ALL YOU EVER WANTED TO KNOW ABOUT BILLING & REIMBURSEMENT BUT WERE AFRAID TO ASK

October 5, 2009

Presented by:
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Bloomington Hospital
Billing and Reimbursement Terminology

Ambulatory Payment Classification (APC)
On August 1, 2000, Medicare implemented a prospective payment system for outpatient services. This visit based payment system used HCPCS codes, assigned to services and supplies, which are classified into different APC groups. Multiple APCs can be paid for one visit although packaging and discounting will be used. Patient co-payment amounts will be based on APC payment instead of charges.

Carrier
A federally designated contractor that processes Medicare claims for Part B benefits that are submitted on a HCFA 1500 billing form. The Carrier for Indiana in AdminiaStar. The Carrier publishes guidelines for coverage and bill submission that may or may not match guidelines published by the Fiscal Intermediary.

Centers for Medicare and Medicaid (CMS)
CMS is the division of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Charge Description master (CDM)
The Charge Description Master is a file of all patient chargeable services and supplies. The CDM contains billing revenue codes, HCPCS codes, the patient charge as well as other information. The information from the CDM is used to generate the patient bill and is the source of department revenue.

Correct Coding Initiative
The CCI is a program of edits that identify mutually exclusive CPT codes that should not be billed together or a modifier is required to allow payment for both services. It is used for hospital outpatient and physician billing.

Fee Schedule
A list of predetermined payments based on a HCPCS code. Physicians are reimbursed on a fee schedule as well as OP durable medical equipment, laboratory services and rehabilitation services.

Fiscal Intermediary (FI)
A federally designated contractor that processes Medicare claims for Part A benefits and some Part B services. The FI processes claims submitted by Hospitals on a UB04 billing form.

HCFA 1500
A billing form used to bill physicians services to the Carrier as well as durable medical equipment to the DME Regional Carrier.

HCPCS – Level I – CPT
The AMA (American Medical Association) developed the Current Procedural Terminology coding system for physicians to use to report medical services and procedures. The five-digit, numeric coding system is updated January 1 of each year. CPT is used by Hospitals to report outpatient surgical procedures, laboratory, radiology and other diagnostic and therapeutic services. Example: 71010 Chest x-ray, single view, frontal.
HCPCS Level II
The Centers for Medicare and Medicaid (CMS) developed a coding system using five
digit alpha-numeric (A-V except S) codes for providers to bill for drugs, supplies and
durable medical equipment. Some services such as Ambulance also bill using Level II
HCPCS. The codes are updated January 1 of each year. Example: J9045 Carboplatin
50mg (chemotherapy drug).

HCPCS Level III
Fiscal Intermediaries and Carriers can develop codes using five digit alpha-numeric
codes (S, W-Z) for unique services or supplies. The trend is to move away from Level III
codes since they add geographic variation to claims data.

ICD-9-CM is a coding system used to assign diagnosis and procedure codes. The codes
are used to group patients into Diagnosis Related Groups (DRGs) for inpatient
reimbursement. The diagnosis code portion of ICD-9-CDM was developed by the World
Health Organization and is used to collect and compare data worldwide. The ICD-9-CM
procedures are used in the United States only.

Local & National Coverage Decisions
LCDs are guidelines published by Intermediaries and Carriers and NCDs are published
by CMS. The guidelines include billing rules as well as coverage limitations for services.

Medicare Part A
Medicare Part A pays for inpatient hospital care, skilled nursing facility care (following a
hospital stay), home health care and hospice care. Inpatient services are measured in
benefit periods. A benefit period begins the first day of inpatient care and ends when the
beneficiary has been out the hospital or skilled nursing facility for 60 consecutive days.
The beneficiary is responsible for the deductible for each benefit period.

Medicare Part B
Medicare Part B pays for outpatient services. Part B requires the beneficiary to pay
monthly premiums. There is an annual deductible and the patient must also pay a co-pay.
The co-pay is based on Medicare APC payments.

Revenue/Reimbursement
The term revenue is equivalent to charges. It is not the Hospital’s payment.
Reimbursement is the correct term for payment received.

Revenue Code
The revenue code is the three-digit number that identifies a specific accommodation or
ancillary charge on the UB04 bill. The revenue code groups like charges together on the
claim. For example, all supplies with a 272 (sterile supply) revenue code would be
grouped together on the UB04. Some managed care contracts use revenue codes as a
method of determining payment.

