), prevent diabetes in populations with prediabetes, and deliver primary prevention. Population health management compels the use of data to inform the intervention strategies that you will use with your populations with diabetes. Examining data for the populations with diabetes helps the RDN and the practice determine which populations will receive a particular kind of care/intervention(s) (e.g., individual or group MNT, DSMT/ES, coaching, case management services, other programs/services, [national diabetes prevention program](#) (NDPP), technology enabled interventions). See the National Diabetes Prevention Program [Lifestyle Change Program](#) and [Curricula](#).

Organizations and practices use population management and analytics to understand population data at the practice level (e.g., disease registries, risk scores, specific reports) and to identify patients who need care or preventive services (e.g., overdue for A1c test or retinal examination). RDNs may use the analytics and reporting tools to inform interventions for diabetes. Examples could include but are not limited to populations with A1c > 9%, A1c parameters (e.g., 8.0-8.9%), comorbidities (e.g., hypertension, hyperlipidemia, obesity), patients who have not filled medications, and/or positive food insecurity screening.

Value-based payments offer greater flexibility in how services are provided, including MNT and other services provided by RDNs; claims and billing requirements should not dictate how, where and when care is provided. RDNs may be able to be more innovative and creative, depending on the environment and the value-based arrangements.

The following questions are to help you begin to identify ways that MNT and RDNs can help the practice perform well in clinical quality and implement effective population management strategies to support the

organization's efforts to earn maximum payments in the value-based payment arrangements. The questions below can prepare you to help other stakeholders (e.g., health care team, administration) understand how MNT and RDNs can be leveraged to achieve the practice's goals related to care improvement and financial sustainability.

1. **Refer to current [HEDIS](#) and [CMS](#) diabetes measures. For which specific measures (or components of a group measure) is there effectiveness data to support the use of MNT alone or in concert with other interventions to achieve the goal of the measures (i.e., the measure numerator)? Standards of care and recommendations change or time. Measure specifications or the measures in use may also change, so answers may be different based on the time period.**
2. **Identify at least two [HEDIS Effectiveness of Care](#) measures that have a connection with MNT or other counseling that is within the general scope of practice of the RDN (e.g., counseling for physical activity).**
3. **The organization is evaluating cost-effectiveness in the delivery of care. If a physician leader asked you how much MNT (i.e., the average "dose") is needed to achieve treatment goals for type 2 DM (e.g., A1c, post prandial targets), how would you answer that question?**

Hint: refer to the Academy's [Evidence Analysis Library](#). You could also refer to other literature to inform

your estimate. There might be several right answers depending on how long someone has diabetes, baseline glycemic control, and treatment goals by population. Provide a general estimate so that the organization can consider population numbers and the resources and cost to the organization for the RDNs to provide care.

4. **The practice has populations with type 1 diabetes, type 2 diabetes, and gestational diabetes who are likely to benefit from MNT, as well as populations with prediabetes, and others at high-risk for diabetes. Individualized MNT may be indicated but it is not realistic to offer MNT for every individual. Some populations may be able to improve health, achieve treatment goals, or delay the onset of disease through other interventions.**

What other interventions (e.g., evidence-based structured programs) could be employed as part of your population management strategy around diabetes, prediabetes, and others at-risk for diabetes? The RDNs do not necessarily have to provide all services but could oversee the delivery of other programs and services. You can also use nutrition and dietetic technicians, registered and health coaches. Services can be provided in-person, via telehealth, or through other technologies, or offered through community partners.

5. **What is your population management strategy for the continuum of diabetes? You can be creative.**

***Population health** refers to "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." Population health also addresses determinants of health, such as medical care, public health programs, social factors, physical environment, personal behavior, and genetics. Examples of populations include geographic regions, ethnic groups, employees, patients in a health care setting, or groups sharing other common characteristics, such as disabled persons or prisoners.¹

****Population health management** is the management of health and outcomes for subpopulations. It can also include a set of actions, backed, and dictated by the flow of information, that guide providers to the best way to providing optimal services to a group of patients with specific health care needs.²

¹ Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003 March; 93(3):380–383.

² Bresnick, J. Is there a true definition of population health management? April 2015. <https://healthitanalytics.com/news/is-there-a-true-definition-of-population-health-management>

From the Academy of Nutrition and Dietetics [Nutrition in Evolving Health Care Delivery Task Force Report](#) September 11, 2020

Handling Denied Claims

Preceptor directions:

- Obtain two or three **EOB** statements and associated claims forms for denied claims for MNT services from your facility's billing office or your practice's files. Remove/or mark up all identifying patient information in accordance with **HIPAA**. Present these modified printouts to your intern. Direct the intern to identify the problem and resolution to obtain reimbursement using the *Coding and Billing handbook* as a resource to explain the terms and process steps required.
- Alternatively, copy and present the following EOB statements to your intern. Direct the intern to identify the problem and resolution to obtain reimbursement using the *Coding and Billing handbook* as a resource to explain the terms and process steps required.
- Give your intern a specified time limit in which the intern should complete the assignment.
- Please schedule a discussion period following the intern's submission of the assignment

What You Need to Know About Rejected and Denied Claims

Rejected Claim: A rejected claim is a claim that cannot be processed because information is incomplete or invalid. An example might contain an inactive or incorrect health insurance member identification number, incorrect address, or missing National Provider Identifier (NPI) number. Rejected claims are "returned" to the submitter *without* being registered in the claim processing system of the payer. Many electronic claims submission platforms do not allow a claim to be submitted if required information is missing, reducing the likelihood that claims are rejected due to incomplete information. Many payers offer tips to avoid or resolve rejected claims in online provider resources.

