The Complete Guide to

Billing and Credentialing Essentials for RDNs

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Academy of Nutrition and Dietetics

INTRODUCTION

Building your practice from the ground up is a rewarding journey that lets you shape your professional path and positively impact your patients' lives. Whether you are a seasoned dietitian branching out on your own or a recent graduate embarking on your entrepreneurial journey, this checklist serves as your roadmap for launching a thriving practice. Each step of this resource is designed to guide you through the process with clarity and efficiency.

This guidebook should not be construed as legal advice and the Academy of Nutrition and Dietetics does not guarantee that all recommendations can be utilized in all states, with all payors or within all situations. Dietitians should seek guidance from an experienced health care attorney. When setting up your private practice, an experienced health care attorney can provide guidance on business structure, insurance contracts, and ensure compliance with state and federal regulations.

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Establishing a Practice

An accountant can offer valuable assistance in financial planning, budgeting, tax preparation and bookkeeping, ensuring financial stability and compliance with accounting standards. By seeking advice from these professionals, RDNs can make informed decisions, minimize risks, and establish a solid foundation for their practice's success.

The comprehensive checklist below will help you navigate the process of establishing a business with confidence and success. More details on each of these steps follow the checklist for valuable insights and strategies for a successful practice.

Business Establishment

- Identify a lawyer and an accountant to advise you
- Identify a business coach or mentor who can provide you with support and be an on-the-ground resource
- Determine the legal structure of your practice (e.g., sole proprietorship, partnership, LLC) and register your business with the appropriate authorities
- Apply for a Tax Identification Number (TIN)
- Familiarize yourself with Form W-9

Licensing and Credentialing

- Obtain all necessary professional licenses and certifications required to practice in your state
- Apply for National Provider Identifier (NPI)
- Complete credentialing and contracting processes with insurance companies and government payers

Practice Management

- Set up necessary infrastructure, including counseling rooms, waiting area, administrative office and equipment (e.g., scales, stadiometers, computers)
- Implement electronic health record (EHR) and practice management software for scheduling, billing and patient records
- Establish policies and procedures for patient scheduling, registration, billing and confidentiality, including HIPPA compliance and data security protocols
- Develop a fee schedule and billing policies, including accepted payment methods and insurance participation

Compliance and Regulatory Requirements

- Ensure compliance with federal, state, and local regulations governing health care practices, including HIPAA, OSHA, and Stark Law
- Stay informed about changes in health care laws and regulations that may affect your practice

Insurance and Risk Management

- Obtain professional liability insurance (malpractice insurance) to protect your practice against potential lawsuits
- Review and update insurance coverage for property, general liability and business interruption
- Implement policies and procedures to mitigate risks related to patient safety and billing errors

Patient Care and Quality Improvement

- Follow clinical protocols and practice guidelines to ensure high-quality patient care and adherence to evidence-based practices
- Implement patient satisfaction surveys and feedback mechanisms to assess patient experience and identify areas for improvement
- Continuously evaluate and update clinical practices and procedures to enhance patient outcomes and satisfaction

Business Establishment

Embarking on your journey to establish a nutrition practice begins with a crucial step: determining the legal structure that best suits your business goals and needs. Two main structure options are highlighted below. Keep in mind that it is best to consult with an accountant and lawyer to determine the best structure for your business.

Choosing your business structure

- Sole Proprietorship: A sole proprietorship is an unincorporated business owned and run by one individual with no distinction between the business and the owner. You may not need to take formal steps to establish one, but obtaining necessary licenses and permits may be required based on your business activities and location.
  - Use the U.S. Small Business Administration's Licensing & Permits Tool to find a listing of federal, state and local permits, licenses and registrations you will need to run a business. In fact, you may already own a sole proprietorship without knowing it. For example, you may be conducting business as *Jane Smith, RDN* (under the individual name) or as *Nutrition Innovations* (under the business name). If you choose a different business name, you will need to file for a fictitious name also known as a "doing business as" (DBA) name. Many sole proprietorships use the owner's social security number for financial matters. While you receive all profits, you're also personally liable for business debts and lawsuits due to the lack of legal separation between you and your business.
  - As a sole proprietor, any business income you earn is considered personal income when you file your taxes. It is your responsibility to withhold and pay all income taxes related to your business.
- Limited Liability Corporation (LLC): An LLC is a hybrid business that marries some of the features of a corporation with some of the features of a sole proprietorship. Forming an LLC allows you to put a "wall" up between your personal assets and your business assets. The income you earn from your LLC is treated as personal income, just like it is if you are a sole proprietor. However, unlike a sole proprietorship, if you are registered with the government as an LLC, your business assets and liabilities are legally separated from your personal assets and liabilities. There is some additional work that comes with creating a corporation such as some annual paperwork, separate tax returns, and additional accounting costs, but the protection is worth the extra effort. Speak with your accountant, business advisor, or lawyer to determine the type of business entity that is best for you.
  - The type of business you select determines which income tax return form you must file. By setting up your business as a separate entity (incorporating), you may be able to reduce your personal tax rate. The IRS has a tool explaining the differences between a sole proprietorship and a corporation.
  - If you create a corporation, your company will have a separate tax ID number called an Employer Identification Number (EIN). You will need an EIN only if you are in a private setting.
  - A tax ID number is not required if you operate a sole proprietorship or an LLC with no employees, in which case you can use your own Social Security Number as a tax ID if you decide not to obtain an EIN. Read more about EINs below.

Creating an EIN

An EIN is a nine-digit number that the IRS assigns in the following format: XX-XXXXXXX. It is used to identify the tax accounts of employers and certain others who have no employees. The IRS uses the number to identify taxpayers that are required to file various business tax returns. Applying for this number is a free service offered by the IRS.

How do you know if you need an EIN?

Any person (or entity) that files taxes needs an identification number of some kind. When you work for someone else, your social security number is used.

If you are going to employ workers, you are generally required to withhold, deposit and report employment taxes. To file the various tax returns, including employment tax returns, you need an EIN. However, a sole proprietor may use his or her social security number in lieu of an EIN if the business has no employees and is not required to file excise, employment, alcohol, tobacco, or firearms returns.

Where/How do you get an EIN?

There are four ways to apply for an EIN, as detailed on the IRS website. The two most common ways to apply:

1. The online EIN application is the preferred method for customers to apply for and obtain an EIN. Once the application is completed, the information is validated during the online session, and an EIN is issued immediately. The online application process is available for all entities whose principal business, office, agency, or legal residence (in the case of an individual) is located in the United States or U.S. Territories. The principal officer, general partner, grantor, owner, trustee, etc., must have a valid taxpayer identification number (social security number, employer identification number, or individual taxpayer identification number) to use the online application.

2. You may obtain an EIN immediately by telephone five days a week, Monday through Friday, from 7 a.m. to 7 p.m. (local time), by calling the IRS at 800–829–4933.

Obtaining an NPI

What is an NPI?

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) mandated that a unique health identifier be created for each health care provider. The Department of Health and Human Services (HHS) released a final rule adopting the National Provider Identifier (NPI) as that unique number and began the implementation.

The NPI is a unique, 10-digit, identification number for health care providers, practitioners, and suppliers of health care services. Much like a social security number, your individual NPI does not change and remains with you, the provider, regardless of changes to your job, location, or name. It is your responsibility to maintain and update the information associated with your NPI to make sure that it is accurate. Each time you apply to become credentialed, you will need to provide your individual NPI, which indicates your provider taxonomy, or classification. More information about NPI taxonomies and classifications.

All HIPAA-covered entities are required by law to obtain an NPI for the transmission of electronic health information. Additionally, an individual provider may still be required to obtain an NPI even if they do not meet the criteria of a HIPAA-covered entity. The National Plan and Provider Enumeration System (NPPES) was developed by the Centers for Medicare & Medicaid Services (CMS) to assign these unique identifiers to individuals and organizations who meet the definition of health care provider or supplier. All RDNs – even those working in settings where they bill incident – should have an NPI and ensure that it is listed on the claim form in either the rendering provider or billing provider NPI box.

What is the NPI used for?

The purpose of the NPI is to uniquely identify a health care provider in standard transactions, such as in coordination of benefits between health plans, in health care claims and medical record systems.

- Each time you verify client/patient benefits or file a claim, you will need to provide your NPI number and/or tax identification number, which may also be required for use in electronic health record systems.
- Payers and other stakeholders can identify provider types, including specialists, through NPI specialist taxonomies. **Ensuring that an RDN's NPI is listed as a rendering provider, even when billing incident to, is crucial for accurate attribution and outcome measurement.**
- The NPI is also an important means of demonstrating a viable workforce of qualified providers to payers and other external stakeholders.

Is there a fee to obtain an NPI?

There is no fee to obtain an NPI.

How long will it take to get an NPI?

The online process will usually issue an NPI number within minutes, but it may take up to 10 days from the time you apply to get a return email with your NPI number. Completing the process through the mail will take longer.

Tips to expedite your NPI online application:

- *User IDs cannot be changed.* Once you have successfully chosen a user ID, secret question/answer combination, and submitted the record, the user ID and secret question/answer combinations will remain tied to your record.
- Use the application's navigation buttons, **Next or Previous**. Do NOT use the browser's Back and Forward buttons.
- If you have a problem with the system and cannot continue, wait 20 minutes before logging on again.
- Once you reach the application submission confirmation page, click on the "View Printer Friendly version" of application button to print a copy of the application for your records.
- Make sure you have plenty of time to complete your application. If you leave before your application is complete, you will have to start over.

Where can I apply for an NPI?

To learn more about how to apply for an NPI visit: https://nppes.cms.hhs.gov/.

NPI Entity Type

There are two NPI entity type codes, one for individuals and one for organizations. All billing providers need an Entity Type 1, but not all providers need an Entity Type 2, unless they own a corporation/organization that renders health care services that they would be billing under.

Entity Type 1: Individuals who render health care services, e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists, and RDNs.

- **ALL RDNs should obtain an Entity Type 1 NPI for professional purposes**. This allows you to render health care services for an organization such as a hospital, home health care agency, medical practice, or pharmacy.
- Individuals may also work as a sole proprietor, which means that you work for yourself, i.e. private practice.

Entity Type 2: Organizations that render health care services or furnish health care supplies to patients. Examples include: hospitals; home health agencies; ambulance companies; health maintenance organizations; durable medical equipment suppliers; pharmacies; diabetes prevention programs; and corporations formed when an individual incorporates, such as an RDN's private practice or group.

Incorporated individuals may obtain NPIs for themselves (Entity Type 1 Individual) and may also obtain NPIs for their corporations (Entity Type 2 Organization).

Organization health care providers may be solely owned corporations, meaning you may still work for yourself, but your business is a legal corporation that you work for.

All RDNs should obtain an NPI for professional purposes.

There is no cost or consequence of having an NPI. An NPI allows CMS and other stakeholders to determine if there is a sufficient number of providers, which is a critical factor in the consideration of expansion of health insurance benefits and/or coverage.

NPIs may be a required component of provider profiles for some electronic health records.

Completing the NPI Application

Step 1: Before you begin, **make sure you have the information in the table below**. This information will be required to complete the **NPI** application form.

Step 2: Read the statements on the NPPES website about truthfulness, verification and privacy.

Step 3: Begin the online application; you will not be able to save your work if you quit before you have completed it. Allow approximately 30 minutes to complete the application.

Information Required for Individual Providers (Entity Type 1 NPI)	**Information Required for Organizations (Entity Type 2 NPI)**
• Provider name • Social security number • Provider date of birth • Country of birth • State of birth *(if country of birth is US)* • Provider gender* • If the provider is a Sole Proprietor • Mailing address • Practice location address* and phone number • Taxonomy (provider type) (Note: registered dietitians and registered dietitian nutritionists should select the provider type "Registered Dietitian - 133V00000X") • State license information (Your license number from the State Board of Dietetics, *if applicable*) • Contact person name • Contact person phone number and e-mail	• Organization/business name • EIN (if you have one registered with the Internal Revenue Service [IRS]) • Name of authorized official for the organization • Phone number of authorized official for the organization • Organization mailing address • Practice location address* and phone number • Taxonomy (provider type; ***see notes below on taxonomy***) • Contact person name • Contact person phone number and e-mail

*Beginning April 3, 2024, NPPES will allow providers to use a post office box as their practice location address if they do not have a physical office other than their home. Additionally, NPPES will have more gender options available. These new options include "X – Unspecified or Another Gender Identity" and "U – Undisclosed."

Taxonomy and Specializations

RDNs should select "Registered Dietitian". Select the general taxonomy (Dietitian, Registered - 133V00000X)) along with as many of the specializations as is appropriate. If you have a current CDR Board Specialist Certification you may want to also select it from the list. Some RDNs may also be other types of providers, and be able to select other NPI taxonomies, as applicable.

Dietary and Nutritional Service Providers:

- Dietetic Technician, Registered – 136A00000X
- Dietitian, Registered – 133V00000X
  - Nutrition, Gerontological – 133VN11101X
  - Nutrition, Metabolic – 133VN1006X (Note: This certification is no longer available through CDR)
  - Nutrition, Obesity and Weight Management – 133VN1201X
  - Nutrition, Oncology – 133VN1301X
  - Nutrition, Pediatric – 133VN1004X
  - Nutrition, Pediatric, Critical Care – 133VN1401X
  - Nutrition, Sports Dietetics – 133VN1501X
  - Nutrition, Renal – 133VN1005X

Deactivation of your NPI

Contact the NPI Enumerator if you want to deactivate your NPI. Reasons for deactivation might include retirement, business dissolution, or death of the health care provider.

The NPI Enumerator staff can assist health care providers with questions regarding the processing of an NPI application or deactivation of an NPI.

The NPI Enumerator may be contacted as follows:

By phone: 1-800-465-3203 (NPI Toll-Free)

1-800-692-2326 (NPI TTY)

By email: customerservice@npienumerator.com

By mail: NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

For more information about NPI numbers, visit the Academy's webpage: www.eatrightpro.org/npi.

Selecting an Electronic Health Record (EHR)

EHRs offer significant benefits for health care providers, enhancing efficiency, accuracy, and collecting quality measures. By automating administrative tasks like appointment scheduling and billing, EHRs can save you time and improve productivity.

