Cracking the Code: Part 1

Alphabet Soup: Understanding the Use of Coding/Billing Terminology

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Session Objectives

• Identify procedure codes for nutrition and nutrition-related services that may be reimbursed by commercial third party payers.

• Recognize coding use and payment trends among RDNs across the country.

• Recognize opportunities to expand nutrition practice to receive payment for nutrition and nutrition-related services in multiple settings.

Academy Coding and Coverage Committee (CCC) External Advocacy

• Monitor Medicare fee schedule and work with CMS regarding Medicare MNT services.
  Outcome: Increased payment to RD providers

• At AMA coding meetings, committee members Jane White, Karen Smith, Keith Ayoob, Jessie Pavlinac and Marsha Schofield represent RDNs’ interests.
  Outcome: New codes for billing RDN services; physician recognition and increased referrals to RDNs

www.eatright.org/mnt
• Partner with external groups (e.g., the Alliance for a Healthier Generation) to increase MNT coverage provided by RDNs.

Outcome: RDN reimbursement for MNT services for obese/overweight children

www.eatright.org/coverage

Terms and Acronyms

CMS = Centers for Medicare & Medicaid Services

Medicare
  Part A: hospital services
  Part B: funds outpatient professional services/
        Dx. Tests/lab, etc.
  Part C: MC Advantage Plans
  Part D: prescription drugs

HIPAA = Health Insurance Portability and Accountability Act

NPI = National Provider Identifier

National Provider Identifier (NPI)

• A 10 digit number used to recognize the provider on claims transactions

• Applicable to all providers (HIPAA requirement)

• Lasts indefinitely; does NOT contain “intelligence”
National Provider Identifier

- Providers get **ONE** NPI, regardless of the number of practice offices.
- Group practices, hospitals, corporations get an NPI (see CMS Medlearn article: http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf)
- Contact the National Plan & Provider Enumeration System
  - Apply over the Web: https://nppes.cms.hhs.gov
  - Apply by phone: 1-800-465-3203 (NPI Toll-Free)

Terms and Acronyms

NPI = National Provider Identifier - standard unique identifier that replaces other provider numbers used on healthcare claims.

Diagnosis codes (ICD-9) = Describe an individual’s disease or medical condition; physicians and trained billers determine these codes

CPT codes = Current Procedural Terminology codes (procedure codes) that describe the service performed by the healthcare professional

HCPCS codes = Healthcare Common Procedure Coding System developed by payers to describe services where no CPT code exists

ICD-9 Diagnosis Codes (determined by MD)

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

**Diabetes Mellitus – 250.XX**
include a 4th digit which indicates the type of complication, and include a 5th digit which indicates the diabetes type and control
  - 250.00 - type II or unspecified type, without mention of complication, not stated as uncontrolled
  - 250.52 - type II or unspecified type, with ophthalmic manifestations, uncontrolled
Coming in October 2014: ICD-10CM & ICD-10-PCS

Transition to ICD-10 will impact all billing software, forms, and billing procedures.

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

Includes about 8,000 categories

More at: www.eatright.org/coverage/

Diagnosis Code Resources

AMA CPT Process

- Code creation and valuation for payment
  - CMS and private payers
- Standardized Uniform Language
  - Medical, surgical procedures/services
- Communications Vehicle
  - Payers—language of reimbursement
  - National/International research standardization
- Research and Quality Assurance
- Pay for Performance (P4P)
AMA RUC Process

Valuation of codes:
• Healthcare provider groups survey members to recommend code values
• AMA panel of physicians and other healthcare professionals determine code values via comparison to existing code values
• Ultimately, health plan determines code payment amounts

Components of CPT Codes

3 components are reviewed to establish a code value:

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

Definition of Work

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

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

3) **Practice liability expense (4.3%)**
   Malpractice insurance

MNT CPT Codes

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

Face-to-Face Time/Unit Billed

For any single “15 minute face-to-face” CPT code:

