



# **Medical Nutrition Therapy Provider Guide**

**October 1, 2015**

Washington State  
Health Care Authority

## About this guide<sup>1</sup>

This publication takes effect October 1, 2015, and supersedes earlier guides to this program.

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
<a href="#"><u>What are the appropriate conditions for referral?</u></a>	Updated ICD diagnosis codes to ICD-10 diagnosis codes.	<b>Effective for claims with dates of services on and after October 1, 2015</b> , the agency requires the use of ICD-10 coding. ICD-9 codes may only be used for claims with dates of service before October 1, 2015.
<b>Various sections</b>	Updated WAC references throughout the document	Certain WAC references were outdated

## How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

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<sup>1</sup> This publication is a billing instruction.

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# Important Contacts

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**Note:** This section contains important contact information relevant to medical nutrition therapy. For more contact information, see the Agency's [Resources Available](#) web page

Topic	Contact Information
Contacting the Agency Medical Assistance Customer Service Center (MACSC)	See the Agency's <a href="#">Resources Available</a> 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 or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	

# Definitions

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This section defines terms and abbreviations, including acronyms, used in this guide. Refer to the agency's online [Washington Apple Health Glossary](#) for a more complete list of definitions.

**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

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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, 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

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## 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 [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) 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](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-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.

# Provider Requirements

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## 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 field #33 (PIN) and NPI number in #33 on the **CMS-1500 claim form**; or
- In the Attending Physician's I.D. form locator on the **UB-04 claim form**.

**Do not bill medical nutrition therapy and nondietitian professional services together on the same claim form. 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 name must be entered in field 17; and
- The NPI in field 17a and referring provider's NPI in field 17b on the CMS-1500 Claim Form; or
- In the appropriate form locator on the UB-04 Claim Form.

## 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.

## 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.

CPT® codes and descriptions only are copyright 2014 American Medical Association.

# 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 may view the Agency's Medical Nutrition Therapy [Fee Schedule](#).

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# Billing and Claim Forms

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**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 form. 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.

## Completing the CMS-1500 Claim Form

**Note:** Refer to the Agency’s [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to medical nutrition therapy:

Field No.	Name	Entry										
24B	Place of Service	Use the appropriate code(s):  <table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Code</th> <th style="text-align: center;">To Be</th> </tr> <tr> <th style="text-align: center;"><u>Number</u></th> <th style="text-align: center;"><u>Used For</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">11</td> <td style="text-align: center;">Office</td> </tr> <tr> <td style="text-align: center;">12</td> <td style="text-align: center;">Home</td> </tr> <tr> <td style="text-align: center;">22</td> <td style="text-align: center;">Outpatient Hospital</td> </tr> </tbody> </table>	Code	To Be	<u>Number</u>	<u>Used For</u>	11	Office	12	Home	22	Outpatient Hospital
Code	To Be											
<u>Number</u>	<u>Used For</u>											
11	Office											
12	Home											
22	Outpatient Hospital											
24G	Days or 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>										

## Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: <http://www.nubc.org/index.html>.