

**Washington Apple Health (Medicaid)**

# Medical Nutrition Therapy Billing Guide

**January 1, 2020**

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

## About this guide\*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

## What has changed?

Subject	Change	Reason for Change
<b>Entire guide</b>	Housekeeping changes, including typographical and hyperlink corrections	To improve usability
<b>Behavioral Health Organization (BHO)</b>	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
<b><u><a href="#">Integrated Managed Care Regions</a></u></b>	<p>Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state:</p> <ul style="list-style-type: none"> <li>• <b>Great Rivers</b> (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)</li> <li>• <b>Salish</b> (Clallam, Jefferson, and Kitsap counties)</li> <li>• <b>Thurston-Mason</b> (Mason and Thurston counties)</li> </ul>	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (IMC).

\* This publication is a billing instruction.

## How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

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# Resources Available

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Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's <a href="#">ProviderOne Resources</a> webpage
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Access E-learning tools	See the agency's <a href="#">ProviderOne Resources webpage</a>

# Definitions

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This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to [chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

**Benefit Service Package** - A grouping of benefits or services applicable to a client or group of clients.

**Note:** Registered Dietitians licensed in the State of Oregon may be assigned an Agency-Certified Dietitian ProviderOne ID/NPI.

**Enteral Nutrition** – The use of medically necessary nutrition products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutrition requirements. Enteral nutrition solutions can be given orally or via feeding tubes. [WAC 182-554-200](#)

**Enteral Nutrition Product** - Enteral nutrition formulas and/or products. [WAC 182-554-200](#)

**Maximum Allowable** - The maximum dollar amount that a provider may be reimbursed by the Agency for specific services, supplies, or equipment.

**Medical Nutrition Therapy** - An interaction between the registered dietitian (RD) and the client or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

**Nutrition assessment**- As part of the Nutrition Care Process, Nutrition Assessment is the collection, interpretation and documentation of information necessary to evaluate nutrition status, needs, and interventions. The information includes food or nutrition-related data; biochemical data, medical tests and procedures;

anthropometric measurements, nutrition-focused physical findings and client history.

**Nutrition care process** - A systematic approach to providing high-quality nutrition care. Provides a framework for the registered dietitian (RD) to individualize care, taking into account the client's needs and values and evidence available to make decisions.

**Nutrition-related diagnosis** - A diagnosis within the scope of practice for a registered dietitian (RD) to diagnose and treat as defined by the Academy of Nutrition and Dietetics.

**National Provider Identifier (NPI)** – A system for uniquely identifying all Providers of health care services, supplies, and equipment.

**Nutritional Counseling** – See Medical Nutrition Therapy.

**ProviderOne** – Health Care Authority's primary provider payment processing system.

**ProviderOne Client ID**- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.

**For example:** 123456789WA.

**Registered Dietitian (RD)** – A dietitian registered with the Academy of Nutrition and Dietetics and certified by the Washington State Department of Health (DOH).

**Women, Infant, and Children (WIC) Program** - The United States Department of Agriculture Special Supplemental Nutrition Program for Women, Infants and Children (WIC) administered by the Department of Health. Direct client services are delivered by contracted local providers. WIC provides nutrition screening, nutrition education, breastfeeding promotion, health and social service referrals, and nutritious foods to pregnant, breastfeeding and postpartum women, infants, and children through the end of the month they turn 5 years of age.

To be eligible, WIC clients must have:

- A nutrition-related health risk; and
- Income at or below 185% of the Federal Poverty Level (FPL) or be enrolled in Medicaid, Food Stamps, or Temporary Assistance for Needy Families (TANF) programs.

# About the Program

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## **What is the purpose of the medical nutrition therapy program?**

The purpose of the medical nutrition therapy program is to ensure that clients have access to medically necessary outpatient medical nutrition therapy and associated follow-ups when:

- Provided by a registered dietitian (RD) meeting the provider requirements listed under [WAC 182-555-0400](#).
- Provided to eligible clients who are 20 years of age and younger with a referral from a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP).

# Client Eligibility

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Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

**It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.**

## Who is eligible for Medical Nutrition Therapy?

[\(WAC 182-555-0300\)](#)

Medical nutrition therapy is available to patients who are age 20 and younger and referred to a registered dietitian (RD) by a:

- Physician
- Physician Assistant (PA)
- Advanced Registered Nurse Practitioner (ARNP).

## How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

### Verifying eligibility is a two-step process:

**Step 1. Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

**Step 2. Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

**Note:** Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:  
Washington Healthplanfinder  
PO Box 946  
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) or call the Customer Support Center.

## Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

**Yes.** Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

**Note:** A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

**Send claims to the client's MCO for payment.** Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in [WAC 182-502-0160](#).

**Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

## Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

### Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

## Apple Health – Changes for January 1, 2020

**Effective January 1, 2020**, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

### IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**  
Go to [Washington HealthPlanFinder website](#).
- **Available to all Apple Health clients:**
  - ✓ Visit the [ProviderOne Client Portal website](#):
  - ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - ✓ Request a change online at [ProviderOne Contact Us](#) (this will generate an email to Apple Health Customer Service). Select the topic “Enroll/Change Health Plans.”

