

Step-by-Step Guide to Medicare Medical Nutrition Therapy (MNT) Reimbursement

2nd Edition, April 2010



Indian Health Service
Division of Diabetes Treatment and Prevention
Albuquerque, New Mexico
www.diabetes.ihs.gov



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Foreword



Research shows that medical nutrition therapy (MNT) reduces illnesses and improves quality of life for people with chronic diseases. That is why, in 2002, Congress authorized the MNT benefit for Medicare beneficiaries with diabetes and certain stages of kidney disease. Since then, many insurance programs offer reimbursements to registered dietitians (RDs) and other qualified nutrition professionals providing MNT services. MNT is effective for patients and increases their access to quality care—a priority for the Indian Health Service (IHS). At the same time, reimbursement for this care also presents a new revenue stream for the Indian health care system.

This edition of the *Step-by-Step Guide to Medicare MNT Reimbursement*, an update of the 2006 publication. It provides IHS, Tribal, and Urban health program staff, especially registered dietitians, with all the information they need for prompt Medicare reimbursement. The guide clearly and concisely illustrates seven steps—from becoming a Medicare-recognized provider to marketing MNT services—and includes useful resources for putting these steps into practice. This edition also contains an update on MNT telehealth reimbursement, a sample electronic MNT superbill, and case studies showing how to use the IHS electronic health record (EHR) and international dietetics and nutrition terminology.

I encourage health care professionals to use the information provided here to minimize administrative inefficiency and maximize reimbursements. Your comments about using this guide are welcome and may be directed to the IHS Medical Nutrition Therapy Action Team (MAT), at IHSMNTActionTeam@ihs.gov. I also want to thank IHS, Tribal, and Urban health program staff; CMS personnel; and American Dietetic Association employees, for their important contributions to this useful publication.

/s/
Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service

Introduction

“At Phoenix Service Unit, we were on track in FY 2009 to nearly double our reimbursement for MNT. I think the single thing that has helped with this increase is using the national MNT template for the electronic health record. We can document ICD9, CPT, and time for each encounter. The MNT template is accurate, legible, and standardized.”

CAPT Edith Clark, Director, Nutrition Services and Director, IHS Southwestern Dietetic Internship Consortium, Phoenix Indian Medical Center, Phoenix, AZ



Dietetic Intern Cheyenne Isaacs and CAPT Edith Clark

Overview of the Step-by-Step Guide to MNT Medicare Reimbursement

The step-by-step guide to MNT Medicare Reimbursement is designed primarily for Indian health care system registered dietitians (RDs). The purpose of the guide is to help you learn how to:

- Document MNT services and outcomes
- Work with your health care facility to bill for MNT services
- Take an active role in seeking MNT reimbursement and
- Market your services within the Indian health care system and to your Tribal members.

The guide is divided into three sections:

MNT Reimbursement Overview

This section introduces you to Medicare MNT reimbursement and the qualifying diagnoses for reimbursement.

The 7 Steps to MNT Reimbursement

This section takes you, step-by-step, through the MNT reimbursement process.

Resource Materials

In these appendices, you will find many helpful resources related to MNT reimbursement, including sample forms, case studies, guidelines, resources and people to contact for help, a glossary, and references.

Many Indian health dietitians shared tips and ideas to create this comprehensive, step-by-step guide. They and others have found that MNT works, saves money, and makes money. Opportunities to be reimbursed for your services are waiting for you. Take advantage of them! Embrace them! **Just do it!**

Frequently Used Abbreviations

AADE.....	American Association of Diabetes Educators
AI/AN.....	American Indian and Alaska Native
CDE.....	Certified Diabetes Educator
CMS.....	Centers for Medicare and Medicaid Services
CPT.....	current procedural terminology <i>or</i> common procedural terminology
DSMT.....	diabetes self-management training*
EHR.....	electronic health record
FQHC.....	federally qualified health centers
ICD-9.....	International Classification of Diseases, 9 th Revision
IDNT.....	International Dietetics and Nutrition Terminology
IHS.....	Indian Health Service
MNT.....	medical nutrition therapy
NCP.....	nutrition care process
NCPM.....	nutrition care process model
NPI.....	national provider identifier
PCC.....	patient care component
PFE.....	patient and family education protocols
RD.....	Registered Dietitian
RPMS.....	Resource and Patient Management System

* DSMT is also known as DSME, or diabetes self-management education. Although DSME is the preferred term, the CMS requires the use of DSMT in reimbursement documentation. Therefore, “DSMT” is used throughout this guide.

SECTION ONE



(L to R): Community Dietitian Sandra Poitra providing MNT to Darlene LaVallie, IHS Turtle Mountain Comprehensive Healthcare Center, Belcourt, ND

Ready...Set...Medical Nutrition Therapy

An Overview of Medicare Medical Nutrition Therapy Reimbursement

The Medical Nutrition Therapy Medicare Benefit



“Working at CMS opened my eyes to how many resources are available for dietitians. Now I know how to apply for reimbursement for our hospital and there are educational opportunities for my clients I never knew existed. Don't miss out on this great opportunity for you, your hospital, and your patients!”

LCDR Susan Jones, Senior Clinical Dietitian
IHS Northern Navajo Medical Center, Shiprock, NM

What is the Medicare Part B MNT benefit?

In January 2002, the Centers for Medicare and Medicaid Services (CMS) established the medical nutrition therapy (MNT) benefit to help lower the nation's health care costs. Providing reimbursement for MNT to certain groups of Medicare beneficiaries recognized the importance of this service in disease management and health improvement.

MNT became a distinct Medicare benefit under Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act (BIPA). Eligible Medicare Part B beneficiaries with diabetes or non-dialysis kidney disease or who are post-kidney transplant are covered for MNT services provided by a registered dietitian (RD) or a nutrition professional who meets Medicare's requirements. These qualified professionals can be reimbursed by Medicare for their MNT services. A treating physician must make the referral for MNT. (See “Step 1: Become a Recognized Medicare Provider.”)

At time of publication, health care providers who are not RDs or nutrition professionals **do not** qualify for Medicare MNT reimbursement. In addition, non-physician practitioners (e.g., nurse practitioners or physician assistants) cannot make MNT referrals that qualify for Medicare reimbursement.

Regulations for MNT can be found in 42 CFR 410.130-410.134) on the Internet at: <http://www.cms.hhs.gov/transmittals/downloads/R154CIM.pdf>.

In January 2006, the CMS added individual MNT to the list of Medicare telehealth services eligible for reimbursement. In January 2011, the CMS added group MNT to reimbursement-eligible services. Providing MNT via telehealth services to patients in rural and underserved areas has enhanced and expanded nutrition services in American Indian and Alaska Native communities.

What are the criteria for reimbursement of MNT Telehealth?

MNT telehealth covers services provided to an individual or group. An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site practitioner and the Medicare beneficiary. As a condition for payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this case, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Reaching Remote Rural Patients through Telehealth



LCDR Diane Phillips, Program Director of the IHS Telenutrition Program in Flagstaff, AZ, is one of the first IHS registered dietitians to venture into the telehealth arena. Since November 2006, LCDR Phillips has used telehealth to deliver real-time MNT services through video conferencing to the Crow Service Unit (Crow, MT) and the Elko Service Unit (Elko, NV). Since then, she has expanded her services to the Hopi Health Care Center (Paolacca, AZ) and the Supai clinic in a remote village on the floor of the Grand Canyon

(Havasupai, AZ). This integration of technology with MNT improves patient self-care management and facilitates continuous, uninterrupted nutrition service in rural health professional shortage areas.

What does the MNT Medicare benefit include?

The MNT Medicare benefit includes:

- 3 hours of initial MNT in the first calendar year (January – December).
- 2 hours of follow-up MNT in subsequent calendar years.

Additional hours of MNT can be provided and reimbursed when the treating physician determines a change in medical condition, diagnosis, or treatment plan that makes additional MNT necessary. The treating physician must provide a new referral. In addition, the treating physician must provide a referral for the 2 hours of follow-up MNT.

The treating physician must provide a referral for MNT, follow-up MNT, or for change in the patient's treatment plan.

Here are additional rules to keep in mind regarding the MNT Medicare benefit as listed on the CMS website: http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part3.pdf.

- The number of hours of MNT can be spread out over any number of sessions during the calendar year (Minimum length of one visit = 15 minutes).
- The 3 hours of MNT start whenever the treatment changes.
- The number of MNT hours cannot be carried over to the next calendar year. For example, a treating physician gives a referral to the beneficiary (your patient) for 3 hours of MNT and the beneficiary uses only 2 hours during the calendar year. The unused 3rd hour cannot be carried over into the following calendar year, but the beneficiary is eligible for 2 follow-up MNT hours (with a new referral from the treating physician).
- MNT services can be provided on an individual or group basis. MNT services for individuals are billed in units of 15 minutes; MNT services for groups are billed in units of 30 minutes. MNT telehealth only covers individual nutrition counseling.
- Every calendar year, the beneficiary must obtain a new referral from the treating physician for follow-up MNT hours.

What is the Medicare MNT payment rate?

The Indian Health Service (IHS) All-Inclusive Rate is the rate negotiated by the IHS for services provided under Medicare Part A. As of February 2010, the outpatient IHS All-Inclusive Rate was \$230 for a single day of patient care (including care and services beyond MNT) for all states except Alaska. In Alaska, the rate was \$407. The IHS renegotiates this rate with the Office of Management and Budget (OMB) each year, so the rate may vary from year to year. Your billing office will have information about current rates.

Payment for MNT services under Medicare Part B follows the physician fee schedule payment rate. The Medicare Part B MNT payment will be 80% (because a 20% patient co-pay applies) or the lesser of **either** the actual charge or 80% of the physician fee schedule amount.

The physician fee schedule varies by state. For example, in New Mexico, the physician fee schedule payment rate is \$65/hour (or \$16.25/15-minute unit). Check with your billing office about the current IHS physician fee schedules for your state.

A RD or nutrition professional who becomes a Medicare provider must accept the approved payment amount for MNT services provided to Medicare beneficiaries. In Medicare language, this is called “accepting assignment.” Please note that the RD does not receive payment directly. Instead, payment is sent to the clinic or facility.

What about payment for MNT from other health insurance plans?

Although this document focuses on Medicare reimbursement, you can seek reimbursement for MNT services from other payers. Many private insurance plans, health maintenance organizations, or preferred provider organizations will pay for MNT services. **Also, find out if your state Medicaid Program reimburses MNT services.**

Every state dietetic association has a reimbursement “expert.” Seek their advice.

Qualifying Diagnoses for Reimbursement

The CMS reimburses MNT services for Medicare Part B beneficiaries who have a diagnosis of diabetes, non-dialysis kidney disease, or post-kidney transplant.

Diabetes: Type 1 and Type 2

The patient must meet one of the following diagnostic criteria for diabetes:

- Fasting glucose \geq 126 mg/dl on two different occasions
- 2-hour post glucose challenge \geq 200 mg/dl on two different occasions
- Random glucose test $>$ 200 mg/dl for a person with symptoms of uncontrolled diabetes

Currently, Medicare does not reimburse MNT services provided for patients with a primary diagnosis of pre-diabetes, impaired fasting glucose (IFG), or impaired glucose tolerance (IGT). Medicare does, however, provide coverage for diabetes screening tests for eligible beneficiaries.

Kidney: Non-dialysis Kidney Disease and Post-kidney Transplantation

Medicare will reimburse MNT services for patients with non-dialysis kidney disease who meet these criteria:

- The patient has chronic renal insufficiency (i.e., reduction in kidney function that is not severe enough to require dialysis or transplantation; Glomerular Filtration Rate (GFR) 13–50 ml/min/1.73m²).
- The patient has end stage kidney disease, but is not on dialysis (i.e., non-dialysis kidney disease).
- The patient has had a kidney transplant (and is eligible for MNT up to 6 months after the transplant).

Practice settings covered for MNT reimbursement

Medicare coverage of MNT services applies in a variety of settings, including hospital outpatient departments, freestanding clinics, physician offices, and home health settings. Federally Qualified Health Centers (FQHCs) also can bill MNT (and DSMT) as a separate service.

MNT services provided through a rural health clinic (RHC) are not a separately billed service. Instead, MNT services at RHCs are billed as part of the IHS All-Inclusive Rate for Medicare Part A.

Telehealth services through interactive audio and video telecommunications in real-time for beneficiaries (patients) who are from an originating site located in Health Professional Shortage Areas (HPSAs) not classified as Metropolitan Statistical Areas (MSAs) may substitute for a face-to-face, “hands on” encounter for individual **and group MNT consultation**.

Medicare reimbursement for MNT **will not be made** if the beneficiary is a hospital inpatient or is in a skilled nursing facility, nursing home, hospice, or end stage kidney disease dialysis facility.

Limitations of Medicare coverage

There are several limitations to Medicare coverage for MNT reimbursement to remember:

- MNT services are not covered for individuals receiving dialysis. Payment is made only for post-kidney transplant patients.
- If the beneficiary has diabetes and kidney disease, the number of hours allowed is either for diabetes or kidney disease.
- Only face-to-face time with the patient is covered (see exception regarding telehealth services described above under practice settings).
- To apply for reimbursement for MNT and diabetes self-management training (DSMT), these services cannot be provided on the same day.



Remember these Points:

- Calendar Year One: 3 hours of MNT max; no “rollover”
- Bonus Time: 2nd referral (use G codes)
- The key to additional hours is a change in treatment plan.
- The 3 hours start again when the treatment changes.

SECTION TWO



(L to R): Roy Smith (patient) with CDR Carol Treat, Alaska Area Nutrition Consultant, Alaska Native Diabetes Program, Anchorage, AK

Let's Get Started...Go!

7 Steps for Medicare Medical Nutrition Therapy Reimbursement

Step I: Become a Recognized Medicare Provider



(L to R): Cecilia Butler counseling a patient

“Becoming recognized Medicare providers has enhanced our profession and increased my referrals.”

Cecilia Butler, Clinical Dietitian and Diabetes Program Coordinator, IHS Santa Fe Hospital, Santa Fe, NM

Becoming a recognized Medicare provider requires two key steps: you need to meet certain criteria as a RD or a nutrition professional and then you need to complete and submit the necessary paperwork. If you need help, ask your business office staff if they can work with you to complete the application process.

What are the criteria for applying to become a recognized Medicare provider?

You must meet the following criteria to apply to become a recognized Medicare provider:

- Bachelor degree or advanced degree in nutrition or dietetics from a regionally accredited college or university
- Completion of at least 900 hours of supervised dietetics practice under the supervision of a RD
- License or certification as a RD or nutrition professional by the state in which the services are provided. (If you practice in a state that does not provide licensure or certification, you can meet this requirement if the Commission on Dietetic Registration recognizes you as a RD, or if you meet the first two criteria above.) This requirement applies to RDs employed or contracted by IHS, Tribal, or urban Indian health systems.
- For Federal employees, if you are a licensed RD and hold a license from a state different from the one in which you work, you can continue to hold any state license for which you have already been accepted. For telehealth MNT coverage, RDs have to be licensed in the same state where the beneficiary (patient) resides.
- RD credential with the Commission on Dietetic Registration. This credential provides proof that education and experience requirements have been met.
- Grandfathered dietitians or nutrition professionals' license or certification as of December 21, 2000, if applicable.

