Academy of Nutrition and Dietetics

CODING AND BILLING

Telehealth services follow many of the same billing and coding best practices as in-person services. RDs are individually accountable for ensuring the service performed and the time spent with patients is accurately documented and payer-specific policies are followed.

Procedure Codes Must Reflect Services Performed

A company may code and bill the services performed; however, the RD maintains accountability for any services billed under their name and NPI. Companies should have policies and procedures in place to ensure services rendered align with services billed (e.g. internal auditing processes, opportunity for the rendering provider to review and confirm billed services, etc.)

- Misalignment between documentation of the service performed and procedure codes may constitute **fraudulent billing**.
- Telehealth companies may have recommended workflows but cannot override federal, state, or payer billing rules.

Services should be billed and coded to the greatest specificity. **Medical nutrition therapy (MNT) for a medical condition not typically classified as preventive should not be coded as preventive to bypass patient cost-sharing or bypass visitation limitations**.

For example, if the patient was counseled primarily for ulcerative colitis, and not heart disease reduction, using Z82.49 - family history of ischemic heart disease, even if true, would not be appropriate as a primary diagnosis.

Another common coding issue involves data review. For instance, if a patient with type 2 diabetes sends a message through their patient portal asking for guidance on adjusting their intake after their blood sugar levels have been consistently elevated postbreakfast following implementation of a new meal plan, the RD might review the patient's inquiry and glucose readings uploaded to the portal. After assessing both the patient's intake and the patient's blood glucose records, the RD may provide recommendations for adjusting carbohydrate portions and timing and include a brief response back to the patient, along with links to educational materials. Under some payer policies, this type of service might be appropriately billed under a code such as *online digital management* or another virtual care code. However, this encounter would not qualify for billing under the MNT codes. The MNT codes are clear that the encounter must be face-toface, either in person or via telehealth.

Documentation Standards for Time-based Billing

The provider's documentation should support all billed time and services and in general should include:

- Start and stop times
- Patient location (state) and setting (virtual, audio-visual, audio only, in-person)
- Patient engagement and level of participation
- Summary of nutrition assessment, nutrition diagnosis/ problem, intervention, and plan
- Education and counseling topics addressed
- Relevant clinical information along with clinical rationale and medical necessity of the service

Payers often have written policies regarding documentation requirements, and it is the responsibility of all organizations and providers to know and follow these policies.

Referral Requirements and Scope of Practice

Why a Referral May Be Needed Even when not Required by State Law or the Payer

If an RD intends to bill using medical diagnosis codes (this is any code other than a Z-code), a referral, order, or other form of documentation as defined by the telehealth company and/or the payer from the diagnosing provider is generally necessary to establish the medical diagnosis being treated and can serve to further support the medical necessity of the MNT intervention. Such information should be recorded in the medical record.

Providers should code to the highest level of specificity for diagnosis codes on the claim form and the diagnosis must be valid for the date of service reported and relevant to the service reported. Providers should use caution if choosing to use a diagnosis not listed in the current referral/order. If using a diagnosis code not listed in the referral, RDs should verify with the diagnosing or treating provider that the condition is still active and if treatment is appropriate and document such verification in the medical record. If the record contains conflicting information, it is the billing provider's responsibility to clarify any discrepancies with the diagnosing provider.[1]

Clinical Judgment, Appointment Cadence, and Medical Necessity

Follow-up care is important, but appointment frequency must always be grounded in clinical need.

RDs should:

- Assess medical necessity of continued care individually for each patient
- Determine appropriate cadence based on:
  - Medical condition(s) and disease state
  - Nutrition goals
  - Patient complexity
  - Readiness for change
  - Risk level and need for monitoring
- Document justification for follow-up visits clearly and thoroughly

For more information about coding and billing, please refer to the Academy's *Best Practices for Registered Dietitians Working with Telehealth Nutrition Companies to Provide Nutrition Services*.

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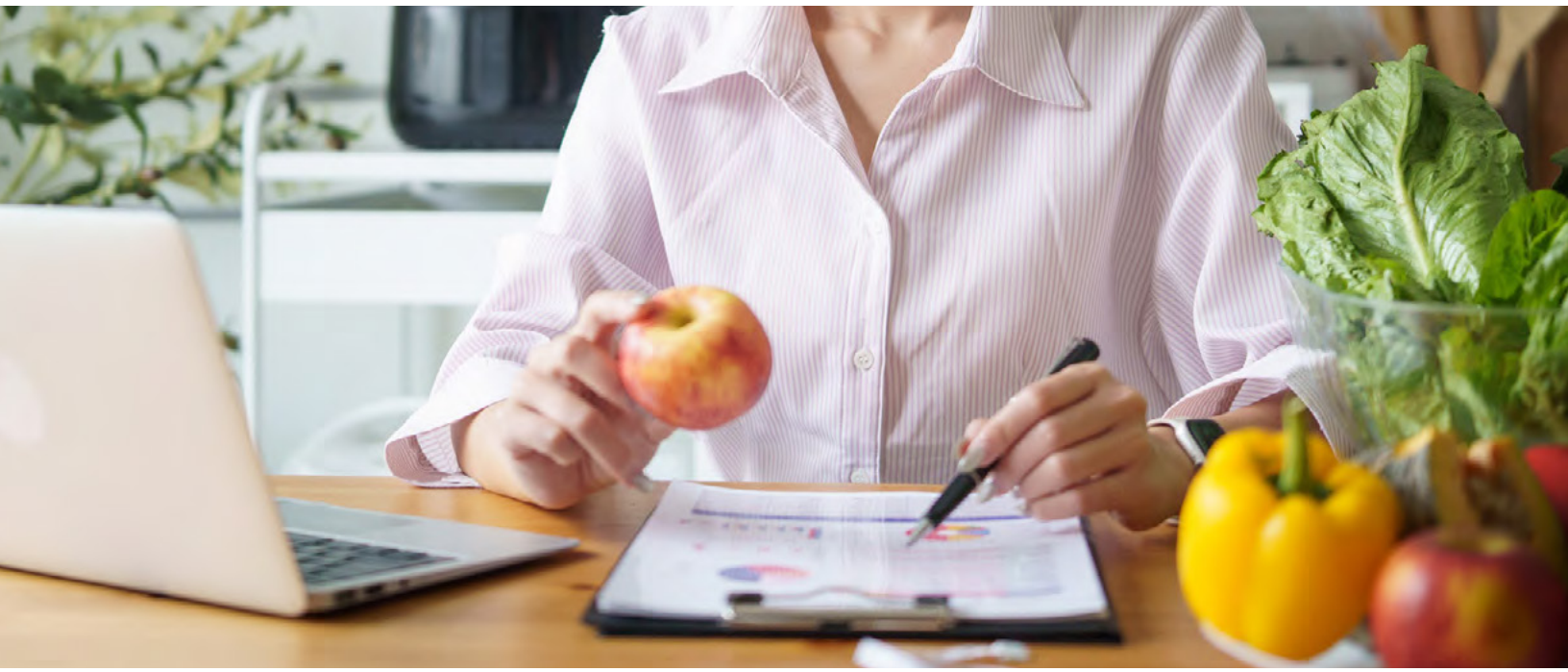

[1] *See* Centers for Medicare & Medicaid Services, & National Center for Health Statistics (2025). ICD-10-CM official guidelines for coding and reporting, FY 2026: Updated October 1, 2025 (October 1, 2025–September 30, 2026). U.S. Department of Health and Human Services.