

Division of Diabetes Treatment and Prevention

Advancements in Diabetes Seminar Show Me the Money! MNT Reimbursement 101

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Diane Phillips:

Thank you Jan and Kelli. My name is Diane Phillips and I am the Nutrition Manager at the Santa Fe Indian Hospital. And as Jan had previously mentioned, I've been involved with MNT for a long time. I've also been involved with Indian Health Service. April will be my 19th year with the Indian Health Service and I recall my first presentation I did and I was introduced as the baby dietitian and now I'm like, "Oh my gosh!" Now, I'm the old one or the senior dietitian, maybe I should refer to myself as.

I first started my career in Santa Fe and I was fortunate to work with great mentors with Jan, with Leeanna Travis, with Tammy Brown, who got me really excited about reimbursement and revenue generation, because historically, dietitians could not bill. Our site along with some of our national partners, really got involved in looking and exploring reimbursement. And from that, we have seen numbers of dietitians grow.

It's definitely an exciting topic and it's very dear to my heart because I've been involved with it for all these years and I'm excited to be here today to share the information with you all and share some potential new avenues for reimbursement as well.

As Jan has already showed us, our objective for today after completing this training, the participants will be able to locate and use the IHS Step-by-Step Guide to MNT Reimbursement. We will be able to identify one change you can make to reduce administrative inefficiencies in your MNT billing process at your site and identify one change that you can make to maximize your MNT reimbursement at your site.

Before we dive into the in and outs of MNT reimbursement, I kind of want to take a step back and look at and discuss who are the different payers and some of the differences between our payers. So, our main payers are Medicare, Medicaid and private insurance.

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities are also qualified and also people with end-stage renal disease who require dialysis or who have had a transplant. When somebody has Medicare coverage, there are additional coverage services under the different parts as far as A, B. I'm not going to get into their C, D, G, all the other ones. But we're just going to focus on A. Well, I'm going to discuss A, but we're going to really focus on Part B today.

Medicare Part A is the part that once you qualify and enroll, everybody receives Part A. So, this essentially is the hospital insurance. Part A covers your inpatient hospital stay, care in a skilled nursing facility, hospice care and some home healthcare.

Part B is a supplemental insurance. So, Part B has to be paid by the beneficiary to receive this benefit. So, there's a monthly fee for people to receive a Part B coverage. So, Part B covers certain doctor services, outpatient care, medical supplies and preventative services.



Within the IHS, a lot of patients are eligible for B. Some choose not to pay for that added service. Some sites choose to pay for that for their beneficiaries. Some Tribes choose to pay for that for beneficiaries. So, as far as whether people are enrolled in B, you can see that when you go into EHR and you look at their details on the face sheet, you'll be able to see if they do have Part B. So, it varies across the board as far who has B and who does not.

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Also, as part of the Medicaid program is also the Children's Health Insurance Program often referred to as CHIP. This provides health coverage to eligible children, both through Medicaid and then separate CHIP programming.

Medicaid and CHIP are both administered by the state according to federal requirements. Both programs are funded jointly by the state and by the federal government. So, the requirements, the coverage for Medicaid varies greatly from state to state because the state is deciding on what services are covered within federal guidelines. So, it's really hard to do a consensus guide to say what services are covered state by state because it varies, and it changes year by year. For myself, I think of the Medicaid A part is the kids part, the care part is for the elderly and that's kind of how I distinguish it for myself.

Private insurance, and this is probably what we're most familiar with in our personal life. Private health insurance is offered through employers, organizations or it is purchased on your own. And of course, the cost of these plans and the coverage of these plans vary greatly.

These are the three main payers within the IHS that we're dealing with, Medicare, Medicaid and then the private insurance aspect. So, any questions so far between Medicare and Medicaid? Okay, I don't see anything.