Furthermore, EHRs enhance communication and information sharing among health care providers, patients, and insurers, improving care coordination; patient portals allow easy access to health information and communication with providers. EHRs also enable data analysis, reporting, and trend identification, enhancing health care outcomes. Additionally, EHRs aid HIPAA compliance by securing patient information with features like access controls and encryption, while streamlining quality metric reporting for regulatory compliance and quality improvement initiatives.

Tips for Selecting an EHR

Choosing the right EHR system for your needs is an important decision for practice owners, as it will shape the way a business manages patient records and streamlines operations. Here are some key tips to keep in mind when selecting an EHR:

- **Assess your practice's needs:** Identify your practice's specific requirements, including workflow processes, specialty-specific features, and integration capabilities with existing systems.
  - Can you create forms specific to your practice's needs?
  - Does the EHR connect with other applications you use such as health apps or Remote Patient Monitoring tools?
  - Are you able to submit claims from within the EHR?
  - Can you send invoices electronically and take credit card payments from within the system?
  - Are patients able to upload their insurance cards and driver license securely?
- **Evaluate usability:** Choose an EHR that is intuitive and user-friendly for both clinicians and staff. Consider factors such as ease of navigation, customization options, and training requirements.
- **Ensure interoperability:** Select an EHR that can seamlessly integrate with other systems and interfaces, such as health information exchanges (HIEs), to facilitate data sharing and care coordination.
- **Check certification:** Verify that the EHR is certified by an authorized certification body, such as the Office of the National Coordinator for Health Information Technology (ONC). Certification ensures that the system meets specific standards for functionality, security, and interoperability.
- **Review vendor reputation and support:** Research the EHR vendor's reputation, reliability and customer support services. Read reviews, use the Payment and Reimbursement Advocacy Affinity Group to request references from current users, and inquire with the vendor about training, technical support, and system updates.
- **Assess security measures:** Prioritize data security and privacy by selecting an EHR with robust security features, such as encryption, access controls, audit trails, and regular security updates. Ensure compliance with HIPAA and other regulatory requirements.
- **Consider cost and return on investment (ROI):** Evaluate the total cost of ownership, including upfront expenses, ongoing maintenance fees, and potential ROI. Calculate the financial benefits, such as increased efficiency, reduced paperwork, and improved reimbursement rates, to determine the system's value proposition.
- **Test before committing:** Request demonstrations or a trial period to test the EHR's functionality, usability and compatibility with your practice needs before making a final decision.

Establishing Policies and Procedures for Your Practice

Before opening your doors to patients, it's essential to establish robust policies and procedures to ensure smooth operations and compliance with legal and ethical standards. Here are key areas to consider:

1. Patient Scheduling: Develop a systematic approach to patient scheduling to optimize clinic efficiency and provide excellent patient care. Consider factors such as appointment types, locations, (virtual vs in-person), duration and availability. Utilize your EHR to streamline the process and minimize scheduling conflicts.

2. Patient Registration: Create standardized procedures for patient registration to gather essential demographic and insurance information accurately. Develop intake forms that capture pertinent details while maintaining patient privacy and confidentiality. Train staff on efficient registration procedures to expedite the check-in process. To address fraud concerns, you will need to collect a copy of the patient's **insurance card** (front and back) along with a copy of their **driver's license** or another photo ID at the time of registration to help ensure the individual presenting the insurance card is indeed the patient.

3. Billing Practices: Establish clear billing practices to ensure accurate and timely invoicing for services rendered. Create a schedule outlining service fees, accepted insurance plans and payment options. Implement procedures for claims submission, including coding accuracy, and timely follow-up on outstanding balances. Regularly review billing processes to identify and address any inefficiencies or errors.

4. Confidentiality and HIPAA Compliance: Maintain strict adherence to patient confidentiality and compliance with HIPAA regulations to safeguard patient information. Develop comprehensive policies and training programs to educate staff on privacy practices, data security protocols, and HIPAA requirements. Implement safeguards such as secure EHR systems, encrypted communication channels, and physical security measures to protect patient data from unauthorized access or disclosure.

5. Data Security Protocols: Implement robust data security protocols to safeguard patient information from cybersecurity threats and breaches. Regularly update software systems and security patches to mitigate vulnerabilities. Conduct regular risk assessments and audits to identify potential security gaps and address them promptly. Educate staff on best practices for data security and provide ongoing training to promote a culture of compliance and vigilance.

By establishing comprehensive policies and procedures for patient scheduling, registration, billing and confidentiality, including HIPAA compliance and data security protocols, you lay a solid foundation for a successful and ethical practice. Prioritize adherence to legal and ethical standards to build trust with patients and stakeholders while mitigating risks to your practice's reputation and viability.

Professional Liability Insurance

Another way to help mitigate risks is with professional liability insurance. No matter how carefully you perform your job, the activities you are involved in daily can put your career and financial stability on the line, making professional liability coverage crucial for practitioners. Most health plans also mandate this coverage for network providers. Professional liability insurance is available through several vendors.

Membership to the Academy of Nutrition and Dietetics provides access to professional insurance discounts. There is an annual cost of a few hundred dollars a year for this policy based on employment status, work hours and coverage needs, but the protection is invaluable. Additional coverage for property and employees can also be added to the RDN's professional liability plan. When applying for liability insurance, make sure to allow a buffer for the number of hours you work. If you offer services beyond MNT or sell items such as supplements, discuss this with your professional liability provider, as this could void your policy, or you may need an additional rider for these services.

Telehealth Professional Liability Insurance

Professional liability insurance typically covers RDNs for alleged failures in providing professional services, which usually includes telehealth, but RDNs should not assume all carriers offer telehealth coverage or coverage across state lines; if not covered, an additional rider may be necessary, especially if practicing in multiple states, and RDNs should verify coverage with their carrier and inquire about the need for a rider, as state laws vary, and should review coverage annually. Keep in mind, RDNs must be licensed in the state(s) in which the patient is receiving services, where licensure is applicable.

As essential as liability insurance is for protecting your practice, it is equally crucial to ensure that your focus extends beyond risk management to encompass both quality management and patient care.

In your journey as a provider new to private practice, adhering to clinical protocols and practice guidelines is paramount to delivering high-quality patient care. By following evidence-based practices, you ensure that your patients receive the best possible treatment tailored to their needs. It is crucial to continuously evaluate and update your clinical practices and procedures to stay current with advancements in health care and improve patient outcomes and satisfaction. Embrace a culture of lifelong learning and improvement, seeking feedback from patients and colleagues, and remaining open to innovation and change. By prioritizing continuous evaluation and refinement of your clinical practices, you position yourself to provide exceptional care and foster lasting relationships with your patients.

Having laid the groundwork for your practice establishment, it is now time to pivot our focus towards credentialing. Credentialing is an important step in gaining recognition and legitimacy within the health care community, allowing you to participate in insurance networks and serve a broader patient base.

Credentialing and Contracting

Why become credentialed?

Credentialing with insurance companies benefits RDNs in several ways. It expands their client base, enhances visibility, and legitimizes their practice within the health care community. Being part of insurance networks also enables the evaluation of health outcomes through claims data, offering valuable insights into nutrition interventions' effectiveness. Overall, becoming credentialed allows RDNs to expand their practice, improve client access, and contribute to community health and wellness by providing essential covered services.

The credentialing policies of insurers and other payers vary. Many payers do credential individual RDNs, but some do not. In some instances, payers may only credential providers in group practices (could be a group nutrition practice or other type of practice) or facilities, clinics, and practices that have RDNs.

Insurers are required to verify that RDNs selected to participate in their network are qualified and possess required credentials (e.g. RD/RDN), license (if applicable), degrees, professional liability coverage, and a clean criminal record.

To begin, you will need to credential with the insurance company in your state or region. This is where you will file all claims and handle payment disputes. Some insurers may require RDNs to request in writing before submitting a credentialing application. The timeline for credentialing varies by payer, ranging from 30 days to several months, so it is essential to inquire about each payer's process. State laws may also impact processing times, so contacting your state's Department of Insurance can provide specific timelines.

Most insurance companies require providers to complete a Council for Affordable Quality Healthcare (CAQH) profile to begin the credentialing process.

What is CAQH?

The CAQH Provider Data Portal streamlines the credentialing process for health care providers offering a centralized platform where providers can create a comprehensive profile and share it with multiple health plans or payer organizations. This eliminates the need for repetitive submissions, allowing providers to complete one form for all participating insurance carriers and control who receives their information.

Benefits of CAQH participation include:

- Time savings by eliminating redundant form-filling across multiple health plans.
- Reduced paperwork and streamlined credentialing and updates online.
- Current practice information maintenance without repetitive form submissions.
- No cost for the service.

Upon completing your CAQH profile, you receive a personal CAQH number. This number may be required when requesting to join an insurer's network. If accepted, the insurer coordinates with CAQH for data sharing.

Each time you would like to credential with a new insurance company, you will provide them with your personal CAQH number and allow them access. Insurance companies may also require you to complete/provide supplemental information. Each time you apply with a new insurer through CAQH, you will update your application with the credentialing data review and attestation.

To maintain your provider information, re-attest every so often via the CAQH Provider Data Portal. Log in, check for any necessary document updates, and upload them. Update information like liability insurance annually or upon policy changes, and state licensure annually if applicable. Remember to save changes made in the "manage information" section. Failure to re-attest may prompt insurers to request credentialing materials directly from you.

It is important to safeguard your CAQH username and password and refrain from sharing it with others including your employer. Utilize the practice management feature within CAQH to facilitate updates to your profile. Sharing login credentials poses a security risk and may result in unauthorized access to sensitive provider information. By utilizing the practice management feature, you can maintain control over who has access to your CAQH profile while ensuring that necessary updates are made efficiently and securely.

For more information on CAQH please view the resources below:

CAQH Provider Data Portal for Providers User Guide

CAQH Provider Data Portal Practitioner Quick Reference

W-9 Form (Request for Taxpayer Identification Number and Certification)

Insurers typically require a Form W-9 for credentialing or out-of-network provider payments. The W-9, provided by the IRS, is not filed with the IRS but is collected by insurance companies. Find the form and instructions on the IRS website and complete it for CAQH and each insurer you credential with.

Completing the W-9 Form

If your EIN was established as an individual using your social security number, you will list your individual name as shown on your income tax return on the "name" line and your address. You may also enter your business, trade, or "doing business as (DBA)" name on the "business name" line. If your business was established as an LLC or an organization using an EIN, you will list your business name as shown on your income tax return on the "name" line.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

Dietitians Legal Business Name

2 Business name/disregarded entity name, if different from above.

Assumed or Doing Business As Name

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . ____

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ____

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ____

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) ____

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

000 Business Street

Requester's name and address (optional)

6 City, state, and ZIP code

City, State 00000

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

0 0 – 0 0 0 0 0 0 0

Form 1099 Miscellaneous

Once you complete a W-9 form with an insurance company, you will receive a 1099 form at the end of each year, reporting any payments made to you in the course of business. This is like your W-2 form that you may receive from your employer for your taxable income. All income must be reported to the IRS.

How do you know with which insurance companies you would like to become credentialed?

As RDNs, navigating through different payor networks can feel like diving into a sea of options. You've probably heard of Fee-for-Service Government Programs like Medicare or Medicaid, as well as Health Maintenance Organizations and Preferred Provider Organizations. But there is a whole world of other payor types out there that might not be as familiar to you, including:

- **ERISA Self-Funded Employee Benefit Plan/ Union Trust**: This is an employer-sponsored health benefit plan where the employer bears financial responsibility for the overall cost of care, rather than an insurer.
- **Exclusive Provider Organization (EPO):** EPOs function similarly to PPOs but require members to receive services exclusively from participating providers.
- **Point of Service (POS):** A POS plan is a blend of PPO and HMO features. It offers the flexibility of a PPO while maintaining cost controls. For instance, POS plans may cover services provided by non-preferred providers (typically specialists), but only with a referral from a primary care physician.

RDNs should consider your existing payor mix, patient population, and MNT coverage offered by plans and employers in addition to the benefits of in-network status and operational considerations, such as whether the practice's administrative processes align with payor requirements such as claim submissions, verifications, data sharing, and outcomes metrics.

The first step is to identify which insurance companies have a presence in your geographic area or larger market space. If you work for a clinic, the practice manager or billing personnel should be able to help you understand the payer mix of the patient population at any given time.

If you are in private practice, one option is to contact local primary care practices to see which insurances they accept. Practices may list the insurance plans accepted on their websites. Referring physicians and other providers will want to refer patients to RDNs who are in-network with their patients' insurance. Because each payer has different policies for credentialing, plan types with different benefits packages for its members, nutrition counseling guidelines, and claims submission (billing) guidelines, understanding all of these variables – and understanding provider agreements – is critical to securing payment for the services provided.

Contracting/Network Management and Provider Services/Relations

In the credentialing process, different personnel from the insurance company or payer are involved, including provider services/relations representatives, coordinators, and contracting/ network management staff. For individual credentialing, work with a provider relations team member to finalize your agreement. For organization-based credentialing, coordinate with your practice administrator to start the process and assess existing contracts' impact on payment.

A provider services/relations representative will assist with completing your contract and addressing reimbursement queries. It is essential to carefully review your provider agreement, detailing payment for CPT® codes and their rates. Payment terms can be negotiable, either initially or in subsequent years, and updates may be needed for new CPT® codes. For more information about CPT® codes that may be used by RDNs visit the Academy's website.

When reading a payor contract there are several key points to pay close attention to:

1. Always obtain a complete copy of the insurance contract for thorough review.
2. Note the contract's expiration date to avoid any lapses in coverage.
3. Understand the coverage provided under contracted plans for MNT services.
4. Review the reimbursement rates for different services provided, place of service, and plan types.
5. Identify the circumstances under which either party can terminate the contract and review any restrictions on patient solicitation post-termination.
6. Determine if there are any provisions allowing the RDN to opt out of specific plans or products.
7. Understand how the insurance company notifies about changes to the contract and the timeframe for such notifications.
8. Clarify payment timelines, methods, submission requirements, and associated fees. These may be subject to state law.
9. Determine the procedures for audits.
10. Understand the process for contract amendments and any unilateral changes the insurance company can make.
11. Review the dispute resolution process including timeline, costs, mediator/arbitrator selection, and the bindingness of arbitration.

