

Washington Apple Health (Medicaid)

Medical Nutrition Therapy Billing Guide

January 1, 2017

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, 2017, 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
All	Fixed broken links, clarified language, etc.	Housekeeping
<u>Fee-for-service clients with other primary health insurance to be enrolled into managed care</u>	Added a new section regarding additional changes for some fee-for-service clients.	Policy change

* 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.

Certified Dietitian – Certified dietitians in Washington State are:

- Dietitians or nutritionists who:
 - ✓ Have met the national educational standards of the Academy of Nutrition and Dietetics;
 - ✓ Are designated as a Registered Dietitian; and
 - ✓ Have met additional specific health education requirements of the Washington State Department of Health, Division of Licensing;

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

- Recognized by the medical profession as legitimate providers of nutrition care; and
- Healthcare professionals who translate scientific information about nutrition and diet into relevant terms for individuals.

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 certified 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 certified dietitian with an 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

How can I verify a patient's eligibility?

Medical nutrition therapy is available to patients who are:

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

In addition to the above, providers must verify that a patient has Washington 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 Washington Apple Health. For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

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

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

Note: Patients who are not Washington 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-managed care plan 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.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's [Managed Care](#) web site, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's [Regional Resources](#) web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Services Billing Guide](#). BHOs use the [Access to Care Standards \(ACS\)](#) for mental health conditions and [American Society of Addiction Medicine \(ASAM\)](#) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service

- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A [BHSO fact sheet](#) is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can be located by looking up the patient assignment in ProviderOne.

Medical Nutrition Therapy

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

 MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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Provider Requirements

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

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

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

Note: When billing the agency, the certified 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 certified 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 certified 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 certified dietitian regarding the referral?

The certified 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 certified 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.

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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.

CPT® codes and descriptions only are copyright 2016 American Medical Association.

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 Professional Rates and Billing Guides 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. 	