Dual eligibles: An overlooked revenue source

Approximately nine million people in the United States are covered by both Medicare and Medicaid. Referred to as “dual eligibles,” these patients are either low-income seniors or those under 65 years of age who meet eligibility requirements of both Medicare and Medicaid. Nearly half of dual-eligible patients initially qualify for Medicare because of a disability rather than their age, and nearly one-fifth have three or more chronic health conditions. This complex care population consumes a disproportionate share of both programs’ spending. Nearly half of dual-eligible patients initially qualify for Medicare because of a disability rather than their age, and nearly one-fifth have three or more chronic health conditions. This complex care population consumes a disproportionate share of both programs’ spending. Sixteen percent of Medicare beneficiaries are dual eligible, yet they account for one quarter of Medicare spending, while 18 percent of Medicaid beneficiaries are eligible and represent almost half of Medicaid spending. Registered dietitian nutritionists (RDNs), through the provision of medical nutrition therapy (MNT), can support efforts to improve health outcomes and control state and federal government spending for this vulnerable population. However, one of the biggest barriers for providing care to this population is failing to have a full understanding of the dual-eligible beneficiary’s coverage.

Understanding the differences
Medicare and Medicaid are two different programs with different coverage and they each operate under different rules. As such, benefits allowed under the combined dual-eligible program can initially be confusing. Medicare is a federally run and funded program and its coverage and benefits are standard across all states. Additionally, Medicare beneficiaries may choose from two main types of Medicare coverage: Original Medicare (Part A and Part B) or Medicare Advantage (Part C). Medicare Advantage plans are health plans offered by a private company that contracts with Medicare to provide beneficiaries with Part A and Part B benefits. There are a variety of Medicare Advantage plans on the market, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), private

Understanding dual-eligible beneficiaries
An individual is said to be “dual-eligible” if he or she is eligible for both Medicare and Medicaid benefits. Although they are often discussed as though they were a homogeneous class of individuals, dual eligibles are very diverse because of the different ways that individuals can become eligible for both Medicare and Medicaid. For example, dual eligibles include young, disabled adults; poor, but relatively healthy older adults; and frail elderly living in nursing homes who have exhausted their incomes paying for long-term care services that are not covered by Medicare.

Image source: Kaiser Family Foundation analysis of a 5% sample of Medicare claims form the Chronic Conditions Data Warehouse, 2010 and Kaiser Family Foundation Medicaid and the Uninsured and Urban estimates based on FY2010 MSIS

New HIPAA audits to target healthcare industry

Now might be a good time to review your policies and procedures for Health Insurance Portability and Accountability Act (HIPAA) compliance. The U.S. Department of Health and Human Services, Office for Civil Rights (OCR) has begun a second phase of audits for covered entities and their business associates. The 2016 Phase 2 HIPAA Audit Program will focus on the healthcare industry, targeting the business associates of healthcare providers, insurers and other HIPAA-covered entities along with the entities themselves. Policies and procedures adopted and employed by covered entities and their business associates will be reviewed to meet selected standards and implementation specifications of the Privacy, Security, and Breach Notification
fee-for-service plans, special needs plans (SNPs), and Medicare Medical Savings Account plans. SNPs are unique in that they limit membership to people with specific diseases or characteristics, and they tailor their benefit and provider choices to best meet the needs of the groups they serve.

Medicaid is a cooperative venture jointly funded by federal and state governments. Within broad national guidelines established by federal statutes, states establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services that are covered. Additionally, state Medicaid programs set payment rates for services and control provider credentialing. Some state Medicaid plans cover MNT services for certain diagnoses and recognize the RDN as a credentialed provider, while other states neither cover MNT nor recognize the RDN. Some states also differentiate their Medicaid program further by giving the program a distinctive name. For example, California’s Medicaid program is called Medi-Cal and Tennessee’s program is TennCare. Finally, the Medicaid landscape gets more complex as one factors in Medicaid managed care plans and alternative benefit plans (plans offered within states as part of Medicaid expansion efforts).

**Coordination of benefits rules**

**When there’s more than one payer, “coordination of benefits” rules decide which one pays first.** The primary source of health insurance for all dual-eligible patients is Medicare, with Medicaid helping with premiums and cost-sharing, and paying for some services not covered by Medicare. That means that RDN reimbursement opportunities may exist if the Medicaid patient is dual eligible. For example, dual eligibles with a diagnosis of diabetes and/or chronic kidney disease (CKD) and post-renal transplantation (up to three years post-transplant) who live in states where the state Medicaid program does not recognize the RDN or cover MNT services are still eligible for MNT services under the Medicare Part B program. An added benefit for the patient is that Medicare requires no co-pays or deductibles for certain preventive services, therefore, the patient does not incur any out-of-pocket costs for MNT and a secondary payment is not required from Medicaid.