UB-04
The UB-O4 is the universal billing form, revised in 2004, to standardize claim
submission by Hospitals.

Prepared by Evelyn Alwine
Evelyn/misc/education-reimbursement/terminology
updated 10/2/2009
Acupuncture

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.

If no electrical stimulation is used during a 15-minute increment, use 97810, 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813, 97814.

Only one code may be reported for each 15-minute increment. Use either 97810 or 97813 for the initial 15-minute increment. Only one initial code is reported per day.

Evaluation and Management services may be reported separately, using modifier 25, if the patient’s condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.

97810  Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97811  Acupuncture, needle(s) reinsertion, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

Other Procedures

(For extracorporeal shock wave musculoskeletal therapy, see Category III codes 0019T, 0010T, 0102T)

97799  Unlisted physical medicine/rehabilitation service or procedure

Medical Nutrition Therapy

97802  Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803  re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804  group (2 or more individual(s)), each 30 minutes

(For medical nutrition therapy assessment and/or intervention performed by a physician, see Evaluation and Management or Preventive Medicine service codes)
ORTHODIC PROCEDURES

ORTHODIC DEVICES - UPPER LIMB

The procedures in this section are considered as "base" or "basic procedures" and may be modified by listing procedures from the "additions" sections and adding them to the base procedure.

SHOULDER ORTHOTIC (SO)

- L3650 Shoulder orthotic (SO), figure of eight design abduction restrainer, prefabricated, includes fitting and adjustment
- L3651 Shoulder orthotic (SO), sangle shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)
- L3652 Shoulder orthotic (SO), double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)
- L3660 Shoulder orthotic (SO), figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment
- L3670 Shoulder orthotic (SO), acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment
- L3671 Shoulder orthotic (SO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
- L3672 Shoulder orthotic (SO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
- L3673 Shoulder orthotic (SO), abduction positioning (airplane design), thoracic component and support bar, includes non-torsion joint/turbbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
- L3675 Shoulder orthotic (SO), vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment
- L3677 Shoulder orthotic (SO), hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment

MED: 100-2.15.250

ELBOW ORTHOTIC (EO)

- L3700 Elbow orthotic (EO), elastic with stays, prefabricated, includes fitting and adjustment
- L3701 Elbow orthotic (EO), elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)

MED: 100-2.15.250

HCPCS ORTHOPEDIC PROCEDURES

- L3702 Elbow orthotic (EO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
- L3710 Elbow orthotic (EO), elastic with metal joints, prefabricated, includes fitting and adjustment
- L3720 Elbow orthotic (EO), double upright with forearm/ elbow cuffs, free motion, custom fabricated
- L3730 Elbow orthotic (EO), double upright with forearm/ elbow cuffs, extension/flexion assist, custom fabricated
- L3740 Elbow orthotic (EO), double upright with forearm/ elbow cuffs, adjustable position lock with active control, custom fabricated
- L3760 Elbow orthotic (EO), with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type
- L3762 Elbow orthotic (EO), rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment
- L3763 Elbow-wrist-hand orthotic (EWHO), rigid, without joints, may include soft interface, strap, custom fabricated, includes fitting and adjustment
- L3764 Elbow-wrist-hand orthotic (EWHO), includes one or more non-torsion joints, elastic bands, turbbuckles, may include soft interface, strap, custom fabricated, includes fitting and adjustment
- L3765 Elbow-wrist-hand-finger orthotic (EWFHO), rigid, without joints, may include soft interface, strap, custom fabricated, includes fitting and adjustment
- L3766 Elbow-wrist-hand-finger orthotic, includes one or more non-torsion joints, elastic bands (EWFHO), turbbuckles, may include soft interface, strap, custom fabricated, includes fitting and adjustment

WRIST-HAND-FINGER ORTHOTIC (WHFO)

- L3806 Wrist-hand-finger orthotic (WHFO), includes one or more non-torsion joint(s), turbbuckles, elastic bands/springs, may include soft interface material, strap, custom fabricated, includes fitting and adjustment
- L3807 Wrist-hand-finger orthotic (WHFO), without joint(s), prefabricated, includes fittings and adjustments, any type
- L3808 Wrist-hand-finger orthotic (WHFO), rigid without joints, may include soft interface material, strap, custom fabricated, includes fitting and adjustment