Now, looking at which services are billable by payer for registered dietitians. Majority of our presentation today is going to be focusing on the Medicare Part B coverage but I will touch on the other ones as well, briefly. So, for Medicare Part B coverage for dietitians, the qualifying diagnoses are diabetes, Type 1 and Type 2, the non-dialysis kidney disease, the post-transplant within the past six months. Let me just put a little asterisk on obesity and we'll get back to that in just a minute.

As far as Medicaid, the qualifying diagnoses will vary greatly state by state. There's a federal benefit which is the early periodic screening and detection. For infants, children, prenatal and postnatal, and they don't word it as MNT they actually, word it as nutrition services covered under that benefit. So, because of the federal benefit and most all of the states have that included in their state plan.

We'll talk a little bit more about this in upcoming slides, but our work is cut out for us to work with our billers to identify, specifically for your state, what other services can you bill for Medicaid. Same thing with private insurance, it's going to vary greatly from state to state, plan to plan. So again, that's another area that we need to collectively with our billing department and even your area dietitians kind of research what other insurance coverage is in your local area.

I wanted to touch on the Medicare Part B coverage for obesity. So, in November of 2011, CMS added a new benefit called, "Intensive Behavioral Therapy for Obesity", for Medicare recipients who have a BMI of 30 or greater. So, the way this current benefit is written is that it will only be covered if it is provided by what they define as a qualified primary care physician or other primary care practitioner. When physicians or providers enroll in Medicare, they have to select their primary specialty practice area.

If the primary provider falls into any of those practice areas listed for the provider enrollment, then they can bill for this obesity coverage. And it will only cover this benefit in the primary care practice setting

and those settings are listed there as well. And if a patient is referred to another facility, specialist, to see a dietitian, the patient is responsible for the payment of these services.

Under this current bill, as dietitians, we cannot bill for this obesity, Intensive Behavioral Therapy for Obesity. Then we know within the IHS, our providers really don't have the time to provide this intensive behavioral therapy. So, a lot of questions come in. As far as in the billing world, you can bill incident to the provider visit. So basically, they bill on the provider but the dietitian provides the service. Within the IHS, our answer for this is no, that within the IHS, we as dietitians should not be billing incident to the provider visit for obesity.

I realize there are dietitians in private practice. Even I know there are some Tribal facilities that are doing this, but as far as our billing requirements within the Indian Health Service the guidance we have been given is that we cannot bill "incident to".

That brings me to what I feel to be as a very important bill right now that is in -- there is a bill in the Senate and in the House of Representatives, and you guys may be wondering why you're getting bombarded with emails maybe from your professional associations, from your practice groups, about the Treat and Reduce Obesity Act of 2017. And I promise not to get political or anything on this, okay? But I just want you guys to be aware that this is currently a bill that's in the House and the Senate right now. And what this bill is asking is for the authority to expand healthcare providers qualified to furnish the intensive behavioral therapy. That's a lot of jargon there below because I just pulled it right out of the bill. But basically, they're asking to add additional primary care providers that may not fit in the specialties they listed on the last slide. So, they're asking to include other practitioners such as clinical psychologists and registered dietitians and nutrition professionals.

The other piece that's included in the bill is just to add the additional practice setting as far as an evidence-based, community-based lifestyle counseling program. So, that's kind of just taking it out of the primary care setting and into the community setting. So, this bill is just asking essentially to add these providers and add this other practice setting.

Why is this such an important bill? I think for us, dietitians, we are already seeing all these patients. Probably most of you, the majority of your patients you do see, meet the definition for obesity. So, it would be nice for us to receive reimbursement and payment for services that we are already providing. Also, in terms of revenue, it's a lot of money. It's a lot of coverage. So, I just wanted to give you a quick little coverage comparison.

Under our current coverage, under Medicare Part B coverage for MNT is, let's say, for type 2 diabetes. So, within the first year, we can provide three hours of service for that Medicare patient. So, let's say I did one 60-minute visit and then I did four 30-minute follow-up visits. So, a total of 12 months or the calendar year, I did five outpatient visits.

