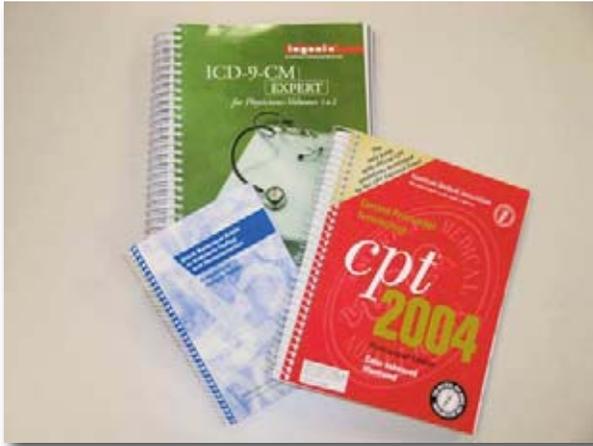




Step 4: Learn More About Procedural (CPT) Codes and Diagnosis (ICD-9) Codes for Reimbursement



“Every provider must understand that accurate ICD-9 and CPT coding is necessary not only for facility clinical statistics, but also for reimbursement purposes. Documentation is critical to support the accuracy of this coding.”

– CDR Sandra Lahi, RHIA, CPC
IHS Office of Information Technology

To successfully document and secure reimbursement for MNT services, it is important that you become familiar with the procedural (CPT) and diagnosis (ICD-9) codes used by the CMS.

What are the CPT codes for MNT services?

Providers use CPT, or Current Procedural Terminology, codes to describe the procedures that were performed during the patient visit.

The MNT CPT codes are unique codes that describe MNT services provided by nutrition professionals. The CMS requires that you use these codes when documenting MNT services for Medicare reimbursement. Table 1 provides the MNT CPT codes.

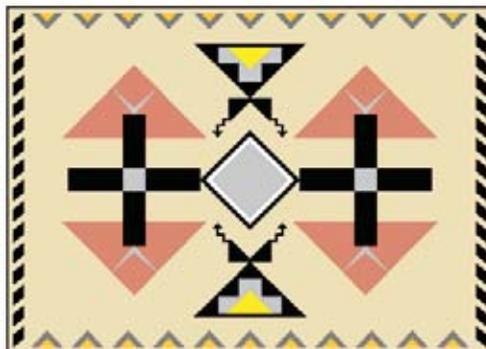




Table 1. MNT CPT codes.

MNT CPT code	Description	Time unit
97802	Initial, individual MNT visit: <ul style="list-style-type: none">• Initial assessment and intervention visit.• Individual, face-to-face visit with the patient.	1 unit = 15 minutes
97803	Follow-up, individual MNT visit: <ul style="list-style-type: none">• Subsequent visit.• Individual, face-to-face visit with the patient.	1 unit = 15 minutes
97804	Group MNT visit with two or more individuals.	1 unit = 30 minutes

The MNT CPT codes are time-based. As an MNT provider, you can bill for multiple time units (e.g., a one-hour, individual session = 4 time units) based on the medical complexity of the patient, but you can only bill for face-to-face time with the patient. This means that you cannot bill for preparation time or post-session documentation time. Note: The IHS recommends that you document exact patient encounter start time and end time. The billing office will translate the start time and end times of the visit into appropriate time units when submitting a patient claim.

What are the ICD-9 codes for MNT services?

ICD-9 codes, or codes from the *International Classification of Diseases, 9th Revision, Clinical Modifications*, are used to describe diagnoses. The 3–5 digit ICD-9 diagnosis codes covered in the Medicare Part B MNT benefit are listed in the following sections of the codebook:

- 250.02: Series codes for diabetes
- 585.00: Series codes for chronic kidney failure

Once the provider documents the diagnosis code, the coding staff will assign the specific code into the system.

You will need to obtain the correct diagnosis from the patient's treating physician. As an RD or nutrition professional, you cannot determine the medical diagnosis because this is beyond the scope of your practice. (Please refer to Kulkarni *et al.*, 2005, for more information on the standards of practice for nutrition in diabetes care.)



What are the MNT G codes?

The CMS established two additional codes for MNT, called G codes. The G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered in the calendar year. This can occur when the treating physician issues an additional referral during the same calendar year and determines a change of diagnosis or medical condition that makes a change in diet necessary. The CMS has not set a specific limit on the number of these additional hours. Table 2 provides the MNT G codes.

Table 2. MNT G codes.

MNT G code	Description	Time unit
G0270	<p>Individual MNT visit:</p> <ul style="list-style-type: none"> • Reassessment and subsequent intervention(s) following the second referral in the same calendar year for a change in diagnosis, medical condition, or treatment regimen (including additional hours needed for kidney disease). • Individual, face-to-face visit with the patient. 	1 unit = 15 minutes
G0271	<p>Group MNT visit:</p> <ul style="list-style-type: none"> • Reassessment and subsequent intervention(s) following the second referral in the same calendar year for a change in diagnosis, medical condition, or treatment regimen (including additional hours needed for kidney disease). • Group visit with two or more patients. 	1 unit = 30 minutes