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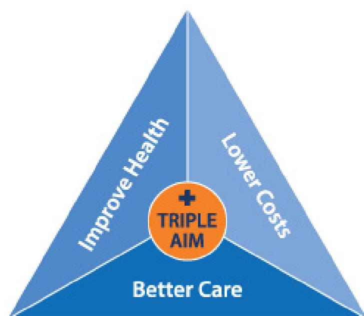
# MNT Provider

Oct 2015 | Volume 14 | Number 5

*Your source for practice management news*

## The two Ps of health care: provision and payment

The impact of the Affordable Care Act has set the health care industry up for significant payment reform over a short time frame. Regulatory changes are driving the transition of health care delivery and payment and are hastening the transformation, demanding providers quickly move to more integrated care delivery with a focus on prevention, quality, and outcomes. At the same time, payers are needing to develop new payment models to meet those goals. In fact, the Centers for Medicare & Medicaid Services (CMS) announced on Jan. 26, 2015, that it is advancing the pace of the shift from a fee-for-service payment system to one centered on outcomes and performance by setting a goal of tying 30% of traditional Medicare fee-for-service payments to quality and value through alternative payment models by the end of 2016. By the end of 2018, 50% of Medicare payments will be tied to these models. As a result, payment mechanisms are moving away from the traditional fee-for-service model, which bases payment on volume of services, toward a more outcomes-based payment methodology. Provision (how health care is delivered) and payment (how health care is paid for) are no longer on independent, parallel paths, but rather on intersecting paths as the US strives to meet the Triple Aim, a concept put forth by the Institute for Healthcare Improvement. (See graphic.)




This shift from "volume to value" is gaining momentum beyond Medicare. Health care organizations and medical practices of all types are charged with redesigning the way they function to achieve the Triple Aim. Private payer organizations are entering into agreements with provider organizations for various models of health care delivery and payment focusing on managing the health of populations. Models such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs) are emerging and being tested across the US. At the same time, providers are increasingly being rewarded for high-quality care as defined and measured by National Quality Forum's (NQF) Measure Applications Partnership (MAP,) and penalized for poor outcomes.

Because value is increasingly

See **Two Ps**, page 4

## Inside:

**The two Ps of health care: provision and payment**......1
**Important update on Medicare denials for renal claims**......1
**Private payer interpretation of ICD-10 coding may vary**......2
**ICD-10 claims submission alternatives for Medicare**......2
**Question Corner**......3
**ICD-10 billing basics for RDNs**......3
**ICD-10 cheat sheet**......4
**Video available on PQRS and VM**......4

## Important update on Medicare denials for renal claims

Academy members who are Medicare providers and submit Part B claims to Novitas Solutions, Inc., should finally see an end to their denials for MNT services provided to Medicare beneficiaries with Stage 4 kidney disease. After long and ongoing conversations between the Academy and the Centers for Medicare & Medicaid Services (CMS), Novitas has corrected its claims processing guidelines to include all of the correct ICD-9/ICD-10 codes for the Medicare MNT benefit for patients with chronic kidney disease. The Academy was recently informed that the change was implemented on Sept. 4, 2015. Medically necessary claims processed after Sept. 4, 2015, should be allowed for the diagnoses codes that they had previously deleted. Novitas is also doing a mass adjustment to find any claims that were denied for the missing diagnoses codes. Providers should watch their remittances for any claim adjustments.

The Academy was vocal in letting CMS and Novitas know of its concern that Medicare beneficiaries with chronic kidney disease who needed MNT services were unable to access those services during this extremely long time period. This unfortunate error also impacted revenue streams for members in the affected states (potentially Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, District of Columbia, Delaware, Maryland, New Jersey, and Pennsylvania). Members who continue to experience problems should contact the Academy's Nutrition Services Coverage team at reimburse@eatright.org.