Now, this is assuming I was the only provider that that patient saw that day and I'll discuss it in our upcoming slides. So, my collection for the five visits would be close to \$1,400.

Why that says minus 20% for Medicare Part B coverage? There is a 20% copay. IHS does not charge that to any of our patients but we don't receive the full 100% reimbursement of the Medicare coverage. So, we have to deduct that 20%, what would be the copay. So, if I see a patient with diabetes for the year, I'm going to get it and get about \$1,400 in reimbursement for that one diabetic patient.

Looking at the Intensive Behavioral Therapy for Obesity, if the bill is passed, the coverage for this bill is one visit per week in the first month, one visit every other week in month two to six. If a patient loses at least three kilograms, they're authorized for one visit a month for the month seven through twelve. What that equates you is 28 visits in the year.

Assuming again you were the only provider seen on that day, our potential collections for those 28 visits minus the copay is \$7,818. So, as you can see, that's a huge difference. So, I currently know this is like five and a half times the revenue that we're currently collecting, so that's why this is really a very important bill. And so, I think most of us dietitians are hoping that this gets passed because it could really help increase our revenue but also lead to increasing our numbers of dietitians at our facilities as well.

I was talking to my CEO about this and I was like, "If I just follow 12 patients under this coverage, that's \$100,000 just for 12 or 13 patients." So with that, I can certainly hire another dietitian.

This brings us back to our IHS Step-by-Step Guide to Medical Nutrition Therapy Reimbursement and I can see some of you are probably familiar with this guide looking at our participant list. Some are familiar, some of you may not. In 2006, the first guide was published kind of as a step-by-step guide. The staff in Santa Fe was working through how do we bill, how do we kind of troubleshoot, what are the steps to make this happen? So, in the process, we said, "Hey, let's make a guide."

The first guide was published in 2006 and between 2006 and 2010, a lot changed. The coverage for MNT changed. They added the coverage for telehealth. I guess actually within 2006 that they added the coverage for telehealth. 2011, they added the group coverage for telehealth. But also, if you think back between 2006 and 2010, is when most of us were transitioning to the electronic health record. We went from PCCs to EHR. We went from paper super-bill to electronic super-bill. So, we went from the old paper IHS referrals to our electronic EHR consult. So, a lot had changed.

That is why in 2010, we had published the updated guide. And then between 2010 and 2012 with the added benefit of the telehealth group, we kind of updated the addendum. There is an addendum. So, we updated that along with updating some of the forms and the electronic records that go along with the EHR.

Where can we find this guide? There are likely paper copies at some of your facilities, but it is no longer being printed but it is available on the IHS website. You can find it under the Division of Diabetes under their clinical resources, under the Standards of Care, Nutrition. You can also find it on the IHS nutrition page under resources. But it's kind of simpler to just go to the search bar within the IHS page and just type in MNT guide or MNT reimbursement and it will pop right up for you.

Also, if you type it into any search engine, it will pop up. Within the guide, there is a chart that compares the benefits between MNT and DSME. In that guide, CMS and our financial intermediary company, let me just say also have that guide or the chart on their website. So, when you do the internet search, it tends to take you right to the PDF document. And if you prefer to watch a video instead of reading about it, there's a really nice Medicine Dish Videocast along with National Institutes of Health and Medicine Dish. So, there is a video called, "Invest in Medical Nutrition Therapy." That also walks you through all of the steps in the reimbursement process.

If you page through the guide, it is structured to go through what are considered to be seven essential steps. Today, I'm going to focus on what -- over the years, we have found that probably may be the most important -- they're all important but some of the ones that are may be key to your success, and I also want to address some of the areas that we receive the most frequent questions as well.