<table>
<thead>
<tr>
<th>Face to face actual time spent:</th>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 unit &gt; 8 minutes to &lt; 23 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>2 units &gt; 23 minutes to &lt; 38 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>3 units &gt; 38 minutes to &lt; 53 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>4 units &gt; 53 minutes to &lt; 68 minutes</td>
<td>60 minutes / 1 hour</td>
</tr>
<tr>
<td>5 units &gt; 68 minutes to &lt; 83 minutes</td>
<td>75 minutes</td>
</tr>
<tr>
<td>6 units &gt; 83 minutes to &lt; 98 minutes</td>
<td>90 minutes / 1.5 hours</td>
</tr>
<tr>
<td>7 units &gt; 98 minutes to &lt; 113 minutes</td>
<td>105 minutes</td>
</tr>
<tr>
<td>8 units &gt; 113 minutes to &lt; 128 minutes</td>
<td>120 minutes / 2 hours</td>
</tr>
</tbody>
</table>
MNT "G" Codes
Healthcare Common Procedure Coding System 2012

G0270
• MNT re-assessment and subsequent intervention(s) following 2nd referral in the same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease); individual; face-to-face; each 15 minutes

G0271
• MNT re-assessment and subsequent intervention(s), group (2 or more individuals), each 30 minutes

Procedure Codes Applicable to RDNs
Education and Training Codes

98960
Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

98961
Each 30 minutes; 2-4 patients

98962
Each 30 minutes; 5-8 patients
Not billable to Medicare; check payer policies to determine use of codes (see handout for details)

Procedure Codes Applicable to RDNs
Medical Team Conference Codes

Minimum 3 professionals, different disciplines

99366 ... participation by non-physician provider, with patient/family present, ≥ 30 minutes

99368 ... participation by non-physician provider, without patient/family present, ≥ 30 minutes
Not billable to Medicare; check payer policies to determine use of codes
(see handout for details)
Codes Applicable to RDNs for Intensive Behavioral Therapy (IBT) for Obesity

- G0447 Face-to-Face Behavioral Counseling for Obesity, 15 Minutes
- ICD-9 diagnosis codes for BMI 30.0 kg/m² or over (V85.30-V85.39, V85.41-V85.45)
- Service can be provided up to 22 times in a 12-month period per CMS schedule
- RDNs can provide IBT as auxiliary personnel in primary care settings
- RDNs must bill as "incident to physician services" (guidelines differ for office-based vs. hospital outpatient clinics)
- Billable to Medicare; check private payer policies for use of code

Learn more at: http://www.eatright.org/Members/content.aspx?id=6442468513

Procedure Codes Applicable to RDNs
Telephone Services

- Non-physician, non-face-to-face assessment and management services by phone. If patient is seen within 24 hours (or next available urgent visit appointment) the call is considered part of the pre-service work of the visit. If the call is in reference to services provided within the prior 7 days, it is considered part of the post-service work of the visit.
  - 98966 ......, 5-10 minutes of "medical" discussion
  - 98967 ......, 11-20 minutes
  - 98968 ......, 21-30 minutes

Not billable to Medicare; check payer policies to determine use of codes. (see handout for details)

Telehealth Services Under Medicare

- Individual Medicare MNT can be provided via tele-health
- Use the MNT code 97802 and modifier “GT”
- Must use an interactive audio and video tele-communications system that permits real-time communication between RDN and patient
- Go to www.eatright.org/practice - Telehealth for details on Medicare MNT telehealth
98969
On-line Medical Evaluation: Online assessment and management service provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network.

Not billable to Medicare; check payer policies to determine use of codes.

99401-99404
Preventive medicine counseling and/or risk factor reduction intervention; individual; 15, 30, 45 or 60 minutes

99411-99412
Preventive medicine counseling and/or risk factor reduction intervention; group; 30 minutes or 60 minutes

Used for persons without a specific illness

Not billable to Medicare; check payer policies to determine use of codes.