How do I become a recognized Medicare provider?

You will need to complete the following forms and paperwork to become a recognized Medicare provider.

National Provider Identifier Application

The first step in becoming a recognized Medicare provider is to obtain a **National Provider Identifier (NPI)**, a 10-digit number assigned to every provider. NPI is a unique identifier for health care providers required by the Health Insurance Portability and Accountability Act (HIPAA) Administrative Standard. All health care providers need a NPI for billing purposes. For additional information on completing a NPI application, visit the person in your health facility who submits these forms for physicians.

The estimated time to complete the NPI application form is 20 minutes. You can apply for a NPI online from the National Plan and Provider Enumeration System (NPPES) contractor at: <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

1. CMS Form 855I Enrollment Application

In addition to obtaining a NPI, you will need to complete CMS Form 855I “Medicare Enrollment Application—Physicians and Non-Physician Practitioners.” You can access the form online at: <http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf>. Along with Form 855I, you will need to submit supporting documentation, such as your RD registration number and a copy of your state license or certification.

2. CMS Form 855R

You may need to complete other forms depending on your practice setting and employment relationship. For example, you may need to complete CMS Form 855R “Medicare Federal Care Reassignment of Benefits Application” to reassign Medicare payment back to the health care facility in which you provide services. This form is needed when you are employed or contracted by a facility that will submit the MNT service claims on your behalf and collect payment for your services. CMS Form 855R is available online at: <http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf>.

Step 2: Make Friends with Your Business Office

“Working closely with the Business Office, we established a relationship that significantly enhanced our efforts to bill successfully for MNT and to capture the data to track reimbursements. Everyone felt a sense of ownership in this.”

Jimmie Strock, Supervisory Dietitian (Retired)
IHS Sells Service Unit, Sells, AZ



(L to R): Priscilla Juan, Lauren Folson, and Mary Lingruen, MNT Billing and Reimbursement Team, and Jimmie Strock, IHS Sells Service Unit

Just as you nurture your relationship with your health care team, you need to foster a cooperative relationship with your business office team. This may include the billing department, compliance officer, finance staff, and medical records coding department.

What should I do to develop a relationship with the business office?

The following steps can help ensure that you form a good working relationship with your business office:

- Introduce yourself to the business office team and meet the billing and coding staff.
- Ask permission to observe their process of entering health care visit data (often called data entry).
- Ask for tips from the business office, data entry, and medical records staff members on how to document properly the information they need to submit claims.
- Ask, “What can I do to make business office processes easier?”
- Inform billing staff and coders about the MNT CPT codes to ensure that these are in RPMS. (See “Step 4: Learn More about CPT and ICD-9 Codes for Reimbursement.”)
- Adopt, adapt, or develop your own MNT referral form. (See Appendix B for sample IHS MNT Referral Forms.)
- Adopt, adapt, or develop your own “MNT superbill.” This pre-printed form itemizes and describes all services and fees to facilitate accurate coding and billing of services. (See “Step 5: Document MNT Services” and Appendix B for sample MNT Superbill Electronic Health Record Version and MNT Superbill with Telehealth Modifier.)
- Work with the billing and information systems staff to track claims and reimbursements and request a quarterly report. (See Appendix B for a sample Third Party Reimbursement Tracking Form and Instructions.)

- Get to know **CMS Form 1500 “Health Insurance Claim Form.”** Although as a RD you will not fill out this form, you need to be familiar with the data fields that will be filled in by the billing staff. Depending on your business office’s procedures, the business office staff either will file CMS Form 1500 electronically or submit it on paper to request reimbursement. (See Appendix B for a sample CMS Form 1500 and page 32 for a list of the Top Ten Documentation Errors to Avoid.)

Step 3: Obtain Treating Physician Referral and Authorization for Patient Visits



(L to R) LT Kelli Wilson with Ronald Fried, Chief Medical Officer, IHS Wewoka Service

“Physician referrals are key to the MNT reimbursement process.”

LT Kelli Wilson, Public Health Nutritionist, IHS Wewoka Service Unit, Wewoka, OK

To obtain reimbursement for MNT services, a **treating physician** must provide a written referral **before** the RD provides MNT services. Physician assistants and nurse practitioners **do not** qualify as referring providers under the Medicare statute concerning MNT.

What are the requirements for the treating physician referral?

The treating physician must make the referral for MNT benefits for eligible Medicare patients who have a diagnosis of diabetes or renal disease or who are within 6 months post-kidney transplant. The physician’s referral is required for:

- each episode of care during the calendar year
- for additional MNT hours if needed in the same calendar year because the treating physician determines a change in medical condition, diagnosis, or treatment plan that results in a change in the diet plan and
- for follow-up MNT in subsequent calendar years

The treating physician’s MNT referral must provide the following information:

- Documentation that MNT services are a necessary and appropriate medical service
- Date of referral
- Written treating physician order for MNT services and
- Treating physician’s signature.

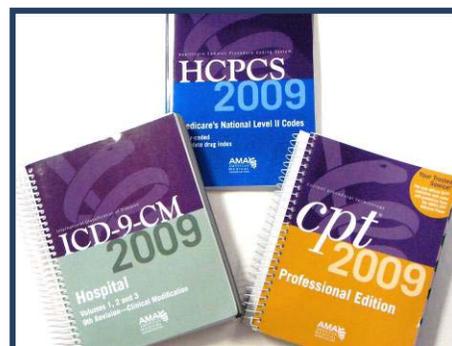
Include the MNT referral and documentation of all MNT services provided in the patient’s medical chart. (See Appendix B for a sample IHS MNT Referral Form and a Diabetes Services Order Form (DSMT and MNT Services). See Appendix C for a sample EHR Nutrition Care Process MNT Note in the case study).

When using the EHR, the referring physician should use the consult tab as the referral mechanism. The RD is responsible for generating a note in the consult tab under “Action” and then click on “Results” to inform the referring physician that the referral has been received. This ties the nutrition consult to the referral.

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 the facility’s clinical statistics, but also for reimbursement purposes. Documentation is critical to support the accuracy of this coding.”

CDR Sandra Lahi, Business Office Coordinator (Acting), Oklahoma City Area Indian Health Service, Oklahoma City, OK



To document and secure reimbursement successfully for MNT services, you will need to become familiar with procedural (CPT) and diagnosis (ICD-9) codes used by the CMS. See Table 1 for a list of the codes, brief descriptions, and the time units for billing.

Table 1. MNT CPT Codes, HCPCS (G) Codes, and Telehealth Modifier

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 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 patient (Reassessment and intervention) 	1 unit = 15 minutes
97804	Group MNT visit with two or more individuals	1 unit = 30 minutes
MNT G Code	Description	Time Unit
G0270	Individual MNT visit: <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	Group MNT visit: <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
Telehealth Modifier	Description	Time Unit
GT	Via interactive audio and video telecommunications system real-time technology through the use of video conferencing equipment	1 unit = 15 minutes

GQ	Via asynchronous telecommunications system store and forward technology	1 unit = 15 minutes
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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.

As shown in Table 1:

- ✓ Use code 97802 for an individual patient's initial assessment and intervention visits (up to 3 hours in the calendar year).
- ✓ Use code 97803 for a patient's follow-up visits (up to 2 hours).
- ✓ Use code 97804 for group visits with two or more individuals (up to 3 hours for each patient for the initial calendar year).

The MNT CPT codes are time unit-based. As a 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. You only can bill for the face-to-face time you have with the patient. This means that you cannot bill for preparation time or post-session documentation time.



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

What are the MNT HCPCS or G codes?

The CMS established two additional Healthcare Common Procedure Coding System (HCPCS) 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 a medical condition that makes a change in diet necessary. The CMS has not set a specific limit on the number of these additional hours.

As shown in Table 1:

- ✓ Use G0270 for an individual patient's reassessment and subsequent interventions after completion of the 3 hours of basic coverage (code 97802) already provided in the same calendar year.
- ✓ Use G0271 for a patient's group reassessment and subsequent interventions following completion of the 3 hours of basic coverage (code 97804) already provided in the same calendar year.

What are the Telehealth modifiers (codes)?

Effective January 1, 2006, the CMS established use of the Telehealth modifiers "GT" (via interactive audio and video telecommunications system) and "GQ" (via asynchronous telecommunications system). The interactive audio and video telecommunications system is through the use of a video conferencing unit conducted in real-time. Asynchronous telecommunications system utilizes the store and forward technology.

As shown in Table 1:

- ✓ Use telehealth modifier GT for MNT via interactive audio and video telecommunications.
- ✓ Use telehealth modifier GQ for services via asynchronous telecommunications system.

What are the ICD-9 codes for MNT services?

ICD-9 codes, or codes from the *International Classification of Diseases, 2009 Revision, Clinical Modifications*, are used to describe diagnoses and are updated annually. ICD-9 codes covered in the Medicare Part B MNT benefit are listed in the following sections of the code book:

- 250.00: Series codes for diabetes
- 585.00: Series codes for chronic kidney failure
- V42.0: Series codes for kidney transplant

You will need to obtain the correct diagnosis from the patient's treating physician. Once the medical provider documents the diagnosis code, the coding staff will assign the specific code into the system.

RDs or nutrition professionals cannot determine the medical diagnosis. This is beyond the scope of your practice. (Please refer to Franz et al, 2008, in the References for more information on the standards of practice for nutrition in diabetes care).

What are the IHS Patient and Family Education (PFE) Education Protocols and Codes?

The IHS Patient and Family Education (PFE) Protocols and Codes are another key part of the IHS documentation process. The codes are not required for reimbursement, but they are essential for documenting and tracking nutrition services provided by RDs.

Any health care provider who provides patient education can use the PFE codes. The codes provide a quick method for documenting the education given during a patient visit. When properly documented, these education codes appear on the RPMS health summary. This 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 a RD provides nutrition education, use the "MNT" code instead of the "N" code. Only RDs can use the "MNT" code when documenting nutrition education. All other education topics such as physical activity, medications, behavioral health, and follow-up should be documented using the general codes.

Some codes also are 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 PFE protocols and codes, visit the IHS Health Education Program website:

<http://www.ihs.gov/NonMedicalPrograms/HealthEd/index.cfm?module=initiative&option=all&newquery=1>

"Talking with Paula has kept me accountable and on track and has helped me realize just how serious diabetes is and how I can control diabetes with the information she told me."

Ramona Sandoval, patient of dietitian Paula Maslonka, IHS Winnebago/Omaha Comprehensive Health Care Facility, Winnebago, NE

Step 5: Document MNT Services

“The Electronic Health Record has enabled IHS to improve patient care documentation, patient continuity of care, and the process for reimbursement for services provided.”

CDR Leslye Rauth, Clinical Application Coordinator,
Office of Information Technology, IHS Headquarters

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

What information do I need to document?

The American Dietetic Association (ADA) has developed the Nutrition Care Process and Model as a tool to guide RDs through the critical thinking process of providing professional services. The model also establishes standardized language for nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Documentation using the format of the Nutrition Care Process Model has replaced the previously used Subjective, Objective, Assessment, and Plan (SOAP) format. Use of this new standardized language by all RDs and nutrition professionals will facilitate data collection and analysis for showing improved health outcomes. (See Appendix E for additional information about the Nutrition Care Process and Model.)

The CMS requires qualifying RDs and nutrition professionals to use nationally recognized protocols to document MNT services. The ADA has developed nationally recognized protocols, also known as evidence-based guidelines. The ADA’s Nutrition Practice Guidelines describe the information you need for documenting MNT visits (see Table 2).

Many dietitians and nutrition professionals now are using these evidence-based guidelines for documenting services provided. To review the diabetes and chronic kidney disease evidence-based nutrition practice guidelines, go to the ADA Evidence Analysis Library at <http://www.adaevidencelibrary.com/> (note: to access the library, you need to be a member of the ADA).

Table 2: Overview of Information Needed to Document MNT Reimbursement

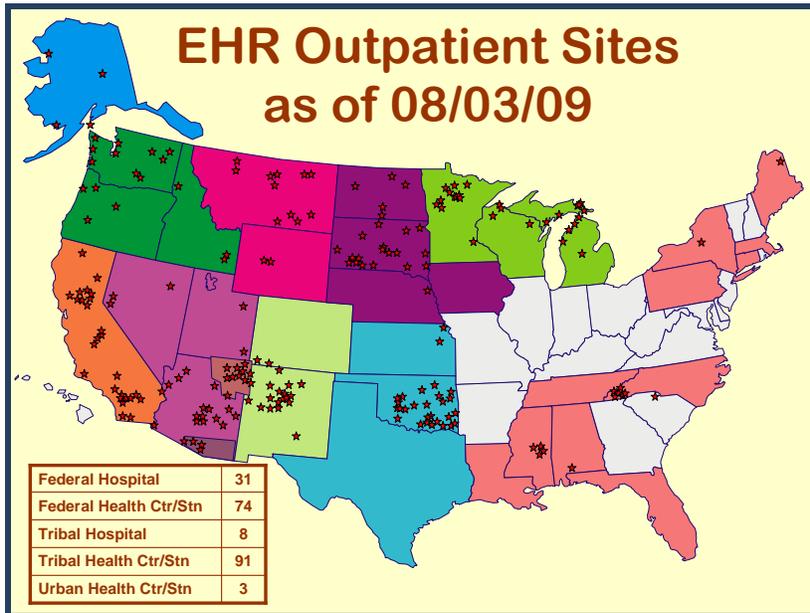
Initial MNT visit: 60-90 minutes	Follow-up MNT visits: 30-45 minutes
<ul style="list-style-type: none"> ▪ Receipt of referral from the treating physician and the name of the primary dietitian ▪ Diagnosis (provided by the treating physician) ▪ Reason for the visit ▪ Start and stop time and date of the visit ▪ <i>Step 1. Nutrition Assessment</i> <p>Obtain and collect data</p> <p>Analyze and interpret using evidence-based standards</p> <ul style="list-style-type: none"> ▪ Step 2. Nutrition Diagnosis ▪ Identify and label problem. <p>Cluster signs, symptoms, and defining characteristics</p> <ul style="list-style-type: none"> ▪ Determine cause and contributing risk factor ▪ <i>Step 3. Nutrition Intervention</i> ▪ Plan: Formulate goals and determine a plan of action with client <p>Implement: Deliver care and carry out actions</p> <ul style="list-style-type: none"> ▪ Step 4. Nutrition Monitoring and Evaluation <p>Monitor progress</p> <p>Measure outcome indicators</p> <p>Evaluate outcomes</p> <ul style="list-style-type: none"> ▪ Schedule follow-up appointment ▪ Include 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) <p>Include RD signature</p>

Please refer to Appendix D 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.

What documentation forms are used in the IHS?

Many health care providers in the IHS are now using the Electronic Health Record (EHR) for documenting MNT services. The figure below highlights the sites using EHR in Indian health facilities.

Figure 1: Indian Health Facilities Using Electronic Health Record



Some facilities may be documenting MNT services using the **PCC Ambulatory Encounter Record** for face-to-face patient encounters. Some Tribes may be using a different documentation form. There may be other facility-approved forms.

Regardless of which form you use, you need to ensure that the forms are complete and accurate so that the data entry and billing offices can submit the claim for reimbursement:

- Enter the start time and end time of the visit.
- Enter the clinic number.
- Include the treating physician referral.
- List the diagnosis(es) from the treating physician.
- Enter the MNT CPT codes.