As your contract is negotiated or renegotiated, consider trends or new information that might inform the scope of services you would like to be able to provide, the reimbursement rate (fee for service), or the use of other payment arrangements with the payer (e.g. Alternative Payment Model arrangement such as a bundled payment). Examples of new information might include adjustments made to the Medicare Physician Fee Schedule, other considerations in your local market, or studies showing the cost-effectiveness of RDNs (e.g., The MNTWorks Toolkit).

Once you have completed your contract, you will work with provider relations and your Electronic Health Record (EHR) vendor to establish electronic explanation of payments (EOP) and the ability to receive electronic funds transfers (EFT). This will be discussed further under "Filing Insurance Claims."

Procedure Codes and Diagnosis Codes

Procedure Codes

Procedure codes fall into two main categories: Common Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes. CPT® codes, created by the American Medical Association, encompass a wide range of diagnostic and therapeutic procedures performed by health care professionals. These codes serve as the standard for reporting medical services and are widely adopted by insurers. On the other hand, HCPCS codes, established by the CMS Alpha-Numeric Editorial Panel, primarily cover items, supplies, and non-physician services not included in CPT® codes. Two common HCPCS code types are S Codes and G Codes.

Medicare, Medicaid, and private insurers utilize both CPT® and HCPCS codes for claims processing. We will review both types of codes below.

It's important to note that each CPT© code has specific criteria that must be met in order to use the code accurately. When coding, it is the provider's responsibility to ensure that the billing code used matches the service delivered. Coding for a service that did not occur is considered fraud and can have serious consequences. Specifically, for RDNs it is essential that the appropriate MNT code is used to accurately reflect the service provided. RDNs should not use another code the describe the provision of MNT.

MNT CPT ® and HCPCS Codes

The MNT CPT® codes are recognized and used by Medicare, most private insurance companies, and Medicaid in some states. These codes best describe the MNT services that registered dietitian nutritionists provide to patients. RDN provider agreements should identify the CPT® codes that the RDN should use to submit claims. Check payer policies for additional information.[1]

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

97803: reassessment and intervention, individual, face-to-face with the patient, *each 15 minutes*

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

G0270-G0271: MNT Reassessment

Private payers may or may not use G codes for MNT. For Medicare, the following G codes (G0270 or G0271) are to be used when additional hours of MNT services are performed beyond the number of hours covered, (three hours in the initial calendar year, and two follow-up hours in subsequent years with a physician referral) when the treating physician determines that additional MNT is medically necessary and has provided the RDN with a new (additional) referral within the same calendar year.

> **G0270**: Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, *each 15 minutes*
>
> **G0271**: group (2 or more individual(s)), *each 30 minutes*

The same CPT® codes are used when MNT is delivered via telehealth. For more information about MNT delivered via telehealth, visit www.eatrightpro.org/telehealth.

The minutes of face-to-face time with the client determine the number of units that can be submitted on a claim.

For RDNs providing Diabetes Self-Management Training (DSMT) as part of an accredited program, the following G codes should be used for billing.

> **G0108**: DSMT services, individual, *per 30 minutes*
>
> **G0109**: DSMT services, group session (2 or more), *per 30 minutes*

These codes may be used by approved suppliers of a Medicare Diabetes Prevention Program (MDPP) providing services to eligible beneficiaries with Medicare Part B coverage.

> **G9873-85**, **G9890** and **G9891**: MDPP services; for information about MDPP services, supplier enrollment, and billing codes, visit the Academy's MDPP page.

Effective January 1, 2025, RDNs can provide and bill for Direct Caregiver Training Services (CTS) under Medicare.

> **G0541-03**: CTS services; for information about CTS services and billing codes, visit the Academy's CTS page.

Additional Codes Recognized by Medicare:

RDNs may be qualified to provide the following services under Medicare when the service is billed 'incident-to' a physician or qualified health care provider; these codes may also be recognized by some private payers. Refer to individual payer policies for use of code and specific coverage parameters.

> **G0438-39**: Annual Wellness Visit
>
> **G0136:** Assessment Social Determinants of Health *(billable when completed as part of the AWV)*
>
> **G0446:** Intensive Behavioral Counseling for Cardiovascular Disease
>
> **G0447** and **G0473**: Intensive Behavioral Therapy for Obesity*

* for additional resources regarding IBT for Obesity see page 78 .

G0511: General Care Management (exclusively for use by rural health clinics and federally qualified health care centers)

G0019 & G0022: Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner

G0023 & G0024: Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator

Additional CPT® Codes within an RDN's Scope of Practice

While many insurers recognize the MNT CPT® codes, there are additional services that an RDN can provide that may fall within an RDN's scope of practice, and for which a private payer could elect to pay RDNs to provide. Please note that the CPT® code would need to be included in the RDN provider agreement/contract for an RDN to submit claims and be eligible for any payment.

0403T and **0488T:** Diabetes Prevention Programs

0591T-0593T: Health and Well-being Coaching

94690: Oxygen uptake, expired gas analysis; rest indirect (separate procedure)

95249-95250: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours

98960-62: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family). Per the CPT® Manual, educational and training services must be provided "using a standardized curriculum to an individual or a group of patients for the treatment of established illness(s)/disease(s) or to delay comorbidity(s). This curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual patient(s)…The content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, non-physician health care professional society/association or other appropriate source."

98966–68: Telephone assessment and management service provided by a qualified nonphysician health care professional

98970-98972: Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days

99366 and **99368**: Medical team conference, with and without the patient and/or family

99401-04: Preventive medicine counseling and/or risk factor reduction intervention(s)

99411-12: Preventive medicine counseling and/or risk factor reduction intervention(s)

99406-07: Smoking and tobacco use cessation counseling visit

99487 and **99489**: Complex chronic care management services

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

S-codes and G-Codes

Private insurers use S codes to report drugs, services, and supplies that lack national codes but are necessary for policy implementation, programs, or claims processing. An example is S9470 (Nutritional counseling, dietitian visit), used before MNT CPT® codes were available. **Medicare does not reimburse for S9470, and this code is not valued under the AMA RVS Update Committee (RUC)**. Submitting claims with S9470 poses underpayment risks when spending extended time with a client. Unlike MNT CPT® codes, S9470 is not time-based. Providers may receive only one unit of payment even after spending four units of time with a patient. Furthermore, S codes lack a universally accepted definition for service levels or elements, failing to accurately represent the value of medical nutrition therapy (MNT). Furthermore, in most instances, the S9470 may not be separately billable. RDNs should clarify usage conditions, payment rates, and negotiate terms in the provider agreement if a payer uses S9470 without MNT CPT® codes.

Medicare uses G codes to identify professional health care procedures and services that lack specific CPT® codes. Private payers may also use G codes for similar purposes. G codes like G0270 inform Medicare about extended care beyond standard Part B benefits. If no appropriate CPT® code is available, inquire with the payer about the use of a G code.

Determining the Units of MNT Codes to Report on Claims

RDNs should report the number of units based on the direct time spent providing services to the patient. Pre- or post-visit activities are not billable and should not be included in the reported units of MNT codes on the claim.

A unit represents the direct (one-on-one, face-to-face) time spent with the patient in 15-minute increments for individual MNT (97802/97803) or 30-minute increments for group MNT (97804). This excludes time spent with other office staff for paperwork or assessments, only considering face-to-face time with the RDN.

For CPT® codes 97802 and 97803, providers bill for a single 15-minute unit for visits lasting between 8 and 23 minutes. The coding convention assumes that each unit represents an average of 15 minutes of direct patient contact time. Medicare uses the 8-Minute Rule to determine the billable units for time-based codes. While the Medicare 8-Minute Rule is probably the most-referenced method for calculating billable units, not all payers follow this rule. Many private payers either have no stated policy or follow Medicare's policy. **Best practice is to contact the payer for specific reporting guidelines prior to providing services and billing.**

8 Minute Rule Guidelines

1	unit	>	8	minutes	<	23	minutes	=	15 minutes
2	unit	>	23	minutes	<	38	minutes	=	30 minutes
3	unit	>	38	minutes	<	53	minutes	=	45 minutes
4	unit	>	53	minutes	<	68	minutes	=	1 hour
5	unit	>	68	minutes	<	83	minutes	=	1 hour 15 minutes
6	unit	>	83	minutes	<	98	minutes	=	1 hour 30 minutes
7	unit	>	98	minutes	<	113	minutes	=	1 hour 45 minutes
8	unit	>	113	minutes	<	128	minutes	=	2 hours

Modifiers

A procedure or CPT® code can be further described by using a two-digit modifier which provide additional information to payers for a claim to be processed correctly.

Modifiers GA, GZ, and GY

Beginning in January 2002, Medicare began using GA, GZ, and GY modifiers. These modifiers are *not* generally used with private insurers.

GA is used when the provider expects the claim to be *denied* as not reasonable and necessary for which they have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary.

GZ is used when the provider expects the claim to be *denied* as not reasonable and necessary for which they do **not** have an ABN on file.

GY is used when the provider expects the claim *does not meet the definition for a Medicare benefit* and the provider does **not** have an ABN on file. Because Medicare does not cover these services or items, the beneficiary is liable for payment. The provider or supplier may use this modifier when a beneficiary needs Medicare to deny the claim so that it can be submitted to a secondary insurance that provides coverage for a beneficiary's condition.

Modifier GT – Interactive audio and video telecommunication systems

Some private payers may require use of a modifier when services are delivered via telehealth. It is important to seek clarification regarding their policies. To learn more about telehealth, visit the Academy website.

Modifier 33 – Preventive Services

The CPT® description states that modifier 33 may be used when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Service Task Force (USPSTF) A or B rating in effect, and other preventive services identified in preventive services mandates (legislative or regulatory). For separately reported services specifically identified as preventive, the modifier should not be used.

Modifier 93 – Telehealth modifier defined as "Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system. "

Some Medicare services and some private payers may require use of this modifier when services are delivered via audio-only methods. It is important to seek clarification regarding their policies.

Modifier 95 – Telehealth modifier defined as "synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system"

Some Medicare services and some private payers may require use of this modifier when services are delivered via telehealth. It is important to seek clarification regarding their policies.

ICD-10-CM Diagnosis Codes

The International Classification of Diseases, Clinical Modification (ICD-10-CM) codes are used by physicians and medical coders to assign ICD-10 codes that reflect the medical diagnoses of individual patients. Each health condition is assigned a unique code of up to six characters. These codes are essential for submitting claims to payers, linking the care provided to a patient's condition. RDNs must obtain accurate diagnosis codes to ensure proper billing, coverage and payment. RDNs cannot make or assign medical diagnoses themselves and should obtain this information from qualified medical providers. Assigning a medical diagnosis is regulated and is considered a medical activity. State laws determine those practitioners, other than physicians, permitted to assign a medical diagnosis and allow physicians to delegate medical activities to practitioners under their supervision. For more information, contact your state licensing board.

Ex: E10 Type 1 diabetes mellitus

- E10.2 Type 1 diabetes mellitus with kidney complications
  - E10.21 Type 1 diabetes mellitus with diabetic nephropathy
  - E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease
  - E10.29 Type 1 diabetes mellitus with other diabetic kidney complication

Diabetes mellitus may or may not have complications, which can manifest with specific symptoms or remain asymptomatic. While it is not within the RDN's scope to diagnose, they can provide treatment and should document accordingly.

ICD-10-CM Z Codes

Z codes are a category of ICD-10 codes used to acknowledge factors influencing health status and to report contact with health services. Z codes cover a wide range of situations, such as encounters reporting BMI, dietary surveillance and counseling, and social determinants of health. As Z codes are not diagnostic codes, RDNs can use these codes independently of a physician referral.

Healthy Individuals/No Diagnoses

Some individuals may have MNT/nutrition counseling benefits without needing a medical diagnosis or referral. When self-referring for nutritional counseling without a specific medical diagnosis, such as for wellness or weight counseling, RDNs must confirm benefits and check if a diagnosis or screening code is required for claims. The ICD-10 code "Z71.3 - Dietary Surveillance and Counseling" may be used when a medical diagnosis isn't needed. However, some payers may not accept Z71.3 alone for payment. RDNs should verify individual plan benefits and coverage and seek clarification from the health plan on claim submission requirements.

Preventative Care Benefits

Health insurance companies may have preventative care policies, general nutrition counseling policies, and specific MNT policies. A provider can determine if a benefit falls under a preventative service or under a MNT policy by reviewing the insurer's coverage documents, policy manuals, or contacting the insurer directly. These documents often outline the specific services covered under each category and the criteria for eligibility.

Additionally, the provider can check if the service aligns with preventive care guidelines, such as those provided by the U.S. Preventive Services Task Force (USPSTF), to determine if it qualifies as a preventive service. Preventive care benefits typically cover conditions related to the prevention of cardiovascular diseases and obesity. Sometimes pre-diabetes is also included under preventative care.

Examples of situations where services *might* be covered under a preventive benefit policy include:

- A 40-year-old client presents with prehypertension and is overweight. The client schedules an appointment with a registered dietitian nutritionist. The RDN provides direction to making diet and exercise changes to decrease blood pressure to normal levels.
- A 35-year-old client presents with elevated triglycerides, and mildly increased total cholesterol and LDL-cholesterol and is normal weight. The client has a family history of heart disease. Client is referred to a registered dietitian nutritionist to support making diet and exercise changes to decrease lipid levels.
- A 9-year-old male, borderline overweight (BMI at the 84% percentile), diagnosed with pre-diabetes (normal fasting glucose levels, but Hgb-A1C of 6.0), and a primary relative (father) with type 2 diabetes. Parents are seeking services to prevent progression to type 2 diabetes. A referral is made to a registered dietitian nutritionist for nutrition counseling.

In these cases, the dietitian still provides MNT and follows the nutrition care process, but the focus is on preventing a condition identified by the USPTF.