Based on local scope of practice, state licensure and/or facility requirements, RDNs who pursue additional training to demonstrate competencies may be eligible to provide other billable services, such as:

• Smoking and tobacco use cessation counseling
• Training on insulin administration devices
• Continuous glucose monitoring

(check local laws and payer policies)
Medicare Performance Measures

Medicare Physician Quality Reporting System (PQRS)

- RDN Medicare providers eligible for a bonus payment (0.5%) if report on at least 3 measures OR report 1-2 measures for at least 50% of claims submitted
- Bonus payment changes to penalty:
  - 2015: 1.5% penalty
  - 2016: 2% penalty
- Details at [www.eatright.org/mnt](http://www.eatright.org/mnt); go to Medicare MNT, then "Medicare Quality Reporting System"
- PQRS measures and procedures updated annually

*Claims reporting: different reporting guidelines apply for reporting via EHR

Medicare 2013 PQRS RDN Measures

Examples of commonly reported PQRS Measures:

- **PQRS1**: Diabetes Mellitus: Hemoglobin A1c Poor Control
- **PQRS2**: Diabetes Mellitus: Low Density Lipoprotein Control in Diabetes Mellitus
- **PQRS3**: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- **PQRS122**: Adult Kidney Disease: Blood Pressure Management
How Does This Coding Data Apply to Me?

Compliance with current regulations:
• NPI/HIPPA
• Correct coding initiatives – payers
• PQRS incentives

Drive future EBP (practice)
• Track Outcomes
  – Health improvement
  – Reimbursement
• Track New Services Requests
• Improve Contracts Negotiation
  – Reimbursement rates
  – Expanded services provision
Academy Resources to Market and Promote MNT Services

Third Party Payer Brochure: For Private Payer CEOs, Medical Directors and Provider Relations executives

Medical Nutrition Therapy MNTWorks® Kit: A marketing tool designed to increase MNT coverage and consumer access to MNT services provided by RDNs

Academy Resources For Your Practice

MNT Provider Newsletter
The MNT Provider newsletter is an essential practice management resource specifically tailored to registered dietitians to assist in navigating and understanding the complexities of Medical Nutrition Therapy coverage and reimbursement. Available monthly online as a free member benefit.

Evidence Analysis Library (www.andeadvidencelibrary.com/)
- Data on MNT Effectiveness
- Data on impact of the RDN and additional cost savings data
Additional Academy Resources


Academy state dietetic association & DPG Reimbursement Representatives: to assist RDNs with local coverage and coding issues (check Academy or affiliate/DPG web page for rep contacts information)

Academy Resources For Your Practice

Case Study

A 66-year-old female has been diagnosed with type 2 diabetes. MDs makes a referral to the RDN for MNT.

MD Progress Note:
  Problem 1: Type 2 diabetes, uncontrolled: 250.02. Patient reluctant to start another medication.
  Referral for MNT; start with 3 visits with RDN

  Weight: 155 lb, trace edema
  BP: 135/72
  Fasting BS: 184 mg/dl, 2 hr. pp 250
  HbA1c: 8.4
  Lipid panel results/LDL: 150mg/dl
Case Study

Key items biller lists on CMS 1500 claim form

1. Complete patient contact/demographic information and visit documentation (EBPG)

2. Enter diagnosis code, 250.02, on line 21
   - Use diagnosis code from physician; review referral form, MD script, or call MD office for code
   (See handout for sample claims form)

3. Enter CPT code 97802 (initial MNT) on line 24d
   - List number of MNT units on line 24g
     For example: 60 minutes = 4 units
     Base # units listed only on time spent with patient (face-to-face)
   - Modifiers (for Medicare MNT Telehealth) if relevant
     List GT modifier on line 24d in "modifier" column

4. PQRS performance measures
   - List PQRS measure, e.g. 3045F, on line 24d
   - List on a separate row, e.g. row 2, from the MNT service

5. Complete provider information
   - RDN name and NPI on line 33 and 33a
   - If MD referral required, list MD and MD NPI on line 17 and 17b.

Questions?

reimburse@eatright.org