Prior to providing services to dual-eligible patients, RDNs should determine the type of Medicare plan in which the patient is enrolled and the coverage allowed under the plan. Often, beneficiaries are unaware of their coverage or forget to show all of their insurance cards, so verification is essential. Some beneficiaries have fee-for-service plans for both Medicare and Medicaid, making rules for providing services and billing

See **Dual eligibles**, page 3

<table>
<thead>
<tr>
<th>Patient Scenario</th>
<th>Insurance Cards</th>
<th>RDN Credentialing</th>
<th>Verify Eligibility</th>
<th>Who to Bill First</th>
<th>Who to Bill Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient with type 2 diabetes who is insured by Medicare Part A &amp; B and Medicaid</td>
<td>2 Insurance cards • Medicare A/B (red/white/blue • Medicaid</td>
<td>Medicare Part B</td>
<td>Confirm Medicare Part B is active and beneficiary is NOT enrolled in a managed care, Advantage, or HMO plan for Medicare</td>
<td>Medicare (no co-pay or deductible)</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient with type 2 diabetes insured by Medicare Part A &amp; Part B and a Medicaid managed care plan (HMO).</td>
<td>3 Insurance cards • Medicare Part A &amp; Part B • Medicaid HMO</td>
<td>Medicare Part B</td>
<td>Confirm Medicare Part B is active and beneficiary is NOT enrolled in a managed care, Advantage, or HMO plan for Medicare</td>
<td>Medicare (no co-pay or deductible)</td>
<td>N/A</td>
</tr>
<tr>
<td>A dual-eligible beneficiary who is covered by a Medicare Advantage (Medicare Part C) plan would like to make an appointment for MNT for a diagnosis of renal disease.</td>
<td>3 Insurance cards • Medicare Part B • Medicaid • Medicare HMO</td>
<td>Medicare Advantage. If not a credentialed provider for the plan, refer the beneficiary back to the primary care provider’s office for authorization request to see a contracted RDN.</td>
<td>Confirm Medicare Part C is active</td>
<td>Medicare Advantage</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient with Crohn's disease who is insured by Medicare Part A &amp; Part B and Medicaid</td>
<td>2 Insurance cards • Medicare Part A &amp; Part B • Medicaid</td>
<td>Medicaid</td>
<td>Confirm Medicaid is active and beneficiary is NOT enrolled in Medicaid managed care plan. Confirm coverage of MNT for this medical diagnosis.</td>
<td>Medicaid</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**QUESTION CORNER**

**Q:** Do registered dietitian nutritionists (RDNs) in hospital-based outpatient diabetes self-management training (DSMT) programs need to get individual National Provider Identification (NPI) numbers to bill DSMT or can they use the hospital’s NPI number?

**A:** If the hospital-based DSMT program uses the hospital provider number (also an NPI number) to bill for DSMT services, individual RDN instructors would not need separate NPIs. If an RDN wants to submit claims for DSMT services as an individual Medicare provider, he or she must have an NPI number. To learn more about DSMT and DSMT programs, visit: https://www.eatrightpro.org/resource/practice/getting-paid/smart-business-practice-and-management/diabetes-self-management-training.

**Q:** What are the key differences between Medicaid and Medicare Advantage plans?

**A:** Medicaid and Medicare Advantage plans are funded by different sources. Medicare is always the primary source of insurance for patients with a diagnosis of diabetes and renal disease. If additional coverage is offered by the Medicare Advantage plan for patients with a diagnosis beyond diabetes and renal disease, the RDN should contact the plan directly. Similar to Medicare, separate credentialing is often required for traditional Medicaid versus Medicaid managed care plans.

**Q:** What are the key differences between Medicaid and Medicare Advantage plans?

**A:** Medicare Advantage plans are required, at a minimum, to offer the benefits of traditional Medicare, which includes MNT services provided by an RDN for patients with a diagnosis of diabetes or CKD. Reimbursement for MNT services for additional diagnoses may also be included in Medicare Advantage, however the physician must request a prior authorization, and approval for those services must take place before providing services. Although funding for these programs comes from Medicare, enrollment as a provider in traditional Medicare does not carry over to Medicare Advantage plans, therefore RDNs must enroll in each Medicare Advantage plan or managed care program prior to providing services and billing. RDNs can contact the provider relations department of the Medicare Advantage or managed care plan to find out how to become credentialed.

