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Your source for practice management news

A new chapter in coding begins

In just a few short weeks, the health care industry will transition from the ninth to the tenth version of the International Classification of Diseases (ICD) code set. The shift to ICD-10 directly impacts facilities, physicians, and billers, as well as registered dietitian nutritionists (RDNs). ICD-10 codes must be used on all HIPAA transactions dated on or after October 1, 2015; otherwise, submitted claims may be rejected, resulting in delays in claims processing and potential delays in reimbursement.

When our Canadian neighbors transitioned to ICD-10 between 2001 and 2004, advanced support systems and analytics tools were not common components of the health care world. And, since that transition pre-dated the HITECH Act, neither were electronic health records. Today, RDNs have reasonable access to a variety of ICD-10 support tools and resources that account for modern developments in the health care environment, including those provided by the Academy of Nutrition and Dietetics and the Centers for Medicare & Medicaid Services (CMS). For ICD-10 resources to help you through the transition, visit the Academy's webpages: http://bit.ly/1KPCjCj.

Inside:

Decoding healthcare payment reform terminology

What's the difference between a bundled payment and an episode payment? How are prospective payments different from fee-for-service payments? Savvy registered dietitian nutritionists (RDNs) and nutrition and dietetics technicians, registered (NDTRs) who want to integrate their services into new payment models need to be able to speak the language. But if you've been confused by the complex terminology and seemingly endless acronyms surrounding health care payment reform, you're not alone. In fact, the confusing language used to describe different payment systems has been cited as one barrier to reaching consensus on significant payment reform issues.

The Payment Reform Glossary, developed by the Center for Healthcare Quality and Payment Reform, was designed to foster a better understanding of payment reform concepts and create a foundation for a common language for developing and discussing payment reform concepts. This free resource contains descriptions of many of the most significant payment reform models proposed or implemented by public and private payers. The glossary offers explicit comparisons and contrasts among key concepts and provides definitions and explanations for over 400 words, names, and abbreviations.

Increase your payment reform language skills so you can define your place in the evolving world of payment reform. Access the glossary at: http://bit.ly/1DKZJbh. For more information about emerging health care delivery and payment models, visit: http://bit.ly/1DKZJbh.

Don't panic over ICD-10

The ICD-10 transition is less than a month away. There's no need to worry about learning all 68,000 ICD-10 codes. Focus on the codes most frequently used by registered dietitian nutritionists (RDNs) and your practice. For a list of ICD-10 codes for which individuals may be referred to an RDN for care, visit: http://bit.ly/1KPCjCj.

Five ways to check your Medicare claim status

The Centers for Medicare & Medicaid Services (CMS) uses a network of contractors called Medicare Administrative Contractors (MACs) to process Medicare claims, enroll health care providers in the Medicare program and educate providers on Medicare billing requirements. MACs also handle claims appeals and answer beneficiary and provider inquiries.

After the implementation of ICD-10, providers can check the status of Medicare claims through their local MAC in a variety of ways:

- Interactive Voice Response (IVR): IVR gives providers access to Medicare claims information through a toll-free telephone number. Visit MAC website for information on the Provider Contact Center and IVR user guide.
- Customer Service Representative (CSR): Visit your MAC website for information on the Provider Contact Center only if you are unable to access claims information via IVR.
- MAC portal: Visit your MAC website for portal features and access.
- Direct Data Entry (DDE): Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. Visit your MAC website for more information.
- ASC X12: The ASC X12 Health Care Claim Status Request and Response (276/277) is a pair of electronic transactions you can use to request the status of claims (via the 276) and receive a response (via the 277). Visit your MAC website for more information.

MACs are assigned a defined geographic area or "jurisdiction" for claims processing. To access an interactive map to determine the MAC assigned to your state, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/providing-the-service-and-billing-under-medicare.

Academy Telehealth Practice Survey

Make your voice heard! Participate in the Academy's Telehealth Practice Survey and help direct the Academy's education and advocacy work around telehealth practice. Respond by October 14 and be eligible to win a prize. To access the survey, visit: www.surveymonkey.com/r/2KL5HLS.

Updated pediatric malnutrition FAQs available

Have you encountered questions while implementing the recommendations from the 2014 Pediatric Malnutrition Consensus Statement? The Academy has updated its frequently asked questions (FAQ) companion document in response to direct queries about how to translate the statement, published by the Academy and A.S.P.E.N. in December 2014, into practice. Direct responses are provided for questions related to the published characteristics, and peer-reviewed literature is provided for responses to other questions (such as how to measure a specific characteristic or additional information related to alternative assessment or intervention options). This document is designed to assist practitioners in implementing the recommendations into their own unique practice setting(s). To access the Pediatric Malnutrition Consensus Statement, visit: http://www.andjrnl.org/. Pediatric malnutrition FAQs can be found at: http://bit.ly/1IyZ6NW.

Making a difference in patients' and clients' lives

The shift to value-based care and payments creates a sharp increase in the need for health care providers and organizations to measure and report outcomes. Registered dietitian nutritionists (RDNs) can track outcomes and create charts and graphs to show RDN impact with the Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII). This free member benefit is now available in practice mode to build your skills before adding it to your practice.

Prove you're making a difference in patients' and clients' lives with ANDHII! For more information or to get started using ANDHII, visit: http://bit.ly/1NcTgJr.

QUESTION CORNER

The clock is ticking and the ICD-10 transition deadline date of October 1, 2015, is fast approaching. This month's Question Corner is dedicated to addressing billing and coding scenarios related to the use of ICD-10 codes to help ensure your transition is seamless.