For online information, direct clients to HCA's [Apple Health Managed Care](#) webpage.

## Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

## Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

**American Indian/Alaska Native (AI/AN)** clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency's [Apple Health managed care webpage](#) and scroll down to "Changes to Apple Health managed care."

## Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency’s [Apple Health managed care webpage](#).

<b>Region</b>	<b>Counties</b>	<b>Effective Date</b>
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

## Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18<sup>th</sup> birthday (alumni)

These clients are identified in ProviderOne as  
**“Coordinated Care Healthy Options Foster Care.”**

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

## Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

# Provider Requirements

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## Who may provide and bill for medical nutrition therapy?

[\(WAC 182-555-0400\)](#)

The agency pays for medical nutrition therapy services when delivered by a registered dietitian (RD).

**Note:** When billing the agency, the RD's national provider identifier (NPI) must be entered in the:

- Billing Provider section of the **professional claim**; or
- Attending Physician Information section of the **institutional claim**.

**Do not bill medical nutrition therapy and nondietitian professional services together on the same claim. These services must be billed separately.**

## When may providers bill the agency for medical nutrition therapy provided in WIC program locations?

Providers may bill the agency for medical nutrition therapy provided in Women, Infants, and Children (WIC) program locations when the medical nutrition therapy is:

- Provided by a registered dietitian (RD) who has an NPI
- Not a WIC service or funded as a WIC service

## Who can refer a client for medical nutrition therapy?

[\(WAC 182-555-0300\)](#)

Physicians, physician assistants (PA), or advanced registered nurse practitioners (ARNP) providers may refer a client to a registered dietitian (RD) for medical nutrition therapy if there is a medical need for nutritional services including assessment, diagnosis, and treatment. Information concerning the medical need and the referral must be documented in the client's chart.

## What are the responsibilities of the registered dietitian (RD) regarding the referral?

The registered dietitian (RD) must:

- Obtain all medical information necessary to do a comprehensive nutritional assessment
- Keep the primary medical care provider apprised of the assessment, prognosis, and progress of the client

**Note:** When billing the agency:

- The referring provider's national provider identifier (NPI) must be entered in the Referring Provider Information section of the professional claim; or
- In the Referring Physician section of the Other Claim Info on the institutional claim.

## When does the agency cover telemedicine?

The agency covers telemedicine when it is used to substitute for an in-person face-to-face, hands-on encounter. Clients enrolled in an agency-contracted MCO must contact the MCO regarding whether or not the plan will authorize telemedicine coverage.

See the agency's [Physician-related Services/Health Care Professional Services Billing Guide](#) for further details.

# Coverage/Fee Schedule

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## What is covered?

The agency covers the following procedure codes listed below.

CPT Code	Brief Description	Policy/Limits
97802	Medical nutrition, indiv, initial	1 unit=15 minutes Maximum of 2 hours (8 units) per year
97803	Medical nutrition, indiv, subseq	1 unit=15 minutes Maximum of 1 hour (4 units) per day
97804	Medical nutrition, group	1 unit=15 minutes Maximum of 1 hour (4 units) per day

## Fee Schedule

You can find the [Medical Nutrition Therapy Fee Schedule](#) on the agency's Provider billing guides and fee schedules webpage.

# Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

## What are the general billing requirements?

Providers must follow the agency [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the agency for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

**Note:** The agency does not pay for medical nutrition therapy services when billed on the same claim as nondietitian professional services.

**Do not bill a physician office call and a medical nutrition therapy visit together on the same claim. These services must be billed separately.**

## What additional documentation must be kept when providing medical nutrition therapy?

([WAC 182-555-0600](#))

In addition to the health care record requirements found in [WAC 182-502-0020](#), the medical nutrition therapy provider must maintain the following documentation in the client's file:

- Referral from the provider
- The medical nutrition therapy provider assessment following the nutrition care process:
  - ✓ Nutrition assessment
  - ✓ Nutrition diagnosis, including the problem, etiology, signs, and symptoms (PES) statement

- ✓ Nutrition intervention
- ✓ Nutrition monitoring and evaluation.
- Any correspondence with the referring provider
- Information on associated medical conditions
- Information concerning the medical need

## **What additional information must be included in the enteral nutrition evaluation when clients are receiving enteral nutrition product paid for by the agency?**

Include determination and documentation of the following:

- The amount of oral and/or enteral nutrition required; and
- The reason why traditional foods alone will not meet an individual's nutritional requirements.

See the current [Enteral Nutrition Provider Guide](#) for a list of criteria and modifiers.

## **How do I bill claims electronically?**

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) webpage, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) webpage.

## Medical Nutrition Therapy

The following claim instructions relate to medical nutrition therapy:

Name	Entry	
Place of Service	Use the appropriate code(s):	
	<b>Code #</b>	<b>To be used for</b>
	11 12 22	Office Home Outpatient hospital
Units	Enter: <ul style="list-style-type: none"><li>• 97802, not more than 8 units per year.</li><li>• 97803, not more than 4 units per day.</li><li>• 97804, not more than 4 units per day.</li></ul>	