Yet another possibility is that the dual-eligible patient is enrolled in a managed care plan for their Medicaid program only. If this is the case, because Medicare is the primary source of insurance with Medicaid as the secondary source, no additional credentialing is necessary by the RDN prior to providing MNT for patients with a diagnosis of diabetes and renal disease. To determine if additional coverage is offered by the Medicare Advantage plan for patients with a diagnosis beyond diabetes and renal disease, the RDN should contact the plan directly. Similar to Medicare, separate credentialing is often required for traditional Medicaid versus Medicaid managed care plans.

Preventive benefits, including the annual wellness visit (AWV) and the intensive behavioral therapy (IBT) for obesity benefit, are also available to dual eligibles through the Medicare program. At this time, RDNs can only provide these services in primary care settings ‘incident to’ the physician, but they offer additional opportunities for the RDN to support comprehensive patient care and increase their value within the health care team.

Navigating the complexities of reimbursement for services provided to dual eligibles can be worth the effort. Dual eligibles can offer RDNs new revenue streams and open up possibilities for expanding business through increased physician referrals. Additionally, those referrals can open doors for communicating and collaborating with primary care and other providers, and may lead to better coordinated care and improved patient outcomes. RDNs can use the MNT effectiveness and cost-effectiveness information contained in the Academy’s Evidence Analysis Library (EAL) as strong evidence that nutrition services provided by RDNs applying the Academy of Nutrition and Dietetics’ Evidence-based Nutrition Practice Guidelines can improve a consumer’s health through decreased doctor visits and hospitalizations and reduced prescription drug coverage. To find out more about dual eligibles, visit: www.eatrightpro.org/resource/practice/getting-paid/who-pays-for-nutrition-services/medicare-advantage-medicarechoice-plans. For a Medicare Administrative Contractor directory interactive map, visit: http://bit.ly/1JMS0vk.

**Contributing author Michele Chynoweth, RD, CDE, has been in private practice for over 30 years. She served on the Academy’s Coding and Coverage Committee, was the Nutrition Entrepreneurs (NE) Dietetic Practice Group Reimbursement Chair, and has participated in numerous state and national workshops and educational sessions addressing coding, coverage, and payment for RDN services.**

---

**Billing reminders for dual eligibles:**

- Medicare is always the primary payer
- RDN must be credentialed with the plan paying for the service
- Always get copies of all insurance cards
- Always verify coverage is active
- Always verify patient’s benefits

---

**Dual eligibles, from page 1**

straightforward for RDNs. Using an interactive voice response system (IVR) or online access provided by the Medicare Administrative Contractor (MAC) processing claims in the area, RDNs can verify the patient’s benefits and determine if the patient has a Medicare fee-for-service plan or an alternate Medicare plan as the primary insurance. If the beneficiary is enrolled in a fee-for-service Medicare Part B plan and the RDN is credentialed as a Medicare provider, no additional credentialing by Medicaid is required. However, not all beneficiaries have fee-for-service options for both plans and additional credentialing may be required by the RDN before providing services and billing.

Alternatively, dual eligibles may be enrolled in a Medicare Advantage plan with Medicaid offering supplemental coverage. Medicare Advantage plans are required, at a minimum, to offer the benefits of traditional Medicare, which includes MNT services provided by an RDN for patients with a diagnosis of diabetes or CKD. Reimbursement for MNT services for additional diagnoses may also be included in Medicare Advantage, however the physician must request a prior authorization, and approval for those services must take place before providing services. Although funding for these programs comes from Medicare, enrollment as a provider in traditional Medicare does not carry over to Medicare Advantage plans, therefore RDNs must enroll in each Medicare Advantage plan or managed care program prior to providing services and billing. RDNs can contact the provider relations department of the Medicare Advantage or managed care plan to find out how to become credentialed.

Yet another possibility is that the dual-eligible patient is enrolled in a managed care plan for their Medicaid program only. If this is the case, because Medicare is the primary source of insurance with Medicaid as the secondary source, no additional credentialing is necessary by the RDN prior to providing MNT for patients with a diagnosis of diabetes and renal disease. To determine if additional coverage is offered by the Medicare Advantage plan for patients with a diagnosis beyond diabetes and renal disease, the RDN should contact the plan directly. Similar to Medicare, separate credentialing is often required for traditional Medicaid versus Medicaid managed care plans.