Each individual health insurance policy is different. **Individual plan benefits and coverage details supersede a payer's general MNT and nutrition counseling policies.** Coding for preventative services can vary between payers. Providers should understand the reimbursement guidelines for nutrition services for each patient's policy, including documentation requirements such as a referral or documented BMI, billing codes, and reimbursement rates.

SECTION IV: Benefits Verification and Coverage

Obtaining Pertinent Medical Information to Verify Benefits

RDNs have various methods to obtain medical information for benefits verification, treatment, and claims submissions. Clients can facilitate information release if no physician referral is needed. If referred by a physician, the physician's office may share information based on HIPAA policy, otherwise, RDNs may request diagnosis information after obtaining patient consent via HIPAA agreement or specific release of information authorization. Having the patient sign the RDN's notice of privacy practices permits coordination of care and billing, including diagnosis verification.

Information Needed for Verifying Patient Benefits and Coverage

When patients are referred or refer themselves for an appointment, you will need the following information to verify insurance benefits. A standard referral page or intake of information is often helpful in collecting the needed information, which should include patient demographic and insurance information. Providers should also obtain secondary or tertiary insurance information as claims are typically submitted to an individual's primary insurance policy first, and then if denied or if a balance remains a claim can be filed with the secondary or tertiary insurance plans.

It is often helpful to request the patient's medical history and/or active health care concerns when the patient is being referred from a physician or other qualified provider. Some individual patient policies may not cover the referring diagnosis but may cover MNT for other conditions that the patient may have. You can follow up with the patient's provider if the patient's reason for referral/diagnosis needs to be updated.

Example: A patient with a third party payer policy may have been referred with ICD-10 code E66.9 (obesity unspecified), but the physician may not have noted that the patient also has diabetes, gastro-esophageal reflux, and hypercholesterolemia.

The policy benefits may only cover MNT for diabetes, but the patient was referred for morbid obesity. The insurance will not pay for the claim if E66.01 is provided as the diagnosis on the claim. The RDN should confirm the diabetes ICD-10 code(s) established by the referring provider, as well as request an updated referral that includes the diagnosis of diabetes.

Verifying Patient Coverage and Benefits

Verifying a patient's insurance benefits for MNT before their appointment ensures cost transparency and guides payment procedures. Whether via online portals or direct contact with the insurance provider, confirming benefits is crucial. Failing to verify coverage may lead to patient responsibility for the bill, complicating payment collection post-service. Addressing denied claims and pursuing payments afterward is time-consuming and impacts cash flow. Verifying benefits beforehand is essential for optimizing financial health and supporting the practice's bottom line. While benefits verification doesn't guarantee payment, it improves reimbursement chances based on coverage details.

Referral Requirements

Some managed care organizations mandate electronic referrals for specialist and ancillary services. Referrals may serve as authorization for patients to receive services from another health care provider, such as an RDN. Obtaining accurate referrals with diagnoses is best practice, as RDNs cannot diagnose medical conditions. Some insurers accept referrals from nurse practitioners or physician assistants, but Medicare requires referrals from treating MDs or DOs.

In-network and Out-of-network Benefits

In-network providers are credentialed with a health plan to serve its members, while out-of-network providers lack such contracts. Out-of-network services may result in higher financial responsibility for insured individuals or lack coverage altogether. RDNs should confirm and understand benefits based on their credentialing status with the patient's insurer.

The No Surprises Act (NSA)

The No Surprises Act became effective January 1, 2022, and aims to shield consumers from unexpected, hefty medical bills that could cause financial strain. It focuses on safeguarding consumers against surprise bills for emergency and non-emergency services from out-of-network providers at in-network facilities, as well as from out-of-network air ambulance services. Providers must furnish patients with a "good faith estimate" of care costs before services, along with clear billing protection notices. Patients can dispute bills exceeding the estimate by at least $400 within 120 days of receipt. To ensure compliance with the law, RDNs need to ensure the following practices are in place for both in-person and telehealth services:

- Verify health insurance coverage prior to the scheduled service.
- For uninsured, self-pay or out-of-network individuals, provide an itemized good faith estimate before the service is scheduled in a way that is accessible to the patient and in the language(s) spoken by the patient(s). Good faith estimates should be prominently displayed (and easily searchable from a public search engine) on your website, in your office, and on-site where scheduling or questions about the cost of services occur.
- Explain the estimate to the patient over the phone or in-person if they request it. Follow up with a written (paper or electronic) estimate.
- Provide a one-page notice and consent document in clear and understandable language that includes:
  - The restrictions on provider regarding balance billing in certain circumstances;
  - Any applicable state law protections against balance billing; and
  - Information on contacting appropriate state and federal agencies in the case that an individual believes a provider has violated the restrictions against balance billing.

Submit provider directory information to health plans to support accurate information for consumers.

Even for patients where the NSA does not apply, RDNs should still have a financial policy that is provided to and signed by every client. The financial policy should explain all practice policies related to fees, patient financial responsibility, and the practice's policies and procedures.

Filing Insurance Claims

Claims submission will vary based on the type of facility you will be billing from. For example, the Health Insurance Claim Form (CMS-1500) is used by allied health professionals, physicians, laboratories and pharmacies to bill supplies and services. However, if you are in an institution (hospitals, rehabilitation centers, ambulatory surgery centers, and clinics), you will bill on a UB-04 form. If you do not own your own practice, you should check with your billing department.

Billing the Insurance Company

You may bill the insurance company for your face-to-face time with the patient. This will be billed using the MNT CPT® codes, in 15-minute increments, referred to as units.

You cannot bill for any equipment, goods, or supplies used in carrying out your services. You may not add these fees, above and beyond the time spent using this equipment, to your charges. If this service is available to the patient above and beyond standard practice, at an additional fee, the provider must provide the patient with notification that these services are not covered and have them sign a release acknowledging that in order to receive these services, they will be at the patient's own expense.

Telephonic and electronic communication are not the same as telemedicine/telehealth, but they are other interventions that can be used by the RDN to improve patient follow up and engagement. Payment for telehealth services can be asked about during the credentialing and contracting process as there may be a separate fee schedule in your provider agreement for services rendered by telehealth. RDNs should follow payer policies for claims submission of services provided via telehealth. For more information about telehealth visit: www.eatrightpro.org/telehealth.

Telephonic and electronic communications can also be asked about in the credentialing and contracting process. If they are not included in your contract, you may bill patients directly for these services as provided for in your provider agreement with the insurer and after the patient has received a written statement of this procedure, or your standard procedure for telephone consultations is posted in your office in a prominent location.

Collection of Fees from Patient

Except for copayments, or when it has been determined that a client/patient does not have any benefit for MNT, a contracted provider shall not require payments from patients prior to receiving a notification (explanation of benefits) of payment from the insurance company, including, but not limited to deductible, coinsurance, or deposit amounts.

Legal Considerations in Collections of Fees: Balanced Billing

Balance billing is when a provider tries to collect payment from a patient/client for the amount that is the difference between a provider's usual and customary rate and the amount paid by the insurance company. For example, if a provider has sets their fees at $150 and the insurance paid $130, the provider will attempt to collect $20 from the patient.

RDNs who become credentialed with a payer and enter provider agreements/contracts are forbidden from using balance billing to collect additional payment from patients. There are some instances where out-of-network providers may be permitted to collect additional payment from the patient, but many states have laws that provide partial or comprehensive consumer protections from balance billing practices. RDNs should understand state laws regarding balanced billing.

Example:

You may bill all patients $37.50/unit for services, which would be $150/hour. This would be your usual and customary charge. This would be the rate that you bill the patient or if the patient has insurance, bill the insurance company.

You may be reimbursed by insurance company A at a rate of $35.00/unit, which would be $140.00/hour.
You may be reimbursed by insurance company B at a rate of $37.50/unit, which would be $150.00/hour.
You may be reimbursed by insurance company C at a rate of $33.00/unit, which would be $132.00/hour.

Reimbursement rates may vary based on fee schedules set by a payer and/or what you are able to negotiate with each payer. RDNs in facilities should work closely with the contracting personnel from their organizations.

During the benefits verification process, RDNs who are out-of-network with a client's plan could take steps to confirm the maximum allowable amount (for 97802, 97803, or 97804) from the payer and request clarification as to whether balanced billing is permitted before agreeing to see a patient. Many EOP and EOB statements will specifically state that collection of additional payment (other than what is already permitted based on patient benefits) is not permitted.

Waiving of Fees

Providers shall not waive any portion of a patient's deductible, coinsurance, copayment, or penalty amount that may be required under a patient's health benefit plan.

Time Limitations for Filing Claims

Check payer policies and state laws to determine when claims must be submitted in order to receive payment.

Usual and Customary Billing Rates

When you bill an insurance company, you will bill for your usual and customary charges. All agencies will be billed the same fee for ALL recipients who receive the same service from you.

Each RDN will want to set their usual and customary billing rates *higher* than their reimbursement rates. If an RDN were to only charge an insurer $100 for a visit and there was an increase in reimbursement of the allowable charge, they would only get paid for the amount they billed. An RDN cannot bill each insurer the individualized contracted reimbursement rate unless it is the same for all insurers; this would mean the RDN would not be billing a usual and customary rate, which is required.

Missed Appointments and Other Fees

Many medical providers or specialists charge a fee for missed appointments and late cancellations (e.g., less than 24-48 hours' notice). Insurance plans do not cover charges for missed appointments; these charges must be billed directly to the patient. The patient must have previously received a written statement of this procedure (in financial policy), or your standard procedure for missed appointments must be posted in your office in a prominent location.

Understanding CMS 1500 Forms

What is a CMS 1500 form?

CMS 1500 is the standard claim form used by a non-institutional provider to bill for services. The CMS 1500 form answers the needs of many health insurers and is the basic form prescribed by CMS for Medicare and Medicaid programs for claims from physicians and suppliers. The CMS 1500 form has space for physicians and suppliers to provide information on other health insurance. It has received the approval of the American Medical Association Council on Medical Services.

Many payers may require providers to file claims electronically unless the provider meets certain exemptions. There are numerous options for submitting claims to payers, including practice management systems or free or low-cost claims clearinghouses. Refer to payer policies. Paper claims are rarely used due to the overwhelming task of processing paper claims. However, you should be familiar with paper claims because some insurers may only accept paper claims if you are not credentialed with them, the claim is a secondary claim, or if the claim must be specially reviewed. Since most paper claims submitted are read electronically using optical character recognition equipment, it is very important that the information is clear and easily read.

When submitting claims for a patient who has health insurance with a national insurance company such as Blue Shield with a plan based in another state, and you have been determined to be a network provider for the patient because you are credentialed with the Blue Shield in your state, you will typically file claims directly with your own state plan. If a client has a health insurance policy from another state, your state or region provider relations or inter-plan department will be responsible for processing the claim in accordance with the subscriber's benefits. Your payment (reimbursement) is determined by the terms of your provider agreement.

Troubleshooting basics if submitting claims by paper:

- Only use an original, red-ink-on-white-paper CMS 1500 claim form which are often available through office or medical supply companies.
- Use black ink to print on the CMS 1500 form.
- Do not print, hand write, or stamp any extraneous data on the form.
- Do not staple, clip, or tape anything to the CMS 1500 claim form.
- Remove pin-fed edges at side perforations.
- Only use lift-off correction tape to make corrections.
- Place all necessary documentation in the envelope with the CMS 1500 claim form.

Format hints:

- Do not use italics or script.
- Do not use dollar signs, decimals, or punctuation.
- Only use upper-case letters.
- Use 10-pica characters and standard dot matrix fonts.
- Do not include titles (e.g., Dr., Mr., Mrs., Rev., or MD) as part of the patient's name.
- Enter all information on the same horizontal plane within the designated field.
- Follow the correct health insurance claim number (HICN) format. No hyphens or dashes should be used. The alpha prefix or suffix is part of the HICN and should not be omitted. Be especially careful with spouses who have a similar HICN with a different alpha prefix or suffix.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use an individual's name in the provider signature field, not a facility or practice name.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

The information below identifies the most requested information required to complete the CMS 1500 form or most online claims programs.

What information is required for a CMS 1500 form?

1) Show the type of health insurance coverage applicable to this claim by marking the appropriate box. For instance, if a Medicare claim is being filed, check the Medicare box. If it is a private insurer, choose "other."

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare#)	☐ (Medicaid#)	☐ (ID#/DoD#)	☐ (Member ID#)	☐ (ID#)	☐ (ID#)	☐ (ID#)

1a) Enter the patient's insurance ID number (this may be listed as Medicare claim number, Medicaid identification number, sponsor's social security number, subscriber ID, ID, identification number, or ID #).

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2) Enter the patient's last name, first name, and middle initial.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3) List the patient's birth date.

MM = Month (e.g., January = 01)

DD = Day (e.g., January 05 = 05)

YY = Two-position year (e.g., 1998 = 98)

Place an "X" on the correct sex/gender.

3. PATIENT'S BIRTH DATE MM | DD | YY	SEX
	M ☐ F ☐

4) List the insured's last name, first name, and middle initial.

This will be the primary insured's information. If the patient is the not the holder of the insurance (subscriber), then the insured name should be listed here.

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5) List the patient's address.

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

6) Place an "X" over the appropriate relationship to insured.

If patient is the primary insured, mark "self."

If patient is married to the primary insured, mark "spouse."

If patient is the child of the primary insured, mark "child."

If patient is a dependent of the primary insured in another format (ex. dependent parent), mark "other."

6. PATIENT RELATIONSHIP TO INSURED

Self ☐ Spouse ☐ Child ☐ Other ☐

7) Enter the insured's address. The telephone number is not required for most payers.

10) In some cases, you will have to note whether the patient's condition is due to employment, accident, etc.

12) The patient or authorized representative must sign and enter either a six-digit date (MM | DD | YY), an eight-digit date (MM | DD | CCYY), or an alpha-numeric date

(e.g., January 1, 1998) unless the signature is on file.

The patient's signature or the statement "signature on file" in this item authorizes release of medical information necessary to process the claim.

Signature by mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________ DATE ______________

13) The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________________

17) This section does not always need to be completed. It only needs to be completed when a referral is required by the insurance policy.

If this section needs to be completed, you will enter a modifier left of the dotted line that indicates whether a provider is referring, ordering, or supervising the service you are providing.