Step 1 is becoming a recognized Medicare provider. Step 2 is making friends with your business office. Step 3, obtaining a treating physician referral. Step 4, using the right CPT and now ICD-10 codes. Step 5 is the proper documentation of MNT services. Step 6, tracking, billing and collection, and then another important piece is marketing your services.

Looking through the seven steps, I'm like thinking to myself, "Okay, what's the most important?" All of these are important but the one that really stands out to me and I feel that's made probably the biggest

impact for most of us who have been successful in billing is really creating making friends with your business office, creating that partnership. So, without our billers, we don't know, we don't know if they're billing. If we don't communicate with them, we don't know are they billing, are they collecting, how much are we billing, how much are we collecting?

If you can get to know your billers, let's say, the famous words of Leeanna Travis were, "Bring treats. Bring chocolate." Everybody likes chocolate so whenever we set up meetings with the billing office, we bought chocolate and they were always excited to see us because we were the chocolate ladies.

Whatever it takes to kind of get in the door to break the ice, set up these meetings with your billers, have them run billing collection reports for you by payer. You want to look through and troubleshoot your areas of denial or non-payment, for each claim that goes through that they deny, they get a paper back telling them why that was denied. So, ask to look at those. Also, it's going to be essential with your business office to explore your state Medicaid coverage and the private insurance coverage.

Our billers, they are the expert. This is their area of expertise. So, use their skills and their knowledge. Our billers have area meetings, national meetings. They have regular calls set up with CMS in order to ask questions. You can ask them a question. They will take it to their larger group and get the answer. If anyone tries to make calls to these payers before, it's a longtime consuming process and we're busy, and we don't have time for that. So, utilize their services to let them help you do their job. So, I think that's super important. This is the group of billers from what used to be the Sells Service Unit.

These are just examples of billing. These are three billing reports by payer. It is broken down by facility. You can see how many patients you saw who qualified or who they thought qualified for the service or for available service. How much they billed, how much was paid, how much was adjusted? And usually, the adjustments are those copays. And then, you can also see that the amount that the outstanding -- the unpaid amount. So, you can look at those unpaid amount and see -- "Okay, why wasn't I paid? Was there missing in my note that prevented me from that payment or was that just not a covered service?" So, without looking at these reports and exploring this with your billers, we have no way of knowing.

Currently, for those of us who are at IHS facilities, we are reimbursed by the OMB rate or the all-inclusive rate. Currently, the all-inclusive rate for Medicare for 2017 is \$349. For 2018, it will be \$383. Currently, the billers are still billing under the 2017 rate. They have not gotten the okay from CMS probably because of the scheduled budget hasn't been approved yet. So, we're currently -- even though we're already into March or actually October. We started our new fiscal year but we're still billing under the old rate.

The way that Medicare coverage works for our IHS patients is that, our facility receives kind of an all-inclusive rate for Medicare. We can bill for one encounter per day. So, if a patient comes in and sees the physician and they see the dietitian, they are only billing for one of those visits. And I'm not sure why it is, but most billers say, "We bill for the doctor visit not the dietitian." It seems to be the standard regardless of who they see first on the day. They say, "It tends to go to a physician."

Currently, the Medicaid OMB rate currently for 2017 is \$391. For 2018, \$427 and Medicaid does the same. They're still billing at the 2017 rate. Your individual states will set the guidelines for how many encounters can be billed at that rate per day. For example, here in New Mexico, we can only bill for two encounters per day.

I just came last year from Arizona. In Arizona, for Medicaid, you can bill up to five encounters per day. So, it's a huge difference from state to state and this is likely we often compare our reimbursement rates to one another from state to state and you can see why there is a huge difference in our rate of reimbursement just because it covers very so much from state to state.

I mentioned how important it was to have a good working relationship with our business office, but we can't leave these other essential partners out of that. And we didn't include these in our guidance and if we do it, these are some other important partners that we definitely need to include.