Resubmitting Rejected Claims: A rejected claim can be resubmitted once the errors have been corrected since the data was never entered into the system. If you are unable to determine why a claim has been rejected, start by confirming the patient demographic and insurance information, and confirm the individual's demographic in-

formation matches health plan data (e.g., address on file at the health plan could be different than a member's living address). Double check to make sure that all fields on the claim contain accurate information. If you do not find any errors, contact provider services of the health plan to doublecheck you have the correct patient information. Be aware that the insurance company will not provide patient data to you, they will only confirm the accuracy of the information you share.

Even though rejected claims never reached the payer, the time to file a claim is still important, as each payer has a certain timeline in which the claim will be considered a *timely filed claim*. For example, Medicare claims must be resubmitted within one year from the date of the service. If not filed within the payers' guidelines, the RDN may not have any rights to payment. RDNs should be familiar with all claims filing deadlines for each payer and any state laws that govern medical claims filing.

Denied Claim: Unlike a rejected claim, which contains incomplete or invalid information, a denied claim is one that has been processed by the payer and determined to be "unpayable." Some common reasons for denied claims for MNT include:

- Service not covered based on benefits
- Diagnosis (ICD-10) not covered (per an individual insurance policy)
- Services exceed the coverage (e.g., number of visits)
- Provider is out-of-network (if person does not have **out of network** benefits)
- Policy not active/member not currently enrolled
- Referring provider NPI information missing (if required)
- **Prior authorization** number required (if applicable)
- Untimely filing: Time limit for claim submission exceeded
- Duplicate claim submission

Managing Denied Claims: Once a claim is received and processed by a health plan, a summary statement will be issued to the provider in the form of an **explanation of benefits (EOB)** or electronic **remittance advice (ERA)**. The EOB/ERA will detail if and how the claim has been paid. Should a claim be denied, the EOB/ERA will note the reason for the denial in the form of Claim Adjustment Reason Codes (CARCs) and/or Remittance Advice Remark Codes (RARCs). CARCs explain the reasons for any financial adjustments to payment such as a denial or reduction in payment, while RARCs further explain an adjustment or relay informational messages that cannot be expressed with a CARC. The Centers for Medicare & Medicaid services requires all Medicare Administrative Contractors (MACs) to use the same standard denial reason codes and statements. Visit the [CMS website](#) for a list of **Medicare Part B** Reason Codes and Statements. State Medicaid programs and individual private payers may use different codes and language. Denied claims are not resubmitted to payers, but they can be appealed. RDNs would follow the provider appeals process as directed by the payer.

Provider Appeal of Denied Claims: If a denied claim is resubmitted without an appeal or a reconsideration request, it may be considered a duplicate submission and you could receive a “duplicate claim rejection” on your resubmission. A provider appeal is an official request for reconsideration of a previous denial. EOB statements provide standard language regarding provider appeals. Each payer has its own set of policies, so always check with the payer for details for resubmitting claims for appeal.

Avoiding Denied Claims: Regardless of the process, appealing claims can be time-consuming and costly. The key to avoiding denied claims is to maintain current client information in your systems and take steps to confirm patient benefits and coverage details before providing services. Many RDNs will call in advance to make sure they get paid, which is the safest way to go, but is time consuming. Alternatively, you can have your patients call their insurance to confirm benefits. Provide your patients with specific questions to ask, such as, do they have a benefit for MNT (CPT® codes 97802-4), are there any exclusions, how many visits are allowed, do deductibles apply, must the provider be in-network, etc. Doing so puts the patient in charge of their benefits.

Always remember to have the patient sign a statement of patient financial responsibility waiver prior to providing services. Financial waiver forms provide notification to patients about the practice’s expectations regarding insurance coverage and associated payment for services. By signing the waiver form, the patient agrees to be financially liable if the item or service is denied coverage.

Provider Explanation of Benefits

Red & Blue Insurance

PROVIDER NAME PROVIDER NUMBER STATEMENT DATE
Debra Dietitian **1234567891** **03/22/21**

Detail of Claims

PATIENT NAME PATIENT ACCOUNT NUMBER MEMBER ID# CLAIM NUMBER
Nancy Nutrition **222-33** **RB987654** **123-456**

			Charges	Charges Not Allowed	Amount Allowed
Service	Procedure Code: 97802	Date(s): 01/28/21-01/28/21	\$300.00	\$300.00	\$0.00
Information	Service Type/Place: 6/OFC No. of Units: 6				
Payment Calculation	Allowed Amount				\$0.00

Plan Payment for this service: \$0.00
Total Patient Responsibility: \$179.10
Total Payment for this Claim: \$0.00

MESSAGE(S) SENT TO YOUR PATIENT:

This is not a covered service under your policy. Please refer to the exclusions part of your contract or benefit booklet.

PATIENT NAME PATIENT ACCOUNT NUMBER MEMBER ID# CLAIM NUMBER
Nancy Nutrition **222-33** **RB987654** **456-123**

			Charges	Charges Not Allowed	Amount Allowed
Service	Procedure Code: 97803	Date(s): 02/25/21-02/25/21	\$250.00	\$250.00	\$0.00
Information	Service Type/Place: 6/OFC No. of Units: 5				
Payment Calculation	Allowed Amount				\$0.00

Plan Payment for this service: \$0.00
Total Patient Responsibility: \$129.15
Total Payment for this Claim: \$0.00

MESSAGE(S) SENT TO YOUR PATIENT:

This is not a covered service under your policy. Please refer to the exclusions part of your contract or benefit booklet.