- If referred, you would list DN.
- If ordered, you would list DK.
- If supervising, you would list DQ.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	
	17b.	NPI

Many times, the referring physician is limited to an MD/DO, so check each insurance policy if a referral is required.

To the right of the dotted line, enter the name of the referring, ordering, or supervising provider. Enter the provider's first name, middle initial, last name, and credentials.

If the physician's handwriting is difficult to read, sometimes it is helpful to lookup the correct spelling and NPI on the NPI registry

17a) Leave Blank

17b) Enter the referring, ordering, or supervising provider's 10-digit NPI number.

21) Enter the patient's diagnosis/condition.

Only one code is required. ***Use the highest level of specificity.*** Enter up to 12 diagnoses in priority order.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind.
A.	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

The "ICD Indicator" identifies the ICD code set being reported. Enter "0" to indicate use of ICD-10-CM diagnosis codes.

23) Prior authorization number may need to be listed if required by the insurance company.

24) There are six horizontal service lines in section 24. This will allow you to bill for up to six different services or dates of service. Most insurances will not allow dietitians to bill for more than one service in a 24-hour period. Some insurances have limits on how often you can bill for your services.

24a) Enter a six-digit (MM | DD | YY) date for each service. This will be the same date.

24. A. DATE(S) OF SERVICE From			To		
MM	DD	YY	MM	DD	YY
1					

24b) Enter the appropriate place of service code. According to the 2020 CPT® manual, the place of service code is to be used on professional claims to specify the entity where services are rendered. It is important to check with each individual insurance company to ensure that each policy's covered benefits in locations other than office (11) settings are included. Note that filing as an independent/private practice RDN versus incident to a physician will also affect the benefit coverage. Some potential place of service codes for MNT services include:

Code	Place of Service
02	Telehealth Provided Other than in Patient's Home
04	Homeless Shelter
10	Telehealth Provided in Patient's Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
17	Walk-in Retail Health Clinic
22	Outpatient Hospital
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
54	Intermediate Care Facility/MHMR
55	Residential Substance Abuse Treatment Facility
57	Nonresidential Substance Abuse Treatment Facility
71	Public Health Clinic

B. PLACE OF SERVICE

Note: For Medicare and some private payers, POS 02 (telehealth provided when the patient is at a location other than their home), is paid at the facility rate. POS 10 (telehealth provided when the patient is at home) is paid at the higher non-facility rate.

24d) Enter the procedure code. This may be a CPT® code or HCPCS code**.** Modifiers may be required for some services or for claims to pay in a certain way. For example, a procedure may be considered a medical treatment (and may require a copay from the patient) unless it includes modifier 33 to indicate preventative. This is insurer-specific, so the RDN will need to ask if the modifier is needed to cover the benefit.

D. PROCEDURES, SERVICES, OR SUPPLIES
(Explain Unusual Circumstances)
CPT/HCPCS | MODIFIER

24e) Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. If more than one diagnosis code is indicated, the provider shall reference only one of the diagnoses codes.

E.
DIAGNOSIS
POINTER

24f) Enter the charge for each listed service**.** List dollars to the left of the dotted line and cents to the right. (The fee amount listed below is for illustrative purposes only.)

F.
$ CHARGES

24g) Enter the number of units representing the length of your visit**.**

G.
DAYS
OR
UNITS

24j) Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

I. ID. QUAL.	J. RENDERING PROVIDER ID. #
NPI	

I. ID. QUAL.	J. RENDERING PROVIDER ID. #
NPI	

25) Enter the provider's federal tax ID (employer identification number or social security number) and check the appropriate check box. Tax identification information is used in the determination of accurate national provider identifier reimbursement. Reimbursement of claims submitted without tax identification information may be delayed.

25. FEDERAL TAX I.D. NUMBER SSN EIN

27) Check the appropriate box to indicate whether the provider accepts assignment. If the RDN is credentialed and contracted with a particular insurance agency, they have contracted a rate with them, and you will accept their assigned payment.

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
YES NO

28) Enter total charges for the services (i.e., total of all charges in item 24f). Generally, this number will be the same as the charge for one date of service. If you are completing the CMS 1500 form for more than one date of service for the same patient, this will be the total of all dates of service charges. (The billing charge example below is only for illustrative purposes.)

28. TOTAL CHARGE
$

29) Enter the amount paid from the patient or primary insurance. Either complete with payment or leave blank.

29. AMOUNT PAID
$

31) Enter the signature of the provider of service or supplier, or his/her representative, and the six-digit date (MM | DD | YY) the form was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32) Enter the service facility location. If the RDN only has one location, then the location will be the same every time. If there is more than one location, the RDN will need to specify.

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33) Enter the provider of service/supplier's billing name, address, zip code, and telephone number.

33. BILLING PROVIDER INFO & PH # ( )	
a. NPI	b.

Electronic Claims Submission Services

Payers may not accept paper claims as a part of regular practice. A clearinghouse is an intermediator between the provider/practice and the insurer where the provider can electronically submit claims. The clearinghouse checks for errors and then sends the claims to the appropriate insurer for review.

The benefits of using a clearinghouse are:

- A decrease in paper, ink and postage
- A reduction in errors (many clearinghouse companies catch errors before the claim is submitted based on missing digits, missing information, or by auto-populating claims using previous demographics)
- Claims are sent in a timelier manner (transmitting an Explanation of Benefits (EOB) electronically and often forwarding to a secondary insurer as soon as the EOB is transmitted)

Depending on the provider's claim volume, submitting electronically could significantly decrease an office's administrative costs and improve cash flow. Many of the electronic health record systems or corresponding practice management systems enable electronic claims submissions for a more seamless transaction.

If you do not have a practice management system in place that allows claims submission, you could evaluate clearinghouses using the following criteria:

- Look for a clearinghouse with minimal fees
- Look for a clearinghouse that does not have a contract or has a shorter contract or trial period
- Look for a clearinghouse with a large payer list. You can request a copy of the payer list prior to signing a contract.
- Look for a clearinghouse with a strong customer support department – this is extremely important when challenges arise

Filing Primary and Secondary Insurance Claims

When a patient has primary and secondary (or more) insurance companies, you will file in the order that the patient reports. You will need to wait until the primary insurance benefits are paid or denied before submitting to the secondary insurance.

If you file the claim electronically with primary insurance, you will most likely need to send in a copy of the explanation of payment of the primary insurance to the secondary insurance. Do not paste, tape, or staple the explanation of payment to a claim. You may also choose to file the secondary claim electronically and wait for the EOP or EOB which states that it is awaiting coordination of benefits with the primary. You would then call the secondary insurance company and document a reference number of the call, along with a fax number where you can send the primary explanation of payment. Both methods will take time, but electronic claims are much easier to track.

How to Read Your EOB or EOP

Statutes in the state where you reside will describe health plans' legal requirements for prompt payment of medical claims. Check the health plan's provider manual to determine payment requirements.

For example, under the North Carolina Department of Insurance, the insurer may need to provide the following within 30 calendar days after receipt of a claim, sent by electronic or paper mail (notification) to the claimant (provider).

Check payer policy for particulars in your state for the specific health plan:

- Payment of the claim
- Notice of denial of the claim
- Notice that the proof of loss is inadequate or incomplete. Asking for more information from you, the provider, Example Medical Records, Physician's Written Referral, etc.
- Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law
- Notice that coordination of benefits information is needed in order to pay the claim. Informing you, the provider, that the patient has another insurance company and that you should either file the claim with the primary insurance or that they are awaiting payment from the primary.
- Notice that the claim is pending based on nonpayment of fees or premiums

Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of 18%, beginning on the following day on which the claim should have been paid.

The format of the EOB may be different for each insurer. It may be formatted the same through the clearinghouse.

Patient's Name / Claimant	Number assigned by providers to identify patient accounts.
Insured / Member Name	This will either be the patient or the person that the insurance policy is under.
Patient / Member Number	The patient's insurance number.
Patient Account Number	The patient's in-house number in your practice.
Claim Number	The number that identifies this particular service claim on this date of service.
Diagnosis	Some claims list the diagnosis code that the biller used when submitting the claim.
Dates of Service	The date the appointment or medical procedure took place.

Place of Service	Place of Service that the appointment took place.
Service Code / Procedure Code	This is the procedure code(s) associated with that date of service.
Number of Services / Units	If the code requires more than one unit, then it may be listed here.
Submitted Charges / Total Charges	The total amount billed by the provider.
Negotiated Amount / Eligible Charges / Contracted Charges	The amount that the plan allows or the contracted amount between the insurer and the provider.
Not Covered / Disallowed Amount	Any amount that is not covered by the plan. It may be 0 or 100% of the billed amount.
Copay / Coinsurance Amount	The amount applied to the service as required by the plan.
Deductible Amount / Applied	The amount applied to the service as required by the plan.
Not Covered / Not Payable / Disallowed Charges	Any amount not covered by the plan whether the procedure is disallowed or the charges exceed the contracted charges.
Patient Responsible / Remaining Member Expense	Amount that the provider will bill the patient.
Payable Amount / Plan Payment / Amount Paid	The amount that the insurer pays the provider. This is usually: INSURANCE ALLOWED AMOUNT – COPAY/COINSURANCE/ DEDUCTIBLE – MEMBER'S % = AMOUNT PAID BY INSURANCE COMPANY

Electronic Funds Transfer (EFT)

Electronic funds transfer is a secure method of claims payment. Many insurances electronically transfer funds directly into the bank account of your choice. Check the health plan's provider manual or web page for information about EFT.

The following outlines the process for setup of an EFT payment to the provider:

- Health care provider must submit:
  - A copy of a voided check or an account verification letter on blank letterhead; and
  - An EFT authorization form, which is generally sent to the health plan's financial services department via fax or through the mail
- The plan's financial services department verifies the bank name and the bank transit or routing number
- After EFT verification, claims will be paid directly to a provider's account
- All EFT payments are made to the group provider number level

The main challenge of EFTs is identifying the payments that go to your bank account. They do not come in with a detailed explanation of where the deposit came from or to whose account this payment should be applied. Bookkeeping must use the EOB or EOP to compare the amount of the deposit.

Handling Patient Denials and Errors

Patient denials should decrease with experience. There are common entry error mistakes such as patient gender or using today's date as the date of birth. There are also errors on the end of the insurance company. Most often, claims that were denied at first will be paid if the RDN uses the provider dispute resolution process.

Once you receive a claim denial, look at the EOB for an explanation for the denied payment. If the reason is not clear, call the insurance company and speak with the claims department. You will then review the claim with the representative to ensure that you entered the correct information. Verify that you entered the correct ID number, name, date of birth, gender, procedure code, and diagnosis code. Often, the insurance company will not provide this data to you, they will only confirm what you tell them you have submitted.

Often, this can be resolved easily by resubmitting the claim. Some insurance companies will require you to refile the paper claim with the word "CORRECTED" across the top.

If there are no errors, the patient has a benefit for MNT, and the patient's diagnosis was not excluded, ask the representative if the claim could be reviewed for medical necessity. In some cases, the insurance company will ask for additional notes or a copy of a physician referral.

Make sure you document the date and time of the call, the name of the representative you spoke with, and any reference number available.

Practice Resources

Essential Patient Forms

For a new practice, establishing a comprehensive and efficient check-in process is crucial for both patient satisfaction and the smooth operation of the clinic. The following list of forms can help ensure that you collect all necessary information from patients at the time of their visit, streamline your administrative processes, and maintain compliance with health care regulations. Most EHRs have templates available for providers to use which can be customized as desired. It is encouraged that providers utilize these forms through their secure EHR whenever possible.

Please note that laws, regulations, and payer policies regarding health care services can vary significantly by location and are subject to change. This document is intended as a general guide and does not encompass all possible legal or payer requirements. It is the responsibility of each provider to ensure compliance with current laws and to verify the information collection requirements of the payers with whom they work. It is recommended to consult with legal and billing experts to tailor your practice's procedures to meet specific obligations.

- **Patient Demographics Form:** Collects basic information such as the patient's name, date of birth, address, phone number, emergency contact, insurance details and communication preferences.
- **Intake Form: Intake forms should be customized to your patient population and/or specialization for that reason an intake form template has not been included. Many EHRs offer intake form templates which can be customized to fit each provider's needs.**
  - Medical history such as the patient's present health conditions, surgeries, hospitalizations, allergies, and family medical history.
  - Medications and supplements to identify all current medications, including prescription drugs, over-the-counter medications, and any supplements patients are taking.
  - Dietary and behavior history for collecting detailed information about an individual's eating habits, nutritional preferences, food-related behaviors, and exercise habits.
- **HIPAA Acknowledgement Form:** Informs patients about their privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and documents their acknowledgment of receipt of this information.
- **Privacy Practices Notice:** Provides a detailed explanation of how the practice may use and disclose protected health information and how patients can access their medical records, in compliance with HIPAA.
- **Financial Policy Agreement:** Outlines the practice's billing, insurance, and payment policies, ensuring patients understand their financial responsibilities.
- **Telehealth Consent Form:** Outlines the patient's agreement to participate in remote health care services and acknowledges the potential risks and benefits associated with telemedicine.
- **Authorization to Release Information Form:** Obtains the patient's consent to share their medical information with specified individuals or organizations, such as family members or specialists.
- **Insurance Verification Form:** Used by the practice to record details verified with the patient's insurance provider, including coverage benefits and any pre-authorization requirements.
- **Superbill:** A detailed invoice used by health care providers to document services rendered during patient encounters, including diagnoses, procedures, and other relevant information.
- **Chart Audit:** Structured tools used by health care providers to review and assess the accuracy, completeness, and compliance of patient medical records within their practice. Providers utilize this form to identify areas for improvement, ensure adherence to regulatory standards, and maintain the quality of patient care documentation.

Additional forms your practice may utilize include:

Advance Beneficiary Notice: Required document used by health care providers to inform Medicare beneficiaries that a particular service may not be covered by Medicare and that the patient may be responsible for payment.

Referral Form: Document used by health care providers to formally recommend or request specialized medical services or consultations for a patient from another health care provider or specialist.