Enter the patient education codes (for more information on the Patient and Family Education codes, see the IHS Health Education Program website: <http://www.ihs.gov/nonmedicalprograms/healthed/>).

- Sign the form, as the RD or nutrition professional who provided the MNT services.
- Remember, billable time is face-to-face.

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. (See Appendix B for a sample PCC Ambulatory Encounter Record.)

Other methods of documenting MNT services within the IHS include:

- PCC+ Customizable Encounter Form—can be customized electronically by the provider or the clinic
- PCC Group Preventive Services Form—used to document group encounters.

How are units of MNT Services documented?

MNT services are billed in 15-minute incremental units. Refer to the chart below to determine the correct number of units for the actual amount of face-to-face time with a patient.

Table 3. CMS Guidelines for Counting Minutes for Timed Codes in 15-Minute Units

Units of Service	Time with Patient
1	≥ 8 minutes - 22 minutes
2	≥ 23 minutes - 37 minutes
3	≥ 38 minutes - 52 minutes
4	≥ 53 minutes - 67 minutes
5	≥ 68 minutes - 82 minutes
6	≥ 83 minutes - 97 minutes
7	≥ 98 minutes - 112 minutes
8	≥ 113 minutes - 127 minutes

Source: Centers for Medicare & Medicaid Services (CMS). Pub 100-04 Medicare Claims Processing Transmittal 1019.

What is the MNT superbill for claims processing activities?

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

A superbill is particularly beneficial if you are using the standard PCC Ambulatory Encounter Record or PCC+ Customized Encounter Form, rather than the Electronic Health Record, to document MNT services. The Electronic Health Record and PCC+ Customized Encounter Form incorporate the CPT and ICD-9 codes into computer-generated forms, minimizing 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 superbill includes a list of ICD-9 and CPT codes and should include areas for entering the following information:

- MNT CPT 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 visit

- Referring treating physician and date and
- Referring physician's and RD's NPI number will be inserted when the claim is submitted by the billing office.

Appendix B includes a sample IHS electronic health record (EHR) superbill and sample superbill with telehealth modifier. You may want to consult with your billing or data entry office before adopting, modifying, or creating a superbill. They may be helpful in providing suggestions on the format and content.

Step 6: Track MNT Services and Reimbursement



“Team Work is needed to increase the revenue generated for IHS facilities. We all must focus on ways to increase available health dollars to help expand services that may be provided at our facilities.”

Roslyn Bolzer, Supervisory Dietitian, IHS Rosebud Hospital, Rosebud, SD

(L to R): Julie Willcuts, Business Office Manager, Roslyn Bolzer, Tanya Pearman, Lead Billing Technician (standing), and Chrisann Long, Billing Technician, IHS Rosebud Hospital

Tracking MNT services and reimbursement provides a wealth of information for you and your MNT practice. Consider developing or adapting a tracking system that will help you record patient visits, the MNT services that you provide, and reimbursement for MNT services. See Appendix B for a sample Third Party Reimbursement Tracking Form and a sample RPMS Billing Report.

What are the benefits of tracking MNT services and reimbursement?

A tracking system for MNT services and reimbursement offers a number of benefits:

It can help you avoid common mistakes that may affect claim reimbursement such as a missing NPI or misspelled beneficiary name.

- It can help you avoid exceeding the number of billable hours allowed for initial and follow-up visits. Since Medicare allows for additional MNT services in the same calendar year with another physician referral that documents a change in condition, diagnosis, or treatment that warrants additional MNT, a tracking system can help you bill all the Medicare allowable hours.
- Tracking MNT services provides information on utilization, receipt of payment for submitted bills, and helps with audits to ensure proper procedures for completion of accurate information on claim forms. This also will help improve billing office efficiency by ensuring that they do not submit MNT claims for services that have exceeded Medicare’s billable hour limits.
- Finally, your billing office may need to submit your claim several times before your claim is paid. A tracking system can help you follow the resubmission process and ensure that your billing office is aggressive about seeking payment for your claims.

What questions should my tracking system address?

Your tracking system should address the following questions to ensure that claims are submitted properly:

- Were the correct MNT CPT codes, time units, and indication of individual and group visits properly entered?
- Were the NPI for the treating physician and RD correctly entered?
- Was the diagnosis code included?
- Does the patient qualify for Medicare Part B benefit? (i.e.--was the patient enrolled in Medicare Part B and have the qualifying criteria for the MNT service?)
- How many hours of MNT were provided?

What should a good tracking system include?

A good tracking system should include the following information:

- Dates of service
- Patient's initials and/or medical record number
- An indication that the treating physician referred the patient
- Type of coverage (e.g., Medicare Part B or private insurance)
- Diagnosis and ICD-9 codes
- Service provided, minutes of service, and MNT CPT code
- Dollar amount and percent of charge reimbursed
- RDs who provided MNT services to the patient
- Setting (e.g., clinic or hospital) that submitted the claim, if the location of your service varies
- Comment section to document additional information, such as why a claim was denied, why a claim was not submitted, or what action you have taken on a claim (e.g., resubmitting the claim with corrected or additional information).

Most IHS claims are submitted electronically. The turn-around time for accepted claims is minimal, usually 14 days. However, it may take more time for you to be notified if your claim has been denied for payment.

If the claim is denied, the billing office is responsible for following up on each unpaid claim to ensure optimal reimbursement. Depending on the reason for the denied claim, the billing office will notify the Medicare fiscal intermediary or review the existing supporting documentation to resubmit the claim for payment. This step is critical and needs to be performed within the timely filing limits set forth by the Medicare fiscal intermediary. Otherwise, the Medicare fiscal intermediary will *not* consider the claim for payment. See the Top Ten Documentation Errors to Avoid on the following page.

Top Ten Documentation Errors to Avoid

Your business office may need to submit a claim several times before it is reimbursed fully. To maximize collections and minimize the number of claims that need to be resubmitted, try to avoid these documentation errors.

1. Diagnosis

- ICD-9 codes missing or invalid
- **Solution:** Provide the ICD-9 code to the highest level of specificity (i.e., include all five digits)

2. Procedure code

- CPT missing or invalid
- **Solution:** Provide the correct CPT

3. Quantity billed

- Units of service out of the billable range
- Incorrect unit format
- **Solution:** Units of service must be equal to or greater than 1 unit of service, but less than 99 units of service. Units of service must follow the following format: 1 unit = 0010 (the fourth digit is the tenths place for decimals)

4. Beneficiary name, identification number, and sex (gender)

- Name misspelled, which may result in an inability to match eligible file
- Identification number (e.g., social security number) missing, incomplete, or incorrect
- Gender missing or incorrect
- **Solution:** Provide the correct and complete name, identification number, and sex of the beneficiary

5. Billing provider

- Assigned group number and NPI of billing provider missing or incorrect
- **Solution:** Provide the correct group and NPI number

6. Late filing

- **Solution:** File claim forms before the deadline. Check with your billing office staff to determine appropriate filing deadlines

7. Modifiers

- Modifiers inappropriate, invalid, or missing
- **Solution:** Provide correct modifiers

8. Performing provider number

- NPI missing, incorrect, or does not match group practice number.
- **Solution:** Provide the correct NPI of performing provider

9. Place of service

- Place of service missing or invalid
- **Solution:** Provide the place of service

10. Payment Name and Address

- Incorrect payment name and address
- **Solution:** Provide the correct name and address to which payment should be made and sent (e.g., Indian Health Service clinic name and address)

Step 7: Market MNT Services



“Medical Nutrition Therapy improves patient outcomes, quality of life, and lowers health care costs.”

CAPT Tammy Brown, Nutrition Consultant, IHS Division of Diabetes Treatment and Prevention, Albuquerque, NM

(L to R):

CAPT Tammy Brown with LCDR John E. Rael, Management and Program Analyst, IHS Office of Resource Access and Partnerships, Albuquerque, NM



**Medical Nutrition Therapy Works,
Saves Money, and
Makes Money.**

MNT Works

- In IHS studies, patients receiving MNT from a RD have better diabetes and lipid control, including:
 - Significantly better A1C levels (diabetes control) from RD education compared to non-RD.
 - 18% reduction in cholesterol/HDL ratio
 - National research on MNT has found:
 - 1- to 2-unit improvement in A1C
 - LDL decrease of 12% to 16%
 - Weight loss with lifestyle intervention
 - Improved patient satisfaction in health programs providing MNT

MNT Saves Money

- MNT reduces physician visits and hospital admissions for diabetes and cardiovascular disease.
- MNT reduces drug costs for treating cholesterol and diabetes.

MNT Makes Money

- Medicare and other third party payers will reimburse for MNT.

The scientific literature provides strong and convincing evidence that people with diabetes and metabolic conditions benefit from MNT when delivered as part of a comprehensive plan of care by a multidisciplinary team. Registered dietitians know this, but do patients, clinic or hospital administrators, billing office staff, and physicians know this? It is important that RDs market and promote MNT services and:

- Let patients, their families, and the community know that RDs are available to provide healthy lifestyle management education integrated into medical management, such as personalized meal planning and exercise counseling.
- Educate people, including health care managers, that MNT services make a difference, improve patient outcomes, and provide a source of revenue.
- Inform physicians, contract health services, and billing office staff of the role they play in ensuring that MNT services are provided to patients and are reimbursed. Ask to be on the agenda at upcoming medical staff meetings to discuss referral procedures and MNT services. Meet with providers to develop policies for treating physicians to refer patients for MNT.

Share information on the MNT reimbursement process

The handouts and guides described below provide information on the MNT Medicare benefit and referral process. You can share this information with health care providers and business managers to help them better understand the MNT reimbursement process.

- The IHS Division of Diabetes Treatment and Prevention has developed a summary chart on “Indian Health Facilities Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT” (see Appendix A). You can help physicians, other health care providers, and billers understand Medicare-covered services for MNT and DSMT by sharing this chart with them. Make copies of the chart and distribute it to these staff members.
- The ADA and the American Association of Diabetes Educators (AADE) have developed a referral form called, “Diabetes Services Order Form for DSMT and MNT Services.” You can use this form to encourage physicians and other health care providers to make referrals for MNT and DSMT services (remember: only physicians can make referrals for MNT). See Appendix B for a copy of the diabetes referral form.
- Be proactive. Get your message out in newsletters and at staff meetings. Distribute the Invest in Nutrition flyer in Appendix F to staff throughout your facility.

Offer an in-service training program

You can develop an in-service training program for your health care team on MNT services and Medicare reimbursement. Partner with your Billing Office team to deliver the presentation. The IHS Division of Diabetes Treatment and Prevention has developed ready-to-use PowerPoint presentations with speaker notes. You can use the PowerPoint presentations as is, or you can modify them to suit your local needs. Contact the IHS Division of Diabetes Treatment and Prevention for the current PowerPoint presentation.

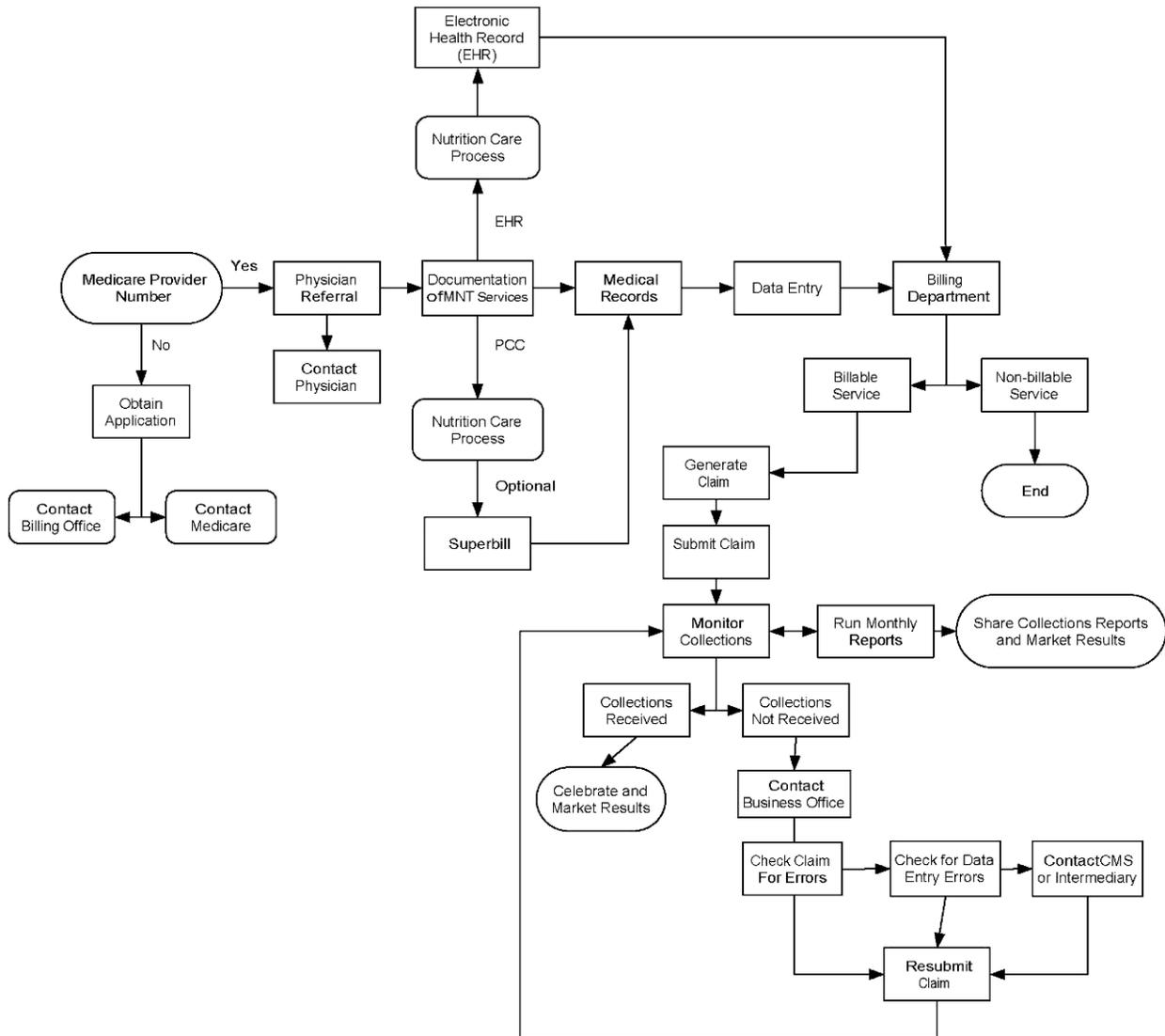
Provide follow-up events

After sharing information and offering in-service programs, consider providing regular follow-up information sessions and thank you events. These follow-up events can help nurture your relationships with the health care team and help grow your nutrition practice. Referrals are a key factor to success.