AMERICAN GOVERNMENT HEALTH SERVICES, INC.
 PO BOX 1122
 THE CITY, ZZ 99887
 1-888-777-6666

MEDICARE
 REMITTANCE
 ADVICE

Interactive Voice Response: 1-888-777-5555
 TTY for hearing Impaired: 1-888-777-4444

Have you considered receiving Electronic Remittance Advice? An Electronic Remittance Advice (ERA) is an outbound electronic data interchange (EDI) transaction that enables you to receive payment information in an electronic file format. The ERA option is so easy! No paper EOMBS to misplace or store.

For more facts and information go to the Web site at:
www.AMGHS.com

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME:	NORA KNOWLEDGE	HIC	1112223333444				ACNT	KNOWLEDGE	ICN	995566773344	ASG Y MOA MA01	
	0927	092713	11	4.0	97802		200.00	0.00	0.00	0.00	CO-119	200.00
REM:	M25	N386										
	0927	092713	11	1.0	G8485		200.00	0.00	0.00	0.00	CO-96	0.00
REM:	M365											
	0927	092713	11	1.0	3044F		200.00	0.00	0.00	0.00	CO-96	0.00
REM:	M365											
	0927	092713	11	1.0	3048F		200.00	0.00	0.00	0.00	CO-96	0.00
REM:	M365											
	0927	092713	11	1.0	G8417		200.00	0.00	0.00	0.00	CO-96	0.00
REM:	M365											
PT RESP	0.00				CLAIMS TOTALS		200.00	0.00	0.00	0.00	200.00	0.00
											NET	0.00

TOTALS: # OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
1	200.00	0.00	0.00	0.00	200.00	0.00	0.00	0.00

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes.

- CO Contractual obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
- 119 Benefit maximum for this time or occurrence has been reached.
- 96 Non-covered charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment if present
- MA01 Alert: If you do not agree with what we approved for the services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal you must write to us with 120 days of the date you receive this notice, unless you have a good reason for being late.
- M25 The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal we will upon application from the patient, reimburse him/her the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
- N365 This procedure code is not payable. It is for reporting/information purposes only. \
- N386 This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of his policies available at www.cms.gov if you do not have web access you may contact the contractor to request a copy of the NCD.

AMERICA'S Healthcare • PO Box 123 • Your City, XZ 12345 • 1.888.999.7777

DATE: 03/31/21
TIN: 00-101010
NPI: 1122334455
GROUP NUMBER: 66778899
GROUP NAME: ABC INDUSTRY
TRACE NUMBER: 010101

**PROVIDER
EXPLANATION OF
BENEFITS**

PATIENT: Ellen Eatwell

MEMBER NAME: Ellen Eatwell
MEMBER ID: 55443322
PATIENT ACCOUNT: EE5544

CONTROLNUMBER: 7654
DATE RECEIVED: 03/24/21
PROVIDER OF SERVICE: Debra Dietitian

DATE(S) OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT	COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP
03/19/21	97803	\$250.00	\$250.00						\$0.00	MB	
	CONTROL # 1092837	\$250.00	\$250.00						\$0.00	#	\$250.00
	SUBTOTAL:										
TOTAL PAYABLE TO PROVIDER									\$0.00		

REMARKS:

(MB): YOU HAVE REACHED THE LIFETIME MAXIMUM BENEFIT ALLOWED BY YOUR PLAN.

(#): PAYMNET OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF A PERFERRED PROVIDER ORGANIZATION.

The member, provider or an authorized representative may request reconsideration or appeal the decision by submitting comments, documents or other information to America's healthcare. Network providers should refer to the administrative guide for claim reconsideration or appeal information. If you are a network provider appealing a clinical or coverage determination on behalf of the member, or a non-network provider appealing a decision on behalf of the member, follow the process for appeal in the members benefit plan document. Document on appeals made on behalf of members will be completed in 30 days of submission or within the timeframe required by law.

America's healthcare is improving service to you by adopting electronic payments and statements as a standard way to pay claims. To obtain information about electronic payments and statements find it on the homepage on America's Healthcare website or contact us at the phone number at the top of the page.

Answers to this assignment will be specific to each facility/private practice. Please refer back to the Case Studies section of this document.

