A Quick Guide to the Medicare MNT Benefit

MNT	Type 1, Type 2 gestational diabetes, non-dialysis kidney disease, and post kidney transplants
Practice Settings	• Ambulatory: private practice; physician offices; clinics; hospital outpatient departments • Excluded: inpatient hospital setting; skilled nursing facilities
Medicare MNT Benefit	• Through National Coverage Determination (NCD) decision, CMS indicated the Medicare MNT benefit basic coverage (year 1) = 3 hours. CMS indicated "an episode of care typically includes 1 hour of initial assessment and four 30 minute follow-up interventions during the first year." Additional hours are considered to be medically necessary and covered if treating physician determines there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care. Follow-up (year 2) = 2 hours
Diabetes Self-Management Training Benefit	• Effective October 1, 2002, Medicare will cover DSMT (Diabetes Self-Management Training) and Medicare MNT in initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service.
Medicare MNT Provider Qualifications and Requirements	Registered dietitian or nutrition professional who meet all the following criteria: • BS degree in nutrition or dietetics. • Completion of 900 hours of supervised dietetics practice. • Licensed or certified as dietitian or nutrition professional by State in which services are performed (if State does not provide licensure or certification, meets other criteria established by Secretary). • Grandfathers dietitian, nutritional professionals licensed or certified as of 12/21/00.
Enrolling as Medicare Provider CMS 855I form	• To clarify which forms to complete, RDs could contact their Medicare carrier and describe their practice settings (and location of) in which MNT benefit is furnished, so carrier can determine required provider forms to complete. • To enroll, complete and submit CMS Form 855 I, Application for Individual Health Care Practitioners form. Forms can be obtained from: --Local Medicare carrier; carriers' names, addresses, phone numbers, etc. on CMS' web page www.hcfa.gov/Medicare/enrollment/contacts --CMS' web page www.hcfa.gov/Medicare/enrollment --American Dietetic Association's web page www.eatright.com/members/statecarriers --Some carriers *may* request copy of state license, registration certificate, or other proof of required qualifications.
Additional Enrollment Forms: 855R, B	• Depending on practice setting and employment relationship, RD may also need to complete: **--CMS 855 R** Application for Individual Health Care Practitioners to Reassign Medicare Benefits --**CMS Form 855 B** Application for health care Suppliers that bill Medicare Carriers

Medicare Provider Identification Number (PIN)	• Upon enrollment, RD will receive PIN, which is used on MNT claims. RD may be required to have a *different* PIN for:
	  • Each practice setting situated in different fee schedule areas.
	  • Each practice setting that is under the jurisdiction of a different carrier.
	  • RDs may practice in a group. In this case the group must obtain a PIN in addition to each individual RD obtaining his/her own PIN.