L to R: Sandra Poitra, Community Dietitian, Betty Hunt, Billing Office Medical Support Assistant, Lisa Belgarde, Billing Office Lead Medical Support Assistant, and Jody Rosendahl, Supervisory Dietitian, IHS Turtle Mountain

Steps for MNT Reimbursement



SECTION THREE

Resource Materials

Appendix A: Summary Chart on IHS Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT

Appendix B: Sample Forms

Appendix C: Indian Health Case Study Using Electronic Health Record (EHR) and Nutrition Practice Guidelines via the Nutrition Care Process

Appendix D: Indian Health Case Study Using PCC Ambulatory Encounter Record and Nutrition Practice Guidelines via the Nutrition Care Process

Appendix E: Nutrition Care Process and Model

Appendix F: Additional Resources

Appendix G: Glossary

Appendix H: References

Appendix A: Summary Chart on IHS Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Statute	<p>Section 105 of the Benefits Improvement and Protection (BIPA) Act of 2000 permits Medicare coverage of MNT services when furnished by a registered dietitian or nutrition professional meeting certain requirements, effective January 1, 2002.</p> <p>Effective January 1, 2006, CR4204 expands to include Registered Dietitians and nutrition professionals as practitioners eligible to furnish and receive payment for telehealth. CMS expanded the list of Medicare telehealth services to include individual MNT as described by HCPCS codes G0270, 97802, 97803.</p> <p>CMS -1502-FC.</p> <p>In January 2011, CMS added group MNT to reimbursement-eligible services.</p>	<p>Section 4105 of the Balanced Budget Act (BBA) of 1997 permits Medicare coverage of outpatient diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards, effective July 1, 1998.</p> <p>In Jan 2011, CMS added individual and group DSMT services as covered services.</p>
Definitions (Related to Medicare Coverage)	<p>MNT means nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or renal disease.</p>	<p>DSMT means providing overall guidance on all aspects of diabetes self-management and glycemic control and is designed to increase the patient's knowledge and skill about the disease, promote self-management behaviors, and prevent complications.</p>
Provider Qualifications and Requirements	<p>Registered dietitian (RD) or nutrition professional who meet the following criteria:</p> <ul style="list-style-type: none"> Minimum of BS degree in nutrition or dietetics Completion of 900 hours of dietetics practice under supervision of RD or nutrition professional Licensed or certified as an RD or nutrition professional by state in which services are performed (federal employees can be licensed or certified in any state) RD credential with the Commission on Dietetic Registration (CDR) is proof that education and experience requirements are met Grandfathered dietitian, nutritional professionals licensed or certified as of 12/21/00 	<p>Program must be accredited as meeting approved quality standards (i.e., <i>National Standards for Diabetes Self-Management Education Programs</i>). CMS-approved national accreditation organizations include the Indian Health Service, American Association of Diabetes Educators, and the American Diabetes Association.</p> <p>NOTE: A diabetes education program cannot seek reimbursement from Medicare until the program has been accredited.</p>

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Qualifying Diagnoses	<p>Diabetes *</p> <ul style="list-style-type: none"> ▪ Type 1 ▪ Type 2 <p>Kidney:</p> <ul style="list-style-type: none"> ▪ Non-Dialysis Kidney Disease. ▪ Post-Kidney Transplant within the last 6 months. <p>*“Diabetes” is diabetes mellitus, a condition of abnormal glucose metabolism, diagnosed using the following criteria:</p> <ul style="list-style-type: none"> ▪ FBS \geq 126mg/dl on two different occasions. ▪ 2-hour post glucose challenge \geq200mg/dl on 2 different occasions. ▪ Or, a random glucose test over 200mg/dl for a person with symptoms of uncontrolled diabetes. <p>Note: At the time of this printing, Medicare does not cover MNT for people with pre-diabetes.</p>	<p>“Diabetes” is diabetes mellitus, a condition of abnormal glucose metabolism, diagnosed using the following criteria:</p> <ul style="list-style-type: none"> ▪ FBS \geq 126mg/dl on two different occasions. ▪ 2-hour post glucose challenge \geq200mg/dl on 2 different occasions. ▪ Or, a random glucose test over 200mg/dl for a person with symptoms of uncontrolled diabetes. <p>Note: At the time of this printing, Medicare does not cover DSMT for people with pre-diabetes.</p>
Limitations of Coverage	<ul style="list-style-type: none"> ▪ No coverage for maintenance dialysis. ▪ If beneficiary has diabetes and kidney disease, the number of hours allowed is for diabetes or kidney disease. ▪ Only face-to-face time with patient. ▪ Both DSMT and MNT services cannot be billed even though both services were provided on the same date. ▪ For telehealth, the originating site must be located in either a non-MSA county or rural health professional shortage area. 	<ul style="list-style-type: none"> ▪ No payment will be made for group sessions unattended (class attendance sheet). ▪ Only face-to-face time with patient. ▪ Both DSMT and MNT services cannot be billed even though both services were provided on the same date.

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Other Conditions of Coverage	<ul style="list-style-type: none"> ▪ The number of hours covered in a 12-month calendar year (episode of care) cannot be exceeded. ▪ Services can be provided on an individual or group basis. <p>An exception to the maximum number of hours may be made if the treating physician determines that there is a change of diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and provides a new referral.</p>	<p>The training must meet the following conditions:</p> <ul style="list-style-type: none"> ▪ Following an evaluation of the beneficiary's need for training, the treating provider must order DSMT. ▪ Included in a comprehensive plan of care (POC). ▪ It is reasonable and necessary for treating or monitoring the beneficiary's condition (signed statement of need). ▪ When training under a POC is changed, the provider must sign it. ▪ In the initial DSMT benefit, 9 of the 10 hours must be provided in a group setting (2–20 individuals) unless special conditions exist. ▪ The beneficiary can be eligible for 2 more hours of follow-up with a written order. The 2 hours of follow-up can be group or one-on-one.
Practice Settings	<p><u>Included</u>: Hospital outpatient department, free-standing clinics, and Home Health.</p> <p><u>Excluded</u>: Inpatient stay in hospital or skilled nursing facility.</p> <p><u>FOHC/RHC</u>: Covered, but included in the all-inclusive encounter rate; not separately billable.</p>	<p><u>Included</u>: Hospital outpatient department and free-standing clinic.</p> <p><u>Excluded</u>: Inpatient hospital, skilled nursing facility, nursing home, or hospice.</p> <p><u>FOHC/RHC</u>: Covered, but included in the all-inclusive encounter rate; not separately billable.</p>
Basic Coverage	<p><u>Initial MNT</u>: 3 hours per calendar year in the first year.</p> <p>(MNT services covered by Medicare include: an initial nutrition and lifestyle assessment, nutrition counseling, diet management, follow-up sessions to monitor progress)</p>	<p><u>Initial DSMT</u>: 10 hours per year in the first year (1 hour individual assessment or specialized training plus 9 hours group classes). Continuous 12-month period need not be on calendar-year basis.</p>

Appendix A: Summary Chart on IHS Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Second Physician Referral	<p><u>Follow-up MNT</u>: 2 hours per calendar year in subsequent years.</p> <p>Hours can be spread over any number of visits during the year (1 visit = minimum of 15 min.)</p> <p>The number of hours can be increased if the treating physician determines there is a change in medical condition, diagnosis, and/or treatment plan and orders additional hours during that episode of care. If an RD determines that a Medicare consumer needs more time to understand and make behavior changes to meet the MNT goals, then the RD obtains a new referral from the treating physician for additional hours of MNT.</p>	<p><u>Follow-up DSMT</u>: 2 hours per calendar year in subsequent years (individual or group training).</p> <p>Hours can be spread over any number of visits during the year (1 visit = minimum of 30 min.)</p>
DSMT and MNT Benefits	The CMS considers DSMT and MNT services to complement each other. This means Medicare will cover both DSMT and MNT without decreasing either benefit as long as the referring physician determines that both are medically necessary.	SAME
Referring (Licensed) Providers	Treating physician.	Physician or qualified non-physician practitioner: nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, clinical psychologist, and clinical social worker who is managing the beneficiary's diabetes condition.
Provider Referral	Physician written referral containing qualifying diagnosis and signature for each episode of care.	Provider written and signed referral for training containing diagnosis and a written comprehensive plan of care (POC). The POC must describe the content, number of sessions, frequency, and duration of the training as written by the provider treating the beneficiary's diabetes condition.

Appendix A: Summary Chart on IHS Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Protocols or Standards	RDs and nutrition professionals should use nationally recognized protocols such as the American Dietetic Association's MNT Evidenced-Based Guides for Practice.	<p>Indian Health Service Integrated Diabetes Education Recognition Program (IDERP) based on IHS Diabetes Standards of Care and National Standards for Diabetes Education. Only program in nation that integrates educational, clinical, and public health standards.</p> <p>"or"</p> <p>American Diabetes Association Recognition Program based on the National Standards for Diabetes Self-Management Education.</p> <p>"or"</p> <p>American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program based on National Standards for Diabetes Self-Management Education.</p>
Billable to Fiscal Intermediary: Medicare Part A	<p>Hospital outpatient clinic department and grandfathered clinics MUST bill to the fiscal intermediary on a CMS 1450 (UB-92). Payment is included in the all-inclusive rate; not separately billable.</p> <p>Telehealth: the originating site bills the all-inclusive rate</p> <p>FQHC – Yes, but costs are bundled into the all-inclusive encounter rate.</p>	<p>Hospital outpatient clinic department and grandfathered clinics MUST bill to the fiscal intermediary on CMS 1450 (UB-92). Payment is included in the all-inclusive rate; not separately billable.</p> <p>FQHC – Yes, but costs are bundled into the all-inclusive encounter rate.</p>
Billable to Medicare Carrier: Medicare Part B	<p>Freestanding clinics bill the carrier on CMS 1500.</p> <p>Telehealth: the distant site bills for the professional services using the appropriate CPT code along with the appropriate telehealth modifier.</p>	Freestanding clinics bill the carrier on CMS 1500.
National Provider Identifier (NPI)	<p>RD or nutrition professional must enroll in the Medicare program and obtain a National Provider Identifier (NPI), to become a recognized Medicare provider. Apply online from the National and Provider Enumeration System contractor at:</p> <p>https://nppes.cms.hhs.gov/NPPES/Welcome.do</p>	N/A
Enrolling as Medicare Provider	<p>In addition to applying for a NPI, complete CMS Form 855I, "Medicare Enrollment Application—Physician and Non-physician Practitioners. You can access the form online at:</p> <p>http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf</p>	Referring provider must be enrolled as a Medicare Part B Provider. Once diabetes education program recognition is received, a copy of the IHS, ADA or AADE certificate must be submitted to Medicare.
CMS Form 855 for Reassignment of Benefits	Complete CMS Form 855R, "Medicare Federal Care Reassignment of Benefits Application," to reassign benefits back to employer.	N/A

Appendix A: Summary Chart on IHS Medicare Part A and B Coverage and Billing Requirements for MNT and DSMT

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
CPT or HCPCS Codes	<p>97802: Initial, individual MNT visit; initial assessment and intervention, face-to-face with the patient, each 15 minutes</p> <p>97803: Follow-up, individual MNT visit; re-assessment and intervention, face-to-face with the patient, each 15 minutes</p> <p>97804: Group MNT (2 or more individuals), each 30 minutes</p>	<p>G0108 Outpatient DSMT services, individual, each 30 minutes.</p> <p>G0109 Outpatient DSMT services, group session, (two or more), each 30 minutes.</p>
Telehealth Modifiers	<p>“GT” (via interactive audio and video telecommunications system—“real-time” through the use of video conferencing equipment)</p> <p>“GQ” (via asynchronous telecommunications system—“store and forward technology”)</p>	<p>“GT” (via interactive audio and video telecommunications system—“real-time” through the use of video conferencing equipment)</p> <p>“GQ” (via asynchronous telecommunications system—“store and forward” technology)</p>
Second Physician Referral (G Codes)	<p>G0270: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.</p> <p>G0271: Medical Nutrition Therapy reassessment and subsequent interventions(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group visit (2 or more individuals), each 30 minutes.</p> <p><u>Free-Standing Clinics:</u> Multiple units of the codes can be used based on medical necessity and the complexity of the MNT decision-making.</p> <p><u>Outpatient Hospital Programs:</u> Report one (1) in the units field regardless of the time spent in the session. Use revenue code 510.</p>	<p>Not Applicable</p> <p><u>Free-Standing Clinics:</u> Multiple units of the codes can be used based on class/session design.</p> <p><u>Outpatient Hospital Programs:</u> Report one (1) in the units field regardless of the time spent in the session. Use revenue code 510.</p>

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Payment	<p><u>Free-Standing Clinics:</u></p> <ul style="list-style-type: none"> ▪ RDs should establish a fee schedule (based on usual and customary MNT fees) for their MNT services. ▪ Allowed payment rates have been established under the physician fee schedule. ▪ Payment will be 80% (because a 20% co-pay applies) of the lesser of <i>either</i> the actual charge <i>or</i> 80% of the physician fee schedule amount. ▪ The CMS applies a geographical adjustment factor (GAF) to the MNT rates in regions of the country. ▪ Deductible and coinsurance apply. <p><u>Hospital outpatient facilities:</u> Included in All-Inclusive rate payment. Deductible and coinsurance apply.</p>	<p><u>Free Standing Clinics:</u> Medicare Part B fee schedule based on geographic state. Deductible and coinsurance apply.</p> <p>NOTE:</p> <ol style="list-style-type: none"> 1. Non-physician practitioners (e.g., RDs or nutrition professionals who are Medicare providers, are eligible to bill Medicare Part B on behalf of the DSMT program. 2. Payment to non-physician practitioners billing on behalf of the DSMT program should be made at the <i>full</i> physician fee schedule. This is because the payment is for the DSMT program and is not being billed for the services of a single practitioner. <p><u>Hospital outpatient facilities:</u> Included in All-Inclusive rate payment. Deductible and coinsurance apply.</p>
Billing for Services Not Covered	Medicare Part B cannot be billed for non-covered MNT or for non-covered MNT services as “incident to physician’s services.”	Medicare Part B cannot be billed for non-covered DSMT.
Medicare Part B Documentation Requirements	<ul style="list-style-type: none"> ▪ Patient name/medical record number ▪ Qualifying medical diagnosis ▪ Written provider referral ▪ Physician signature ▪ RD name and signature ▪ Date of service ▪ Time in – Time out and total time (to calculate number of units) ▪ MNT CPT code ▪ Individual or group encounter* ▪ Visit number with cumulative time spent with patient to date* <p>(*Recommended to facilitate timely and accurate billing)</p>	<ul style="list-style-type: none"> ▪ Patient name/medical record number ▪ Qualifying medical diagnosis indicating condition requiring training ▪ Written provider referral and signed statement of need on initial encounter ▪ Date of original referral on all subsequent visits* ▪ Physician signature ▪ Date of service ▪ Time in – Time out and total time (to calculate number of units) ▪ DSMT G codes ▪ Individual or group encounter* ▪ Visit number with cumulative time spent with patient to date* <p>(*Recommended to facilitate timely and accurate billing)</p>
Resources: Medicare Part A	<ul style="list-style-type: none"> ▪ IHS Handbook ▪ www.trailblazerhealth.com/parta/ihs 	<ul style="list-style-type: none"> ▪ IHS Handbook ▪ www.trailblazerhealth.com/parta/ihs