Answers and Discussion Notes

Case Study 1a – Private Practice	Answers and Discussion Notes
<p>The scenario: You are in private practice in your own office. You are newly starting out and have no staff yet. You are a provider with a number of third party payers.</p> <p>The phone rings and you answer it.</p> <p>The person on the phone is John Doe. He explains he was told to call you by his doctor and make an appointment. He was recently diagnosed with type 2 diabetes. His doctor wants him to lose weight.</p> <p>1. What questions do you have or information do you need to obtain from Mr. Doe concerning his insurance while he is on the phone?</p>	<p><i>Do you have insurance? If so, whom are you insured with? What is your insurance identification number, exact spelling of your last name on your name on the insurance card and your date of birth?</i></p> <p><i>Who referred you?</i></p> <p><i>Do you know if you need a referral to see a specialist? If you need a referral do you know if your doctor has made a referral through your insurance?</i></p>
<p>Mr. Doe says he has Blue Cross Blue Shield (BCBS) through his work and has the written referral from his doctor.</p> <p>2. Now that you know Mr. Doe's insurance carrier and he says he has a referral, what additional information do you need about Mr. Doe's insurance and referral?</p>	<p><i>Am I an in-network provider for BCBS?</i></p> <p><i>Am I covered under his plan?</i></p> <p><i>What type of plan do you have? Is it an HMO?</i></p> <p><i>Is the referral written on a prescription pad or is it an insurance (BCBS) generated document?</i></p> <p><i>Request insurance health plan (BCBS) contact information (phone, email or website) to confirm coverage.</i></p>
<p>You call Mr. Doe's BCBS.</p> <p>3. What information do you need to have to speak or check online with his insurance?</p>	<p><i>Your name, NPI number and EIN.</i></p> <p><i>Mr. Doe's name as it appears on his insurance card, his insurance identification number and date of birth.</i></p>
<p>4. What questions do you need to ask Mr. Doe's insurance company in order to determine if your MNT will be covered for Mr. Doe?</p>	<p><i>Does Mr. Doe's plan cover MNT for diabetes?</i></p> <p><i>If so, how many visits or units are allowed and in what time frame?</i></p> <p><i>Is a referral required? Who can generate the referral? How will the referral be received? How long is a referral good for?</i></p> <p><i>Does Mr. Doe have a copayment or deductible? If so, what is it?</i></p>
<p>Mr. Doe was approved by BCBS for 24 units of MNT for 180 days starting December 15, 2020. The first appointment is made for Mr. Doe for January 2, 2021 at 1:00 p.m.</p> <p>It is January 2 at 1:00 p.m. Mr. Doe has arrived to your office for his MNT.</p> <p>5. What must you obtain from him at the appointment?</p>	<p><i>Completed patient registration form</i></p> <p><i>A copy (front and back) of his insurance card.</i></p> <p><i>The referral.</i></p> <p><i>A signature on file providing permission to bill his insurance.</i></p> <p><i>A signature from Mr. Doe for receipt of HIPAA Notice of Privacy Practices.</i></p> <p><i>His copayment or deductible (if it is established at the time of appointment).</i></p>

Case Study 1a – Private Practice	Answers and Discussion Notes
<p>After the appointment you will need to submit an insurance claim form for Mr. Doe’s service.</p> <p>6. What is the name of the insurance form to complete in private practice?</p>	<p><i>1500 claim form.</i></p>
<p>7. On the attached insurance form, complete the information for it to be submitted to Mr. Doe’s insurance company.</p>	<p><i>Refer to completed 1500 claim form.</i></p>
<p>You submit the claims to BCBS on January 2. It is now March 1 and you have not received any information on the claim.</p> <p>8. As a result of not receiving an EOB or any communiqué on the claim by March 1, what should you do?</p>	<p><i>Confirm BCBS received the claim.</i></p> <p><i>There is a time limit from date of service for claims to be submitted.</i></p> <p><i>Explain why you want to follow up on the claim.</i></p>
<p>You receive the EOB and the claim was paid.</p> <p>9. If the claim was denied, what can you learn from the EOB?</p>	<p><i>The reason the claim was denied.</i></p>



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Blue Cross Blue Shield

PO Box XX
Anywhere XX 22222

CARRIER

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John										3. PATIENT'S BIRTH DATE MM DD YY 01 01 60 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
5. PATIENT'S ADDRESS (No., Street) 123 Main Street										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Hometown STATE ZZ										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE 11111 TELEPHONE (Include Area Code) (111) 222-3333										8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED SIGNATURE ON FILE DATE										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE John Friendly										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
A. E11.9 B. E66.3 C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS PC/INTER F. \$ CHARGES G. DAYS OR UNITS H. EPST/ Priority Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1 01 02 21 01 02 21 02 97802 AB XX 00 6 NPI 222222222										25. FEDERAL TAX I.D. NUMBER 9987654321 SSN EIN <input checked="" type="checkbox"/>									
2 										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
3 										28. TOTAL CHARGE \$ 0 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use									
4 										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.)									
5 										32. SERVICE FACILITY LOCATION INFORMATION Mary Smith RDN 234 Central Ave Anywhere ZZ 11111									
6 										33. BILLING PROVIDER INFO & PH # Mary Smith RDN 234 Central Ave Anywhere ZZ 11111									
SIGNED Mary Smith RDN DATE 01/02/2021										a. 9987654321 b. 9987654321									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FCHM 1500 (02-12)

Clear Form

PATIENT NAME
Nancy Nutrition

PATIENT ACCOUNT NUMBER
222-33

MEMBER ID#
RB987654

CLAIM NUMBER
456-123

			Charges	Charges Not Allowed	Amount Allowed
Service	Procedure Code: 97803	Date(s): 02/25/21-02/25/21	\$250.00	\$250.00	\$0.00
Information	Service Type/Place: 6/OFC No. of Units: 5				

Payment Allowed Amount \$0.00
Calculation

Plan Payment for this service: \$0.00

Total Patient Responsibility: \$129.15

Total Payment for this Claim: \$0.00

MESSAGE(S) SENT TO YOUR PATIENT:

This is not a covered service under your policy. Please refer to the exclusions part of your contract or benefit booklet.

