

Washington Apple Health (Medicaid)

Medical Nutrition Therapy Billing Guide

January 1, 2018

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, 2018, and supersedes earlier guides to this program.

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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
<u>Client Eligibility</u>	<p>This section is reformatted and consolidated for clarity and hyperlinks have been updated.</p> <p>Effective January 1, 2018, the agency is implementing another FIMC region, known as the North Central region, which includes Douglas, Chelan, and Grant Counties.</p>	Housekeeping and notification of new region moving to FIMC

* This publication is a billing instruction.

How can I get agency provider documents?

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

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

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Important Contacts

Note: This section contains important contact information relevant to medical nutrition therapy. For more contact information, see the agency's [Billers and Providers](#) web page

Topic	Contact Information
Contacting the Agency Medical Assistance Customer Service Center (MACSC)	See the agency's Billers and Providers web page
Becoming a provider or submitting a change of address or ownership	
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	

Definitions

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.

Dietitian (RD) – A dietitian registered with the Academy on Dietetic Registration and certified by the Washington State Department of Health.

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 - A face-to-face interaction between the dietitian and the client and/or client’s guardian for the purpose of evaluating and making recommendations regarding the client’s nutritional status.

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.

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

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, and providers are paid for, outpatient medical nutrition therapy when:

- Medically necessary.
- Provided by a dietitian with a ProviderOne ID/National Provider Identifier (NPI).
- Provided to Agency-eligible clients who are 20 years of age and younger with an EPSDT referral.

Client Eligibility

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?

Medical nutrition therapy is available to patients who are:

- Referred by an EPSDT provider.
- Age 20 and younger.

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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

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](#) web page.

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
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 or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization eligible?

[Refer to WAC 182-538-060 and WAC 182-538-095 or WAC 182-538-063]

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

Note: To prevent billing denials, please 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 plan. 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.

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.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have [fully integrated managed care \(FIMC\)](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do 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 FIMC, see the agency's [Changes to Apple Health managed care webpage](#).

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Apple Health managed care webpage](#).

North Central Region – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

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 18th birthday (alumni)

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

See the agency’s [Apple Health managed care page](#), Apple Health Foster Care for further details.

Provider Requirements

Which provider specialties may be paid for medical nutrition therapy provided by a dietitian?

The agency pays the following provider specialties when medical nutrition therapy is provided by dietitians to agency-eligible clients:

- Advanced Registered Nurse Practitioners (ARNP)
- Dietitians
- Durable Medical Equipment (DME)
- Health Departments
- Outpatient Hospitals
- Physicians

Note: When billing the agency, the dietitian's NPI must be entered:

- In Billing Provider section of the **professional claim**; or
- In the 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 dietitian who has an NPI
- Not a WIC service and therefore is not documented or funded as a WIC service

Who can refer a client for medical nutrition therapy?

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) providers may refer a client to a dietitian for medical nutrition therapy if there is a medical need for nutritional services. Information concerning the medical need and the referral must be documented in the client's chart.

What are the responsibilities of the dietitian regarding the referral?

The dietitian 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 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.

What are the appropriate conditions for referral?

The agency covers medical nutrition therapy when *medically necessary*. Medical conditions that can be referred to a dietitian include, but are not limited to, the following:

Inadequate or Excessive Growth - e.g., failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile.

Inadequate Dietary Intake - e.g., formula intolerance, food allergy, limited variety of foods, limited food resources, poor appetite.

Infant Feeding Problems - e.g., poor suck/swallow, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, limited information and/or skills of caregiver.

Medical Nutrition Therapy

Chronic Disease Requiring Nutritional Intervention - e.g., congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, gastrointestinal disease.

Medical Condition Requiring Nutritional Intervention - e.g., iron-deficiency anemia, familial hyperlipidemia, pregnancy.

Developmental Disability – e.g., increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, tube feedings.

Psycho-Social Factors - e.g., behaviors suggesting eating disorders. Clients with eating disorders should also be referred to the Division of Mental Health or its representatives (e.g., Regional Support Network) for treatment.

Obesity – Use diagnosis codes E66.09, E66.1, E66.8, E66.9, E66.01 or E66.3 on your claim.

Please note the following information for certified dietitians when billing for clients (generally adults) who are completing the approval process for bariatric surgery:

Clients receive an approval letter with an authorization number for dietitian visits; four units for the initial visit (CPT 97802) and two units for subsequent visits twice a month for 6 months (97803). You must bill with the authorization number on the claim. If you have questions about the authorization number and the span of dates approved, call MACSC (see *Important Contacts*). For dietitian visits billed in the outpatient setting, use the appropriate revenue code. However, do not use revenue code 942 which is used for diabetic education only.

Coverage/Fee Schedule

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 web page.

Billing

Effective for claims billed on and after October 1, 2016

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](#).

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 are the general billing requirements?

Providers must follow the agency's [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

What additional records must be kept when providing medical nutrition therapy?

Enrolled providers must keep a copy of:

- Documentation that the WIC program is unable to provide all or part of the medically necessary enteral nutrition product (formula)
- The referral from the EPSDT provider
- The comprehensive medical nutrition therapy evaluation
- Any correspondence with the referring provider
- Information concerning the medical need and the referral must be documented in the client's file

What additional information do I include 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](#) web page, 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 \(EDI\)](#) web page.

The following claim instructions relate to medical nutrition therapy:

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