ADDITIONS

- L3669 Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each

DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION

- L3900 Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated
- L3901 Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, cable driven, custom fabricated

EXTERNAL POWER

- L3904 Wrist-hand-finger orthotic (WHFO), external powered, electric, custom fabricated

Note: Special Coverage Instructions: Noncovered by Medicare; Carrier Discretion; Quantity Alert; New Code; Recycled/Reinstated; Revised Code; 2009 HCPCS
### Tabular List

#### 403 Hypertensive Renal Disease

- **Includes:**
  - Arteriolar nephritis — Inflammation of the kidney due to arteriolar ischemia.
  - Arteriosclerosis:
    - Kidney — Thickening and loss of elasticity of the arterioles of the kidney.
    - Renal arteries — Thickening and loss of elasticity of the small arterial branches serving the capillaries.
    - Arteriosclerotic nephritis (chronic) (interstitial) — Sclerosis and hardening of the kidney due to hypertension.

- **Hypertensive:**
  - Nephropathy — Functional disease of the kidney due to hypertension.
  - Renal failure — The cessation of the excretory function of the kidney due to hypertension.
  - Uremia (chronic) — The toxic condition produced by the kidney's excessive retention of by-products due to hypertension.

- **Excludes:**
  - Acute renal failure (584.5-584.9)
  - Renal disease stated as not due to hypertension
  - Renovascular hypertension (405.0-405.9 with fifth-digit 1)

  The following fifth-digit subclassification is for use with category 403:

  0. WITHOUT MENTION OF RENAL FAILURE

  1. WITH RENAL FAILURE

#### 403.0 Malignant

- **CIC**

#### 403.9 Unspecified

- **CIC**

#### 404 Hypertensive Heart and Renal Disease

- **Includes:**
  - Cardiorenal — Synonym for Hypertensive Heart and Renal Disease.
  - Cardiovascular renal — A form marked by hypertensive disease of the heart, blood vessels, and kidneys.

- **Any condition classifiable to 402 with any condition classifiable to 403**

  Use additional code to specify type of heart failure (428.0, 428.20-428.23, 428.30-428.33, 428.40-428.43)

  The following fifth-digit subclassification is for use with category 404:

  0. WITHOUT MENTION OF HEART FAILURE OR RENAL FAILURE

  1. WITH HEART FAILURE

    2. WITH RENAL FAILURE

    3. WITH HEART FAILURE AND RENAL FAILURE

#### 404.0 Malignant

- **CIC**

#### 404.9 Unspecified

- **CIC**

#### 405 Secondary Hypertension

- **Includes:**
  - Elevated arterial blood pressure due to various primary diseases.

#### 405.0 Malignant

- **CIC**

#### 405.01 Renovascular

- **CIC**

#### 405.09 Other

- **CIC**
Medicare Severity Diagnosis Related Groups (MS-DRGs)

What are DRGs?

The Diagnosis Related Groups methodology is a classification system adopted by the Centers for Medicare and Medicaid (CMS) on October 1, 1983, as a method to reimburse hospitals providing health care to Medicare patients. Patients in a particular DRG use approximately the same amount of services. Effective October 1, 2007, Medicare Severity-DRGs were implemented (MS-DRGs). There are 745 MS-DRGs.

Since 1983 other payors have adopted DRGs as a method of reimbursing hospitals.

How are MS-DRGs assigned?

The principal diagnosis (the diagnosis that is primarily responsible for the patient being admitted), as well as other information, including secondary diagnosis, procedures, age and sex are used to assign a patient to a MS-DRG.

For MS-DRGs, Medicare (CMS) assigned one of three severity levels to each diagnosis code.
- MCC — major complications or comorbidities
- CC — complexities or comorbidities
- Non-CC — non complications or comorbidities

The presence of secondary diagnoses and its severity level will determine if the case is classified to a higher MS-DRG.

How is the hospital reimbursed?

Each DRG is assigned a different payment amount.

A hospital is only reimbursed one DRG per admission regardless of the number of diagnosis treated. In some cases, the patient’s charges are greater than the DRG payment and the hospital must absorb the loss. The patient cannot be billed for the difference. If, on the other hand, the DRG payment is greater than the patient’s charges, the hospital is allowed to keep the difference.

