Coding, billing and ethics—Oh, my!

Ethics is a component of practice for all registered dietitians (RDs), no matter the practice setting. However, RDs who provide medical nutrition therapy (MNT) services and bill for those services face some unique ethical questions in their practices. The line between ethical issues and legal issues can easily become blurred, as can the line between ethical practices and good business practices. The March issue of the *Journal of the Academy of Nutrition and Dietetics* features an Ethics in Action column, “Elements of Ethical Billing,” which offers valuable guidance about the ethics of billing for nutrition services and is a “must read” for RDs providing MNT services (*J Acad Nutr Diet*. 2012;112[3]:432-434).

We spoke with Jane White, PhD, RD, LD, FADA, coauthor of the Journal article, to identify some areas of confusion that could potentially lead to an ethical dilemma when billing for MNT services. Dr. White addressed the following examples of practice situations that would necessitate ethical decision making.

**How does an RD determine which CPT codes are appropriate for reporting and billing for MNT services?**

Ethical practice dictates that the provider select procedure codes that most accurately describe the services performed. The MNT CPT codes (97802, 97803, and 97804) most appropriately describe MNT services provided by RDs, and thus these are the codes of choice to use when billing third-party payers. RDs may want to bill for their services using Evaluation and Management (E/M) codes in an effort to successfully secure reimbursement for their services and/or an enhanced level of reimbursement. However, before using E/M codes, RDs should review the CPT Common Procedural Terminology Manual, or visit the Academy website (www.eatright.org/Members/content.aspx?id=7495) to understand the use and proper selection of these codes to avoid potential upcoding. Upcoding is a fraudulent practice in which provider services are billed for higher CPT procedure codes than are appropriate for the services that were actually performed, resulting in a higher payment by Medicare or other third-party payers. RDs should also be familiar with payer policies regarding coding for services.

**Can I bill Medicare for MNT services using 97803 and G0270 on the same day of service if the beneficiary has used his or her maximum annual allowance for hours of MNT services and I obtain a second referral from the physician after the visit?**

I have excellent relationships with physicians, and I know they will order the additional services based on my request.

No matter how certain the RD may be that the physician will order a service, it would be unethical to bill for services without the physician referral in hand at the time the service is provided. Per Medicare regulations, the G code G0270 is to be used when additional MNT is ordered in the same calendar year. The provision of these additional MNT services must be based on a second referral from the treating physician for a change in diagnosis.
Malnutrition webinar offered

Join us Wednesday, May 23, 2012 at 2 p.m. Eastern, 1 p.m. Central, 11 a.m. Pacific for a 90-minute live webinar, “From Theory to Practice: Optimizing Recognition and Documentation of Adult Malnutrition.” In September 2011, the Academy and A.S.P.E.N. released new recommendations for the identification and documentation of adult malnutrition. Widespread use of these criteria will help to standardize the diagnosis of adult malnutrition and provide more accurate estimates of its incidence. This webinar, offering 2.0 CPE hours, will provide participants with the knowledge and practical tools needed to design comprehensive, team-oriented systems for effective recognition and documentation of adult malnutrition.

Join us wherever it’s convenient for you. Learn in a group from your office or individually, from home or car. The registration fee for Academy members who register before May 14, 2012, is $109 per listening site; beginning May 14, the fee is $134 per listening site. For more information or to register, visit: www.eatright.org/pd/malnutrition.

Academy and Aetna work together to resolve issues with denied claims

After a long journey, the Academy is pleased to announce that registered dietitians who had in-network claims denied by Aetna between January 2009 and the present may now resubmit those claims for processing and payment. If you are affected by this agreement, you need to take action by June 4, 2012. To read the details and learn what you need to do, visit: www.eatright.org/members/aetna.

ICD-10 compliance delayed until Oct. 1, 2014

If rules proposed by the Department of Health and Human Services (HHS) are finalized as written, health care providers and other covered entities under Health Information Portability and Accountability Act (HIPAA), including registered dietitians, will have additional time to prepare for implementation of the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). On April 17, 2012, HHS published a proposed rule that would delay the compliance date from Oct. 1, 2013, to Oct. 1, 2014. The proposed extension comes in response to provider groups that expressed concern over their ability to prepare and fully test their systems to ensure a smooth transition to the new code sets. Read more at: www.CMS.gov/apps/media/press/release.asp?Counter=4329. The Academy of Nutrition and Dietetics’ Nutrition Services Coverage Team continues to provide information and resources to assist members with the migration to ICD-10 at: www.eatright.org/Members/content.aspx?id=6442465636.