Q: After the ICD-10 transition, if my Medicare patients have recurring appointments for medical nutrition therapy (MNT), will a new referral with ICD-10 codes be required prior to providing and billing for subsequent services?

A: The Centers for Medicare & Medicaid Services (CMS) is not requiring that providers, such as registered dietitian nutritionists (RDNs), obtain updated referrals to continue services after ICD-10 implementation on October 1, 2015; however, claims must contain a valid ICD-10 diagnosis code. Physicians will need to provide the appropriate ICD-10 code to the RDN for claims submitted after the transition deadline. Referrals created after the transition to ICD-10 must use ICD-10 codes. For more information about finding and maintaining referrals, read, Making Nutrition Your Business, available at: www.eatrightstore.org

Q: If the ICD code is missing from my patient's referral form, can I assign an ICD-10 code on a claim form or superbill based on a patient's reported diagnosis and/or body mass index (BMI) using office measurements of height and weight (for overweight/obesity)?

A: In general, determining a client's medical diagnosis is out of the scope of practice of the registered dietitian nutritionist (RDN). To minimize potential risk, the RDN should obtain diagnosis information from the physician if at all possible and document the efforts taken to obtain the information, recommends Stacy Cook, legal counsel with Barnes & Thornburg LLP. With the increased complexity of the ICD-10 code set compared to the ICD-9 set, the need to follow best practice becomes even more important to minimize not only risk but also the chances for a denied claim.

In limited situations, the RDN may be able to assign a diagnosis code on a claim form. Z codes for BMI are unique in that they are based on physical measurements that are within the scope of practice for an RDN to perform. The Z codes can be entered as a primary diagnosis when a person who is not currently sick or injured encounters the health care system for a specific reason or when circumstances or problems influence a person's health status, but are not themselves a current illness or injury.

While best practice is for the RDN to obtain information from the client's treating physician in order to obtain a clear and accurate understanding of the client's condition, if physician information (such as the medical diagnosis) is not available, RDNs should use the best available information to determine the diagnosis code to list on the claims form in accordance with payer claims processing policies. If the RDN does not have anything to back up the use of the ICD-10 code, the payer might take the position that the claim was misleading or even false. RDNs should

See **Question Corner**, page 4

Do you have a question for the Question Corner?

E-mail your question to **reimburse@eatright.org** to have it answered in an upcoming issue of the *MNT Provider*.

also check with providers to see if a policy exists for reporting the medical diagnosis on a claim when a physician-derived diagnosis is unavailable. For a list of ICD-10 codes for RDNs, visit: http://bit.ly/1KPCjCj.

Q: What happens if I use the wrong ICD-10 code when reporting quality measures in the Physician Quality Reporting System (PQRS)?

A: For all quality reporting completed for program year 2015, physicians or other eligible professionals (EPs), such as RDNs eligible for PQRS, will not be subjected to a penalty if certain steps have been taken. There will be no penalty if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients, and the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code(s) used from the correct family of code. For more information about 2015 PQRS reporting requirements for RDNs, visit: http://bit.ly/1I03IYI.

Q: Will private payers observe the same one-year period of claims payment review leniency as Medicare for ICD-10 codes if the codes submitted are from the appropriate family of codes?

A: The official guidance for claim submission leniency only applies to Medicare services billed under the Medicare Fee-for-Service Part B physician fee schedule. Registered dietitian nutritionists (RDNs) should contact each private payer with whom they have a contract to determine whether the payer will offer similar audit flexibilities.

Q: Are any health plans not required to transition to ICD-10 codes?

A: Insurers not subject to the Employee Retirement Income Security Act of 1974 (ERISA) are therefore exempt from ICD-10 coding may include workers' compensation plans, property and casualty plans, and auto plans. However, some of these plans have decided to move to ICD-10 on their own and others have been mandated to move to ICD-10 through state law. RDNs are encouraged to check with private payers to determine which will not be accepting ICD-10 codes after October 1, 2015.

Q: Do I still need to use ICD-10 codes if I am submitting paper claims to Medicare and other third-party insurers?

A: Yes. Aside from the exceptions noted above, all entities covered by the Health Insurance Portability Accountability Act (HIPAA) must use ICD-10 codes on claims, whether they be submitted on paper or electronically, beginning October 1. Claims that do not contain ICD-10 diagnosis codes for services provided on or after the implementation date will not be processed and will be considered non-HIPAA compliant. For a list of ICD-10 codes for RDNs, visit: http://bit.ly/1KPCjCj.

Q: Will I need to order new CMS-1500 forms to accommodate new ICD-10 codes?

A: No. The CMS-1500 form (02/12), the standard paper claim form that healthcare professionals and suppliers use to bill Medicare when a paper claim is allowed, will not change as a result of the transition to the ICD-10 code set. On June 10, 2013, the White House Office of Management and Budget (OMB) replaced the old CMS-1500 form (08/05) with the current CMS-1500 form (02/12), which contains changes to more adequately support the use of the ICD-10 diagnosis code set. This revised form offers providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes when billing. After October 1, RDNs can continue using the CMS-1500 (2/12) form as usual, with the exception of noting ICD-10 codes in place of ICD-9 codes. For help in understanding the CMS-1500 form, read the billing guide for RDNs, available at: http://bit.ly/1fBEy0v or visit: http://bit.ly/1LmjALi.

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Telephone: 312/899-0040

Editor: Mara Bujnowski, MAEd, RD
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