Case Study 1b – Private Practice - Telehealth	Answers and Discussion Notes
<p>The scenario: You are in private practice in your own office. You are newly starting out and have no staff yet. You are a provider with a number of third-party payers. You provide services in person as well as via telehealth.</p> <p>The phone rings and you answer it. The person on the phone is John Doe. He explains he was told to call you by his doctor and make an appointment. He was recently diagnosed with type 2 diabetes. His doctor wants him to lose weight. He would like the appointment to be telehealth.</p> <p>1. What questions do you have, or information do you need to obtain from Mr. Doe concerning his insurance while he is on the phone?</p>	<p>Do you have insurance? If so, whom are you insured with? What is your insurance identification number, exact spelling of your first and last name as it appears on your insurance card and your date of birth?</p> <p>Who referred you?</p> <p>Do you know if virtual services or telehealth is available through your plan?</p> <p>Do you know if you need a referral to see a specialist? If you need a referral, do you know if your doctor has made a referral through your insurance?</p>
<p>Mr. Doe says he has Blue Cross Blue Shield (BCBS) through his work and has the written referral from his doctor.</p> <p>2. Now that you know Mr. Doe's insurance carrier and he says he has a referral, what additional information do you need about Mr. Doe's insurance and referral?</p>	<p><i>Am I an in-network provider for BCBS? Am I covered under his plan?</i></p> <p><i>What type of plan do you have? Is it an HMO?</i></p> <p><i>Is the referral written on a prescription pad/printed from an electronic platform, or is it an insurance (BCBS) generated document?</i></p> <p><i>Does the plan allow for services via telehealth?</i></p> <p><i>Request insurance health plan (BCBS) contact information (phone, email, or website) to confirm coverage.</i></p>
<p>You call Mr. Doe's BCBS.</p> <p>3. What information do you need to have to speak or check online with his insurance?</p>	<p><i>Your name, NPI number, and EIN. Mr. Doe's name as it appears on his insurance card, his insurance identification number, and date of birth.</i></p>
<p>4. What questions do you need to ask Mr. Doe's insurance company to determine if your MNT will be covered for Mr. Doe?</p>	<p><i>Does Mr. Doe's plan cover MNT for diabetes? If so, are services allowed to be conducted via telehealth? If so, how many visits or units are allowed and in what time frame?</i></p> <p><i>Is a referral required? Who can generate the referral? How will the referral be received?</i></p> <p><i>How long is a referral good for?</i></p> <p><i>Does Mr. Doe have a copayment, coinsurance, or deductible? If so, what is it?</i></p>
<p>Mr. Doe's plan does allow for the same number of telehealth visits as in-person visits. He was approved by BCBS for 24 units of MNT for 180 days starting December 15, 2020. The first appointment is made for Mr. Doe for January 2, 2021, at 1:00 p.m. It is January 2 at 1 p.m. and Mr. Doe has signed into his telehealth appointment.</p> <p>5. What must you obtain from him at the appointment?</p>	<p>Completed patient registration form.</p> <p>Telehealth consent form.</p> <p>A copy (front and back) of his insurance card. The referral.</p> <p>A signature on file providing permission to bill his insurance.</p> <p>A signature from Mr. Doe for receipt of HIPAA Notice of Privacy Practices.</p> <p>His copayment or deductible (if it is established at the time of appointment).</p>
<p>After the appointment you will need to submit an insurance claim form for Mr. Doe's service.</p> <p>6. What is the name of the insurance form to complete in private practice?</p> <p>7. On the attached insurance form, complete the information for it to be submitted to Mr. Doe's insurance company.</p>	<p>CMS 1500 claim form.</p> <p>Refer to completed 1500 claim form.</p>
<p>You submit the claims to BCBS on January 2. It is now March 1 and you have not received any information on the claim.</p> <p>8. As a result of not receiving an EOB or any communiqué on the claim by March 1 what should you do?</p>	<p>Confirm BCBS received the claim by calling or checking online. You will need the date of service and billed amount. There is a time limit from date of service for claims to be submitted. Be sure to record your call reference number in case you need to call again about the claim.</p> <p>Explain why you want to follow up on the claim.</p>
<p>You receive the EOB and the claim was paid.</p> <p>9. If the claim was denied, what can you learn from the EOB?</p>	<p>The reason the claim was denied.</p>



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Blue Cross Blue Shield

PO Box XX
Anywhere XX 22222

CARRIER

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John										3. PATIENT'S BIRTH DATE MM DD YY 01 01 60 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John																													
5. PATIENT'S ADDRESS (No., Street) 123 Main Street										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																													
CITY Hometown					STATE ZZ					CITY					STATE																																		
ZIP CODE 11111					TELEPHONE (Include Area Code) (111) 222-3333					ZIP CODE					TELEPHONE (Include Area Code)																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>																													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. OTHER CLAIM ID (Designated by NUCC)																													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																													
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.																																							
SIGNED SIGNATURE ON FILE DATE										SIGNED SIGNATURE ON FILE																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL										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 John Friendly										17a NPI 1123456789										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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										A E11.9 B E66.3 C D										23. PRIOR AUTHORIZATION NUMBER																													
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. EPSTI Priority Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										1 01 02 21 01 02 21 02 97802 AB XX 00 6 NPI 222222222										2 NPI																													
3 NPI										4 NPI										5 NPI																													
6 NPI										25. FEDERAL TAX I.D. NUMBER 9987654321 SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 0 00 29. AMOUNT PAID \$ 0 00 30. Rsvd 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.) Mary Smith RDN 01/02/2021										32. SERVICE FACILITY LOCATION INFORMATION Mary Smith RDN 234 Central Ave Anywhere ZZ 11111 * 9987654321										33. BILLING PROVIDER INFO & PH # Mary Smith RDN (222) 555-6666 234 Central Ave Anywhere ZZ 11111 a. 9987654321 b.																													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FCHM 1500 (02-12)