	• Medicare Carrier uses these PINs in its accounting system to insure that: payment amounts are correct; payment is sent to the correct recipient (for tax reasons, among others) (e.g., RD as recipient vs. hospital as recipient).
Physician Referral and Docu-mentation	• Physician's referral for MNT is required: ☐ Physician can be treating physician or specialist who is treating beneficiary. • Referral must indicate the order for MNT, beneficiaries' diagnosis (related to covered MNT benefit), physician's Unique Physician Identification Number (UPIN) and referral must be signed by physician. • Documentation by RD of furnished MNT (initial, follow-up) in beneficiary's medical record.
MNT Protocols	• When furnishing the MNT benefit, the final regulations state recognized protocols, such as those developed by the American Dietetic Association, are to be used. Nutrition Practice Guidelines are available for purchase on CD-Rom from American Dietetic Association.
CPT Codes for MNT benefit	• CPT Code 97802: MNT, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (used once, for initial visit only). • CPT Code 97803: MNT re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes. • CPT Code 97804: Group MNT (2 or more persons), each 30 minutes. Time-based MNT-specific CPT codes are listed once on the claim, but multiple units of code may be entered.
UN-Adjusted Medicare Allowed Reim-burse-ment Rates	CMS indicated Medicare will, "Pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts." Allowed payment rates have been established under the physician's fee schedule. The RD payment amount, 85% of physician amount, without the geographic adjustment factor is: • MNT CPT Code 97802 - $15.01 per 15 min. unit = $60.04 per hour (= 4 units) • MNT CPT Code 97803 - $15.01 per 15 min. unit = $60.04 per hour (= 4 units) • MNT CPT Code 97804 - $ 5.94 per 30 min. unit = $11.88 per hour (= 2 units) Medicare reimburses 80% of the approved amount after the beneficiary has reached his/her annual $100 deductible. Remaining 20% of the approved amount, known as coinsurance, is the amount the beneficiary pays out-of-pocket.
Adjusted Rates	• CMS applies a *geographical adjustment factor* (GAF) to the MNT rates in regions of country; thus, rates may vary from one region to another. • Refer to American Dietetic Association's web site for GAFs and adjusted MNT rates.
MNT Claims	• RD must be Medicare provider to submit MNT claim for Medicare reimbursement. • Beneficiary must have Part B insurance. • MNT must be billed on HCFA 1500 form (can be purchased at office supply stores) ☐ *Key data elements required on claim (but not limited to): Beneficiary information (including Medicare ID number); RD's name and Medicare PIN; referring physician's name and UPIN; RD's usual and customary MNT fee; CPTcode and number of units of code billed; ICD-9 diagnosis code(s); place of service code; dates of service; and beneficiary's signature *.* * In lieu of signing claim, beneficiary may sign a statement that is retained in provider's file. Patient's signature authorizes release of medical information necessary to process claim. "Signature on file" is then printed on claim. • Provider must send MNT claim to the local Medicare Carrier. • Carrier reimburses the provider directly for MNT services rendered.
Medicare	• RDs should establish a fee schedule for their MNT services.

Provider Fee Setting, Billing Requirements and Payment Regulations	A fee schedule should be used for all patients, including Medicare beneficiaries. • RD who is Medicare provider charges beneficiary her/his usual/customary MNT fee. • A beneficiary may have more than one type of insurance or coverage that will pay for services and procedures before, or along with, Medicare. The RD or hospital billing department must determine if a private insurance plan should be billed first before Medicare. Here Medicare is the secondary insurer. • If no other insurance exists, and beneficiary qualifies, RD bills Medicare and "accept assignment" with regard to payment for MNT. Accepting assignment means: ☐ RD must accept Medicare *approved* payment as payment in full for MNT. ☐ RD must collect the co-payment and any unmet deductible from beneficiary. • RD cannot bill beneficiary, or his/her secondary insurance for difference between RD's usual and customary fee and Medicare's approved payment amount. • If the beneficiary has secondary insurance, that policy *may* cover Medicare deductible and/or coinsurance amounts
Billing Medicare Part B For Non-Covered MNT	• Medicare Part B *cannot* be billed for non-covered MNT, nor can RD bill Medicare for non-covered MNT as "incident to physician's services". • Only client may be billed for MNT that is not currently covered under Part B. • If client has secondary insurance, he/she may submit claim to insurance; plan may/may not cover the MNT.
When RD Does Not Become Medicare Provider	• If RD does *not* become Medicare provider, she/he *cannot* ***furnish*** covered MNT benefit to Medicare beneficiaries; RD should refer beneficiary to RD who is Medicare provider. • RD who does *not* become Medicare provider cannot bill Medicare. • If RD still wishes to ***furnish*** MNT for diabetes or non-dialysis kidney disease to Medicare beneficiaries, RD must **opt out** of Medicare by entering into a private contract with each beneficiary: • CMS delineates regulations for opting out • Opt out period is for two years. • RD must fully understand all ramifications of opting out. • The American Dietetic Association's web page includes additional details on opting out; Medicare carrier's web pages may also provide opt out information.

By: Mary Ann Hodorowicz, RD, LD, MBA, CDE…LLC
Author of: *MNT/DSME Reimbursement Manual, EZ Forms for the Busy RD*
maryann@RDLink.com 708-361-1290