Our coders are super beneficial as well. They are going to assist you in making sure you are choosing the right, let's say, the CPT codes, diagnoses codes. They're going to help you set up your super-bill, your super-bill pick list within the EHR. So, utilizing their expertise and having them help you create a pick list within EHR will simplify your charting process, so it will make it much quicker. They can also help your pick list for education codes as well. They're also who we want to pick up and call if we can't figure out.

If you see somebody and there's no medical diagnosis for the patient and if it's a child and we know it's still going to be covered under Medicaid, what diagnosis do I choose? And then, they're going to be one to say, "Hey. Okay, choose --." There is one called like, "Fear of Learning" about -- something with fear of learning, which I've never heard of. But your coder, they know that so definitely call them.

Your CACs are essential partners, in helping you get everything set up, just right in EHR. They can customize some of your pick list. They can help you with your EHR template. And we'll talk about the national template in just a few minutes.

We're fortunate enough as dietitians. The lady pictured in the slide is Captain Leslye Rauth. They know we're fortunate enough that we have a dietitian who is a headquarters' CAC. So, she has been instrumental in helping us develop the national nutrition template and she's a great person to go to because she has expertise, so she can also help us out and she knows the ins and outs of being a dietitian so it's a huge asset. But also, definitely develop that partnership with your local CAC.

Another essential partnership is going to be your chief medical officer. And why this becomes so important is you want the medical staff to buy in for MNT, but you also need the partnership so they can help you put policies and standing orders into play so that other people can order the referral, so you can order your own referral, so can order labs. So, it's really important to our practice that we maintain the good relationship with our chief medical officer as well.

So, this brings us into our Step 3. It's obtaining a treating physician referral. So, I already mentioned that the top bullet point, for MNT, for Medicare Part B coverage, the referral needs to come from a primary care provider, an MD. So, mid-level providers are not considered able to do the referral. So, we want to put policies in place that the referral is coming from the physician who oversees maybe the mid-level provider, whoever their partner if they're on the same care team, that would go under the physician's name so that we can bill for that service.

As far as the referrals, a new referral is needed in the following cases. So, every new calendar year, January to December. Come January, a new referral is needed. So, it's not if I get a referral in December, I'm good until December. It is written as of January until December. So, you get a referral in December and you got to get another in January.

Other times that you'll need a new referral is within the first year. If you've exceeded the three hours and you need more hours of service for the patient, you want to request another referral. When you've exceeded the two hours in subsequent years, you need to get another referral.

If there is a change in condition or in treatment, again, we want to request another referral. And this also resets the hours too or should they reset, but they add additional hours. And as far as with the change in condition in treatment, it's not spelled out that you have to stop at two or three hours. There's not a written limit on that.

I would say our best practice is that we get EHR consults. I mean that's kind of a best practice. We prefer that. That way you can track your referrals, you can track them, you can see whether they've been resolved. However, and we've asked this to our financial intermediary company, "Does it have to be a separate like written or electronic referral?" And they said, "For IHS because we utilize the same electronic health record system. We're looking at the same lab, where we can read the provider's note." So, if the provider has written a referral into their note, that will suffice. Now, of course, that is not a best practice and we still encourage people to go the other route of utilizing the consult.

Definitely, if you can, let's say, train your staff or train them to use the consult because it will make your job easier. They just do it in their note and they no-show or they never got scheduled, you have no way of following up with that patient. So, we want to definitely encourage that.

Here is an example of an electronic consult. This is one I use here. There are other ones that we have that are quite a bit more detailed. We have just found, or I have found over the years that the more detail that's on it, the more providers don't use it and fill it out. So, we made it quick and simple and easy to obtain the most information with least amount of time. So, we have our medical staff agreed to go with this format.

Moving onto Step 4, so this is looking at the CPT and ICD-10 code. So, for that, like I said, work with your coders and your CAC to set up pick lists within EHR so that your commonly used diagnoses are already on the pick list, that you're not doing a lot of searching to try to find which is the right one to use.

