Washington State Health Care Authority

Washington Apple Health (Medicaid)

Medical Nutrition Therapy Billing Guide

July 1, 2023

Washington State Health Care Authority

Disclaimer

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

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2023**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-555 WAC.

The Health Care Authority 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.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, visit the HCA website.

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* This publication is a billing instruction.

Washington State Health Care Authority

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Telemedicine	Added the following underlined text to the first bullet: "Telemedicine policy, billing, and documentation requirements, under Telemedicine policy and billing	To clarify information providers should be aware of when providing services to HCA clients via telemedicine

Washington State Health Care Authority

Table of Contents

Resources Available

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

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC and WAC 182-555-0200 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 HCA-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 HCA 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.

Washington State Health Care Authority

About the Program

What is the medical nutrition therapy program?

Medical nutrition therapy is an intensive, focused, and comprehensive nutrition therapy service that:

- Involves in-depth individualized nutrition assessment.
- Relies heavily on follow-up to provide repeated reinforcement to aid with behavior change.

Washington State Health Care Authority

Client Eligibility

Most Apple Health clients are enrolled in an HCA-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 HCA'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 may receive medical nutrition therapy services?

Medicaid clients may receive medical nutrition therapy services provided by a registered dietician (RD) when there is a medical need for nutritional services including assessment, diagnosis, and treatment. See Provider Requirements for information regarding who may provide medical nutrition services.

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 HCA 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 HCA'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 HCA's Program Benefit Packages and Scope of Services webpage.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications webpage.** Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. 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 HCA-contracted MCO, if appropriate. See HCA'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 HCA-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.

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 HCA-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. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO with the exception of American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. 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

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

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 18 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**."

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 HCA's Foster Care and Adoption Support (FCAS) 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 HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

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

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

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Washington State Health Care Authority

Provider Requirements

Who may provide medical nutrition therapy services?

Medical nutrition therapy services may be provided by a registered dietician (RD) when there is a medical need for nutritional services including assessment, diagnosis, and treatment. A referral to an RD by one of the following healthcare professionals is required:

- Physician
- Physician's assistant (PA)
- Advanced registered nurse practitioner (ARNP)

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

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

When may providers bill HCA for medical nutrition therapy provided in WIC program locations?

Providers may bill HCA 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

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 HCA, 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**.

Washington State Health Care Authority

Coverage/Fee Schedule

What is covered?

HCA covers the following procedure codes listed below.

CPT® Code	Short description	Place of Service	Limits	Policy
97802	Medical nutrition, indiv in	11, 12, 22	1 unit = 15 minutes Maximum of 2 hours (8 units) per year	• Clients age 21 and older must meet the EPA criteria. See the EPA criteria list for details. If EPA criteria is not met, prior authorization is required. • May not exceed 96 total combined units of CPT® code 97803 and 97804, per calendar year.
97803*	Medical nutrition, indiv subseq	11, 12, 22	1 unit = 15 minutes Maximum of 1 hour (4 units) per day	
97804*	Medical nutrition, group	11, 12, 22	1 unit = 15 minutes Maximum of 1 hour (4 units) per day	

Note: Clients age 20 and younger do not require authorization.

Fee Schedule

You can find the Medical Nutrition Therapy Fee Schedule on HCA's Provider billing guides and fee schedules webpage.

Telemedicine

Telemedicine is covered under HCA's Medical Nutrition Therapy Program. Refer to HCA's **Provider Billing Guides and Fee Schedules webpage,** under *Telehealth*, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine/telehealth policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and *Clinical policy and billing for COVID-19*.

Washington State Health Care Authority

Authorization

Authorization is HCA's approval for covered services, before the services are provided to clients, as a precondition for provider payment. **Prior authorization (PA), expedited prior authorization (EPA), and limitation extensions (LE) are forms of authorization.**

What is expedited prior authorization (EPA)?

EPA is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill HCA for diagnostic conditions, procedures, and services that meet the EPA criteria, the provider must **use the 9-digit EPA number**. The first 5 or 6 digits of the EPA number must be **87000 or 870000**. The last 3 or 4 digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the **Authorization** or **Comments** section when billing electronically.

HCA denies claims submitted without a required EPA number.

HCA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to HCA on request. If HCA determines the documentation does not support the criteria being met, the claim will be denied.

> **Note:** HCA requires prior authorization either by online submission or written/fax prior authorization if the EPA criteria is not met.

EPA documentation guidelines

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon HCA's request. If HCA determines the documentation does not support the EPA criteria requirements, the claim will be denied.

EPA Criteria List

A complete EPA number is nine digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria.

If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior Authorization).

Clients age 20 and younger do not require EPA.

EPA Number	Service Name	CPT® Code	Criteria
870001644	Medical nutrition, indiv in	97802	Clients age 21 and older must have one of the following medical conditions: • Body mass index (BMI) of 30 kg/m2 or higher • Cardiovascular risk factors (hypertension, dyslipidemia, congestive heart failure) • Diabetes mellitus • Chronic kidney disease
870001644	Medical nutrition, indiv subseq	97803	Clients age 21 and older must have one of the following medical conditions: • Body mass index (BMI) of 30 kg/m2 or higher • Cardiovascular risk factors (hypertension, dyslipidemia, congestive heart failure) • Diabetes mellitus • Chronic kidney disease
870001644	Medical nutrition, group	97804	Clients age 21 and older must have one of the following medical conditions: • Body mass index (BMI) of 30 kg/m2 or higher • Cardiovascular risk factors (hypertension, dyslipidemia, congestive heart failure) • Diabetes mellitus • Chronic kidney disease

What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

> **Note**: A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

To request an LE, a provider must submit in writing, and receive HCA approval prior to providing the service, all of the following:

- The name and ProviderOne Client ID of the client
- The provider's name, ProviderOne Client ID, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

See Documentation requirements for PA or LE.

What is prior authorization (PA)?

Prior authorization (PA) is the process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations.

For examples on how to complete a PA request, see HCA's Billers, providers, and partners webpage.

> **Note**: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests as described in WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within five business days of the receipt of the additional information. If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.
- Is in sufficient detail to enable the recipient to learn why HCA's action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA's determination.
- Includes the client's administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Requesting prior authorization (PA)

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **prior authorization webpage** for details).

Documentation requirements for PA or LE

Written or fax

For all requests for PA or LE, the following documentation is required.

If providers chose to submit a written or fax PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the mailed/faxed request and must be typed.
- Charts and justification to support the request for authorization.

Submit written or fax PA requests (with forms and documentation) to:

- **By Fax**: (866) 668-1214
- **By Mail**: Authorization Services Office, PO Box 45535, Olympia, WA 98504-5535

Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Washington State Health Care Authority

Billing

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

What are the general billing requirements?

Providers must follow HCA 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 HCA 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: HCA 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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA'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.