Medicare Benefits & CMS Coverage Guidelines	MNT Medical Nutrition Therapy	DSMT Diabetes Self-Management Training
Resources: Medicare Part B	<ul style="list-style-type: none"> ▪ Medicare Part B Newsletter 9/1/2001. No 01-020. Pages 27–28. ▪ www.trailblazerhealth.com/partb/ihs ▪ ADA Web site: www.eatright.org ▪ Electronic Code of Federal Regulations Title 42: Public Health, Chapter IV (MNT) 	<ul style="list-style-type: none"> ▪ Medicare Part B Newsletter 9/1/2001. No 01-020. Pages 31–32. ▪ www.trailblazerhealth.com/partb/ihs ▪ AADE Web site: http://www.diabeteseducator.org ▪ Electronic Code of Federal Regulations Title: 42: Public Health, Chapter IV (DSMT)
Claim Follow-up	<p>Medicare B IHS hotline: 1-866-448-5894. Ask for claim check status. Have available patient Medicare number and date of service.</p> <p>Trailblazer DDE online system: Each facility business office should have access to this electronic system.</p>	<p>Medicare IHS hotline: 1-866-448-5894. TrailBlazer's DDE Online System. Each facility's business office may have access to this electronic system.</p>

Appendix B: Sample Forms

1. IHS MNT Referral Form (Electronic Version)

Consults... Done

MIDDLE TEAM PATIENT CONSULT

Audiology	Infection Control Report	Patient Benefits Coordinator
Behavior Health	Internal Medicine	Pediatrics
Chemical Dependency	Native Womens Clinic	Podiatry
Community Health Rep.	Nutrition	Public Health Nursing
Dental	Optometry	Respiratory Therapy
Diabetes Education	Diabetic Shoes	SDPPI
Ear Nose Throat	Orthopedics	Social Services
Health Education	Outside Consult	Wellness
	Outside Order	Services Under Arrangement

Reason for Request: NUTRITION, WEST TEAM

Rapid City Indian Health Service

Nutrition Service

Reason for Consult:

- New Diabetes
- Weight Loss
- Cholesterol
- Hypertension
- Other

Last HGB & HCT:

HGB	1	SEP 27, 2006@11:46:26
HCT	40	SEP 27, 2006@11:46:26
MCV	1	SEP 27, 2006@11:46:26

A1C UAS DEC 12, 2006@12:00

Patient informed of Referral: * Yes No

Best to contact patient at:

Provider comments if any:

* Indicates a Required Field Preview OK Cancel

IHS MNT Referral Form (Electronic Version) –Continued

Order a consult

Consult to Service/Specialty: NUTRITION, WEST TEAM

Urgency: ROUTINE

Attention: [Empty]

Patient will be seen as an: Inpatient Outpatient

Place of Consultation: CONSULTANT'S CHOICE

Provisional Dx (REQUIRED): Diabetes

Reason for Request: Rapid City Indian Health Service Nutrition Service

Reason for Consult: New Diabetes

NUTRITION, WEST TEAM Cons CONSULTANT'S CHOICE

Buttons: Accept Order, Quit

IHS-EHR: RAUTH, LESLYE L *****RAPID CITY SD, IHS*****

User: Patient Tools Help CLEAR

Demographic: 999999 09-Mar-1956 (53) F

Current Status: OUTPATIENT CLARK, LEROY

DOB: 06-Oct-2009 09:43

Location: Ambulatory

Physician: Ellis, Genie M

Consults List:

- Oct 06, 09 (p) NUTRITION, WEST TEAM Cons Consult # 13675
- Oct 06, 09 (p) NUT
- Sep 08, 09 (c) OUF
- Aug 27, 09 (c) INF
- Aug 04, 09 (p) SOI
- Jul 20, 09 (p) SOC
- Jul 20, 09 (c) INFE
- Jul 10, 09 (c) OUT
- Jun 23, 09 (p) SEF
- Jun 02, 09 (p) SKA
- Jun 02, 09 (c) OUT
- Dec 20, 07 (p) NO
- Apr 10, 07 (p) PHH
- Apr 10, 07 (p) PHH
- Apr 09, 07 (p) PHH

Order Information:

- To Service: NUTRITION, WEST TEAM
- From Service: OUTPATIENT
- Requesting Provider: CLARK, LEROY
- Service is to be rendered on an OUTPATIENT basis
- Place: Consultant's choice
- Urgency: Routine
- Orderable Item: NUTRITION, WEST TEAM
- Consult: Consult Request
- Provisional Diagnosis: Diabetes
- Reason For Request: Rapid City Indian Health Service

Reason for Consult: New Diabetes

Last HGB & HCT:

HGB	1	SEP 27, 2006	11:46:26
HCT	40	SEP 27, 2006	11:46:26
MCV	1	SEP 27, 2006	11:46:26

A1C: UAS DEC 12, 2006 11:00

Patient informed of Referral: Yes

Best to contact patient at: Home 774-4857

Provider comments if any: Request family education

Inter-facility Information: This is not an inter-facility consult request.

IHS MNT Referral Form (Electronic Version) –Continued

The screenshot displays the IHS EHR interface for patient RAUTHLESLEY L. The patient is identified as an outpatient, 53 years old, female, with a date of birth of 09-Mar-1956. The current consult is dated 06-Oct-2009 09:43 AM, conducted by Ellis, Genie M. The consult is for a Nutrition Service, with the reason for the consult being New Diabetes.

Consult History:

- Oct 06, 09 (p) NUTR
- Sep 08, 09 (c) OU
- Aug 27, 09 (c) INF
- Aug 04, 09 (p) SOI
- Jul 20, 09 (p) SOC
- Jul 10, 09 (c) INFE
- Jul 10, 09 (c) OUT
- Jun 23, 09 (p) SEP
- Jun 02, 09 (p) SKA
- Jun 02, 09 (c) OUT
- Dec 20, 07 (p) NO
- Apr 10, 07 (p) PHH
- Apr 10, 07 (p) PHH
- Apr 03, 07 (p) PHH

Lab Results:

Test	Result	Date/Time
HGB & HCT	1 SEP 27, 2006 811:46:26	1 SEP 27, 2006 811:46:26
HCT	40	SEP 27, 2006 811:46:26
MCV	1	SEP 27, 2006 811:46:26

A1C: UAS DEC 12, 2006 812:00

Status: PENDING
Last Action: PRINTED TO

Facility Activity Log:

Activity	Date/Time/Zone	Responsible Person	Entered By
CPDS RELEASED ORDER	10/06/09 10:02	CLARK, LEROY	RAUTH, LESLEY L
PRINTED TO PRC097	10/06/09 10:02		

Notes:

- Inter-facility Information: This is not an inter-facility consult request.
- No local TIU results or Medicine results available for this consult.

2. IHS MNT Patient Referral IHS Form 199-1

IHS 199-1 (REV. 01/89)

PATIENT REFERRAL NOTICE

INSTRUCTIONS (This form may be used by Medical, Dental, and Paramedical personnel to refer DIH Beneficiaries for medical, dental or related services)

1. TO (Name, title, and address of person or organization to whom referral is made.)			
2. NAME OF PATIENT	3. SEX	4. BIRTH DATE	5. REGISTRATION
6. ADDRESS	7. TRIBE	8. RESERVATION	
9. ADDITIONAL IDENTIFICATION			
10. REASON FOR REFERRAL (Type of service requested) RD to provide Medical Nutrition Therapy for _____ (hours) for _____ (note reason) (e.g., controlled, uncontrolled, change in medical management)			
<input type="checkbox"/> Type 1 Diabetes, controlled <input type="checkbox"/> Type 2 Diabetes, controlled <input type="checkbox"/> Gestational Diabetes, controlled <input type="checkbox"/> Type 1 Diabetes, uncontrolled <input type="checkbox"/> Type 2 Diabetes, uncontrolled <input type="checkbox"/> Gestational Diabetes, uncontrolled			
Complicating conditions: <input type="checkbox"/> HTN <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Nephropathy due to _____ <input type="checkbox"/> Neuropathy <input type="checkbox"/> Other _____			
11. SIGNIFICANT MEDICAL OR DENTAL FACTORS (Including diagnosis, prognosis, treatments, etc.)			
YOUR GOALS FOR PATIENT:			
<input type="checkbox"/> Improve A1c <input type="checkbox"/> Improve Dyslipidemia <input type="checkbox"/> Weight Management <input type="checkbox"/> Improve BP <input type="checkbox"/> Change in Medical Management* <input type="checkbox"/> No previous MNT/nutrition education <input type="checkbox"/> Other _____			
EXERCISE RESTRICTIONS:			
<input type="checkbox"/> None → Initial and date _____ (Indicates medical clearance) <input type="checkbox"/> Restrictions: _____			
CLINICAL DATA: (May attach current Health Summary)			
Ht _____ Wt _____ Blood Pressure _____ (include date)			
A1c _____ LDL-C _____ HDL-C _____ TG _____ Microalb or Up/Ucr _____ Cr _____ Hgb _____ Ketones _____			
Date(s) () () () () () () () ()			
MEDICATIONS: (May attach current Health Summary)			

*MANAGEMENT TRAINING NEEDS:			
Insulin _____			
Monitoring _____			
Nutrition _____			
Other _____			
COMMENTS:			

12. REPORT BY PARAMEDICAL PERSONNEL			
13. FROM (Name, title, and address of person making referral)			14. DATE
UPIN: _____			

3. MNT Superbill – Electronic Health Record Version

IHS/EHR RAUTH,LESLEY L *****RAPID CITY SD, IHS*****

User Patient Tools Help CLEAR

Privacy Patient Chart RPMS Up To Date Communication

Demo Patient 999999 09-Mar-1956 (53) F OUTPATIENT RAUTH,LESLEY L 06-Oct-2009 09:43 Ellis,Genie M MCKNEXED Postings CWAD

Adult Health Summary Visit Brief RCIS RX DM flowsheet DM Supplement Head Start Immunizations

Notifications Cover Sheet Assessment Notes Orders Medications Labs Prob/POV Services REPORTS D/C Summ Consults

Historical Services Surgical Add to Current Visit Add Delete

Visit Date	CPT Code	Description	Facility	Qty	Diagnosis	Prim	Modifier 1	Modifier 2
02/04/2007	58150	Total Hysterectomy	Rcrh	1				
01/22/2007	47600	Cholecystectomy	Rcrh	1				
11/23/2006	00099	DR. SURGEON	Rapid Reg	1				
06/22/2006	45330	Sigmoidoscopy	Aberdeen Urban	1				
09/07/2004	31505	DIAGNOSTIC LARYNGOSCOPY	Rapid City					
09/10/2003	66984	CATARACT SURG W/IOL 1 STAGE	Rapid City			Left side		Postoperative Management Only
04/21/2000	12051	INTMD WND REPAIR FACE/MM	Rapid City					
01/11/1999	11040	DEBRIDE SKIN PARTIAL	Rapid City					

Super-Bills Display Freq. Rank Code Description Cols 3

Erg
Immunizations - All
Laceration Repair
Medical Nutrition Therapy
Nursing Procedures (01)
Nursing- Procedures (30/80)
Nursing-respiratory (01)
Nursing-respiratory (30/80)
Optometry
 Show All

97802 - Medical Nutrition Therapy, Initial Assessment And Intervention, Individual, Face-to-face With The Patient, Each 15 Minutes
 97803 - Medical Nutrition Therapy, Re-assessment And Intervention, Individual, Face-to- Face With The Patient, Each 15 Minutes
 97804 - Medical Nutrition Therapy, Group (2 Or More Individual(s)), Each 30 Minutes
 G0270 - Medical Nutrition Therapy, Reassessment And Subsequent Intervention(s) Following Second Referral In Same Year For Change In Diagnosis, Medical
 G0271 - Medical Nutrition Therapy, Reassessment And Subsequent Intervention(s) Following Second Referral In Same Year For Change In Diagnosis, Medical

Evaluation and Management New Patient Established

Type of Service	Level of Service	Complexity	Approx. Time	CPT Codes
Office Visit	<input type="checkbox"/> History and Exam			
Consultation	<input type="checkbox"/> Brief Nurse Visit		5 min	99211
Preventive Medicine	<input type="checkbox"/> Problem Focused	Straightforward	10 min	99212
Emergency Services	<input type="checkbox"/> Expanded	Low	15 min	99213
Other ER Services	<input type="checkbox"/> Detailed	Moderate	25 min	99214
Initial Hospital Care	<input type="checkbox"/> Comprehensive	High	40 min	99215
Subsequent Hospital Care				
Observation Inpatient Care				
Hospital Discharge				

Visit Services Add Edit Delete

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provide
97802	Medical Nutrition Therapy, Initial Assessment And Intervention, Individual, Face-to-face With The Patient, Each 15 Minutes	2		Y			RAUTH

RAUTH,LESLEY L ABRRCMMAN,RAPIDCITY-ABERDEEN,IHS.GOV RAPID CITY 06-Oct-2009 09:49

4. MNT Superbill with Telehealth Modifier

The screenshot displays the RPMS-EHR software interface. At the top, the patient information includes 'Demo, Tarzan' (DOB: 10-Mar-1960) and 'NUTRITION-GENERAL' (CLARK, EDITH M) on 15-Dec-2009 at 15:02. The provider is 'PSU-YAHC / Ohman, Valerie J'. The interface is divided into several sections:

- Overview:** Includes Cover Sheet, Graph Vitals, and Data Entry options.
- Coding:** A list of CPT/E-M/HCPCS codes is visible on the left, with '97802' selected.
- Super-Bills:** A table lists codes and their descriptions:

Code	Narrative	Qty	Diagnosis	Prim	Modifier 1	Modifier 2	Provider
97802	1st Mnt Indiv, Unit = 15min, Max, 90	4		Y	Interactive telecommunication		CLARK, EDITH M
- Edit Procedure for Current Visit:** A form where the procedure is 'Medical Nutrition, Indiv, In' and the narrative is '1st Mnt Indiv, Unit = 15min, Max 90'. The diagnosis is 'Diabetes Type II/unspec U' with a 1st modifier of 'Interactive Telecommunication'. The quantity is set to 4.
- Visit Services:** A table showing the selected service and its details.

The bottom of the screen shows the system tray with the date and time (15-Dec-2009 15:11) and various application icons.

Third Party Reimbursement Tracking Form and Instructions –*Continued*

Third-Party Reimbursement Tracking Form Instructions

Date:	Provide date of service
Patient:	Patient's initials and/or ID#
MD:	Patient referred by MD? Y (Yes) N (No)
Setting:	Indicate where service was provided: RD (RD Office) MD (MD Office) OTH (Other)-Explain
Payer:	List name of insurance company
Payer Type:	List type of insurance plan: Case Mgmt Case Management HMO Health Maintenance Organization Indemnity Traditional Health Plan, e.g., 80/20 IPA Independent Practice Association POS Point of Service PPO Preferred Provider Organization Public Medicaid Plans Self-Ins Self-Insured Companies
Diagnosis:	List primary and secondary (if any) diagnoses
ICD-9-CM:	Document diagnosis code(s) used on super bill or claim form
Service Provided:	List words used to describe your service on super bill or claim form
Minutes:	Record amount of face-to-face time spent with patient
CPT Code:	Enter service code (if any) used to describe your service
Claim:	Claim submitted by: PT (Patient) RD (Dietitian) MD (Physician) NS (Not submitted)
\$ Amount Reimbursed:	List dollar amount reimbursed by insurance company or applied to deductible. Indicate "0" if not reimbursed, and "0-NS" if not submitted
% of Charges Reimbursed:	Provide percentage of your charge reimbursed by the payer
Comments:	Use this row to clarify: - Why claim was denied. - Date(s) and time(s) claim was resubmitted. - Why claim was not submitted. - Any other useful information.