For MNT billing, for our Medicare, the diabetes or the end-stage renal disease needs to be the primary diagnosis on that super-bill. So, if you're seeing a diabetic patient but today maybe you're focusing more on hyperlipidemia, you still want to put your diabetes as a primary diagnosis and your hyperlipidemia as a secondary diagnosis in order for that to be covered.

The ICD-10 codes that you're choosing, they should be matching the medical diagnosis for the reason that the patient was referred to you. Again, important reason to use the consult to make sure we're billing for what we were referred to the patient. What is important thing to add also, as dietitians, we cannot diagnose. So, if you're seeing a patient, let's say, for diabetes and obesity and obesity is not listed on their IPL being the integrated problem is that is not on there, you need to ask the provider to add that diagnosis. We as dietitians are not -- I know, technically, we can enter it but we are not authorized to add that. So, it should be coming from the physician. So, just shoot your provider an instant message just saying, "Hey, can you add this?" Or, message within EHR to add a diagnosis or go and talk to them.

Here are the CPT codes that are used for Medicare Part B MNT reimbursement for using 97802. That's for your initial visit and this is billed as 15-minute increments. Their 97803 is for your follow-up visit, again, a 15-minute increment. Your 97804, this is for a group visit for two or more individuals and this is billed for each 30-minute intervals. And people often ask, "Well, it is really important to do the unit because we're only -- whether I see him for 15 minutes or 60 minutes, I'm still getting the same reimbursement", which is true. However, we want to follow the CMS guidelines and bill the proper way. So, if we do get audited, that definitely has to -- the units need to be in there.

Below are the G codes. Those are the hit pick codes. Those are the codes that are used when you request additional hours of service beyond the initial two and three hours of service. Then, you would end up using one of the two G codes below.

For the ICD-10 codes, ICD-10 is quite a bit more complicated than ICD-9, so I did not list all the codes because there are so many more components to comprising the correct coding, but we should be using the 10 codes. But I'm going to show a pick list here. So, this is looking at a super-bill, using just

regular plain English for the diagnosis. And so, you can see if I choose chronic kidney disease stage four, this little box pops up.

In that red circle, I have the ICD-10 codes. You don't have to memorize the codes. As long as you work with your coder to get these set up correctly, it'll kind of link over. I mean, they're double checking it too, to make sure you chose the right code.

As far as this is looking at the electronic super-bill for the CPT code, so this is where we're choosing, for instance, on this one, I chose 97802 in that first red circle, you can see the quantity is four. And so, that is where -- there's a lot of different ways you can document units. But for me I document my units within the CPT code right there. And that is set up for 15-minute increments. So, when I choose four, they know that was an hour visit. If there's anybody on here who is doing telehealth, this is where you would want to document whether -- this is what distinguishes the mode of service.

MNT is the same whether it's in person or in telehealth, you would document telehealth right here where it says, "Modifier." So, you would choose interactive telecommunication and I would input the GT modifier onto the claim.

Step 5 brings us to our MNT documentation. These are the requirement CMS states that need to be included in our note. Of course, for our records, we're going to always have the patient's name, the record, the diagnosis, the referral, the physician's signature, RD's name and signature, the date. So, the time in and time out, and this was there just so you can capture your unit. So, I'm going to show you few different ways of doing that. I already showed you one by using the unit on the super-bill. Let's do other ways you can track that.

Using the right codes and then distinguishing whether it's a group or individual which -- you would be doing that through the code as well. And internally, if you want to track the number of time spent with the patient, you can track that. But most of us, I think, kind of internally track that. CMS is also tracking it too with the reimbursement.

As far as documenting our medical nutrition therapy, that workgroup along with the help of Leslye Rauth, has developed a national nutrition EHR template utilizes the nutrition care process and incorporates the dietetic standard, the dietetic language for nutrition care. So, it's currently being updated. As you probably know, the Academy keeps changing these terminologies every year. And so, hopefully in 2018, we'll have a new one really incorporating the new technology.