PATIENT DEMOGRAPHIC FORM

Personal Information

Full Name: ___________________________________ Date of Birth (MM/DD/YYYY):______________

Social Security Number: ________________________

Assigned Gender at Birth: ❑ Male ❑ Female

Gender Identity (optional): ❑ Male ❑ Female ❑ Non-Binary ❑ Transgender
❑ Other (please specify): _______________

Preferred Pronouns (optional): _____________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other (please specify): ___________

Preferred Language: __________________ Race/Ethnicity (optional): __________________

Contact Information

Address: ____

City: ____________________________ State: ___________ Zip Code: ______________________

Primary Phone: ______________________ Secondary Phone: _____________________________

Email Address: ____

Emergency Contact

Name: _________________________________ Relationship: ______________________________

Phone Number: _________________________

Insurance Information

Primary Insurance: ____________________________ Policy Holder Name: __________________

Policy Holder DOB: __________________________ Policy Number: ________________________

Relationship to the patient: ____________________________

Secondary Insurance (if applicable): _____________ Policy Holder Name: ____________________

Policy Holder DOB: ___________________________ Policy Number: _______________________

Relationship to the patient: ____________________________

Employment Information

Occupation: ______________________________ Employer: ______________________________

Employer Address: ____

Work Phone: __________________________

Communication Preferences

Preferred Method of Contact: ❏ Phone ❏ Email ❏ Mail ❏ Text Message

Opt-in for Appointment Reminders: ❏ Yes ❏ No

Primary Care Physician: _________________________ Phone Number: ____________________

Consent for Treatment

By signing below, you consent to receive medical nutrition therapy deemed appropriate for your condition. You understand that you have the right to ask questions about any proposed treatment and to withdraw consent at any time.

Signature of Patient or Patient's Representative:_______________________________________

Relationship of Representative to Patient: ____

Signature of Witness (required if patient unable to sign)_________________________________

Date: _______________________

[Note: This form is a template is only a template and may need adjustments to comply with federal, state, and local regulations as well as specific practice requirements. Providers may also need to modify the template based on the needs of their patient population.]

HIPAA NOTICE OF PRIVACY PRACTICE

Effective Date:

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

(Place contact name and practice information here)

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

Practice Name understands that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all records of your care generated by the ***Practice Name***, whether made by ***Practice Name*** personnel or your personal doctor.

This Notice will tell you about the ways we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

- make sure that protected health information that identifies you is kept private;
- notify you about how we protect protected health information about you;
- explain how, when and why we use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information without your written authorization.

For Treatment. We may use protected health information about you to provide, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other ***Practice Name*** personnel who are involved in taking care of you.

Practice Name staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside ***Practice Name*** who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care.

We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at the ***Practice Name***. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health- related benefits or services that may be of interest to you.

For Payment for Services. We may use and disclose protected health information about you so that the treatment and services you receive at the ***Practice Name*** may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at ***Practice Name*** so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose protected health information about you for health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care.

For example, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many ***Practice Name*** patients to decide what additional services the practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other ***Practice Name*** personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort.

Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information

Health Risks. We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

Business Associates. We may disclose information to business associates who perform services on our behalf (such as billing companies); however, we require them to appropriately safeguard your information.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Special Government Functions. If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Correctional Institutions and Other Law Enforcement Custodial Situations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Worker's Compensation. We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

- We may share with a family member, relative, friend or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to ***Practice Name***. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted to ***Practice Name*** In addition, you must provide a reason that supports your request. We will act on your request for an amendment no later than 60 days after receiving the request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by;
- Is not part of the information which you would be permitted to inspect and copy; or
- We believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to ***Practice Name***. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5.

To request restrictions, you must make your request in writing to .

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to ***Practice Name***. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting .

OTHER USES AND DISCLOSURES

We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with ***Practice Name*** or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

PATIENT WRITTEN ACNKOWLEDGEMENT CONFIRMING RECEIPT OF PRIVACY NOTICE

I have received the HIPAA Privacy Notice.

Signature of Patient or Patient's Representative*: ___________________________________

Relationship of Representative to Patient: ____

Signature of Witness (required if patient unable to sign) _____________________________

Date: ________________________

*if patient is a minor or otherwise has an authorized representative.

[Note: This form is a template is only a template and may need adjustments to comply with federal, state, and local regulations as well as specific practice requirements. Providers may also need to modify the template based on the needs of their patient population.]

Sample Financial Policy for [Practice Name]

Welcome to [Practice Name].

At [Practice Name], we are committed to providing exceptional nutritional counseling and support. Understanding our financial policy is important, and we encourage you to ask questions if you have any concerns. Our policy is designed to ensure that the payment process is clear and manageable for our patients.

Insurance and Billing

- **Insurance Coverage:** We participate with several insurance plans. However, coverage varies significantly by policy, and it is your responsibility to understand your benefits. Our office will work with your insurance company to verify benefits and provide you with an estimate prior to your visit. It is the patient's responsibility to understand any co-payments, deductibles, or co-insurance that may apply.
- **Co-payments and Deductibles:** All co-payments and deductibles are due at the time of service. Failure to pay your portion may result in a rescheduling of your appointment.
- **Non-covered Services:** Some services may not be covered by your insurance plan. Payment for these services is due at the time of your visit or upon billing.
- **Out-of-Network Services:** If our practice is not within your insurer's network, you may still receive services, but payment may be required upfront. We can provide you with the necessary documentation to submit a claim to your insurance for reimbursement.
- **Self-Pay:** For clients without insurance coverage, payment is due at the time of service. We offer a detailed fee schedule for all our services, available upon request.

Billing and Payments

- **Payment Methods:** We accept cash, checks, and major credit/debit cards. Payment is due at the time of service unless prior arrangements have been made.
- **Outstanding Balances:** Clients with outstanding balances will receive monthly statements. We kindly ask that balances are paid within 30 days of the statement date. For accounts unpaid after 90 days, we may take further action, including referral to a collection agency. We understand that financial situations can change and encourage you to communicate with us if you encounter difficulties in settling your account.
- **Payment Plans:** We understand that health care costs can be a burden. Should you have trouble meeting your financial obligations, please contact our billing office to discuss payment plan options.

Cancellation and No-Show Policy

Appointments: Your appointment time is reserved just for you. If you need to cancel or reschedule, please provide at least 24 hours' notice. Missed appointments without adequate notice may incur a $50 fee.

Refunds

Overpayments will be refunded after a review of your account and ensuring all claims have been processed by your insurance company.

Acknowledgment

By seeking care with us, you agree to the terms outlined in this financial policy. You hereby authorize the use of your health insurance benefits for payment directly to the health care provider for services rendered. You understand that as the patient, or their guarantor, you are financially responsible for any balance not covered by my insurance. You also authorize the release of any medical information necessary to process your insurance claims. Your understanding and cooperation help us continue to provide high-quality nutrition services. Please sign below to acknowledge your agreement and understanding.

Signature of Patient or Patient's Representative*: ______________________________________

Relationship of Representative to Patient: ____

Signature of Witness (required if patient unable to sign)_________________________________

Date: _______________________

*if patient is a minor or otherwise has an authorized representative.

Please keep a copy of this policy for your records. We're here to support your health and wellness journey, and clear communication about financial policies is part of how we maintain a trusting and effective client-practice relationship. If you have any questions or need clarification on any aspect of this policy, don't hesitate to contact our office.

[Note: This form is a template is only a template and may need adjustments to comply with federal, state, and local regulations as well as specific practice requirements. Providers may also need to modify the template based on the needs of their patient population.]

Permission to Receive Dietitian Services Using Telehealth

Name: ___________________________________ Date: ______________
(Please print)

Purpose: The purpose of this form is to obtain your permission for a telehealth appointment with a registered dietitian nutritionist.

What is Telehealth: Telehealth is a way to have your appointment with your registered dietitian nutritionist ("dietitian") using audio and visual electronic communications. If the use of audio-visual technology (computer/tablet/smartphone) is not possible, it may be possible to use the telephone (voice only) in some situations.

Other electronic communications, including text messaging, secure email, or a Health Insurance Portability and Accountability Act (HIPAA) compliant patient portal may also be used to share health information with you related to your appointment.

Benefits and risks: The benefits of telehealth include not having to leave your home or travel outside of your local area. You will not be in the same room as your dietitian, so there may be some limitations to the appointment and the appointment may feel different. Technical problems could interrupt or stop your visit before it is completed. An in-person appointment still may be necessary after the telehealth appointment.

Privacy: Telehealth visits will not be recorded. Try to be in a private place, if possible. If people are close to you, they may hear something you do not want them to know. Your dietitian will obtain your consent prior to allowing someone else from their office to observe the appointment (such as a dietitian student). Even with the use of HIPAA-compliant technology, an internet connection that is private and secure (i.e., not using public Wi-Fi), and taking precautions to protect your privacy, there is a chance/risk that security measures could fail causing a breach of privacy.

Privacy and sharing data from mobile health applications: The sharing of data from mobile applications with your dietitian is at your discretion. Your dietitian is not responsible for privacy and data breaches that could occur through the sharing of data from mobile health applications during a telehealth appointment. Likewise, if you choose to use text-messaging, or to use unencrypted emails or public Wi-Fi for sharing information with your dietitian or for telehealth services, your dietitian is not responsible for privacy and data breaches that could occur.

Your rights: You have the right to refuse telehealth services or limit what information is shared when receiving telehealth services. You may withdraw your permission for a telehealth appointment at any time, including during the appointment.

Confidentiality and medical records: All existing privacy and confidentiality laws apply to information used or disclosed during your telehealth appointment. All laws concerning patient access to medical records and copies of medical records apply to telehealth appointments. Your dietitian will maintain records of your telehealth appointments as required by law.

Limitations: Your dietitian will notify you if there are any limitations or special requirements for your telehealth visit based on the state where you live or the state where services are provided.

Authorization and Consent:

- I understand how telehealth will work and the reasons for using it with my dietitian.
- I understand that receiving services using telehealth is not the same as an in-person visit.
- I understand that I can stop a telehealth appointment any time, for any reason, or stop using telehealth for future visits. If need to let my dietitian know if I do not want to use telehealth again:
  - Call ________________ and say you want to stop, -OR- sign into your patient portal and send a message to say you want to stop.
- I understand there are risks to receiving telehealth services, such as technical difficulties, and breaches of privacy even with the use of secure communications systems.
- I understand that should an emergency medical situation arise during the appointment, including a behavioral or mental health crisis, my dietitian may direct me to emergency medical services, such as the emergency room, or may call 911 on my behalf for emergency services. I understand that my dietitian is not responsible for providing emergency services or any health care services other than the dietitian's telehealth visit.
- I understand that my insurance may not cover telehealth services, and that my out-of-pocket costs may be different for telehealth than for services provided in-person.
- I understand that if I decide to stop using telehealth services, that decision will not negatively affect my care and treatment.

My dietitian has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all my questions have been answered. I have read and agreed to a telehealth appointment. My consent shall remain in effect for the duration of care, or until __/__/__(date state law requires reconsent), or until I revoke my consent in writing.

Signature of Patient or Patient's Representative*: ______________________________________

Relationship of Representative to Patient: ____

Signature of Witness (required if patient unable to sign)_________________________________

Date: ________________________

*if patient is a minor or otherwise has an authorized representative.

REFUSAL: I refuse to participate in telehealth appointments as described above.

Signature of Patient or Patient's Representative*:______________________________________

Relationship of Representative to Patient:____

Signature of Witness (required if patient unable to sign)_________________________________

Date: ________________________

*if patient is a minor or otherwise has an authorized representative.

[Note: This form is a template is only a template and may need adjustments to comply with federal, state, and local regulations as well as specific practice requirements. Providers may also need to modify the template based on the needs of their patient population.]

Authorization for Release of Information

Patient Full Name: ___________________________ Date of Birth (MM/DD/YYYY): ___________

Address: ____

City: ____________________________ State: ___________ Zip Code: _________________________

Primary Phone: ______________________ Email Address: __________________________________

I, [Patient's Name], hereby authorize [Health care Provider's Name] to release and disclose my protected health information to the following individual(s) or organization(s):

Name of Recipient: ____

Recipient Address: ____

Purpose of Disclosure: ____

Information to be disclosed: ____

Name of Recipient: ____

Recipient Address: ____

Purpose of Disclosure: ____

Information to be disclosed: ____

Name of Recipient: ____

Recipient Address: ____

Purpose of Disclosure: ____

Information to be disclosed: ____

This authorization is granted for the purpose of diagnosis, treatment, and any other health care-related information as indicated above This authorization shall remain valid for one year from the date of this document or until revoked by me in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it.

By signing below, I acknowledge that I have read and understood the terms of this authorization.

Signature of Patient or Patient's Representative*:____

Relationship of Representative to Patient: ____

Signature of Witness (required if patient unable to sign) ___________________________________

Date: _________________________

*if patient is a minor or otherwise has an authorized representative.

[Note: This form is a template is only a template and may need adjustments to comply with federal, state, and local regulations as well as specific practice requirements. Providers may also need to modify the template based on the needs of their patient population.]

What you Need to Know: MNT Referrals

General Information

Most providers now use an e-referral system. These systems should be utilized for referrals whenever possible as they streamline workflows, reduce administrative burden, and enhance patient outcomes.

In the event a provider does not have an electronic referral system in place the MNT referral form can be used. The MNT referral form is designed to provide the RDN with the necessary patient and client information from the primary care provider to initiate MNT. In addition to documenting the medical necessity for MNT, a completed and signed referral form meets legal and regulatory requirements that allow the RDN to provide and bill for the MNT services. For example, under Medicare Part B for MNT, a physician referral is required before the RDN provides and then submits claims for the MNT service(s). Some medical providers may not be familiar with the legal and regulatory requirements that link the referral to the initiation of the MNT services, so it is important that RDNs are fully informed. Additional information needed for the MNT visit can also be obtained through a review of the medical record, if available. The original referral form should be kept in the medical record and a copy within the nutrition office.

It may be beneficial to collaborate with medical directors, compliance officers and physicians in your institution or clinics or physician offices to implement a process for outpatient MNT referrals. Some medical offices may feel that HIPAA (Health Insurance Portability and Accountability Act) privacy regulations will not allow them to share their client's medical information. The reminder that MNT services and the RDN are part of the "Chain of Trust," as listed on the bottom of the sample referral form, will assist in this process. Recall that health care professionals may use and disclose protected health information without patient's written authorization for treatment purposes, including coordination or management of the patient's medical treatment or services.