Stollman LA, editor. *Nutrition Entrepreneur's Guide to Reimbursement Success*, 2nd ed. Chicago, IL: American Dietetic Association, 1999 (2001 Update), Appendix 12.

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6. CMS Form 1500 (Health Insurance Claim Form)

1500 HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05																
PCIA <input type="checkbox"/>																
CARRIER	PATIENT AND INSURED INFORMATION	PHYSICIAN OR SUPPLIER INFORMATION	1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>)	7. INSURED'S ADDRESS (No., Street)	8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>)	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____
			14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a. _____ 17b. NPI _____)	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/>) \$ CHARGES _____	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) (1. _____ 2. _____ 3. _____ 4. _____)	22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	23. PRIOR AUTHORIZATION NUMBER _____	24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I.D. QUAL I. ID. QUAL J. RENDERING PROVIDER ID. #			
			25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For 24E, 24F, and 24G) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION (a. _____ b. _____)	33. BILLING PROVIDER INFO & PH # () (a. _____ b. _____)					

7. Diabetes Services Order Form (DSMT and MNT Services)

Diabetes Services Order Form (DSMT and MNT Services)

*Indicates required information for Medicare order

PATIENT INFORMATION			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient's Last Name	First Name	Middle	
Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare HICN # <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Phone	Work Phone	Other Contact Phone	

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)	MEDICAL NUTRITION THERAPY (MNT)
<p>Medicare: 10 hours initial DSMT in 12 month period, plus 2 hours follow-up DSMT annually</p> <p>*Check type of training services and number of hours requested:</p> <p><input type="checkbox"/> Initial group DSMT: <input type="checkbox"/> 10 hours or <input type="checkbox"/> no. hrs. requested</p> <p><input type="checkbox"/> Follow-up DSMT: <input type="checkbox"/> 2 hours or <input type="checkbox"/> no. hrs. requested</p> <p><input type="checkbox"/> Additional insulin training: <input type="checkbox"/> no. hrs. requested</p> <p>*Patients with special needs requiring individual DSMT</p> <p>Check all special needs that apply:</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive Impairment</p> <p><input type="checkbox"/> Language limitations <input type="checkbox"/> Other <input type="text"/></p>	<p>Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.</p> <p>*Check the type of MNT and/or number of additional hours requested:</p> <p><input type="checkbox"/> Initial MNT <input type="checkbox"/> Annual follow-up MNT</p> <p><input type="checkbox"/> Additional MNT services in the same calendar year, per RD recommendations <input type="checkbox"/> no. additional hrs. requested</p> <p>Please specify change in medical condition, treatment and/or diagnosis:</p> <input type="text"/>

<p>*DSMT Content</p> <p><input type="checkbox"/> All ten content areas, as appropriate</p> <p><input type="checkbox"/> Monitoring diabetes <input type="checkbox"/> Diabetes as disease process</p> <p><input type="checkbox"/> Psychological adjustment <input type="checkbox"/> Physical activity</p> <p><input type="checkbox"/> Nutritional management <input type="checkbox"/> Goal setting, problem solving</p> <p><input type="checkbox"/> Medications <input type="checkbox"/> Prevent, detect and treat acute complications</p> <p><input type="checkbox"/> Preconception/pregnancy management or gestational diabetes management <input type="checkbox"/> Prevent, detect and treat chronic complications</p>	<p>CURRENT DIABETES MEDICATIONS</p> <p>Specify type, dose and frequency</p> <p>Oral:</p> <input type="text"/> <p>Insulin:</p> <input type="text"/> <p>Patient now uses: <input type="checkbox"/> Pen <input type="checkbox"/> Needle <input type="checkbox"/> Pump</p>
--	---

<p>* DIAGNOSIS</p> <p>Please send recent labs for patient eligibility & outcomes monitoring</p> <p><input type="checkbox"/> Type 1 uncontrolled <input type="checkbox"/> Type 1 controlled</p> <p><input type="checkbox"/> Type 2 uncontrolled <input type="checkbox"/> Type 2 controlled</p> <p><input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Other <input type="text"/></p>	<p>PATIENT BEHAVIOR GOALS/PLAN OF CARE</p> <input type="text"/>
---	--

<p>Complications/Comorbidities</p> <p>Check all that apply:</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> PVD</p> <p><input type="checkbox"/> Renal disease <input type="checkbox"/> Retinopathy <input type="checkbox"/> CHD</p> <p><input type="checkbox"/> Non-healing wound <input type="checkbox"/> Pregnancy <input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Mental/affective disorder <input type="checkbox"/> Other <input type="text"/></p>	
--	--

*Signature and UPIN # *Date / /

Group/practice name, address and phone:

Revised 8/31/05 by the American Dietetic Association and the American Association of Diabetes Educators after substantial review and consultation. Authors do not recommend or endorse any revisions or modifications.

9. RPMS Billing Report

RPMS Billing Report Sample

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LISTING of ALL BILLS for ALL BILLING SOURCES SEP 24, 2009 Page 1
 with APPROVAL DATES from 01/01/2009 to 09/24/2009 provided by DEBBIE DIETITIAN
 with PROCEDURE RANGE from 97802 to 97804
 Billing Location: SUNSHINE HOSPITAL

=====

Insurer	Claim Number	Export HRN	Billed Date	Date Amount	Paid Paid	Amount
---------	--------------	------------	-------------	-------------	-----------	--------

=====

STATISTICAL REPORT for ALL BILLING SOURCES SEP 24, 2009 Page 1
 with APPROVAL DATES from 01/01/2009 to 09/24/2009 provided by DEBBIE DIETITIAN
 with PROCEDURE RANGE from 97802 to 97804
 Billing Location: SUNSHINE HOSPITAL

=====

CLINIC	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	UNPAID AMOUNT
--------	---------------	----------------	---------------	-------------	---------------

(REPORT COMPLETE):

=====

STATISTICAL REPORT for ALL BILLING SOURCES SEP 23,2009 Page 1
 with PAYMENT DATES from 01/01/2009 to 09/23/2009 provided by DEBBIE DIETITIAN
 Billing Location: SUNSHINE HOSPITAL

=====

CLINIC	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	UNPAID AMOUNT
--------	---------------	----------------	---------------	-------------	---------------

SUNSHINE HOSPITAL HO					
DIETARY	1	1	253.00	0.00	253.00
	1	1	253.00	0.00	253.00

TOTAL COVERED INPATIENT DAYS 0

(REPORT COMPLETE):

Appendix C: Indian Health Case Study Using Electronic Health Record (EHR) and Nutrition Practice Guidelines via the Nutrition Care Process

Case Presentation

Mrs. Dancing Eagle was referred by Dr. Browning on November 1st for MNT for uncontrolled Type 2 diabetes and weight loss.

Mrs. Dancing Eagle is a 66 year old female with Type 2 Diabetes. She was diagnosed with Type 2 diabetes about 10 years ago, but Mrs. Dancing Eagle states that she was unaware she had diabetes.

She remembers being told her sugar was high a few times over the years. She stated she is usually really thirsty and often gets up numerous times during the night to use the bathroom.

Mrs. Dancing Eagle was brought into the clinic after slipping and falling on the ice injuring her knee. At this time she was told she had diabetes.

Lab Reports from 10-18-09
A1c: 11.3
Direct Measure LDL: 130
HDL: 25
Triglycerides: 620

Height: 62"
Weight: 235 #
BP: 160/95
Medications: none

Mrs. Dancing Eagle takes care of her four grandchildren, ages 3, 5, 7, and 10. Her daughter and her four grandchildren live with her. She states she has no alone time, always taking care of everyone else. She has been having financial problems ever since her son was put in jail. She enjoys sewing but her arthritis in her wrist is so painful that she can no longer sew.

Usual Diet History:

Breakfast: Busy with the kids, usually 2 cups of coffee with sugar and cream, large glass of Sunny D, sometimes leftover supper

Lunch: Mac-n-cheese, or hot dogs, or ramen noodles, coke

Supper: pork chops, fried potatoes (fried in lard), 2 sl. white bread, sweet tea

Snacks: can't skip dessert every night before bed, usually fruit cocktail. Fruit, candy bars, pastries, sweet tea.

SMBG: none, doesn't have meter

Exercise: housework and running after the kids

Etoh/Tobacco: neither

Today's Vitals:

Weight: 235.00 lb
Height: 62.00 in
BMI: 43, extreme obesity
Last Blood pressures: 160/95 Nov 01, 2009

Laboratory History:

A1c: 11.3 Nov 01, 2009
LDL (direct measure): 130 Nov 01, 2009
HDL: 25 Nov 01, 2009
Triglycerides: 620 Nov 01, 2009

Medications:

Metformin 500mg BID, simvastatin 20 mg, lisinoprol 20 mg, started on Sunday

ASSESSMENT

Total energy intake: approximately 2500 kcal/day
Type of foods/meals: irregular meals and snacks
Total carbohydrate: processed, sugar sweetened beverages and sweets
Area(s) and level of knowledge: no diabetes knowledge
Physical activity: no regular activity. TV/screen time: 2 -3 hours per day.
Total calories, estimate needs: For weight maintenance: ~2000 kcal per day, for weight loss: 1500 kcal/day.
Method for estimating needs: Mifflin St. Jeor with actual weight.

NUTRITION DIAGNOSIS

Excessive carbohydrate intake related to regular intake of sugar sweetened beverages as evidence by diet recall and A1c level.
Food & nutrition related knowledge deficit related to a balanced diabetic diet as evidence by self reported knowledge.

NUTRITION INTERVENTION

Nutrition Prescription: High fiber, low fat, carbohydrate controlled diet.
Carbohydrate budget: breakfast: 30-45 grams, lunch: 30-45 grams, dinner: 30- 45 grams, snacks: 15-30 grams. Short term goal to decrease intake by 500 kcal/day and increase activity and reduce carbohydrate intake. Longer term goal: decrease daily intake to 1500 kcal/day to decrease body weight 5-10% in 6 months.
Modify distribution, and type, of carbohydrate for a more balanced intake.
Purpose of the Nutrition Education, to educate patient on the importance of a balanced carbohydrate controlled diet. How to use blood glucose monitor and when to check blood sugar levels at home.
Recommended Modifications: evenly distribute carbohydrates throughout the day.
Intervention strategy: Motivational Interviewing and Goal Setting

Referral to community diabetes program for educational classes, support group and involvement in fitness activities.

MONITORING EVALUATION TERMINOLOGY

Continue regular follow up visits to monitor carbohydrate intake and Alc levels, and home blood glucose levels.

Behavioral Goals:

-
- Self blood glucose monitoring 2-3 times/day (am fasting and after largest meal)

Timing and consistency of meals, consume regular meals and evenly distribute carbohydrates throughout the day

- Switch to sugar-free beverages

Patient Goals: (patient stated goals)

Switch to diet pop

Eat regular meals, not skip meals

Watch my carbohydrate intake, limit to 2-3 servings per meal

Begin checking my blood sugar 2 - 3 times per day

Patient Education:

1 DM-HM: 15 min.; INDIVIDUAL; Understanding-GOOD

Comment:

2 DM-MNT: 30 min.; INDIVIDUAL; Understanding-GOOD

Comment:

Scheduled Appointments:

Patient is scheduled to return to clinic: December 1, 2009 @ 2:00 pm

MNT TRACKING

Activity Time:

Time in: 10-Nov-2009 10:00 Time Out: 10-Nov-2009 11:10

CPT codes: MEDICAL NUTRITION, INDIV, IN Qty=4 (97802)

/es/ DIANE L. PHILLIPS, RD

Signed: 11/09/2009 14:32

2. Follow-up Visit

TITLE: DIETARY NOTE
DATE OF NOTE: DEC 01, 2009@02:00 ENTRY DATE: DEC 01, 2009@03:30
AUTHOR: PHILLIPS,DIANE L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

MEDICAL NUTRITION THERAPY FOLLOW UP VISIT

Dancing Eagle, Juanita, 66 year old FEMALE. Referred on 01-Nov-2009 by Dr. Browning. Initial visit, November 10, 2009.

Purpose of today's visit:

- 1) Diabetes Mellitus, Type 2, Uncontrolled [P]
- 2) OBESITY

Patient states she is feeling much better. She has begun attending the Tribal Diabetes Program classes and started going to the wellness center during diabetes hour. She is no longer drinking regular pop and sweet tea. Using Splenda® in her tea and coffee.

Social History:

Daughter and her four grandchildren are stilling living with her. She was able to visit her son in jail and he is doing well.

Nutrition & Lifestyle History:

Usual Meals:

Breakfast: oatmeal, hard boiled egg, coffee with creamer and Splenda®

Lunch: soup, crackers or sandwich (ham or roast beef w/lettuce, tomatoes and onion), diet coke

Dinner: green chile stew, whole wheat tortilla (1/2) or pork chops, broccoli, baked potato, water

Snacks: fruit, raw vegetables, nuts

Beverages: water, diet coke, coffee and tea sweetened with Splenda®

Food Intolerance: lactose

MONITORING EVALUATION TERMINOLOGY

Mrs. Dancing Eagle has begun regularly monitoring her blood sugar. She is checking AM fasting and after lunch or supper. She is no longer using regular sugar or regular pop. She has begun using diet pop and Splenda®. She is trying to limit carbohydrates but is having a hard time understanding how to count the carbohydrates. She has been attending the diabetes classes at the tribal diabetes center and she is also attending the diabetes hour at the wellness center 3 to 5 times per week. She is able to recall nutrition goals and is very motivated to make lifestyle changes.

Self Monitoring Blood Glucose at agreed upon rate: 2-3 times per day

AM fasting: 280, 200, 178, 212, 185

Postprandial: 200, 225, 250, 195, 170

Physical Activity: Routine Exercise going to the wellness center 3 -5 times a week, working w/ DM Program to increase intensity and duration of cardio and weight workout

Today's Vitals:

Weight: 227 lbs	Dec 01, 2009
Last weight: 235 lb	Nov 10, 2009
Last Height: 62in	Nov 10, 2009
Last blood pressures: 149/ 80	Dec 01, 2009

Laboratory History:

A1C: 8.5 Nov 30, 2009

Type of foods/meals, Meal/snack pattern: 3 meals a day, and afternoon and evening snack.

Total carbohydrate, Source of carbohydrate: Working on limiting intake to 2-3 serving of carbohydrate per meal and 1 to 2 servings per snack. Including whole grains.

Plan: Continue to work on nutrition prescription: High fiber, low fat, carbohydrate controlled diet. Carbohydrate budget: breakfast: 30-45 grams, lunch: 30-45 grams, dinner: 30- 45 grams, snacks: 15-30 grams. Today we focused on more in depth skills and knowledge on carbohydrate counting in order to meet carbohydrate budget/plan. Reduction in Alc, weight, and BP. Patient states better understanding and is able to return demonstrate carbohydrate counting principles and how to read the food label to interrupt carbohydrate content and serving. Continue to work on reduction of carbohydrate intake and increase diabetes self care skills and knowledge.