# Private payer interpretation of ICD-10 coding may vary

The Centers for Medicare & Medicaid Services (CMS) is offering a one-year grace period for submitting claims with ICD-10 codes as long as they contain an ICD-10 coding errors from the right family of codes, but not all large commercial payers are following their lead. Results of an informal survey of major payers, published in Healthcare Payer News, revealed that reimbursement policies and leniency for ICD-10 coding following the first year of the transition vary among insurers. Anthem Spokesperson Gene Rodriguez told Healthcare Payer News that Anthem will honor the one-year grace period, but Cigna was slightly less liberal with their coding policies. According to statements made by Cigna Spokesman Mark Slitt, all claims"must have a valid ICD-10 code for a date of service on or after Oct. 1, 2015. A code will be invalid if it has not been coded to the full number of characters required." Slitt added that "when sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it will be acceptable to report the appropriate 'unspecified' code." Sidney Hebert, Humana's vice president of provider network operations, announced this month at a Medical Group Management Association conference in Nashville that Humana made the decision to "not drive specificity into the early stages of the implementation because it was going to drive so much complexity and misunderstanding." However, Herbert noted that "as we learn more, you'll see policy adjustments and coding alerts coming out of the payers saying 'here's what we've discovered, here's how we're going to measure it, here's what we're requiring around specificity.'"

Specificity requirements for ICD-10 codes used in submitting private payer claims may vary among payers, and policies may change over time, but the need for all registered dietitian nutritionists (RDNs) to work with their patients' medical provider to obtain the diagnosis code remains the same. It is not within the scope of practice of an RDN to make a medical diagnosis. The only exception is in the case of body mass index (BMI) codes, which represent a mathematical calculation based on measurements that are within the RDN's scope of practice to perform. Codes used on claims should align with the diagnosis made by the physician or primary care provider. In fact, the enhanced degree of specificity built into ICD-10 codes makes obtaining the correct diagnosis code by the physician or primary care provider even more important.

Each private payer establishes its own set of policies and those policies can change, so RDNs should check payer policies to determine if there is leeway on the level of specificity for ICD-10 coding prior to submitting claims. Questions about how a payer interprets the transition or what level of specificity is needed for billing with ICD-10 codes should be directed to the payer's provider relations department. Knowledge is power, and in the case of the ICD-10 transition, it may also be money as well. For a copy of the billing guide for RDNs, visit: http://bit.ly/1W2E8OG. A list of ICD-10 codes for RDNs is available at: http://bit.ly/1NUt4nL.

# ICD-10 claims submission alternatives for Medicare

If you are having difficulties submitting ICD-10 claims to Medicare as a result of an inability to complete the necessary systems changes or due to issues with billing software, vendor(s), or clearinghouse(s), there are claims submission alternatives available for you.

## Free billing software

Registered dietitian nutritionists (RDNs) and other Medicare providers who submit claims to Medicare Administrative Contractors (MACs) may download free billing software offered on MAC webpages. The software, intended to provide an ICD-10 compliant claims submission format for submitting fee-for-service (FFS) claims to Medicare, requires either a Network Service Vendor (NSV) or dial-up or both to transmit claims. Submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliance on or after Oct. 1, 2015, and the software does not provide coding assistance. Information about the free billing software and NSV is available on each of the MAC websites. (Note: While the software download is free, there may be fees associated with submitting claims through an NSV or dial-up.)

## Provider Internet portals

In some cases, RDNs may be able to use their MAC's provider Internet portal to submit ICD-10-compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission; however, Internet portal claim submission is not available for institutional or supplier claims.

Information about registering for access to provider Internet portals is available on each of the MAC websites.

## Paper claims

RDNs may submit paper claims with ICD-10 codes to Medicare. In order to qualify to submit paper claims, RDNs must meet the requirements for a waiver of Administrative Simplification Compliance Act (ASCA) provisions. Information about submitting paper claims and ordering claim forms is available on each of the MAC websites. To find more information on eligibility to submit paper claims, visit: www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html. For a list of MACs, visit: http://bit.ly/1HjzWGA. For more information and access to all MACs webpages, visit the *Contractors' ICD-10 Claims Submission Alternatives Web Pages* at: www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf.