There are admissions that exceed certain charge parameters. These are referred to as “outliers” and result in additional reimbursement to the hospital. However, the bills of these patients usually exceed additional reimbursement. Outlier payments protect the Hospital from catastrophic health care cases.

NOTE: The patient cannot be billed for remaining balance. A “notice of non-coverage” letter must be sent to a patient when the “medical necessity” of admission or continued stay is not met. Only then can a patient be billed for hospital days and/or services covered by their health plan.

What is the effect of DRG reimbursement?

Receiving a fixed amount for each admission forces hospitals to evaluate the delivery of health care. Only by providing necessary services in the most cost-effective manner without sacrificing quality can a facility hope to survive. When the “medical necessity” of acute hospital care is no longer met, other healthcare resources must be utilized.

Healthcare payors, by analyzing historical data, will be better able to predict the DRG utilized by their beneficiaries and the resulting expense.
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<td>861.22</td>
<td>Lung laceration without mention of open wound into thorax</td>
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<td>Lung laceration with open wound into thorax</td>
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<td>874.02</td>
<td>Open wound of trachea, without mention of complication</td>
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<td>874.12</td>
<td>Open wound of trachea, complicated</td>
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| **$8,401** | **DRG 184 Major Chest Trauma with CC**  
GMLOS 3.8 AMLOS 4.6 RW 0.9611                   |
|         | Select principal diagnosis listed under DRG 183                                               |
| **$6,902** | **DRG 187 Pleural Effusion with CC**  
GMLOS 4.2 AMLOS 5.5 RW 1.1947                   |
|         | Select principal diagnosis listed under DRG 186                                               |
| **$5,630** | **DRG 188 Pleural Effusion without CC/MCC**  
GMLOS 3.2 AMLOS 4.1 RW 0.9745                   |
|         | Select principal diagnosis listed under DRG 186                                               |
| **$6,485** | **DRG 190 Chronic Obstructive Pulmonary Disease with MCC**  
GMLOS 5.1 AMLOS 6.5 RW 1.1138                   |
|         | Select principal diagnosis listed under DRG 193                                               |
| 491.1  | Mucopurulent chronic bronchitis                                                                 |
| 491.2  | Obstructive chronic bronchitis                                                                 |
| 491.8  | Other chronic bronchitis                                                                        |
| 491.9  | Unspecified chronic bronchitis                                                                  |
| 492.0  | Emphysematous bleb                                                                             |
| 492.8  | Other emphysema                                                                                |
| 493.20 | Chronic obstructive asthma, unspecified                                                         |
| 493.21 | Chronic obstructive asthma with status asthmaticus                                               |
| 493.22 | Chronic obstructive asthma, with (acute) exacerbation                                            |
| 494    | Bronchiectasis                                                                                 |
| 496    | Chronic airway obstruction, not elsewhere classified                                             |
| 506.4  | Chronic respiratory conditions due to fumes and vapors                                          |
| 506.9  | Unspecified respiratory conditions due to fumes and vapors                                      |
| 748.61 | Congenital bronchiectasis                                                                       |
| **$7,225** | **DRG 193 Simple Pneumonia and Pleurisy with MCC**  
GMLOS 5.5 AMLOS 6.9 RW 1.2505                   |
|         | Select principal diagnosis listed under DRG 190                                               |
| 074.1  | Epidemic pleurodynia                                                                           |
| 480    | Viral pneumonia                                                                                |
| 481    | Pneumococcal pneumonia (strepococcus pneumoniae pneumonia)                                     |
| 482.2  | Pneumonia due to Hemophilus influenzae (H. influenzae)                                           |
| 482.3* | Pneumonia due to Streptococcus                                                                  |
| 482.9  | Unspecified bacterial pneumonia                                                                |
| 483*   | Pneumonia due to other specified organism                                                        |
| 485    | Bronchopneumonia, organism unspecified                                                          |
| 486    | Pneumonia, organism unspecified                                                                |
| 487.0  | Influenza with pneumonia                                                                       |
| 511.0  | Pleurisy without mention of effusion or current tuberculosis                                   |
| 511.8  | Pleurisy with other specified forms of effusion, except tuberculous                             |
| 511.9  | Unspecified pleural effusion                                                                   |
| 506.1  | Acute pulmonary edema due to fumes and vapors                                                  |
| 514    | Pulmonary congestion and hypostasis                                                            |
| 518.4  | Unspecified acute edema of lung                                                                 |
| 518.5  | Pulmonary insufficiency following trauma and surgery                                             |
| 518.81 | Acute respiratory failure                                                                      |
| 518.83 | Chronic respiratory failure                                                                    |
| 518.84 | Acute and chronic respiratory failure                                                          |
| **$5,913** | **DRG 194 Simple Pneumonia and Pleurisy with CC**  
GMLOS 4.5 AMLOS 5.3 RW 1.0235                   |
|         | Select principal diagnosis listed under DRG 193                                               |
| **$4,852** | **DRG 195 Simple Pneumonia and Pleurisy without CC/MCC**  
GMLOS 3.5 AMLOS 4.1 RW 0.8398                   |
|         | Select principal diagnosis listed under DRG 193                                               |
Contractor Information