Customizing the Form

This form is provided as a pdf-fillable document so it may be used as is or adapted to include more specific information, based on the patient or client population served by your practice.

Some ways to customize the form include:

- Insert your company/facility logo in the upper right-hand corner of the form.
- Insert your company/facility name, address, phone, fax and/or email addresses in the fields at the top of the form.
- Insert ICD-10 codes and descriptions specific to the patient population (s) served by your practice. Refer to "Common ICD-10-CM Codes related to Nutrition Services" for a quick reference list.
- Remember to save your customized form.

Either the existing form or your customized version can be shared with referral sources as a hard copy and/or as an electronic document. You can also post it on your website for easy access.

Electronic Health Records and Referrals

Most health care facilities and provider offices (including RDNs) use electronic health records. Referral formats within such systems will likely be predetermined by your facility, negating the need for written referral forms. At a minimum the electronic referral format should include the referring physician's name and NPI, purpose of referral and medical diagnosis with ICD-10 code. Many of these fields can be populated from existing data tables within the EHR (e.g., physician name, physician NPI, ICD-10 code). The use of digital referrals also supports CMS Promoting Interoperability objectives to improve the safe sharing of information. RDNs may want to talk with their facilities about being included in the drop-down list of providers to receive patient/client records. As part of the Promoting Interoperability performance category under the Merit-based Incentive Payment System (MIPS), eligible clinicians must be able to send and request/accept a summary of care document using consolidated-clinical document architecture (C-CDA) from a certified EHR to meet reporting requirements.

For more information on Nutrition Informatics visit:

www.eatrightpro.org/practice/practice-resources/nutrition-informatics

For more information on EHRs and referral notes, visit:

- www.hl7.org/implement/standards/product_brief.cfm?product_id=509
- https://hl7.org/fhir/us/ccda/StructureDefinition-Referral-Note.html

Referral for Medical Nutrition Therapy (MNT)

Date:	Patient name:
Day time phone number:	Insurance: (Attach copy of front & back of card)
DOB:	Home address: Zip:

Above is referred for *medical nutrition therapy as a necessary part of medical treatment* and prevention of complications for diagnoses listed.

Referral Needs: ☐ New Diagnosis ☐ New treatment plan ☐ New complication

Special Needs: ☐ Language ☐ Hearing/Speech/Vision ☐ Learning/Processing

☐ Other:

✔ **Check all diagnoses that apply to this referral**

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

✔ **Anthropometric data and Lab work** (Please attach or complete)

Height: ______________ Weight: _____________ BP: ____/ _____

Hct/ Hgb	FBS &/or pc	Hgb A1c	Total Chol	HDL LDL	Non HDL	Trig	Ua Micro Albumin/Cr	BUN/ Cr	EGFR	Na/K	Phos/ PTH	Vit D

✔ **Exercise/Activity Plan**

☐ **Release:** may walk 20-30 min 5-7 x/week or ____

☐ **Not Released:** ____

✔ **Medications** – Please attach list

Physician signature X_________________________MD/DO Phone ______________________

NPI: __________________ __________________________ Fax ________________________

Print MD/DO Name

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.

Advanced Beneficiary Notices for the Medicare MNT Benefit

The information contained in this document is for reference use only and does not constitute the rendering of legal, financial, or other professional advice of the Academy of Nutrition and Dietetics.

Registered dietitians who are participating in the Medicare program as providers for medical nutrition therapy (MNT) for diabetes and non-dialysis kidney disease should understand and use appropriate forms, such as the Advanced Beneficiary Notice (ABN), prior to providing MNT services to Medicare beneficiaries. Beginning June 20, 2023, RDN providers, physicians, practitioners and suppliers should use the Advance Beneficiary Notice of Non-Coverage (ABN) (Form CMS-R-131) with expiration date 01/31/2026 for all situations where Medicare payment is expected to be denied. An ABN should not be used with Medicare Advantage plans.

What is an advanced beneficiary notice?

An Advanced Beneficiary Notice (ABN)[1] is a written notice used by Medicare providers and suppliers to notify Medicare beneficiaries, before the service is provided, of the following:

- That Medicare will probably deny payment for the service/supply,
- The reason why the provider expects Medicare to deny the payment, and
- The Medicare beneficiary is personally and fully responsible for payment if Medicare denies payment.

In addition to the above items, the ABN must also describe the service, include the patient's name, patient's signature, and date, and if needed include space for a witness's signature and date. The intent of ABNs is to empower Medicare beneficiaries to be active participants in their own health care treatment decisions. The beneficiary or his or her representative must choose only one of the three options listed in section G of the ABN form.

A properly executed ABN serves as notice to a Medicare beneficiary, the patient, that the beneficiary is responsible for the payment if Medicare denies payment. ABNs should be used when the RDN or provider is unsure that a service will be considered medically necessary or may exceed the frequency and duration of the covered service. ABNs are not required for care that is statutorily excluded (e.g. MNT for other diagnosis besides diabetes and non-dialysis kidney disease). However, the ABN can be issued voluntarily in these cases in place of the Notice of Exclusion from Medicare Benefits (NEMB). In this case the beneficiary acknowledges in section G of the ABN that is service is not covered and accepts financial responsibility.

ABN Use — Examples:

- **Example 1:** You receive a referral from a physician to see a Medicare patient for MNT services for diabetes. The patient lives in Florida part of the year, and Arizona part of the year. You see the Medicare beneficiary in your practice in Arizona, and neither you nor the client has access to the patient's medical records in Florida. You review the medical record from the physician in Arizona and your screening is inconclusive as to how many MNT visits for diabetes this person has had in the last 12 months. You should complete the ABN and explain its use with the Medicare beneficiary before seeing the patient for MNT for diabetes.
- **Example 2:** (An ABN may be applied to an extended course of treatment provided the notice identifies each service for which Medicare is likely to deny payment. However, a separate notice is required, if additional services, for which Medicare is likely to deny payment, are furnished later in the course of treatment.) A patient with the diagnosis of diabetes has attended all the Medicare MNT visits allowed in an episode of care. This patient's condition has consistently and progressively improved as evidenced by a change in A1C values from 9.5% to 8.0%. The referring physician's evaluation is that with an addition one to two MNT visits

[1]CMS Web page; https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

the patient will improve to A1C goal of 7%. The RDN receives this referral for an additional two visits. Medicare will probably not cover these visits since the Medicare patient has exceeded the MNT duration and frequency requirements of the benefit. Therefore the RDN must tell the patient in advance and in writing, that Medicare will probably not cover the service. The patient receives the ABN from the RDN and is requested to sign and date the statement. With this advance notice, the patient knows that he/she will have to pay the provider the entire billed amount should Medicare deny payment.

Sample ABN Copy

The Centers for Medicare & Medicaid Services has created a sample ABN that can be used as a template for RDN Medicare providers in private practice or Medicare facilities who require this form. Whether RDN Medicare providers use CMS' ABN form or another ABN form created by your facility, remember to use a consistent form that is personalized with the following components:

- The RDN/facilities' letterhead
- Description of the service
- Reason why the service may not be covered
- The patient's name, billing account number, signature and date
- Space for a witnesses' signature and date

CMS' ABN form includes these components and uses large font size for easy readability by the Medicare beneficiary. Access the ABN form from the CMS Web page.

Sample Language to Use

A critical point about filling out the ABN that must be observed is that terminology used on the form must describe why Medicare is unlikely to cover the service. CMS does not accept statements like, "I never know if Medicare will deny payment" and similar generalizations for advance notice purposes. Following are a few examples of acceptable statements of reasons RDNs believe that Medicare is likely to deny payment for MNT services.

- Medicare does not usually pay for this many visits or treatments.
- Medicare usually does not pay for like services by more than one dietitian during the same time period.
- Medicare usually does not pay for this many services within this period of time.
- Medicare usually does not pay for more than one visit a day.
- Medicare usually does not pay for like services by more than one dietitian.
- Medicare usually does not pay for this service.

Patient Refuses to Sign ABN

If the ABN is completed and presented to the patient, and during the discussion about the patient's responsibility to pay for the service if Medicare denies payment, the patient refuses to sign the ABN — what do you do? What are your options? RDNs could refuse to provide the service, or RDNs could decide to provide the MNT service even without the signed ABN. In either case you must document the patient's refusal to sign the ABN and have a witness (a co- worker) also sign the ABN. If Medicare payment is denied, the Medicare beneficiary will be responsible for the payment.

Situations Where an ABN May Not Be Required for MNT Services

There are a few cases when an ABN may not be required for MNT services for diabetes and non-dialysis kidney disease since the RDN is confident that Medicare will cover the services. These situations may include:

The Medicare beneficiary meets the diagnosis criteria for MNT services for diabetes or non-dialysis kidney disease, a physician referral and

chart documentation is provided specifying the medical necessity for MNT for the beneficiary with diabetes or non-dialysis kidney disease, and the individual has never received MNT by an RDN.

The Medicare beneficiary meets the diagnosis criteria for MNT services for diabetes or non-dialysis kidney disease, a physician referral and chart documentation is provided specifying the medical necessity for MNT for the beneficiary with diabetes or non-dialysis kidney disease, and the individual has not exceeded the MNT episode of care (the frequency and duration of MNT for diabetes or non-dialysis kidney disease).

The Medicare beneficiary meets the diagnosis criteria for MNT services for diabetes or non- dialysis kidney disease, a physician referral and chart documentation is provided specifying the medical necessity for MNT for the beneficiary with diabetes or non-dialysis kidney disease, and the individual has not exceeded the MNT episode of care (the frequency and duration of MNT for diabetes or non-dialysis kidney disease) and the Medicare beneficiary is not enrolled in a Medicare Diabetes Self-Management Training (DSMT) program. In this case, the coordination of care between the DSMT program and MNT program, that may potentially limit MNT services, will not apply.

Practice Tips

The ABN form must include all required components and be used consistently with Medicare beneficiaries before the MNT services are provided. On the ABN form, be specific when listing why Medicare may deny the services. CMS does not accept statements like, “I never know if Medicare will deny payment” and similar generalizations for advance notice purposes.

Practice Management

RDNs in private practice must have policies and procedures in place regarding ABNs. As part of the Medicare audit process set up to monitor MNT Medicare practices, RDNs should review ABN use/appropriateness. The following ABN checklist can be used to develop ABN policies and procedures.

Good Record Keeping

- Document receipt of each advance beneficiary notice (ABN) and make a copy for the patient, even though CMS regulations only require copies when requested. It is good practice to give patients a copy so there are fewer surprises when they get the bill.
- File the original copy in the patient’s office record.
- When patients refuse to sign an ABN, inform them of the consequences and document the conversation.

Advance Beneficiary Notices (ABN) Must Be Used if the Service:

- Is for investigative or research use only,
- Does not meet medical necessity requirements according to your local medical review policy or CMS National Coverage Limitations,
- May only be paid for a limited number of times within a specified time period and this visit may exceed that limit (Note: ABNs are also required if there is no diagnosis, sign, symptom, or ICD-10-CM code provided, and if one cannot be obtained from the ordering physician.)

Medical Necessity

- Review each patient’s diagnosis, symptoms, disease(s) or ICD-10-CM code(s) for medical necessity, according to local medical review policy or National Coverage Limitations
- Document the reason for determining that a test or service is not medically necessary. Obtain any documentation necessary to support your reason in case of an audit.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_______________below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D.**_____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. ☐ **OPTION 2.** I want the **D.**______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. ☐ **OPTION 3.** I don't want the **D.**____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

Example Document

How to Fill Out an ABN Form

A: Notifier: Provider must place his or her name, address and telephone number at the top of the notice. If the billing and notifying entities are not the same, the name of more than one entity may be given in the notifier area.

B: Patient name: Provider must enter first and last name of the beneficiary receiving the notice. The middle initial should be used if there is one on the beneficiary's Medicare card.

C: Identification number (optional): Medicare numbers or Social Security numbers must not appear on the notice.

D: Items or services believed to be non-covered: In the note: Providers must list the specific items or services believed to be non-covered in the blank within the notes as well as in the first block of the table. In the case of partial denials, providers must list in the blank the excess component(s) of the item or service for which denial is expected. Always list specific items or services believed to be non-covered.

E: Reason Medicare May Not Pay: Providers must explain in beneficiary-friendly language why they believe the items or services may not be covered by Medicare.

F: Estimated Cost: Providers must complete this blank to ensure the beneficiary has all available information to make an informed decision about whether to obtain potentially non-covered services. Providers must make a good faith effort to insert a reasonable estimate for all the items and services listed. In general, we would expect the estimate to be within $100 or 25 percent of the actual costs, whichever is greater. Multiple items or services that are routinely grouped can be bundled into a single cost estimate.

G: Options: The beneficiary or his or her representative must choose only 1 of the 3 options.

1. Option 1: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose option 1.
2. Option 2: Allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. No appeal rights are associated with this option.
3. Option 3: This means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

H: Additional info: Providers may use this space to provide additional clarification they believe will be of use to beneficiaries. For example: a statement advising the beneficiary to notify his or her provider about certain tests that were ordered but not received. An additional dated witness signature could be put here or other annotations.

I: Signature: The beneficiary or representative must sign the notice to indicate he or she received the notice and understands its contents. If a representative signs, he should indicate "representative" after his or her signature.

J: Date: The beneficiary or representative must write the date he or she signed the ABN. If the beneficiary has physical difficulty writing and requests assistance in completing this blank, the date may be inserted by the provider.