## QUESTION CORNER

**Q:** Will Medicare reimbursement rates for medical nutrition therapy (MNT) services billed under the ICD-10 code set be the same as reimbursement rates for the same services billed under the ICD-9 code set?

**A:** Yes. The transition to ICD-10 codes does not change payment rates. While ICD-10 diagnosis codes may influence claim acceptance, the transition to these new codes has no effect on the Current Procedural Terminology (CPT) codes used to report services provided under the Medicare Physician Fee Schedule. Medicare payment rates for services under Part B are based on CPT codes, not ICD-10 codes. CPT codes are codes that describe the service rendered by the health care professional, such as a registered dietitian nutritionist (RDN). The MNT codes 97802, 97803 and 97804 are CPT codes that RDNs use on Medicare claims to report nutrition services provided by the RDN to Medicare beneficiaries.

RDNs should keep in mind that a claim could be denied if the diagnosis does not warrant payment for the procedure (for example, billing Medicare for MNT services for diagnoses other than diabetes and non-dialysis kidney disease). As always, RDNs should monitor future payment rules for impact on reimbursement. For more information on procedure and diagnosis codes and ICD-10 codes for RDNs, visit: http://bit.ly/1FURs5Q. To access the Medicare Physician Fee Schedule for RDNs, visit: http://bit.ly/1JMS0vk.

**Q:** Can I contact my new patient's physician to ask questions about the patient for treatment purposes before my patient has signed a HIPAA consent form?

**A:** Yes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require patients to sign consent forms before covered entities (such as registered dietitian nutritionists (RDNs) and other health care providers) may share information for treatment purposes. Under HIPAA, "treatment" is defined as "the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another." The HIPAA Privacy Rule prohibits a covered entity from using or disclosing protected health information (PHI) unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities. Under these circumstances, providers such as RDNs and physicians, may share patient treatment information with other health care professionals without obtaining a signed patient authorization. For more information on HIPAA requirements and for a copy of a RDN checklist for HIPAA compliance, visit: http://bit.ly/1RbkvSZ. To read the fact sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," visit: www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html.

**Q:** Is there a way to opt out of Medicare electronically?

**A:** No, there is not currently an option to submit an opt-out affidavit to Medicare online. While providers may not opt out of Medicare electronically, many MACs have affidavit forms available on their website for downloading. Registered dietitian nutritionists (RDNs) who wish to opt out of Medicare must have a National Provider Identifier (NPI) number and must sign and submit a formal written affidavit to their Medicare Administrative Contractor (MAC). The affidavit must include the practitioner's NPI number and specific language stating that the RDN has explicitly chosen this option.  She, or the practice's billing office, must also agree not to file any claims for Medicare Part B service, nor receive payment for covered services from Medicare. Additionally, she must agree to enter into private contracts with each Medicare beneficiary prior to providing Medicare Part B covered services to the beneficiary. The private contract must contain certain detailed components and must be signed by both the RDN and the Medicare beneficiary before the service is provided. The opt-out agreement remains in effect until a written notification is submitted by the provider, even if her place of employment changes. For more information about opting out of Medicare, visit: http://bit.ly/1OaYKVN For details about the requirements for opting out of Medicare, visit: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf To locate your MAC's website, visit: www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

## ICD-10 billing basics for RDNs

Keep these four simple steps in mind when billing for registered dietitian nutritionist (RDN) services provided on or after Oct. 1:

1. Use ICD-10 codes
2. Get the code from the physician/referring provider
3. Use the correct ICD-10 indicator on the 1500 claim form
4. Use Academy resources to support your work
   - Common ICD codes used by RDNs: http://bit.ly/1FURs5Q
   - MNT referral form: http://bit.ly/1JMS0vk
   - The superbill webinar: http://bit.ly/1Hey4ki