Preventive benefits, including the annual wellness visit (AWV) and the intensive behavioral therapy (IBT) for obesity benefit, are also available to dual eligibles through the Medicare program. At this time, RDNs can only provide these services in primary care settings ‘incident to’ the physician, but they offer additional opportunities for the RDN to support comprehensive patient care and increase their value within the health care team.

Navigating the complexities of reimbursement for services provided to dual eligibles can be worth the effort. Dual eligibles can offer RDNs new revenue streams and open up possibilities for expanding business through increased physician referrals. Additionally, those referrals can open doors for communicating and collaborating with primary care and other providers, and may lead to better coordinated care and improved patient outcomes. RDNs can use the MNT effectiveness and cost-effectiveness information contained in the Academy’s Evidence Analysis Library (EAL) as strong evidence that nutrition services provided by RDNs applying the Academy of Nutrition and Dietetics’ Evidence-based Nutrition Practice Guidelines can improve a consumer’s health through decreased doctor visits and hospitalizations and reduced prescription drug coverage. To find out more about dual eligibles, visit: www.eatrightpro.org/resource/practice/getting-paid/who-pays-for-nutrition-services/medicare-advantage-medicarechoice-plans. For a Medicare Administrative Contractor directory interactive map, visit: http://bit.ly/1JMS0vk.

**Contributing author Michele Chynoweth, RD, CDE, has been in private practice for over 30 years. She served on the Academy’s Coding and Coverage Committee, was the Nutrition Entrepreneurs (NE) Dietetic Practice Group Reimbursement Chair, and has participated in numerous state and national workshops and educational sessions addressing coding, coverage, and payment for RDN services.**

---

**Billing reminders for dual eligibles:**

- Medicare is always the primary payer
- RDN must be credentialed with the plan paying for the service
- Always get copies of all insurance cards
- Always verify coverage is active
- Always verify patient’s benefits

---

**QuestIoN CorNer**

**Q:** Yet another possibility is that the dual-eligible patient is enrolled in a Medicare Advantage plan or managed care program prior to providing services and billing. RDNs can contact the provider relations department of the Medicare Advantage or managed care plan to find out how to become credentialed.

**A:** If the hospital-based DSMT program uses the hospital provider number (also an NPI number) to bill for DSMT services, individual RDN instructors would not need separate NPIs. If an RDN wants to submit claims for DSMT services as an individual Medicare provider, he or she must have an NPI number. To learn more about DSMT and DSMT programs, visit: https://www.eatrightpro.org/resource/practice/getting-paid/smart-business-practice-and-management/diabetes-self-management-training.**
Rules. Every covered entity and business associate is eligible for an audit, from individual and organizational providers of health services; health plans of all sizes and functions; health care clearinghouses; and a range of business associates of these entities.

The OCR has started sending out e-mails to obtain and verify contact information for covered entities and business associates in the healthcare industry for possible inclusion in the pool of potential audit subjects. In the coming months, OCR will notify the selected covered entities in writing through email about their selection for a desk audit. “Getting an audit letter, even if it’s only for confirmation of a covered entity’s contact information, should serve as notice to healthcare leaders,” said Timothy McCrystal, partner at Ropes & Gray, a law firm specializing in serving clients in key centers of business, technology and government. McCrystal advises letter recipients to pull out and review their HIPAA security risk assessment checklist, assess compliance status and spend time and resources remediating open issues. RDNs can learn more about the HIPAA Omnibus Rule, covered entities and business associates by visiting the Academy website, at: http://bit.ly/1S0htWT. Tips for HIPAA compliance are available at: http://bit.ly/1qsTjYU. For information on the OCR’s 2016 Phase 2 HIPAA Audit Program, visit: www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html.

Medicare qualifications and benefits? A: Each state establishes its own Medicaid eligibility standards within broad set of national guidelines. States also determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer their own program. Whereas under Medicare, financial status is not a factor and benefits are standard across all states. Individuals over age 65 and those under age 65 with certain disabilities, end-stage renal disease, Lou Gehrig’s disease, or those receiving a disability pension from the Railroad Retirement Board may qualify for Medicare.

Q: How can I find out what Medicare Advantage plans are located in my area?

A: RDNs can view all Medicare Advantage plans (traditional Medicare and Medicare Advantage plans) in their area through a zip code search in the Medicare Plan Finder. This search tool compares programs, and includes the company name, plan name, service area and phone information. To access the Medicare Plan Finder, visit, www.eatrightpro.org/resource/practice/getting-paid/who-pays-for-nutrition-services/medicare-advantage-medicarechoice-plans.

Do you have a question for the Question Corner?

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