Contractor Name
National Government Services, Inc.

Contractor Number

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Contractor Type
Carrier

FI

Article Information

Article ID Number
A46071

Article Type
Article

Key Article
Yes

Article Title
Medical Nutrition Therapy (MNT) Services – Medical Policy Article

AMA CPT / ADA CDT Copyright Statement
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Primary Geographic Jurisdiction

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Secondary Geographic Jurisdiction
Not applicable
Original Article Effective Date
12/01/2007

Article Revision Effective Date

Article Text

Billing Instructions for Medical Nutrition Therapy
Medical Nutrition Therapy services are covered as of January 1, 2002, for patients with diabetes or renal disease.

_The initial episode of MNT is for 3 hours the first year and 2 hours each additional year, but additional hours may be covered beyond the hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary._

_MNT Service can be billed to FIs when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for MNT services through the local FI if the nutritionists or registered dietitians reassigns their benefits to the hospital._

_The only applicable bill types are 13X, 14X, 23X, 32X and 85X._

ICD-9-CM Codes That Support Medical Necessity

For patients with diabetes:

250.00-250.03 Diabetes mellitus without mention of complication
250.10-250.13 Diabetes with ketoacidosis
250.20-250.23 Diabetes with hyperosmolarity
250.30-250.33 Diabetes with other coma
250.40-250.43 Diabetes with renal manifestations
250.50-250.53 Diabetes with ophthalmic manifestations
250.60-250.63 Diabetes with neurological manifestations
250.70-250.73 Diabetes with peripheral circulatory disorders
250.80-250.83 Diabetes with other specified manifestations
250.90-250.93 Diabetes with unspecified complication
648.80-648.84 Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, abnormal glucose tolerance

For patients with renal disease:

403.0 Hypertensive Chronic Kidney disease, malignant
403.1 Hypertensive Chronic Kidney disease, benign
403.9 Hypertensive Chronic Kidney disease, unspecified
585.1 Chronic kidney disease, Stage I
585.2 Chronic Kidney disease, Stage II (mild)
585.3 Chronic Kidney disease, Stage III (moderate)
585.4 Chronic Kidney disease, Stage IV (severe)
585.5 Chronic Kidney disease, stage V
585.6 End stage renal disease
585.9 Chronic Kidney disease, unspecified
593.9 Unspecified disorder of kidney and ureter

For patients who had successful kidney transplant:

V42.0 Organ or tissue replaced by transplant, kidney

Claims submitted for any other conditions will be denied as not medically necessary under Section 1862(a)(1)(A) of the SSA.

Coverage Topic
Nutrition Therapy Services (Medical)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

13x Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14x Non-Patient Laboratory Specimens
23x SNF-outpatient (HHA-A also)
32x HHA-inpatient or home health visits (Part B only)
85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

CPT/HCPCS Codes

97802 MEDICAL NUTRITION THERAPY; INITIAL ASSESSMENT AND INTERVENTION, INDIVIDUAL, FACE-TO-FACE WITH THE PATIENT, EACH 15 MINUTES
97803 MEDICAL NUTRITION THERAPY; RE-ASSESSMENT AND
INTERVENTION, INDIVIDUAL, FACE-TO-FACE WITH THE PATIENT, EACH 15 MINUTES

97804 MEDICAL NUTRITION THERAPY; GROUP (2 OR MORE INDIVIDUAL(S)), EACH 30 MINUTES

The following HCPCS codes should be used after the completion of the 3 hours of basic coverage under 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours.