# ICD-10 cheat sheet

ICD-10 preparation is just one challenge of many that health care providers need to manage in the changing world of health care delivery and payment. Although making a medical diagnosis is not within the scope of practice of a registered dietitian nutritionist (RDN), RDNs still need to become familiar with ICD-10 codes most frequently used in their practice. A relatively quick way to familiarize yourself with these ICD-10 codes is to develop an ICD-10 cheat sheet. RDNs can also use the cheat sheet to customize paper and electronic forms, facilitate referrals for MNT services, and to develop super bills.

Where can RDNs find ICD-10 codes to make their cheat sheet? Visit the Academy webpages at: http://bit.ly/1NUt4nL. Can't find those few unusual codes you're looking for? Visit www.ICD10Data.com, a free reference website designed to help providers and billers easily look up ICD-10 codes.

**Two Ps**, from page 1

becoming part of the equation for all payers and providers, payment reform and accountability for health care outcomes is essential. Across the country, there is widespread experimentation and subsequent adoption of payment models that carefully consider the most important elements of care for specific health conditions and procedures and anticipate expected health outcomes, while also assigning value to of all of the health care services involved. Registered dietitian nutritionists (RDNs) are in a unique position to demonstrate value, cost-effectiveness, and the role the RDN plays in positive health outcomes and in improved population health.

No one knows exactly what payment will look like in the future, but we do know the focus on quality and cost containment are not going away. And, since some fee-for-service compensation will continue, many health care providers will have a foot in both worlds of payment. To excel in the changing health care marketplace, RDNs must be prepared to change the way they think and do business and embrace the opportunities and challenges that the new health care delivery and payment models present. New models of care, focused on improving health care quality and decreasing per capita cost of care, are a perfect fit for RDNs. Whether it is public or private payers, RDNs have demonstrated value and efficacy for improved patient outcomes with a wide variety of medical conditions throughout the life cycle. RDNs also bring value to the multidisciplinary team by providing care coordination, evidence-based care, and quality-improvement leadership. RDNs should take action to lead changes necessary to integrate RDN services into new models of care and expand access to RDNs and their services.

Learn more about the rapidly changing health care landscape, new models of health care delivery and payment, and the value proposition for RDNs in new models of care by visiting: http://bit.ly/1J854rS. Read the Journal article, "Registered Dietitian Nutritionists Bring Value to Emerging Health Care Delivery Models," available at: www.andjrnl.org/article/S2212-2672(14)01358-6/fulltext. Find out what you can do to promote and integrate RDN services into evolving delivery and payment models. Read the Nutrition Services Delivery and Payment Action Plan available at: http://bit.ly/1W5N9Ma. Visit your Affiliate or Dietetic Practice Group website to find your Reimbursement Representative. (Reimbursement Representatives are member volunteers who can help you learn how to partner with other RDNs to develop and cultivate key relationships with decision makers and stakeholders necessary to expand delivery and payment of nutrition services in your area.) Watch future issues of the MNT Provider for an announcement about the revised RDNs in Primary Care toolkit.

## Video available on PQRS and VM

Watch the new video, *"What Medicare Eligible Professionals Need to Know in 2015,"* developed by the Medicare Learning Network (MLN), and get the facts on how your 2015 Physician Quality Reporting System (PQRS) participation determines how the Value-Based Payment Modifier (VM) is applied to your 2017 reimbursement. To find out how to get started with PQRS, visit: http://bit.ly/1I03IYI. For more information on PQRS, visit: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html. For more information on VM, visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Physician-FeedbackProgram/index.html.

*MNT Provider* (ISSN: 1540–370X) is published monthly by the Academy of Nutrition and Dietetics; 120 South Riverside Plaza; Chicago, IL 60606-6995. Telephone: 312/899-0040

Editor: Mara Bujnowski, MAEd, RD
Nutrition Services Coverage

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