The way the template is structured, it is structured into each section of the template. That way, you can work on different sections and go back to them opposed to if it was all encompassed in one note. If you closed it and went on to another patient, you would lose it. By breaking into the sections, you can work on different sections and you won't lose it. In the end, it combines it all into one note.

I'm going to click on -- imagine with highlighted nutrition. When I click nutrition, this is what shows up. That way, I tie my visit to the date of referral and who they are referred by and the diagnosis. If I will click on C, diagnostic terminology, it would bring me to this page. This top section here, once you click on these little sections; the intake, clinical, behavioral, it kind of unrolls, so it's kind of everything is tucked under to make the note a little bit shorter. So, as you can see, I clicked on the three and then on the left over here, I clicked on the knowledge and beliefs and all those opened up.

If you're not familiar with it, I would recommend getting with your CAC to help you get that imported into your site.

Your CAC can also modify it to customize it for what your local needs are.

Section H and I in the template is another place that you can document. You can track the time in and out if you want to do it that way. It will also pull in the CPT code that you already used. So, obviously that's kind of redundant. But we tried to encompass everybody's preferences so depending on -- obviously, I wouldn't click both of these, but whichever is your preference for tracking, you can use.

We're kind of wrapping up. We're kind of pulling this all together, the tools for success. So, we have tools out there that are meant to help you all to make your job easier. So, definitely you can follow the Step-by-Step Guide to MNT Reimbursement. Utilize the national nutrition template. Definitely create those partnerships with your billing office, with your coders, with your CAC. The other pieces being proactive with your medical staff.

We want to advocate for our services. We want to give them list of ideas of what are billable services or what services -- I mean, we don't only see people who are billable, but I find that there's a lot of confusion about, "Oh, I thought you only saw diabetics." So, we want to let them know. I can see every diagnosis and you may prioritize for your facility what diagnoses receive priority, but we want to let our providers know who and what we can see. We look at targeting some of our billable services to -- as much as we kind of hate to say this but money talks. And so, administrators are looking at the revenue, looking at what we're bringing in. So, we know we're going to collect a lot from seeing kids, potentially more from seeing kids and prenatal than we do for diabetics who aren't eligible for Medicare yet.

Target some of those services. We also know that intervening earlier in life will have a greater impact later on in life too, so targeting some of those billable services as well.

All right, that brings us to our questions.

Jan Frederick:

Diane, are you seeing we've gathered up all the questions for you. You've got a lot. I've tried to group them for you a little bit.

Diane Phillips:

Yeah, I thought I was going to go too fast but then -- okay, so our first question -- thanks for grouping them. Let's see, related to referrals. "If a mid-level provider enters the referral, do you need to go to the MD and ask them to rewrite the referral? Can the mid-level put the MD's name?"

Oh, sorry I didn't read the question out loud. "If a mid-level provider enters the referral, do they need to go to the MD and ask them to rewrite the referral or can the mid-level provider put the MD's name in the visit and enter the referral for them?" So, this is why you want to have like standing orders or depending on how your facility is set up. We try to get it set up that -- a mid-level would also put their -- because usually mid-levels have another doctor who they work with or consult with. So, we would just have the mid-level put that physician's name also in there as one of the providers on that referral too.

I would do that to save time instead of rewriting. That's why a lot of us have standing orders in place that we as the dietitian can just reorder the consult ourselves too. It's very efficient if you can have your nursing staff or your health tech, your medical assistant order the consult just when they're going through the screening and say, "Okay, this is a diabetic patient." They haven't seen a dietitian this year and if they can order, and they know to put it under the doctor's name. So, that can be helpful.

If a patient is seen by the mid-level but you have the MD co-sign on the referral, but the MD has not seen that patient, can you still bill? Usually within the Indian Health Service, our patients are seeing a lot of different providers within the visit.

