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

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Chair, Academy Nutrition Services Payment Committee

Disclosures

I have no commercial relationships to disclose relevant to the topic being presented.

Session Objectives

• Identify procedure codes for nutrition and nutrition-related services that may be reimbursed by Medicare and/or commercial third party payers.
• Recognize opportunities to expand nutrition practice to receive payment for nutrition and nutrition-related services in multiple settings.
• Recognize coding use and payment trends among RDNs across the country.
• Recognize new tools and resources included on the Academy’s website to help educate RDNs on this topic.
Academy Coding & Coverage Committee (CCC)

Becky Sulik, RDN, CDE, LD - Chair
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- Jane White, PhD, RD, LDN, FAND (RUC Panel Rep)

Staff:
- Marsha Schofield, MS, RD, LDN, FAND
- Mara Bujnowski, MAEd, RD

NSPC Purpose/Member Benefits

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

Advocacy
Increase RDN recognition and coverage for RDN services.

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

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

National/Grassroots
Public Payers/Private Payers

Introductory Terms & Acronyms

AMA: American Medical Association
- Code Creation Panel → Services Descriptors
RUC: RVS Update Committee
- Code Valuation Panel → Payment
RVS: Resource-Based Relative Value System
HCPAC: Health Care Professionals Advisory Committee (non-physician panel)
NCPT: Academy developed standardized language used to describe the Nutrition Care Process; used in the documentation of nutrition services provision
- does not replace ICD-9 diagnosis
Basic Terms and Acronyms

CMS: Centers for Medicare & Medicaid Services

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

HIPAA: Health Insurance Portability & Accountability Act

NPI: National Provider Identifier

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

National Provider Identifier (NPI)

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

Become a Qualified Provider

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

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

More Basic Terms and Acronyms

Codes: international/national numeric designations used to describe:

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

ICD-9 Diagnosis Codes

*(determined by MD)*

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

**Diabetes Mellitus – 250.XX**
include a 4th digit which indicates the type of complication, and include a 5th digit which indicates the diabetes type and control
- 250.00 - type II or unspecified type, without mention of complication, not stated as uncontrolled
- 250.52 - type II or unspecified type, with ophthalmic manifestations, uncontrolled
### Coming 10/15??: ICD-10CM & ICD-10-PCS

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

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

Includes about 8,000 categories

More at: [www.eatrightPRO.org](http://www.eatrightPRO.org)

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### Diagnosis Code Resources

![Image](image1.png)

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### Components of CPT Code Values

3 components are reviewed to establish a code value:

1) **Work - describes the service provided (48.3%)**

   - **Pre-service work**
     - Review (medical) records, lab work, obtain vitals, room set up, informed consent, etc.

   - **Intra-service work**
     - History and presenting problem, review of systems, treatment options, create &/or distribute educational materials, arrange follow-up and/or referral as needed

   - **Post-service work**
     - Documentation, communication with referring physician, care coordination, short-term (7d) communication with patient as needed
Definition of Work

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

Components of CPT Code Values

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

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

MNT CPT Codes

97802
- MNT initial assessment and intervention, individual, face-to-face, each 15 minutes

97803
- MNT, reassessment and intervention, individual, individual, face-to-face, each 15 minutes

97804
- MNT, group, 2 or more individuals, each 30 minutes

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(search: cpt® Code/Relative Value Search)
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 2014

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, 3 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)

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**Procedure Codes Applicable to RDNs**

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

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

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

[www.eatrightPRO.org](http://www.eatrightPRO.org) → Practice → Getting Paid → Nuts&Bolts

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**Procedure Codes Applicable to RDNs**

**Medicare Annual Wellness Visit (AWV)**

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

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

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

Learn more at:

[www.eatrightPRO.org](http://www.eatrightPRO.org) → Practice → Getting Paid → Nuts&Bolts
Medicare Annual Wellness Visit (AWV)

What does it include?

- Health Risk Assessment
- Medical/family history
- Height, weight, BMI, blood pressure and other routine measurements
- List of current providers and suppliers
- Screening for cognitive impairment
- Screening for depression
- Assessment of functional status
- Establishment of a written screening schedule
- Establishment of a list of risk factors and conditions for which treatment is being received or recommended
- Personal health advice and appropriate referrals for education or preventive services

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 telehealth

Use the MNT code 97802 and modifier “GT”

• Must use an interactive audio and video telecommunications system that permits real-time communication between RDN and patient
• Go to www.eatrightPRO.org for details on Medicare MNT telehealth
### Procedure Codes Applicable to RDNs

#### Online Medical Evaluation

**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)*

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#### Preventive Medicine

**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)*

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#### Chronic Care Management

**99490**

Chronic care management services; at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.
### Complex Chronic Care Coordination Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99487</td>
<td>Complex care coordination services; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month</td>
</tr>
<tr>
<td>99489</td>
<td>Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month</td>
</tr>
</tbody>
</table>

Cannot report if care plan is unchanged or requires minimal change.
Requires medical decision making of moderate or high complexity.