Clear Form

Case Study 2 – Hospital-Based Non-Medicare

Answers and Discussion Notes

<p>The scenario: Adult ambulatory care dietitian receives a consult from the Family Medicine Clinic for Mr. Bobby Jones to receive Medical Nutrition Therapy for Diabetes. Mr. Jones is 40 years old.</p> <p>1. What information must the referring physician provide?</p>	<p><i>Patient name/medical record number.</i></p> <p><i>Qualifying medical diagnosis – ICD-10 CM code.</i></p> <p><i>Written provider referral.</i></p> <p><i>Physician signature.</i></p>
<p>2. Before seeing the patient, what must you verify?</p>	<p><i>That the patient has insurance.</i></p> <p><i>That the insurance company recognizes the hospital as a provider and the dietitian as a provider.</i></p> <p><i>That the service is covered by the payer if the patient has insurance.</i></p> <p><i>That the patient is willing to pay for the service (since it is a non-covered benefit) if the patient does not have insurance.</i></p>
<p>3. If you are not a provider for an insurance company, how do you become a provider?</p>	<p><i>Contact the facility department that administers the insurance contracts and find out if dietitians have been designated as providers; work with that department if the work has not yet been done.</i></p>
<p>4. If a patient was referred for MNT for a non-covered service, what form would the patient need to sign?</p>	<p><i>Advance beneficiary notice (ABN) of non-covered services or an equivalent document of patient financial responsibility.</i></p>
<p>5. What are the units of service for each of these codes?</p>	<p><i>You will need to check with the insurance carrier to see what they will cover.</i></p>
<p>6. Now that you have provided the MNT and documented the service, what CPT® codes are available for you to use?</p>	<p><i>97802, 97803 and 97804 are the most common codes.</i></p>
<p>7. What is the maximum number of visits you can see the patient?</p>	<p><i>It depends on the insurance company; many follow the Medicare regulations and use 15 minutes for 97802 and 97803 and 30 minutes for 97804. Always check.</i></p> <p><i>Again, it depends on the insurance company and what they allow; remember that different companies administer different plans and may have different nutrition benefits. Never assume all BCBS plans cover MNT or that the plan for Mr. Jones is the same as the plan for Ms. Smith, whom you saw last week for Diabetes.</i></p>
<p>8. What if a patient needs more time due to the complexity of the disease, change in treatment, etc.? What do you do? What codes will you bill?</p>	<p><i>You may need to obtain a new referral from the physician.</i></p> <p><i>The insurance company will let you know what codes to use.</i></p>
<p>9. If your institution did not have electronic billing, which form would you use to bill for this service?</p>	<p><i>UB-04 form</i></p>

Case Study 3a – Hospital-Based Medicare	Answers and Discussion Notes
<p>The scenario: Susie Jones is a newly hired dietitian in an ambulatory clinic in a hospital. As a new employee specific criteria must be met and specific forms must be filled out before providing Medical Nutrition Therapy to Medicare patients.</p> <p>1. What qualifications must you meet and what paperwork must you complete to become a Medicare provider?</p>	<p>Registered Dietitian.</p> <p>Licensed or certified credential if the state in which she is practicing has licensure or certification.</p> <p>CMS 855I – Medicare Enrollment Application for Physicians and Non-Physician Practitioners.</p> <p>Credentialed with the institution.</p>
<p>Ms. Jones receives a consult from the Family Medicine Clinic for Ms. Betty Jo Smith to receive Medical Nutrition Therapy for her Chronic Kidney Disease. Ms. Smith is 65 years old and is a Medicare beneficiary.</p> <p>2. What information must the referring physician provide?</p>	<p>Patient name/medical record number.</p> <p>Qualifying medical diagnosis – ICD-10-CM code.</p> <p>Written provider referral.</p> <p>Physician signature.</p>
<p>3. Before seeing the patient, what must you verify?</p>	<p>That the patient has Medicare part B.</p> <p>That the service being requested is covered by Medicare.</p> <p>If the patient does not have Medicare part B, that the patient is willing to pay for the service since it is a non-covered benefit.</p>
<p>4. What MNT services are covered by Medicare part B?</p>	<p>Diabetes Mellitus – Type 1, Type 2 and Gestational.</p> <p>Chronic Kidney Disease not on dialysis with a creatinine clearance/estimated glomerular filtration rate (eGFR) between 15-59 ml/mm/ 1.73m²</p> <p>OR post-kidney transplant within 3 years of transplantation.</p>
<p>5. If a patient was referred for MNT for a non-covered service, what form would the patient need to sign?</p>	<p>Advanced beneficiary notice of non-covered services.</p>
<p>6. What three CPT® codes are available for you to bill under?</p>	<p>97802.</p> <p>97803.</p> <p>97804.</p>
<p>7. What are the units of service for each of these codes?</p>	<p>97802 and 97803 – 15 minutes.</p> <p>97804 – 30 minutes.</p>
<p>8. What are the maximum hours that you can bill CMS for each of these codes in the first year you see the patient? Subsequent years?</p>	<p>97802 – can only be used once for initial assessment of a new patient or for the initial assessment of a patient who has not received the MNT benefit in over 3 years.</p> <p>97803 – reassessment and all interventions after the initial visit.</p> <p>97804 – billed only for group visits, initial and subsequent</p> <p>First year – 3 hours total.</p> <p>Subsequent years – 2 hours total.</p>
<p>9. What if a patient needs more time due to the complexity of the disease, change in treatment, etc.? What do you do? What codes will you bill?</p>	<p>You would need to obtain a new referral from the physician.</p> <p>G0270 – individual.</p> <p>G0271 – group.</p>
<p>10. If your institution did not have electronic billing, which form would you use to bill for this service?</p>	<p>1500 claim form or the UB-04 form</p>
<p>11. Since you are working in a hospital, is the amount CMS will pay you per unit of service for MNT more or less than if you were in private practice? Why?</p>	<p>Less; it is assumed that since you work in a hospital, you would have less overhead/practice costs.</p>