Medicare revalidation required

To meet requirements of the Affordable Care Act, the Centers for Medicare & Medicaid (CMS) is requiring all Medicare providers and suppliers, including registered dietitians (RDs), to revalidate or certify the accuracy of their existing enrollment information. While revalidation typically occurs every five years, CMS is currently undertaking an “off-cycle” revalidation process now for all providers, which means you may receive a revalidation request before your current five-year period ends. RDs should not attempt to revalidate their enrollment information until they are requested to do so by their Medicare Administrative Contractor. Revalidation is simple and can be done online via the Provider Enrollment Chain and Ownership System (PECOS) or manually using paper 855 enrollment applications. RDs as individual providers will not need to pay application fees. If you are not sure whether you have been issued a revalidation letter, visit the following CMS web page: www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp#TopOfPage.

Save time: Submit your Medicare enrollment application with an e-signature

The Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) now allows providers and suppliers to sign Medicare enrollment applications electronically. In the Internet-based PECOS, all individual provider applications that do not include new reassignments may e-sign the application as part of the submission process. This provision applies to physicians and non-physician practitioners but does not change who is required to sign the application.
QUESTION CORNER

Q: I am a registered dietitian (RD) in private practice. My business model is based on self-pay clients rather than dealing with billing insurance companies. Is it okay for me to provide medical nutrition therapy (MNT) services to Medicare beneficiaries with diabetes as self-pay clients?

A: If you become a Medicare provider, you must bill Medicare for all covered Medicare services provided to Medicare beneficiaries. It is illegal to do otherwise. If an RD wants to provide MNT services to Part B Medicare beneficiaries for diabetes and renal disease but not bill Medicare for this service, she must formally opt out of Medicare and enter into a written private contract with each beneficiary. Section 4507 of the 1997 Balanced Budget Act, also known as private contracting, made opting out possible. It states that nothing in the Medicare law “shall prohibit a physician or practitioner from entering into a private contract with a Medicare beneficiary for any item or service” if certain conditions are met. Private contracts with Medicare patients are legal if the contracts meet certain conditions specified in the law, most notably that the RD agrees not to submit any Medicare claims nor receive any payment from Medicare for services provided to any Medicare beneficiary for two years. Since the opt-out period lasts for two years, you will also have to file and renew affidavits with Medicare every two years regarding your opt-out status. If you choose to opt out of Medicare, do so properly and remain in compliance with the opt-out conditions; otherwise, your private contracts are null and void. You have 90 days after the effective date of opting out to change your mind and return to Medicare as if you had never left. Just notify the same carriers to whom you sent your affidavit(s) and refund any money you received from private contracts. Note that an RD does not need to opt-out of Medicare to bill patients for MNT services for diagnoses that are not covered under Medicare Part B. For more detailed information on opting out of Medicare, consult Section 3044 of Part 3 of the Medicare Carriers Manual at http://cms.hhs.gov/manuals/14_car/3b3026.asp#1639.html.

Q: I am an RD in private practice exploring new ways to expand my practice. If I were to see clients referred to me by a fitness club and paid the club a certain fee for each client, would this be characterized as fee-splitting?

A: Fee-splitting is a fairly complicated topic and occurs when a health care provider or supplier receives a fee for referring a patient. Fee-splitting is illegal in some states because it represents a conflict of interest that may adversely affect patient care and well-being. Patients may not necessarily be referred to the most appropriate practitioner to provide their on-going care but will instead be referred to practitioners or facilities with which the referring individual has a fee-splitting or commission payment type of arrangement. Fee-splitting prohibitions vary from state to state, and RDs should understand the rules in their locale. Also, when evaluating such situations, state and federal kickback prohibitions need to be taken into consideration. For example, the federal anti-kickback statute prohibits individuals or entities from knowingly and willfully offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid or any other federally funded programs.