G0270 MEDICAL NUTRITION THERAPY; REASSESSMENT AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), INDIVIDUAL, FACE TO FACE WITH THE PATIENT, EACH 15 MINUTES

G0271 MEDICAL NUTRITION THERAPY, REASSESSMENT AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION, OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), GROUP (2 OR MORE INDIVIDUALS), EACH 30 MINUTES

Other Information

Other Comments

References:

- CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 4, section 300-300.6.
Medicare Preventive Service – Glaucoma Screening and Medical Nutrition Therapy (MNT) Teleconference Summary

May 5, 2009    12:00 p.m. - 1:00 p.m., ET

On May 5, 2009, National Government Services conducted a teleconference on Glaucoma Screening and Medical Nutrition Therapy two of the many preventive services that Medicare offers the beneficiary. This teleconference is part of the monthly sessions we will be offering on preventive services. The objective of this teleconference was to provide an understanding of the coverage and billing requirements for Glaucoma Screening Tests and Medical Nutrition Therapy so that claims will be submitted correctly.

The next preventive service teleconference will be held on June 25, 2009 from 12:00 p.m. – 1:00 p.m. ET, where we will talk about Prostate Cancer Screening and Smoking Cessation Counseling.

Highlights from the session include the following:

- Why Prevention is important
- Glaucoma Screening
  - Coverage
  - High Risk categories
  - Coding
  - Payment and cost-sharing
- Medical Nutrition
  - Coverage
  - Coding
  - Payment and cost-sharing

Questions & Answers
The following questions were asked during the registration process and at the session. Responses to questions that need additional research will be posted on our Web site once available. Beneficiary, and claim-specific questions cannot be published due to PHI; those questions are handled off-line of the teleconference through telephone follow-up.

Questions and answers may have been rewritten for clarity.

We are an acute care hospital and there is some confusion over whether or not we should be using the CMS-1500 claim form for these services. Or, should we be using the UB-04, 1450 claim form and using Type of Bill (TOB) 131?
You should be billing these preventive services on a TOB 131 and using the UB-04 claim form. When the services are rendered as an outpatient in an acute care hospital, this is the correct way to bill.
Are there any specific diagnosis codes for the MNT Services?
The regulations state that the diagnosis code must be for diabetes.

What about the diagnosis for the Glaucoma Screening?
The diagnosis for Glaucoma Screening is V801.

When we are billing on the 1500 claim form to the Carrier/Medicare Administrative Contractor (MAC) for MNT, and we are a hospital. How are we reimbursed, are we reimbursed the Medicare Physician Fee Schedule (MPFS), or are we reimbursed under OPPS?
The MNT is paid under the MPFS when billed to the Carrier/MAC. Just to be clear some hospitals may be using a 1500 claim form for the professional services and you will submit that claim to the Carrier/MAC. You also will submit the hospital charges on a UB-04, 1450 claim form and that goes to the Fiscal Intermediary (FI)/MAC.

We know we need a physician’s order for MNT. However, many of our clinics have nurse practitioners. Can a nurse practitioner order MNT?
In the regulations, it does not state that a nurse practitioner or non-physician practitioner (NPP) can order MNT services. It states that MNT has to be ordered by a physician.

For MNT, it is my understanding that a diet prescription is not needed, just a diagnosis code for diabetes or renal disease. Is that correct?
That is correct.

If the beneficiary does not have a diabetic or a renal disease diagnosis, should we just not bill Medicare and are we able to just charge that patient for service since it’s not a covered diagnosis?
You will have to have the beneficiary sign an Advance Beneficiary Notice (ABN) form, when the services are not reasonable and necessary. On the ABN they would agree that they will be responsible for the services.

We sometimes have diabetic patients that may have been diabetic for 10 years or so and now they’re finally Medicare eligible. Their blood sugar is not well controlled. Would that person then not be eligible for Medicare coverage for the MNT benefit?
The first requirement for this benefit is to have a physician order and the beneficiary would have a diagnosis of diabetes or renal disease. After, that it would be up to that physician if they felt that a person that had diabetes for those many years if they need this MNT benefit.