I was going to say for the most part, it's likely that they will have encounter them at some point. But if you have your standing order in place written that for MNT, "So and such, so and such can write for this doctor." So, if you put that standing order in place, that should cover you even if the patient has not ever seen that -- doctor hasn't seen that exact patient.

"Do you have a sample referral policy in order for the referral to be under the MD's name for the mid-levels?" There are different policies written. Yes, there are ones out there. So, Linda we can work to get you one of those to you.

"Is a new referral for each new calendar year required for all three payers?" Okay. So, if you've exceeded the first year, if you've already seen that patient for three hours with one of the qualifying diagnosis for Medicare, yes, you need a new referral. So, you've seen -- the three hours but you need to talk some more or change their medication or some kind of treatment, or now they have hypertension. Yes, you can request for an additional, another referral for additional services.

"Is a new referral needed for each calendar year for Medicaid and private insurance?" That would be a good question you would want to take to your billing department. Most of the time it's not calendar year, it's usually like -- if you got it in June, it's good until June. But you need to verify that with your billing department for that specific payer.

"Does the RD track the three hours they provide MNT or allow the business office to do that? I'm just not how to keep up with this without billing more hours, than we are allowed to bill." So, it's a good question, Greg. I guess, for me, I kind of like look at it myself because I kind of know who I'm seeing and I can kind of judge. Our billers are not tracking it. We've been told by CMS that they track it. So, if you've exceeded your three, they're going to kick back and they're not going to pay it. So, they told us that they are tracking it and so that's why it's important to look at your denials to see your denial may be exceeded levels of service or hours of service then you know, "Okay, I got to go back and get a second referral."

"If a patient is coming in for medication adjustment, can the visit be billed as MNT even though the program is not an accredited program?" So, in order for us to bill for medical nutrition therapy, you would be going through the standards of care for providing nutrition. Are you doing a full assessment, diagnosis, intervention with that patient? If you're following the MNT protocols and in the course of doing that you've adjusted the medication, I say yes, if you're just only adjusting the medication then no. But if you were an accredited program, you could.

"For renal patients, does the primary diagnosis only be ESRD or CKD?" Yes, both of those should be okay and your coder should switch it to the right code. They tend to use those two interchangeably. I know the CMS words it as, "ESRD", but we know on the billing side, the ICD-10 side, it's listed as CKD, so either of those should be okay.

"Is CKD stage 4 also covered under MNT reimbursement?" Every stage of chronic kidney disease is covered for MNT.

"If RD has a patient come into the office without a nutrition consult -- can we order nutrition consult for them under the PCPs name and have the PCP sign off on the consult?" So, again, this depends of how your orders are written. I have mine written that I can order consult under the provider's name. So, we have that policy in place. So, if your policy states that, then yes, you could do that. If you don't have that policy in place, then run over real quick and ask your doctor to order it for you. Technically, it should be there before you see the patient.

"If you are AADE accredited, can the mid-level provider -- MNT referral using the program MD as a requested referral?" Yeah, I don't see why not. So, they're kind of using their diabetes program doctor to do an MNT referral. So, that should be fine.

“Telehealth question, does telehealth need to be video-based or phone-based encounters?” So, the coverage for telehealth is only using video conferencing equipment. There are different modalities to do it but yes, it has to be a modality that you are seeing and hearing each other in real time, so you cannot bill for phone-based encounters.

Some people have like a mechanism such as -- we'll call it Skype but it's not called Skype, but Skype or FaceTime. If you're using your phone but there is a video component in real time, then that's okay. But not just the voice, you have to be able to see each other and hear each to bill for that.

“The telecommunication MNT, is this billable or covered for reimbursement?” So, whoever at the national level who created the modifiers, they wrote it and they called it-- instead of calling it like telehealth, they used “telecommunication” which makes it a little bit confusing. So, telecommunication as far as a telephone is not billable.