Patient Goals:

Continue monitoring blood sugar 2 to 3 times per day

Continue going to wellness center, increase to 5 time per week

Begin counting carbohydrates and recording intake in log book

Patient Education:

1 DMCN-FL: 15 min.; INDIVIDUAL; Understanding-GOOD
Comment:

2 DMCN-CC: 30 min.; INDIVIDUAL; Understanding-GOOD
Comment:

Scheduled Appointments:

Patient is scheduled to return to clinic: January 14, 2010 @ 10:00 am

MNT TRACKING

Activity Time:

Time in: 01-Dec-2009 14:10 Time Out: 01-Dec-2009 15:20

CPT codes: MED NUTRITION, INDIV, SUBSEQ Qty=4 (97803)

/es/ DIANE L. PHILLIPS, RD

Signed: 12/01/2009 16:33

Appendix D: Indian Health Case Study Using PCC Ambulatory Encounter Record and Nutrition Practice Guidelines via the Nutrition Care Process

1. Initial Visit

IHS-803 (5/98) P.L. 96-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date: 11-10-09
 Arrival Time: 10:00 AM
 Clinic: 67
 Appt. Y Walk-in

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)			PROVIDERS	AFFIL.	DIS.	INITIALS / CODE
Remove	Move to Inactive	Move to Active				
			1		29	DLP

TEMP PULSE RESP

BP: _____

WT: 235 GM KG LB-O

HT: 62 CM IN

HEAD CM IN

VISION - UNCORRECTED R L

VISION - CORRECTED R L

ORDER INITIALS

HCT. _____
 UA _____
 HCG _____
 BS-FBS-R _____
 CBC _____
 Urine culture _____
 Throat culture _____
 Stool culture _____
 STS _____
 GC _____
 PAP _____
 Pelvic _____
 Breast _____
 Mammogram _____
 Rectal _____
 Chest X-ray _____
 EKG _____
 Soak _____
 Hep B # _____
 Hep A # _____
 OPV # _____
 DTP # _____
 DT aP # _____
 DT _____
 Td _____
 MMR # _____
 Varicella _____
 Influenza _____
 Hib TITER/AC/HIB # _____
 Padvax Hib # _____
 Pneumo Vax _____
 PPD _____ mm

CHIEF COMPLAINT: Newly Dx Diabetic, here to see the Dietitian
 SUBJECTIVE: Referred on 11-01-09 by Dr. Brownning. Pt seen in ER w/ knee injury +
 OBJECTIVE: was Dx w/ type 2 Diabetes.

Nutrition Assessment: Intake ~ 2500 kcal/day. Irregular meals + snacks. Diabetes knowledge, physical activity, Est needs: w/ maintenance! 2000 kcal/day, for w/ loss: 1500 kcal/day. Method: Mi-Plan St. Jean selected w/.

Nutrition Diagnosis: Excessive CHO intake related to regular intake of sugar sweetened beverages as evidence by diet recall + A1c level. Food + nutrition related knowledge deficit related to a balanced diabetic diet as evidence by self reported knowledge.

Nutrition Intervention: Nutr Rx: ↑ fiber, low fat, CHO controlled diet. CHO budget: 30-45 grams/meal + 15-30 grams/snack. Modify + distribute CHO to balance intake. Nutr Ed: Importance of BS control + CHO controlled diet. Use of home BS monitor. Strategy: motivation/interviewing + goal setting. Refer to community DM Program for ed classes, support group + group fitness activities.

Injury? Yes No If yes, Date: _____ ETOH Related Employ. Rel.

Cause: _____ Place: _____

Monitoring + Evaluation: Cont regular follow up visits to monitor CHO intake.

OTHER TESTS/PROCEDURES ORDERED: A1c level + home blood glucose levels.

PROBLEM LIST #	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)	Health Factors
A-A1-C	<u>Diabetes Type 2, uncontrolled</u>	
	<u>97802 - Medical Nutrition Therapy (60 minutes)</u>	

REPRODUCTIVE FACTORS: G P LC SA TA LMP FP METHOD DATE BEGUN

PROBLEM LIST NOTES: STORE NOTE FOR PROB. # REMOVE NOTE #

STORE NOTE FOR PROB. #

MEDICATIONS: _____ MEDICATIONS/TREATMENTS/PROCEDURES/PATIENT EDUCATION: DM-HM-G-15min-DP
DM-MNT-G-30min-DP

HR # 9999 SSN # _____ REVISIT REFERRAL TO: 12-01-09 DATE 2:00pm TIME

NAME: Dancing Eagle, Jucunita PURPOSE: Evaluate behavior changes, goals + A1c + home BS levels

B DATE: 10-21-43 SEX: F IRISE: Crow INSTRUCTIONS TO PATIENT: SIGN RELEASE Switch to diet pop
 Eat regular meals, not skip meals
 Watch CHO intake, limit to 2-3 servings/meal
 Begin checking BS 2-3 times/day.

RESIDENCE: Crow DATE: 11-10-09 PROV. SIGNATURE: Diane J. Phillips, RD, LD, CDE

FACILITY: Crow Service Unit

2. Follow-up Visit

IHS-803 (5/98) PL. 96-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date: 12-01-09

Arrival Time: 2:10 AM

Clinic: 607

Appt. Walk-in

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)			AFFIL.	DIS.	INITIALS / CODE
Remove	Move to Inactive	Move to Active			
			1	29	DLP

TEMP _____ PULSE _____ RESP _____

B/P: 114/78/80

WT: 227 GM KG LB-O

HT: 62 CM IN

HEAD: CM IN

VISION - UNCORRECTED: R _____ L _____

VISION - CORRECTED: R _____ L _____

ORDER: HCT _____ UA _____ HCG _____ BS-F/BS-R _____ CBC _____ Urine culture _____ Throat culture _____ Stool culture _____ STS _____ GC _____ PAP _____ Pelvic _____ Breast _____ Mammogram _____ Rectal _____ Chest X-ray _____ EKG _____ Soak _____ Hep B # _____ Hep A # _____ OPV # _____ DTP # _____ DT #P # _____ DT _____ Td _____ MMR # _____ Varicella _____ Influenza _____ Hib TITER/ ActHIB # _____ Padvax HIB # _____ Pneumo Vax _____ PPD _____ mm _____

CHIEF COMPLAINT: Follows Up MNT Visit

SUBJECTIVE/OBJECTIVE: Referred on 11-01-09 by Dr. Browning. Initial Visit: 11-10-09

Nutrition Monitoring & Evaluation:
Self monitoring blood glucose at agreed upon rate: AM fasting + postprandial (after lunch or supper) AM: 280, 200, 178, 212, 195. Postprandial: 200, 225, 250, 195, no.
Physical Activity: regular exercise, going to wellness center 3-5 times per week. Working w/ DM program to monitor & education of cardiac + weights.
Type of food/meal, meal pattern: 3 regular meals per day + afternoon evening snack.
Total carbohydrate, source of CHO: working to limit to 2-3 servings/meal, currently 3-5 servings/meal. Including whole grains.

Plan: Continue to work on nutrition Rx: ↑ fiber, low fat, CHO controlled diet.
Nutrition Ed: more in depth skills + knowledge on CHO counting in order to meet CHO budget/plan (30-45gms/meal + 15-30gms/snack). Pt shows better understanding + is able to return demonstrate CHO counting principles + how to read the food label to interpret CHO content + servings. Continue to work on reduction in CHO intake + increase diabetes self care skills + knowledge.

Injury? Yes No If yes, Date: _____ ETOH Related Employ. Rel.

Cause: _____ Place: _____

PROBLEM LIST #	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)	Health Factors
	<u>Diabetes Type 2, uncontrolled</u>	
	<u>97803-Medical Nutrition Therapy (60 minutes)</u>	

REPRODUCTIVE FACTORS: G _____ P _____ LC _____ SA _____ TA _____ LMP _____ FP METHOD _____ DATE BEGUN _____

PROBLEM LIST NOTES: STORE NOTE FOR PROB. # _____ REMOVE NOTE # _____

STORE NOTE FOR PROB. # _____

MEDICATIONS: _____ MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION: DMCN - FL - G - 15min AP
DMCN - CC - G - 30min AP

9999
 Dancing Eagle Juanita
 10-21-43 F Crow
 Crow
 row Service Unit 12-01-09

(REVISIT/ REFERRAL TO: Jan 14, 2010 @ 10:00am)
 PURPOSE: Evaluate behavior changes + further nutrition ed
 INSTRUCTIONS TO PATIENT: SIGN RELEASE
 ① Cont to monitor BS 2 to 3 times/day
 ② Cont going to wellness center, increase to 5x/week
 ③ Begin counting CHO + record intake in log book

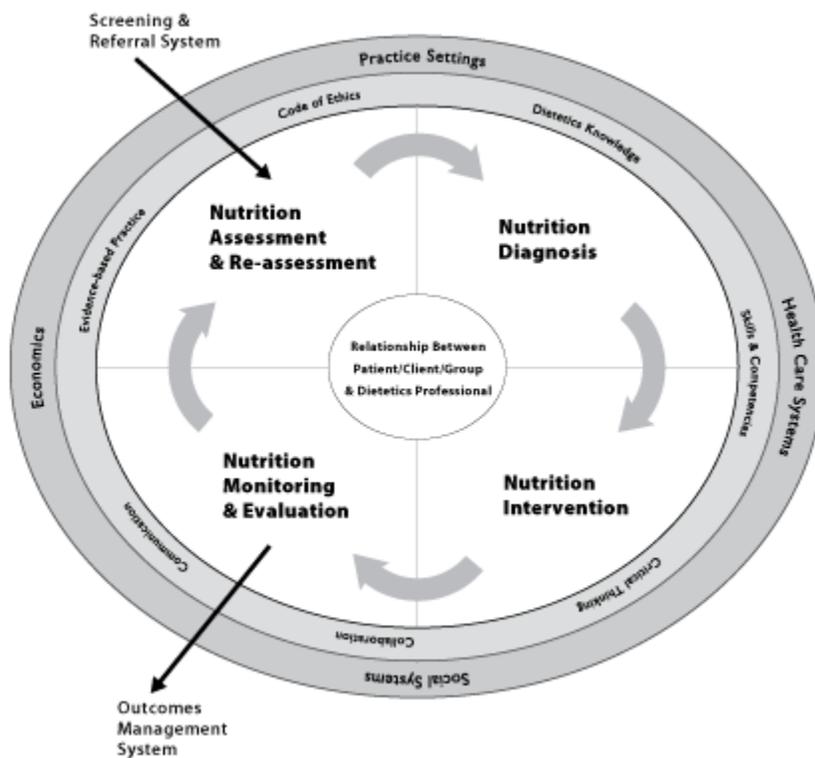
PROV. SIGNATURE: Diane R Phillips RD, LD, CDE

Appendix E: Nutrition Care Process and Model

The American Dietetic Association has conceptualized quality Nutrition Care in terms of a series of steps as illustrated in the figure below:

- Nutrition Assessment & Re-assessment
- Nutrition Diagnosis
- Nutrition Intervention
- Nutrition Monitoring & Evaluation

Nutrition Care Process and Model



Source: American Dietetic Association Evidence Library. <http://adaeal.com/ncp/> Accessed February 2010. Copyright 2010 American Dietetic Association. All rights reserved. Reprinted with permission.

An example of applying the Nutrition Care Process in diabetes MNT provided by a RD is shown in table on the following pages.

Application of Nutrition Care Process in MNT for Diabetes

Application of Nutrition Care Process (NCP)	MNT Provided by RD for Diabetes (for individual)
Nutrition Screen/Referral	The physician provider sends the RD a written referral for MNT for diabetes. The referral includes information regarding current labs, medications, and other medical diagnoses.
Nutrition Assessment	The RD performs a comprehensive nutrition assessment utilizing the <i>Diabetes Type 1 and 2 Evidence-Based Nutrition Practice Guideline for Adults and Toolkit</i> , as well as the best available current knowledge and evidence, client data, medical record data, and other resources.
Nutrition Diagnosis	After analyzing assessment data, the RD makes initial nutrition diagnosis(es)—i.e., inconsistent carbohydrate intake (NI-5.8.4), inconsistent timing of carbohydrate intake throughout the day, day-to-day, or a pattern of carbohydrate intake that is not consistent with recommended pattern based on physiological or medication needs.
Nutrition Intervention	The RD provides counseling and, with the client, determines interventions using the cognitive-behavioral model, including problem solving, motivational interviewing, goal setting, and self-monitoring. The RD plans follow-up over multiple visits to assist with behavior/lifestyle changes relative to the nutrition diagnoses and medical condition/disease(s).
Nutrition Monitoring and Evaluation	The RD monitors hemoglobin A1c (A1C), microalbuminuria, body mass index, serum lipids, goals for food plan/intake, activity, and other behavior changes. The RD implements changes to MNT (patient nutrition goals, nutrition intervention, and counseling) in future visits based on outcomes and assessments at each visit.
Nutrition Documentation (supports all steps of the NCP)	The RD documents MNT initial assessment, nutrition diagnosis(es), and intervention(s); shares documentation with referring physician and keeps copy on file.
Outcomes Management Systems	Based on RD analysis, critical thinking, and review of data from the patient's medical history and other healthcare professionals, the RD aggregates individual and population outcomes data, analyzes and shares with quality improvement department/group, as indicated. The RD and the rest of the team implement improvements to MNT services based on results.

Source: American Dietetic Association Diabetes White Paper, October 2008.

Appendix F: Additional Resources

1. IHS Medical Nutrition Therapy Action Team

First and foremost, if you have questions about Medicare reimbursement for MNT services and need help, please contact a member of the IHS Medical Nutrition Therapy Action Team (MAT Team) in your Area. These RDs are willing to help you to maximize Medicare MNT reimbursement for your facility. You can reach the MAT Action Team by email: IHSMNTActionTeam@ihs.gov

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2. Invest in Nutrition Flyer



Invest in Nutrition

Medical Nutrition Therapy works, saves money, and makes money.

MNT makes money.

- Third Party Payers will reimburse for Medical Nutrition Therapy
- This is a sample of total collections* for FY 2009 from 4 IHS Service Units

Service Units:

- Phoenix Indian Medical Center
- Northern Navajo Medical Center
- Sells Service Unit
- Whitehorse Service Unit

*Note that reimbursement rates vary from state to state.

Steps to Increase Collections:

- Start by checking current collections - Ask your Billing Office to run reports for MNT reimbursable visits
- Support MNT Billing – Everyone has a role in maximizing MNT reimbursement
- IHS has developed a *Step-by-Step Guide to MNT Reimbursement* for staff to use as a model to maximize IHS billable services – 2nd edition to be released Spring 2010
- Hiring more RD's = increased collections
Only Registered Dietitians can provide MNT services

"Teamwork among providers, administrators, and data entry and billing personnel makes a difference – not only to the health of patients, but also to a clinic's financial bottom line."
CAPT Kelly Aton, MD, MPH, FACP
Director, IHS DDP

MNT works.

