



Step 5: Document MNT Services



“Documentation issues remain. However, the Electronic Health Record will simplify the reimbursement process by making a seamless connection between the RD’s CPT coding and business office billing.”

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

To obtain reimbursement for MNT services, you must properly document the services that you provide. The government, private insurance, and health care accrediting agencies require that you submit complete and accurate documentation.

What information do I need to document?

The CMS *requires* that qualifying RDs and nutrition professionals use nationally recognized protocols to document MNT services. The American Dietetic Association (ADA) has developed nationally recognized protocols, which are also known as evidence-based guidelines. The ADA’s Nutrition Practice Guidelines describe the information you need to document MNT visits (Table 3). **We strongly urge you to use these evidence-based guidelines.** To obtain these guidelines, visit the website: www.eatright.org (click on “Shop Online”, click on “Professional Reference”, and scroll down to “MNT Evidence-based Guides for Practice CD-ROMs”).





Table 3: Overview of information needed to document MNT reimbursement.

Initial MNT visit: 60–90 minutes	Follow-up MNT visits: 30–45 minutes
<ul style="list-style-type: none"> • Receipt of referral from the treating physician and name of the primary dietitian. • Diagnosis (provided by the treating physician). • Reason for the visit. • Start and stop time and date of the visit. • <i>Step 1. Nutrition assessment</i> <ul style="list-style-type: none"> - Obtain and collect data. - Analyze and interpret using evidence-based standards. • <i>Step 2. Nutrition diagnosis</i> <ul style="list-style-type: none"> - Identify and label problem. - Cluster signs, symptoms, and defining characteristics. - Determine cause and contributing risk factor. • <i>Step 3. Nutrition intervention</i> <ul style="list-style-type: none"> - Plan: Formulate goals and determine a plan of action with client. - Implement: Deliver care and carry out actions. • <i>Step 4. Nutrition monitoring and evaluation</i> <ul style="list-style-type: none"> - Monitor progress. - Measure outcome indicators. - Evaluate outcomes. • Schedule follow-up appointment. • RD signature. 	<ul style="list-style-type: none"> • Start and stop time and date of the visit. • Lab data and measurements. • Progress to goals. • Adjustments to care plan. • Interventions: New and reinforcement MNT services, and rationale for the new treatment. • Barriers and solutions. • Follow-up plans. • Discharge of patient (when MNT is complete or patient ends services). • RD signature.



(Please refer to Appendix B for a case study that describes how to document MNT services during the initial and follow-up visits in the Indian health system using the ADA-recommended format. Appendix D provides information on how to obtain the nutrition practice guidelines and the standardized nutrition care process and language.)

What documentation forms are used in the IHS?

The standard form most commonly used in the IHS for documenting MNT services is the **PCC Ambulatory Encounter Record** for face-to-face patient encounters. (Please refer to Appendix C for a sample PCC encounter form.)

You will need to ensure that the PCC Ambulatory Encounter Record is complete and accurate so that the data entry and billing offices can submit the claim:

- Enter the start time and end time of the visit.
- Enter the clinic number.
- Include the treating physician referral.
- List the diagnosis from the treating physician.
- Enter the MNT CPT codes.
- Provide your signature as the RD or nutrition professional who provided the MNT services.

Note: The IHS recommends that you document the exact patient encounter start time and end time. The billing office will translate the start and end times of the visit into appropriate time units when submitting a patient claim.

Other methods of documenting MNT services within the IHS include:

- Electronic Health Record.
- PCC+ Customizable Encounter Form, which can be electronically customized by the provider or clinic.
- PCC Group Preventive Services Form, which is used to document group encounters.

No matter what method you use for documentation, the data entry and billing offices need the same elements of information to submit patient claims for reimbursement.

What is the MNT super bill for claims processing activities?

A super bill, also known as an encounter or charge ticket, is an efficient way to document care. Although a super bill does not get submitted to Medicare, Medicaid, or third party health insurance, you can use it to identify billable MNT services for the billing office.



A super bill is particularly beneficial if you are using the standard PCC Ambulatory Encounter Record, rather than the Electronic Health Record or PCC+ Customized Encounter Form, to document MNT services. The Electronic Health Record and PCC+ Customized Encounter Form incorporate the CPT and ICD-9 codes into computer-generated forms; this minimizes coding errors for data entry and billing. The PCC Ambulatory Encounter Record, on the other hand, does not include codes unless someone manually adds them. To help remedy this problem, the super bill includes a list of ICD-9 and CPT codes. It should also include areas for the following information:

- MNT CPT codes.
- ICD-9 codes.
- Clinic name and address.
- RD provider information, such as name, phone and fax number, and signature.
- Patient name.
- Start time and end time of the visit.
- Referring treating physician and date.

Appendix C includes a sample IHS super bill. You may want to consult with your billing or data entry office before adopting, modifying, or creating a super bill. They may be helpful in providing suggestions on the format and content of the super bill.

What are the IHS Patient Education Protocols and Codes?

The IHS Patient Education Protocols and Codes (PEP-C) are another key part of the MNT Medicare reimbursement process. The codes are not required for reimbursement, but they are essential for documenting and tracking MNT services appropriately.

Any health care provider, such as a physician, RD, or community health representative, who provides patient education can use the codes. The codes provide a quick method of documenting the education given during a patient visit. When properly documented on a PCC form, the data entry staff can enter these education codes into RPMS. This information appears on the RPMS health summary, which informs health care providers if a patient has received education on specific topics, as well as the patient's level of understanding, readiness to learn, barriers to learning, and behavior changes assessed during the encounters.

When an RD provides nutrition education, you should use the "MNT" code. Only an RD can use the "MNT" code when documenting nutrition education. MNT is more comprehensive than nutrition education. MNT includes *not only* nutrition education *but also* the full array of patient therapies, such as medication, physical activity, and behavioral health.



One limitation associated with the codes is their lack of detail on patient education. You should provide specific education information in the SOAP (subjective, objective, assessment, plan) note. (In the case study in Appendix B, you will see examples of SOAP notes in the PCC forms.)

The codes are also used for tracking and synthesizing data for the Government Performance and Results Act (GPRA) indicators, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and Clinical Reporting System (CRS).

For more information on the IHS PEP-C, visit the website: www.ihs.gov (click on “Nationwide Programs and Initiative s” and select “Patient Education Protocols and Codes” under “Section Highlights”).