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

### Activities may include:

- Communication with family/caregivers
- Communication with home health agencies/community services
- Collection of health outcomes data
- Patient/caregiver education
- Assessment and support for treatment regimen adherence
- Identification of available community and health resources
- Facilitating access to care and services for patient/family
- Development/maintenance of comprehensive care plan
Procedure Codes Applicable to RDNs with Additional Training

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)*

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CPT Code Resources

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Medicare Performance Measures: PQRS Codes ([www.eatright.org/mnt](http://www.eatright.org/mnt))

- RDN Medicare providers can avoid a downward payment adjustment if report on at least 9 measures across 3 National Quality Domains for at least 50% of Medicare FFS patients.
- If provider sees at least 1 Medicare patient in a face-to-face encounter, must report at least 1 cross-cutting measure (as part of the 9).
- 2015 reporting data determines the downward payment adjustment (-2%) to be applied in 2017
  - Payment in 2015 based on 2013 reporting (potential -1.5% downward adjustment)
  - Payment in 2016 based on 2014 reporting (potential -2% downward adjustment)
Medicare 2015 PQRS RDN Measures

2015 PQRS Measures Applicable to RDNs:

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

Qnetsupport@sdps.com

* Denotes a "cross-cutting" measure

Medicare Performance Measures:
PQRS Codes (www.eatright.org/mnt)

- Details and free webinar available at www.eatrightPRO.org; go to PRACTICE->Getting Paid->Nuts & Bolts of Getting Paid
- PQRS measures and procedures updated annually
- Report PQRS measures using QDCs (Quality Data Codes)
  Example: 3046F
- Coming in 2018: Value Modifier Payment (ties PQRS with cost)

The 2013 Academy Coding Survey Results
Email Invitation:
Provision of MNT in Ambulatory Care (Billable) Settings (ACS):
- All member/non-member RDNs in Academy/CDR database;
  - Not retired
  - Email address
  - US residence
  - Total Emailed n = 82,262
  - Total Respondents n = 5,840
- Provide 8/or manage provision of MNT in ACS n = 3,628
  - Completed entire survey n = 3,015 (~83%)

Coding Survey Demographics:
Response by Practitioner Type

Employment Status:
Response by Practitioner Type
22.8% of total respondents don’t carry or don’t know if they carry malpractice insurance.
Case Study

A 66 year old female has been newly diagnosed with Type 2 DM.

MD Progress Note:
- Type 2 DM, uncontrolled; 250.02
- Patient reluctant to start another medication.
- Referral for MNT, 3 visits
- Weight: 155 lbs, trace edema
- BP 135/72
- HbA1c: 8.4
- LDL: 150mg/dl, TG: 275 mg/dl

Case Study

Key items biller lists on CMS 1500 claims form
Even if RDN doesn't bill themselves, you should/may need to provide codes and information included on claim – YOU are responsible for all services billed under your name

1. Complete patient contact/demographic information & visit documentation (EBPGs)
2. Enter ICD-9 code 250.02 on line 21
   Use diagnosis code from the referring physician (PCP); review referral form, MD prescription, or call MD office for diagnostic (ICD-9) code.

(see handout for sample claims form)
Case Study

Key items to list on CMS 1500 claims form (cont.)

3. Enter CPT code 97802 (initial MNT) on line 24d
   - List number of MNT units on line 24g (your documentation should contain the number of face-to-face (f-2-f) minutes you spent with the patient
   For example: 60 minutes = 4 units – base # units you list on actual f-2-f time spent with patient
   Modifiers, if relevant (i.e., Medicare, Telehealth MNT)
   - List GT modifier on line 24d in "modifier" column

Your “To Do” List:  1.0

✓ Malpractice Insurance Coverage: www.eatright.org/Members/MAP
✓ Establish a Usual & Customary Fee
✓ Compliance with current regulations:
   • NPI → HIPPA required
   • Correct coding
   • PQRS Incentives → Penalties

Your “To Do” List:  2.0

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