- MNT will improve GPRA Performance Outcomes
 - Blood glucose control
 - MNT intervention decreased A1C levels by 20%¹
 - Blood pressure control
 - Blood Pressure decrease of 16.1/9.9 mm Hg²
 - Blood lipid control
 - Total Cholesterol decreased by 13%, LDL decreased by 15%, Triglycerides decreased by 11%³
- In IHS studies, patients receiving MNT from a Registered Dietitian (RD) have improved glucose and lipid control
 - Significantly better A1C from RD education compared to non-RD education⁴
 - 20% reduction in LDL and 4.6% increase in HDL⁵
- National Research on MNT has found:
 - Significant improvement in A1C from regular MNT visits⁶
 - RD services reduced office visits by 16.9% for CVD and 23.5% for DM⁷
 - The Diabetes Prevention Program found that "every 2.2 pounds of weight loss decreased risk of type 2 diabetes by 16%"⁸

MNT saves money.

- MNT can reduce health costs for patients with uncontrolled diabetes by up to 34%⁹
- MNT has the potential to pay for itself and provide savings for other hospital and clinic services⁹
- Every percentage point drop in A1c reduces the risk of diabetes complications by 40%⁹
- The cost of treating a patient with controlled diabetes (A1c less than 7%) is up to \$4000 less per treatment, than a patient with uncontrolled diabetes¹⁰
- U.S. Department of Defense saved \$3.1 million in the first year of a nutrition therapy program utilizing RDs counseling 636,222 patients with cardiovascular disease, diabetes, and renal disease¹¹
- MNT results in improved daily glucose monitoring, A1c, cholesterol levels and weight

Want to increase your revenue?
 Contact the IHS Division of Diabetes Treatment and Prevention
 Medical Nutrition Therapy Action Team today.
 Email : IHSMNTActionTeam@ihs.gov / Call: 928-214-3947

3. American Dietetic Association (ADA) Evidence-Based Guidelines

Use the ADA evidence-based guidelines to apply cutting-edge, synthesized research to your practice! The Guidelines are FREE to ADA members.

ADA Chronic Kidney Disease and Nutrition Evidence Analysis Project, 2008.

<http://www.adaevidencelibrary.com/topic.cfm?cat=1400>.

Accessed February 2010.

ADA Diabetes Type 1 and 2 Evidence-based Nutrition Practice Guideline for Adults: Executive Summary of Recommendations, March 2008.

<http://www.adaevidencelibrary.com/topic.cfm?cat=3252>.

Accessed February 2010.

ADA Diabetes Evidence-based Nutrition Practice Guidelines for Gestational Diabetes, December 2008.

<http://www.adaevidencelibrary.com/topic.cfm?cat=3731>.

Accessed February 2010.

4. ADA Website MNT Reimbursement Page

American Dietetic Association web page dedicated to MNT Reimbursement.

<http://www.eatright.org/HealthProfessionals/content.aspx?id=8175>

<http://www.eatright.org/HealthProfessionals/content.aspx?id=6863>

Accessed February 2010.

5. ADA Nutrition Care Process and Terminology

International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process, Second Edition, 2009, American Dietetic Association, Chicago, IL.

This reference book is a comprehensive guide for implementing the Nutrition Care Process using standardized language for Nutrition Assessment (labels for specific data used in nutrition assessment and reassessment), Nutrition Diagnosis (labels for specific nutrition problem), Nutrition Intervention (labels for types of nutrition interventions implemented) and Nutrition Monitoring and Evaluating (labels for types of data used to judge effectiveness of nutrition care). New to this edition are the sections on Nutrition Assessment along with revisions to the Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation sections.

<http://www.eatright.org/Shop/Product.aspx?id=4996>. Accessed February 2010.

Pocket Guide for International Dietetics & Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process, Second Edition, 2009, American Dietetic Association, Chicago, IL.

<http://www.eatright.org/Shop/Product.aspx?id=4995>. Accessed February 2010.

Nutrition care process and model part I: the 2008 update.

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6. CMS Website Medicare Learning Network

The Medicare Learning Network website has quick reference guides, Web-based training modules, publications and pamphlets, videos and CD-ROMS at:
<http://www.cms.hhs.gov/mlnngeninfo/> Accessed February 2010.

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals.**
The guide includes information on Medicare coverage of MNT. You can access this information on the Medicare Learning Network's Preventive Services page:
www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
(Click on "Educational Products" in the "Downloads" section and select the link to the publication under "Guides.") Accessed February 2010.
- **CMS offers a brochure on Medicare-covered diabetes services** that includes information on Medicare coverage of MNT. You can access this information on the Medicare Learning Network's Preventive Services page:
www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
(Click on "Educational Products" in the "Downloads" section and "Diabetes-Related Services" under "Guides.") Accessed February 2010.

7. IHS Division of Diabetes Treatment and Prevention Diabetes Best Practices

The Indian Health Diabetes Best Practices documents (updated in 2009) cover 19 topics in diabetes treatment and prevention, including adult weight management, breastfeeding, cardiovascular disease, chronic kidney disease, nutrition and physical activity, diabetes in youth, and many more. Each Indian Health Diabetes Best Practice provides:

- Guidelines for the best practice
- Key recommendations
- How to monitor progress and outcomes, including key measures
- Specific clinical, community, and organization recommendations
- How to evaluate and sustain your program
- Tools and resources, including examples of current best practice programs and additional contacts and references
- Specific suggestions on improving the best practice program in the Indian Health System.
- <http://www.diabetes.ihs.gov/index.cfm?module=toolsBestPractices>. Accessed February 2010.

8. IHS Division of Diabetes Treatment and Prevention Clinical Guidelines Resources

The resources listed below can be found on the IHS/DDTP website at:

<http://www.ihs.gov/MedicalPrograms/diabetes/index.cfm?module=toolsClinicalGuidelines>.

Accessed February 2010.

IHS Standards of Care for Patients with Type 2 Diabetes (PDF - 234 KB). Updated clinical guidelines for providers. Revised March 2009.

IHS Guidelines for the Care of Adults with Prediabetes and/or the Metabolic Syndrome in Clinical Settings (PDF - 513 KB). Updated clinical guidelines for providers. Revised September 2008.

Prevention and Treatment of Type 2 Diabetes Mellitus in Children, With Special Emphasis on American Indian and Alaska Native Children. Clinical report from *Pediatrics* (October 2003)

Promoting a Healthy Weight in Children and Youth (PDF - 529 KB). This IHS report outlines clinical strategies on five childhood obesity prevention and treatment recommendations for health care professionals in Indian Health Service, Tribal and urban Indian health clinical settings. The report's five recommendations are based on the best available clinical evidence regarding the prevention and treatment of childhood overweight. (December 2008).

9. Other Organizations, Programs, and Resources.

- **American Association of Diabetes Educators**
www.diabeteseducator.org/
- **American Diabetes Association**
www.diabetes.org
- **Centers for Disease Control and Prevention Division of Diabetes Translation**
<http://www.cdc.gov/diabetes/>
- **MedlinePlus for diabetes information**
www.nlm.nih.gov/medlineplus/diabetes.html
- **National Diabetes Education Program**
<http://ndep.nih.gov/>
- **National Institute of Diabetes and Digestive and Kidney Diseases**
<http://www2.niddk.nih.gov/>
- **National Kidney Foundation**
<http://www.kidney.org/>
- **TrailBlazer Health Enterprises, LLC (a CMS-contracted intermediary and carrier)**
www.trailblazerhealth.com

Appendix G: Glossary

ADA Nutrition Practice Guidelines and Models

A systematic problem-solving method professionals use to think critically and make decisions to address nutrition-related problems and provide safe, effective, high quality nutrition care.

Note: The ADA now uses the preferred term, “Nutrition Care Processes.”

Accept Assignment

An agreement among Medicare, health care providers, and suppliers of health care equipment and supplies. Accepting assignment means the providers or suppliers agree: (1) to receive direct payment from Medicare; and (2) to accept the Medicare-approved amount as payment in full for the service. The health care provider cannot collect additional fees for the service.

All-Inclusive Rate

See definition for “IHS All-Inclusive Rate.”

Beneficiary

The person who has health insurance through Medicare or Medicaid.

Bill

See definition for “Claim.”

Claim

A request for payment for a provided service. The terms “claim” and “bill” are used for Medicare Part A inpatient services (submitted to CMS fiscal intermediaries) and Medicare Part B outpatient services (submitted to CMS carriers).

CMS: Centers for Medicare and Medicaid Services

The U.S. Federal government agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP).

CMS Form 1500

The form, or electronic equivalent, that health care providers use to submit bills to Medicare Part B carriers and other insurance companies.

CMS Form 1450 (also called UB92)

The form, or electronic equivalent, that health care providers use to submit bills to Medicare Part A fiscal intermediaries, primarily for Medicare Part A services, and some Part B services.

CPT Codes (Current Procedural Terminology Codes)

Codes used to communicate to payers the procedures performed during the patient visit. The Medical Nutrition Therapy CPT codes are unique codes that describe MNT services provided by nutrition professionals. The CMS requires use of these codes in reimbursement documentation of MNT services for patients with diabetes, non-dialysis kidney disease, or post-kidney transplant.

Distant Site

The site at which the practitioner delivering the service is located at the time the service is provided via a telecommunications system.

DSMT: Diabetes Self-Management Training

An interactive and collaborative process that involves the person with diabetes and the diabetes educator. This process includes: (1) assessment of the individual's specific education needs; (2) identification of the individual's specific diabetes self-management goals; (3) education and behavioral intervention directed toward helping the individual achieve self-management goals; and (4) evaluation of the individual's progress toward self-management goals. You must be an IHS, American Association of Diabetes Educators, or American Diabetes Association accredited diabetes education program to receive Medicare reimbursement for DMST. For more information on Medicare reimbursement for DMST, please refer to Appendix A.

Note: DSMT also is known as DSME, or Diabetes Self-Management Education. Although DSME is the preferred term, the CMS requires the use of DSMT in reimbursement documentation.

EHR (Electronic Health Record)

A longitudinal collection of electronic health information about individual patients or populations. Also known as an electronic patient record or computerized patient record.

End Stage Kidney Disease

The complete or near complete failure of the kidneys to function to excrete wastes, concentrate urine, and regulate electrolytes.

Note: End stage kidney disease also is known as end stage renal disease (ESRD).

Episode of Care

The care provided during one calendar year (January 1 through December 31).

FQHC (Federally Qualified Health Centers)

Facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. A FQHC includes an outpatient program or facility operated by a Tribe or Tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

G Codes

Codes for Medicare-covered MNT services, when additional hours of MNT services are performed beyond the number of hours typically covered (3 hours in the initial calendar year and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.

HCPCS (Healthcare Common Procedure Coding System)

A set of health care procedure codes based on the American Medical Association Current Procedural Terminology (CPT). Commonly pronounced *Hick-Picks*.

HIPAA (The Health Insurance Portability and Accountability Act)

The Act mandates the standards to use for the electronic exchange of health care data; what medical and administrative code sets should be used within those standards; the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and the types of measures required to protect the security and privacy of personally identifiable health care information.

HPSA (Health Professional Shortage Area)

A geographic area, population group, or health care facility designated by the Federal government as having a shortage of health professionals.

ICD-9 Codes (International Classification of Diseases, 9th Revision, Clinical Modifications)

Diagnostic codes used in hospital inpatient medical records. Also used on claims processing forms in hospital outpatient settings, physician offices, and RD practices.

IHS All-Inclusive Rate

The rate negotiated by the IHS for services provided under Medicare Part A. The IHS renegotiates this rate with the Office of Management and Budget (OMB) each year, so the rate may vary from year to year.

Medicaid

A health care program, sponsored by the Federal government and State governments, which pays for medical care for those who cannot afford it. The program typically helps low-income individuals or families, as well as elderly or disabled individuals. To receive Medicaid, an individual must meet certain requirements (such as income level). Although all States participate in the Medicaid program, each State manages its own program and sets different requirements and other guidelines.

Medicare

The Federal government's health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end stage kidney disease (i.e., patients with permanent kidney failure who need regular dialysis or a kidney transplant).

Medicare Carrier

A private company that contracts with Medicare to process Medicare Part B bills.

Medicare Fiscal Intermediary

A private company that has a contract with Medicare to pay Part A and some Part B bills. Also called an intermediary.

Medicare Part A (Facility/Hospital Insurance)

Medicare hospital insurance that pays for inpatient hospital stays, hospice care, home health care, and care in a skilled nursing facility. MNT or other nutrition services are not a separately reimbursed service under Medicare Part A coverage. Instead, these services are included in the room and board services covered under Medicare Part A. The fiscal intermediary uses the IHS All-Inclusive Rate to reimburse services provided to patients who have Medicare Part A coverage (see definition for "IHS All-Inclusive Rate").

Medicare Part B (Professional Provider Medical Insurance)

Medicare medical insurance that helps pay for physicians' services, outpatient hospital care, and other medical services that are not covered by Medicare Part A. The carrier uses the physician fee schedule to reimburse for Medicare Part B services (see definition for "Physician Fee Schedule").

Medicare Secondary Payer

Any situation when another payer or insurer pays a beneficiary's medical bills before Medicare pays any medical bills. For example, a Medicare secondary payer may pay the first 85% of the bill, and Medicare will pay the remaining 15% of the bill.

Note: "Payer" is also spelled as "payor."

MNT: Medical Nutrition Therapy

A specific application of the Nutrition Care Process in clinical settings focused on management of diseases. MNT involves in-depth nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. MNT services are defined in the Federal (Medicare Part B) statute as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management, furnished by a registered dietitian or nutrition professional...pursuant to a referral by a physician." MNT is provided by licensed/certified (as applicable) registered dietitians and nutrition professionals.

Nutrition Care Process and Model

The framework for the critical thinking process used by dietetics professionals as they provide nutrition services to their clients/patients, and comprised of four steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation.

NPI: National Provider Identifier

A standard, unique identifier for health care providers used when filing and processing health care claims and other transactions.

Nutrition Provider

A registered dietitian or nutrition professional as defined by the Medicare MNT statute.

Payment Rate

The total payment that a hospital or community mental health center receives when it provides outpatient services to Medicare patients.

PCC (Patient Care Component)

A form used in IHS to document clinical care.

Physician Fee Schedule

The payment rates for MNT services under Medicare Part B. The Medicare Part B MNT payment is 80% (because a 20% patient co-pay applies) of the lesser of *either* the actual charge *or* 80% of the physician fee schedule amount. The physician fee schedule varies by State.

Private Insurance

Private insurance is insurance provided through an entity either for profit or not-for-profit and other than the Federal government or a State government.

Provider

A hospital, a health care professional, or a health care facility.

Real Time Video Conferencing/Communication

Reimbursement for Medicare Telehealth services requires the RD to use an interactive audio and video telecommunications system permitting real-time communication between the

distant site (where the RD is located) and the originating site (where the beneficiary/patient is located).

Registered Dietitian (RD)

A health professional with a bachelor's degree or higher in nutrition or dietetics who meets certification or registration requirements.

Rural Health Clinics (RHCs)

Clinics located in areas designated by the Bureau of Census as rural and by the Secretary of the DHHS as medically underserved, or underserved, or having an insufficient number of physicians and meet the requirements under 42 CFR 491.

Superbill

A pre-printed form that itemizes and describes all services and fees.

Telehealth

The use of health information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site.

TrailBlazer Health Enterprises, LLC

A CMS-contracted intermediary and carrier. For more information, visit the website at: www.trailblazerhealth.com.

UB92

See definition for "CMS Form 1450."

Appendix H: References

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