I understand that there is three (3) hours for MNT in the first year. After the first year it is two (2) hours each additional year? Does that reset at any time? Or is it two hours indefinitely?
It is two hours indefinitely.
We are a Federally Qualified HealthCare Center (FQHC) and we bill for MNT. Can these services be provided by a registered dietitian if referred by a physician?
Yes. A registered dietitian can do this. But under this MNT I did not see your bill type for FQHC listed as a service that Medicare would cover. So it may be that it may be packaged into the payment you receive for your facility and you are not able to bill for it separately.

As an FQHC will we get paid a visit payment when we provide MNT services?
According to Change request CR 4385 this is the information for FQHCs and MNT services:

MNT services are now considered core FQHC services and are reimbursable as a visit under the FQHC all-inclusive payment rate when rendered by qualified practitioners.

- Section 5114 of the DRA expanded the FQHC definition of a face-to-face encounter to include encounters with qualified practitioners of outpatient DSMT and MNT services when the FQHC meets all relevant program requirements for the provision of such services.
- The Medicare program makes payment directly to the FQHCs for covered services furnished to Medicare beneficiaries.
- The FQHC services are covered when furnished to a patient at the clinic or center, the patient’s place of residence, or elsewhere (e.g., at the scene of an accident).
- Effective for services furnished on or after January 1, 2006, FQHCs MNT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals.
- In other words, if all relevant program requirements are met, these services are included under the FQHC benefit as billable visits.

I’m a provider; how would I know if the beneficiary is in their first year, or if they are in their second year for MNT? Or, if the have used their benefit elsewhere in another facility?
If the beneficiary has used their MNT benefit at another facility, that facility has to bill Medicare so that we can have a record of the service being rendered. Providers can check the Common Working File (CWF) to see when the beneficiary is eligible to have this service rendered again. If CWF is not populated with this information, that could mean that we have not received a claim for that service or the beneficiary has not had the service rendered before. Providers should ask the beneficiary if they have the MNT services previously and if yes, ask them when and bill accordingly. The CWF is updated by the claims we revive from providers, so we depend on providers of service to submit claims so we can populate that information on CWF. The billing staff in the facilities should be aware of how to access CWF or providers can call their respective Interactive Voice Response (IVR) to get eligibility information for the beneficiary.

Is MNT different regarding the Home Health Agency (HHA)? Is this just for outpatient or a clinic?
It is only for outpatient services that are not related to the home healthcare that beneficiary may have. The home health agency they may provide this, but it is not something that they can bill separately to the Medicare program.
But if we don't have the DSMT is this a part of it?
MNT is a not part of DSMT. The MNT benefit is a separate benefit under preventive services. These two services are provided to a diabetic beneficiary, but they are two totally separate benefits.

I have a question regarding the actual billing; there is a little confusion here. Say a patient comes in for their initial assessment, and you're billing in 15-minute increments and they use only one hour. That's their initial visit so we use Current Procedural Terminology (CPT) code 97802. They come back for another visit and we use CPT 97803, and for the reminder of the year the three hours are up. After they use their three hours in the first year, and now they are coming to us in the second year and there is a change in diagnosis. That is when we should be using the G Healthcare Common Procedure Coding System (HCPCS) codes is that correct?
Yes, that is correct.

Should we issue an ABN if we know that the services are not reasonable and necessary?
Yes. When the providers know that Medicare is going to possibly deny the service an ABN should be issued when services are going to be denied due to not be reasonable and necessary.

For the MNT, the physician has to order the service, and a nutritionist can perform the service? Is that correct?
Yes. A Registered dietitian or nutrition professional can perform this service.

The Part B (Carrier) claims started getting rejected when I billed with CPT codes 97802, and 97803. When I called provider care, I was told that the provider had to be certified through the American Diabetes Association (ADA). For MNT, does the provider have to be certified by the ADA to provide this service?
In the regulations it does not state that the provider has to be certified by the ADA to provide MNT services. If the provider renders Diabetes Self Management Training (DSMT) then the facility does have to have been certified by the ADA. However, these are two separate preventive benefits and should not be confused with each other.

The ADA also oversees the Commission of Dietetic Registration (CDR) which is where you get your Registered Dietician (RD). There may be some confusion with the acronym of ADA. The acronym also stands for American Dietetic Association

Can we get to the CWF by going into the Fiscal Intermediary Standard System (FISS)?
Yes, CWF can be accessed by going into FISS. Once you log into FISS, instead of typing FSS) on the blank screen, depending on where the provider is located they would type in HIQA or ELGA to access CWF.