Case Study 3b – Hospital-Based Medicare – Telehealth	Answers and Discussion Notes
<p>The scenario: Jordan is a newly hired dietitian in an ambulatory clinic in a hospital. As a new employee, specific criteria must be met and specific forms must be filled out before providing Medical Nutrition Therapy to Medicare patients.</p> <p>1. What qualifications must you meet and what paperwork must you complete to become a Medicare provider?</p>	<p><i>Registered Dietitian.</i></p> <p><i>Licensed or certified credential if the state in which she is practicing has licensure or certification.</i></p> <p><i>CMS 855I – Medicare Enrollment Application for Physicians and Non-Physician Practitioners.</i></p> <p><i>Credentialed with the institution.</i></p>
<p>Through the hospital's Electronic Health Record (EHR), Jordan receives a consult from the Family Medicine Clinic for Ms. Garcia to receive Medical Nutrition Therapy for her chronic kidney disease. Ms. Garcia is 65 years old, a Medicare beneficiary and lives in a rural area.</p> <p>2. Does she meet the geographical requirements for Medicare to pay for her MNT visit provided via telehealth?</p>	<p><i>Yes. There are not specific mileage requirements. Metropolitan statistical areas need to be looked up to confirm eligibility: https://data.hrsa.gov/tools/medicare/telehealth.</i></p>
<p>3. What information must the referring physician provide?</p> <p>a. Can the referral come from a mid-level provider (PA, NP, etc.) in the Family Medicine Clinic?</p>	<p><i>Patient name/medical record number.</i></p> <p><i>Qualifying medical diagnosis – ICD-10-CM code.</i></p> <p><i>Written provider referral.</i></p> <p><i>Physician signature.</i></p> <p><i>No. At this time, Medicare only accepts physician referrals</i></p>
<p>4. As part of the hospital's EHR, you can see that Ms. Garcia has Medicare Part B coverage.</p> <p>Which diagnosis are approved by Medicare Part B to receive MNT services?</p>	<p><i>Diabetes Mellitus – Type 1, Type 2 and Gestational.</i></p> <p><i>Chronic Kidney Disease not on dialysis with a creatinine clearance/estimated glomerular filtration rate (eGFR) between 15-59 mL/min/1.73m² OR post-kidney transplant within 3 years of transplantation.</i></p>
<p>5. Before Jordan calls Ms. Garcia, to schedule the appointment, she reviews the medical record which indicates it is a new diagnosis which Ms. Garcia has not counseled on before.</p> <p>a. What is the maximum number of hours the patient can be seen for approved Medicare conditions?</p> <p>b. If this were not a new diagnosis, how would the number of hours allowed change?</p>	<p><i>3 Hours.</i></p> <p><i>It would decrease up to 2 hours per year.</i></p>
<p>6. Jordan calls Ms. Garcia to schedule the appointment. What needs to be confirmed for the visit to be able to occur?</p> <p>Jordan explains how she will receive the meeting invite and notifies her that it is a secure platform. Through the platform she will have the ability to e-sign all consents and forms and pay her co-pay. Since this was an initial visit, a 60- minute consult was scheduled. Ms. Garcia was a few minutes late and 49 minutes were therefore spent meeting face to face with her.</p>	<p><i>That she has audio and visual capabilities.</i></p>
<p>7. What should be added to the documentation since the visit was provided via telehealth?</p>	<p><i>A statement indicating that the service was provided via telehealth and that the patient had both audio and visual capabilities.</i></p>
<p>8. What CPT code should be used?</p>	<p><i>97802</i></p>
<p>9. What are the units of the CPT® code should be charged?</p>	<p><i>3</i></p>
<p>10. What needs to be adjusted on the billing form?</p>	<p><i>The place of service code should be changed from 22 (on campus- outpatient hospital) to 02 (telehealth)</i></p>
<p>11. Medicare will not adjust their reimbursement rate to the hospital due to payment parity. Define parity as it relates to telemedicine payment.</p>	<p><i>Payment parity means reimbursement for telemedicine care is the same as in-person care.</i></p>