In general, if a professional is paid for the services he or she performs, fee-splitting can be avoided. While each practitioner is ultimate responsible for his/her own ethical conduct, RDs should never pay for referrals. It would be in the best interest of the RD to establish a contract with the gym that is not based around fees for referrals. Determining what to do when an ethical dilemma arises can be tricky at times. The Academy’s Code of Ethics should be used to guide dietetics practitioners in their professional practice and conduct when normal and assertive business decisions become issues of concern. RDs should also seek advice of legal counsel to ensure compliance with state and federal laws.

Note: Information in this newsletter is intended for reference use only and does not constitute the rendering of legal, financial or other professional advice of the Academy of Nutrition and Dietetics.

5010 enforcement delayed, again

The Centers for Medicare & Medicaid (CMS) Office of E-Health Standards and Services announced it would delay the enforcement of the mandated move to Version 5010 transaction standards for three additional months. The original deadline for the conversion to the Version 5010 standards was Jan. 1, 2012. In November 2011, the CMS announced that, although it was not changing the actual deadline for complying with the standards, it would delay enforcement three months, until March 31, 2012. The most recent CMS statement delays action against non-compliant medical practices, hospitals and other healthcare entities through June 30, 2012.
How should RDs determine how many units to bill for an individual MNT encounter? Should they round up to the next number of units of service?

The CPT Common Procedural Terminology Manual provides clear answers to these questions. Each of the MNT CPT codes is associated with a specific number of minutes of service based on the face-to-face time spent with the client. According to the American Medical Association, a unit of time is attained when the midpoint is passed (see chart). A typical MNT encounter requires billing multiple units of these codes. So, for example, if you spend 50 minutes face-to-face with the client, you would bill for 3 units. It would be unethical (and fraudulent) to inappropriately round up the number of units billed (e.g., an RD should not bill 2 units for a 20-minute face-to-face encounter).

When billing for MNT services, can an RD take into account the time spent reviewing the client's medical record, weighing the client, and documenting the encounter afterward?

No. It would be both unethical and fraudulent to include this time when determining the number of units to bill for a service because payment rates for each CPT code already take into consideration preparation time for the patient visit and postservice documentation. Therefore, this time should not be counted when calculating the number of units billed. The selection of a code and the number of units billed for those codes that can be billed in multiple units should be based only on face-to-face time with the client.

Ethics in health care is a hot topic these days. What advice can you give me as I begin to write policies and procedures for my new practice?

A key component to an ethical practice is having clear policies and procedures for conduct and billing that are applied in a consistent manner. Refer to the profession’s Code of Ethics as you develop these documents for your practice. Procedures and policies should also take into consideration the scope of professional practice, licensure laws, local laws and regulations, payers’ coverage guidelines and sound business practices. Once your policies and procedures are developed, have your legal counsel review them to ensure compliance with local laws and regulations.

For more information on ethics in practice, coding and billing, review the Academy Code of Ethics: www.eatright.org/codeofethics. You may also wish to consult the Ethics Education Toolkit. A source of information for members and credentialed practitioners about the Academy/CDR Code of Ethics, this toolkit includes a PowerPoint presentation, script, activities and handouts for download: www.eatright.org/About/Content.aspx?id=6442466073.

<table>
<thead>
<tr>
<th>Number of CPT Units to Bill</th>
<th>Actual Time Spent Face-to-Face</th>
<th>Example</th>
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<tbody>
<tr>
<td>1</td>
<td>≥ 8 minutes to &lt; 23 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>2</td>
<td>≥ 23 minutes to &lt; 38 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>3</td>
<td>≥ 38 minutes to &lt; 53 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>4</td>
<td>≥ 53 minutes to &lt; 68 minutes</td>
<td>60 minutes/1 hour</td>
</tr>
<tr>
<td>5</td>
<td>≥ 68 minutes to &lt; 83 minutes</td>
<td>75 minutes</td>
</tr>
<tr>
<td>6</td>
<td>≥ 83 minutes to &lt; 98 minutes</td>
<td>90 minutes/1.5 hours</td>
</tr>
<tr>
<td>7</td>
<td>≥ 98 minutes to &lt; 113 minutes</td>
<td>105 minutes</td>
</tr>
<tr>
<td>8</td>
<td>≥ 113 minutes to &lt; 128 minutes</td>
<td>120 minutes/2 hours</td>
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