The ABN can be found on www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

Insurance Information Collection Form

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Client/Patient Full Name: ______________________________

Health insurance company or government sponsored health insurance: ______________________________

Date: ______________Time: ___________ Representative (if using telephone): ______________________________

Policy type: ☐ Medicare Part B ☐ Medicare Advantage ☐ Medicaid or CHIP ☐ Commercial

☐ Other or additional information (PPO, HMO, other): ______________________________

Benefit period (plan year) and future termination date: ______________________________

Does the member have a benefit for Nutrition Counseling/Medical Nutrition Therapy? Y / N

Indicate CPT® codes (e.g., 97802 and 97803, or 97804) for MNT/nutrition counseling and the established diagnosis(es) (ICD10 codes). ______________________________

Established diagnosis(es)/ICD10s covered*: ______________________________

Comments/instructions regarding correct use of codes(s) or combination for claims:

Exclusions (related to the MNT benefit):
Is a referral from a physician or other health care provider required? Y / N

Coverage Details: Obtain coverage details based on your provider status. Note: It may be helpful to understand both in and out of network benefits. This information can be communicated to the patient/client and assist them in making an informed choice.

In Network	Y / N	**Out of Network**	Y / N
# of units, if applicable	____________	# of units, if applicable	____________
Subject to deductible?	Y / N	Subject to deductible?	Y / N
Amount of deductible	____________	Amount of deductible	____________
Accumulation of deductible (amount)	____________	Accumulation of deductible (amount)	____________
Copay or Coinsurance	____________	Copay or Coinsurance	____________
Telehealth Coverage?	Y / N	Telehealth Coverage?	Y / N

Notes:

Reference # for benefits verification, date, time______________________________

*If MNT coverage is not available for a diagnosis of overweight/obesity, consider checking coverage for the Z codes corresponding to estimated or known BMI (e.g., Z68 codes). These Z codes may be classified under preventive health benefits, and could be covered even if the diagnosis of overweight or obesity is not. It's also possible that both an E series code and a Z code are needed for coverage and payment for the RDN's services.

Checklist for Insurance Benefits and Coverage Verification

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Checklist for Insurance Benefits and Coverage Verification

Obtaining and documenting the following information when confirming benefits and coverage details by phone or online will help ensure accurate understanding of client benefits and inform the potential payment for the RDN. Documentation of the information in this checklist is essential to resolving issues related to claims payment should they arise.

Disclaimer: This checklist is designed for information purposes only and does not guarantee payment from an insurance company or other payer.

Policy Type: This refers to the patient's type of health insurance policy. There can be many different types of policies. Medicare Part B, Medicare Advantage (Medicare Part C), Medicaid or CHIP, commercial, or other government-sponsored insurance. Policies can be further described by type: PPO, HMO, EPO or others.

Benefit period: Confirm that the client's insurance policy is active. Note the benefit period, the length of time during which a benefit is paid, and the future termination date. Often this benefit period is the same as the calendar year (January 1 – December 31), but in some cases the benefit period differs. It is important to pay attention to the benefit period, especially regarding the number of visits/benefit period and if/when clients have deductibles.

Does the policy have nutrition counseling/ MNT benefits: Document whether the client has a benefit for MNT/nutrition counseling. Specify or look up (online verification) the MNT CPT® codes during the benefits verification. In most instances you will also need to provide patient diagnosis(es) information using relevant ICD10-code(s) established by a physician or other provider qualified to assign medical diagnoses.

ICD-10 The International Classification of Disease, Clinical Modification (ICD-CM) is a classification used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization in the United States. For more information, visit the Academy's website. Note which of the client's diagnoses/conditions relevant for the MNT, via specific ICD-10 codes, are covered or not covered under the individual's policy. This information is needed for claims submissions where you will provide only the relevant, and covered ICD-codes in a claim.

The assignment of medical diagnoses is a regulated activity. It is not within the scope of practice of the RDN to assign any diagnoses (by assigning ICD-10) in any state.

Confirm any exclusions for coverage for MNT: Document the situations under which MNT is not covered under the individual's policy.

Confirm MNT benefits based on provider status (in-network vs. out-of-network):

In-network benefits apply to services provided by a dietitian contracted with the health plan or organization.

Out-of-network benefits may be provided by a dietitian that is not credentialed with the patient's health plan. Out-of-network benefits are often accessible at a higher financial responsibility to the insured patient.

Is a referral required from a physician or other qualified health care provider? In some instances, a referral for MNT from a client/patient's health care provider may be required. Be sure to confirm what provider type can make the referral under the patient's plan.

Is prior authorization required? If yes, inquire about this process.

Reference (phone or other form of online confirmation) number: Obtain the reference number for the benefits confirmation. This is a very important step and may be essential in resolving any issues regarding coverage for the patient and payment for the RDN.

In/Out-of-Network Boxes

In/out-of-network benefits as applicable: If you are not in network with a client's plan, confirm the details of the out-of-network benefit, if applicable.

Request and document any limits on the number of visits/sessions, or hours: Limit on the number of units might be stated in the health plan billing policies but is not something that is part of an individual's plan policy details.

Confirm whether any deductible applies: The specified dollar amount for certain covered services that the member must incur before the insurance pays any claims. Clients may have different deductible requirements for in-network and out of network services. The deductible does not include copayments, member coinsurance, charge in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.

Co-payment (co-pay): A fixed dollar amount which is due and payable by the member at the time a covered service is provided. (Example: $25)

Co-insurance: The sharing of allowable charges by the insurance company and the patient for covered services, usually stated as a percentage of the allowed amount after the deductible has been satisfied. (Example: Insurer pays 80%; Member's Coinsurance is 20%) Some policies have a coinsurance maximum – the maximum amount of coinsurance that the patient is obligated to pay for covered services per calendar year/benefit period.

Reference number: Document the electronic or telephonic reference number for the benefits verification.

Date/time/representative: Document the date and time of the call as well as the representative's name.

Instructions for Model Superbill for MNT Services

General Information

The sample superbill is a customizable template for use by registered dietitian nutritionists (RDNs) when an RDN does not, or is unable to, submit claims to payers. For the professional rendering services, it provides a means to document services, fees, codes and other information required for insurance companies and client tax purposes. A superbill may be used by clients for health savings accounts, flexible spending accounts, tax purposes, or to try to obtain reimbursement from their health plan.

A superbill is not a guarantee of reimbursement for a client. The ability of a health plan member to obtain reimbursement from a health plan is dependent on individual member benefits and coverage for MNT, as well as health plan policies regarding member reimbursement.

Customizing the Form

This form is provided as a pdf-fillable document so it may be used as is or adapted to include more specific information, based on the patient or client population served by your practice. Some ways to customize the form include:

- Insert your company/facility logo in the upper right-hand corner of the form.
- Insert your company/facility name, address, phone, fax, and/or email addresses in the fields at the top of the form.
- Insert your name, NPI and state license number (if applicable) in the fields at the top of the form.
- Insert ICD-10 codes and descriptions specific to the patient population(s) served by your practice. Refer to "Common ICD-10-CM Codes Related to Nutrition Services" for a quick reference list. *Note: Best practice dictates obtaining ICD-10 codes from the client's physician to ensure proper specificity. It is not within an RDN's scope of practice to make a medical diagnosis.*
- Insert Current Procedural Terminology (CPT®) codes used in your practice from the drop-down list. Additional lines are provided to add additional CPT® codes. Note: Individual payers and health plans set policies as to what CPT® codes are recognized for payment by specific professional provider types.
- Remember to save your customized form.

Medical Nutrition Therapy (MNT) Superbill

Date of Service:	Provider name:
Patient name:	Rendering Service Address:
Address:	Tax ID:
Phone:	NPI:
DOB:	License #:
Referring Provider Name:	Referring provider NPI:

Diagnoses

✓	ICD-10	ICD-10 Description	✓	ICD-10	ICD-10 Description

Office Procedure

✓	CPT Code/Description	POS	Modifier	Units	Fee
			Total Charge		
			Amount Paid		
			Balance Due		

RDN Name:____

RDN Signature: ______________________________________

Preparation and Tips for Payer Audits

Audits are a common practice in health care, designed to ensure accuracy, compliance, and quality of patient care documentation. This document aims to provide an overview to help navigate the auditing process.

Understanding the Process

If you're subject to an audit—whether it is from an external group like a Medicare carrier or another insurance payer, or an internal audit within your facility—you will be guided by the auditor on the necessary documentation. You will typically need to present records of the services you provided during a certain period, including items such as the physician referral form, lab results, chart notes, claims forms, and patient details like insurance ID numbers. Electronic Health Records (EHRs) can significantly ease this process by ensuring that all necessary information is organized and readily available for retrieval.

Effective and timely communication with auditors is crucial throughout the audit process. This includes responding quickly to any requests for information or if clarification on requests is needed. If you face any challenges during the audit, don't hesitate to seek support from legal counsel or reach out to the Nutrition Services Coverage team at the Academy. Sharing and adopting best practices and strategies is invaluable for successfully navigating audits.

Conducting self-audits

Conducting internal chart audits is a beneficial practice for all health care providers. Internal chart audits help ensure compliance with regulatory requirements, billing accuracy, and quality of care. By reviewing patient records internally, providers can identify areas for improvement, address documentation discrepancies, and mitigate risks associated with external audits by health insurance payers or regulatory agencies. This not only helps prevent fraud and abuse but also serves as an educational tool to enhance providers' skills in coding and documentation.

It is recommended to conduct self-audits at least annually, with more frequent audits—monthly or quarterly— depending on the results of previous audits, the size of the practice, or if new risks are identified. Experts recommend sampling 20-30 encounters per full-time clinician. You may also choose to do smaller targeted audits such as targeting a specific billing code, place of service or modifier.

After auditing, results should be documented and analyzed to identify areas for improvement or further education, with corrective actions planned and implemented swiftly, ideally within 60 days of identifying an issue. If your self-audit uncovers coding and billing issues, even minor ones, that may suggest non-compliance or inadvertent overpayment, it's advisable to seek guidance from a health care attorney right away. A health care attorney can advise you on if additional action is needed beyond a corrective action plan.

Regular self-audits not only prepare you for external audits but also contribute to the improvement of MNT service quality.

Chart Audit Template

Date:

Reviewer:

Patient Identifier (ID Number/ Name):

Provider Name:

Provider NPI:

	Yes	**No**
Chart contains patient details including name, address, date of birth, sex, race and ethnicity. Client name and identifier should be on every page?		
Referral is on file complete with diagnosis, reason for referral and is signed and dated by the referring provider (MD or DO for Medicare)?		
If services are not medically necessary or are not a covered service under Medicare, is there an Advanced Beneficiary Notice on file?		
The reason for the encounter along with relevant medical history has been documented?		
The provider assessment list tools and techniques used, questionnaires, screenings and tests, as well as the findings?		
All medications and supplements are listed?		
Allergies are documented in the chart?		
Patient problems are identified, analyzed and a nutrition diagnosis is included in the chart?		
Nutrition plan of care is included in the chart and notes specific recommendations provided, including: • Patient/care giver education regarding their nutrition and medical diagnosis • Nutrition recommendations supportive of medical necessity of the services provided • Nutrition prescription		
Does the documentation support the ICD-10 and procedure codes that are billed?		
Client-centered goals with expected outcomes are established, discussed, and documented with the patient?		

	Yes	No
Recommendations for continued care, referrals, care coordination services or the discontinuation of treatment as deemed appropriate, are documented accordingly?		
Is the total time spent with the patient documented?		
Does the claim form match the diagnosis, procedure code, time spent and service modality?		
Are all signatures present, legible, dated and timestamped?		
Does the number of units match the documented face to face time?		
Are modifiers applied appropriately, and is their use supported by documentation?		
Is the place of service noted?		
Does the documentation support the frequency and duration of the services provided?		
If students were present or involved in any aspect of the encounter were their contributions documented and co-signed? If applicable, was consent obtained and documented in the chart for their involvement?		
Were any addendums signed, dated, and timestamped?		

Document reasons for any “No” and determine an action plan for correcting in future documentation.

IBT Quick Guide

Intensive Behavioral Therapy (IBT) is a valuable Medicare benefit designed to address obesity through evidence-based behavioral interventions. RDNs play a pivotal role in delivering IBT services as your expertise in nutrition counseling and behavior change uniquely positions you to support patients in achieving sustainable weight loss and improving their overall health outcomes.

The information in this guide is specific to Medicare. Guidelines and codes for Medicaid and private payers may vary. Beneficiaries with Medicare Advantage Plans have access to IBT, similar to traditional Medicare plans, but they may need to use an in-network provider. If services are obtained from an out-of-network provider, the beneficiary may face a copayment.

Billing and Coding Basics

Target Population and Patient Eligibility	Patients must be Medicare Part B beneficiaries with a BMI ≥ 30 kg/m2 that are attentive and alert at the time counseling is provided.
Eligible Providers	Service must be billed by a qualified primary care provider (General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatric Medicine, Geriatric Medicine, Nurse Practitioner, Certified Clinical Nurse Specialist, Physician Assistant). RDNs may provide the service "incident to" a qualified PCP as auxiliary personnel.
Eligible Locations	Physician's office, outpatient hospital, independent clinic, state or local public health clinic, rural health clinics, federally qualified health centers, critical access hospitals.
HCPCS/CPT® Codes	• G0447 Individual: 15 min • G0473 Group, 2-10 Patients: 30 min BMI should be documented in medical record prior to the visit and providers should use the original BMI for all visits when billing.
ICD-10 Codes	• Z68.30-Z68.39 • Z68.41-Z68.45
Visit Limits	• 22 times in a 12-month period, in accordance with the following schedule: – One face-to-face visit every week for the first month – One face-to-face visit every other week for months 2 to 6 Beneficiaries may have one face-to-face visit per month from months 7 to 12 if they achieve a 3-kg (6.6-lb) weight loss in the first 6 months. The weight loss must be documented in the PCP medical record for reimbursement. If the initial weight loss goal isn't met, RDNs must stop the service for 6 months before reassessing patient readiness to continue. If the patient is eligible after reassessment, the first 6 months of IBT can be restarted, keeping in mind the limit of 22 visits in a 12-month period.
Documentation Requirements	• Minimum requirements: initial BMI, weight changes, IBT visit number, and start and end time of session should be documented in the medical record. • Optional but helpful documentation: assessment of learning needs, barriers, readiness to change; fall risk assessment; documentation of education topic, learner response, and method.
Payment Rates	• Primary care offices: Medicare Physician Fee Schedule • HOPD: Hospital Outpatient Prospective Payment System • RHC/FQHC: All-Inclusive Rate

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