Case Study 4 – Value-Based Payments

Answers and Discussion Notes

<p>Refer to the current HEDIS and CMS diabetes measures.</p> <p>6. For which specific measures (or components of a group measure) is there effectiveness data to support the use of MNT alone or in concert with other interventions to achieve the goal of the measures (i.e., the numerator)?</p>	<ul style="list-style-type: none"> • Reduce the percent of high-risk adults with diabetes with A1c \geq 9% • Achieve A1c reductions < 8% and < 7% respectively • Blood pressure: Use or add MNT to achieve blood pressure treatment goals (< 140/90)
<p>7. Identify at least two HEDIS Effectiveness of Care measures that have a connection with MNT or other counseling that is within the general scope of practice of the RDN.</p>	<ul style="list-style-type: none"> • Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents • Controlling High Blood Pressure • Adult BMI Assessment • Physical Activity in older adults
<p>The organization is evaluating cost-effectiveness in the delivery of care.</p> <p>8. If a physician leader asked you how much MNT (i.e., the average “dose”) is needed to achieve treatment goals for type 2 DM (e.g., A1c, post prandial targets), how would you answer that question?</p>	<ul style="list-style-type: none"> • Interns can refer to the Academy’s Evidence Analysis Library to inform their answers. • Interns could also refer to robust studies regarding the intensity and frequency of MNT for diabetes to inform this estimate. EAL summaries are conducted periodically and may not include more recent studies, so updated studies should be considered as part of the answer. • There could be several answers depending on the duration of diabetes, baseline glycemic control, and different treatment goals by population (e.g., older adults have different treatment goals). There may not be one “right” answer, but rather a range of answers that can inform the “dose” of MNT. Studies using telehealth and remote physiologic monitoring may further inform the effective “dose” of MNT and other interventions needed to improve care and achieve treatment goals. • Provide a general estimate so that the organization can consider population numbers and the resources and cost to the organization for the RDNs to deliver care. <p><i>Evidence Analysis Library Recommendations Summary (2015)</i></p> <p><i>The registered dietitian nutritionist (RDN) should implement three to six medical nutrition therapy (MNT) encounters during the first six months and determine if additional MNT encounters are needed. In studies reporting on the implementation of an initial series of RDN encounters (three to eleven; total of two to sixteen hours), MNT significantly lowered HbA1c by 0.3% to 2.0% in adults with type 2 diabetes and by 1.0% to 1.9% in adults with type 1 diabetes during the first six months, as well as optimization of medication therapy and improved quality of life.</i></p> <p><i>The registered dietitian nutritionist (RDN) should implement a minimum of one annual medical nutrition therapy (MNT) follow-up encounter. Studies longer than six months report that continued MNT encounters resulted in maintenance and continued reductions of A1C for up to two years in adults with type 2 diabetes, and for up to six and a half years in adults with type 1 diabetes.</i></p>

Case Study 4 – Value-Based Payments

The practice has populations with type 1 diabetes, type 2 diabetes, and gestational diabetes who are likely to benefit from MNT, as well as populations with prediabetes, and others at high- risk for diabetes.

Individualized MNT may be indicated but it is not realistic to offer MNT for every individual. Some populations may be able to improve health, achieve treatment goals, or delay the onset of disease through other interventions.

9. What other interventions (e.g., evidence-based structured programs) could be employed as part of your population management strategy around diabetes, prediabetes, and for others at-risk for diabetes?

The RDNs do not necessarily have to provide all services but could oversee the delivery of other programs and services. You can also use nutrition and dietetic technicians, registered and health coaches. Services can be provided in person, via telehealth, or through other technologies, or offered through community partners.

10. What is your population management strategy for the continuum of diabetes? You can be creative.

Answers and Discussion Notes

There could be many correct answers:

- *Use disease registries and/or analytics to examine the populations of diabetes.*
- *Conduct proactive outreach (data/reports) to populations with A1c \geq 9% and others identified as high risk based on the organization's criteria.*
- *Offer individual MNT for all who are DM high-risk (assumes risk stratification).*
- *Offer combination individual and group MNT (in-person and virtual) for moderate risk.*
- *Develop internal protocols for referrals for MNT, including standing orders based on criteria established by the health care team/organization.*
- *Use remote patient monitoring for moderate and high-risk populations, as appropriate.*
- *Provide MNT using a combination of in-person, telehealth and telephonic interventions based on what is appropriate for individuals.*
- *Offer DSMT/ES to all individuals with diabetes (offer in-person and virtual sessions).*
- *Provide on-demand content such as patient videos regarding specific diabetes topics (could be original or outsourced).*
- *Offer group MNT for lowest risk populations with DM.*
- *Offer food as medicine cooking classes for diabetes.*
- *Provide food insecurity screenings and referrals to resources. Screenings are conducted by medical assistants.*
- *Start a diabetes prevention program and have NDTRs trained to deliver the NDPP.*
- *Alternatively, refer individuals to other organizations in the community that offer the National Diabetes Prevention Program. Some individuals may be able to access other DPP services made available through their health plan or even an employer. Many health plans have contracts with other DPP providers in the community or companies that offer virtual DPP.*
- *Offer individual MNT for populations with prediabetes where the NDPP is not appropriate (e.g., such as when weight loss is undesirable).*
- *Consider use of trained health coaches to help patients who need additional support regarding behavior change.*

Populations at risk for diabetes:

Individual MNT as appropriate. Refer patients to programs available through health plan vendor programs such as Wellness services and health coaching offered through other vendors. These are services that might be available to health plan members outside of the medical setting (discounted gym memberships. Patients could also be referred to other community-based programs.

Physical activity:

Identify community resources to engage populations in physical activity. Test the use of apps in different populations.

Other answers might include but would not be expected:

- *Continuous Glucose Monitoring for type 2 DM (e.g., high risk)*
- *Use of health and well-being coaches for patients who need additional support around behavior change*
- *Contracting with a vendor for other diabetes virtual services*
- *Patient education content made available on demand*

