Medicare 2012 fee schedule changes will impact RDs

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period that updates payment policies and rates for physicians and nonphysician practitioners for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. CMS is required to annually issue a final rule that reflects current law. Under current law, providers will face steep across-the-board reductions in payment rates, based on a formula—the sustainable growth rate (SGR)—that was adopted in the Balanced Budget Act of 1997. Without Congressional intervention, Medicare payment rates to providers paid under the MPFS for services in CY 2012 will be reduced by 27.4 percent. This is the eleventh time the SGR formula has resulted in a payment cut. However, except in CY 2002, Congress has always stepped in at the last minute to avert the cuts.

Although it is uncertain whether Congress will intervene to delay Medicare Part B payment reductions for CY 2012, there are several changes to the Medicare program that will affect registered dietitian (RD) practices in a positive way. The following aspects of the new regulations released by CMS specifically impact RDs:

- **New Medicare Annual Wellness Visit (AWV) mandates.**
  As of January 1, 2011, CMS added the AWV as a benefit for Medicare beneficiaries (see October 2011 MNT Provider). Under a physician’s supervision, RDs may provide services included in the AWV. As of January 1, 2012, CMS has made the health risk assessment (HRA) a mandatory requirement for the AWV and has “modestly” increased payments for the AWV to account for the increase in staff time needed. The HRA is a form the provider practice will develop (CMS provides no ready-made template) for patients to complete either before or during an AWV. It is intended to be a plain-English form that takes no more than 20 minutes to complete and asks patients a wide variety of questions to help determine their risk factors. This information is used as the foundation for each Medicare 2012 fee schedule changes will impact RDs

Updated Diabetes Services Order Form now available

More than 25 percent of Americans age 65 years and older have diabetes, and yet diabetes self-management education, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) have historically been underutilized Medicare benefits. In response, the American Dietetic Association American and the Association of Diabetes Educators jointly developed the Diabetes Services Order Form as an easy and convenient way for physicians and qualified nonphysician practitioners to refer their Medicare patients with diabetes for MNT and DSMT services. The form was first developed in 2005 and has recently been updated. To read the backgrounder and download the updated form, visit: www.eatright.org/coverage.
patient’s personalized prevention plan, which is already required by the AWV.

- **RD Medicare providers can continue to report quality measures in 2012 and receive incentive payments.** The Physician Quality Reporting System (PQRS) provides incentive payments and payment adjustments to identified eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare patients. Bonus payments for PQRS will equal 0.5 percent of reporting RDs’ Medicare charges for 2012. Individual RDs or a group of RDs in one practice can report measures via claims, electronic medical records or registries. However, the reporting threshold for claims-based reporting has been lowered from 80 percent to 50 percent of the eligible professional’s Medicare Part B Physician Fee Schedule for patients seen during the reporting period to which the measure applies. PQRS information is posted in the Physician Quality Reporting System section of the American Dietetic Association (ADA) website: www.eatright.org/mnt.

- **RDs potentially benefit from alignment of PQRS and Electronic Health Record (EHR) Incentive Program:** PQRS reporting requirements are now identical to those under the EHR Incentive Program. Also, RDs can now report all 44 EHR measures from the program under PQRS. CMS also allows for submission of the PQRS EHR measures via an EHR data submission vendor in addition to direct submission from an eligible provider’s EHR-based product to CMS.

CMS has also corrected an anomaly regarding several group service codes, including those for medical nutrition therapy (MNT) and outpatient diabetes self-management training (DSMT) services. Because the services are billed per patient receiving the service, CMS argues that the time for these codes should be divided by the typical number of patients per session. For MNT-related current procedural terminology (CPT) and G codes and definitions, visit: www.eatright.org/Members/content.aspx?id=7495&terms=97804. While this modification is not ideal, CMS did utilize information provided by ADA to determine the typical group size for these services. In addition, similar changes have been made regarding group service codes used by other health care providers.

The final rule will appear in the November 28, 2011, Federal Register. In the meantime, to access the 2012 final Medicare fee schedule notice, go to: www.ofr.gov/OFRUpload/OFRData/2011-28597_PI.pdf

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### What is a health risk assessment (HRA)?

CMS defines the HRA as an evaluation tool that addresses, at a minimum, the following topics:

- Demographic data, including but not limited to age, gender, race and ethnicity
- Self assessment of health status, frailty and physical functioning
- Psychosocial risks, including but not limited to depression/ life satisfaction, stress, anger, loneliness/social isolation, pain and fatigue
- Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (seat belt use) and home safety
- Activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls) and bathing
- Instrumental activities of daily living (IADLs), including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications and ability to handle finances

For more information on HRAs, refer to the Centers for Disease Control and Prevention’s Interim Guidance for Health Risk Assessments, which is available on the CMS website at: www.cms.gov/coveragegeninfo/downloads/healthriskassessmentsCDCfinal.pdf.
**QUESTION CORNER**

**Q:** I know that the Centers for Medicare & Medicaid Services (CMS) released an updated version of the Advance Beneficiary Notice of Noncoverage (ABN; form CMS-R-131) to replace the 2008 version, but I don’t see a difference between the old and new version. Can I still keep using the 2008 version?

**A:** The 2011 version, approved by the Office of Management and Budget, contains no substantive changes from the 2008 version of the notice, except that the release date “3/11” is printed in the lower left-hand corner of the 2011 version. However, beginning January 1, 2012, all providers, practitioners and suppliers paid under Medicare Part B, as well as hospice providers and religious nonmedical health care institutions paid exclusively under Part A, must use the 2011 version of the ABN form. ABNs issued after January 1, 2012, that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors. For additional information about providing the Medicare Part B MNT service and billing using the ABN form, visit: www.eatright.org/Members/content.aspx?id=7306.

**Q:** What is the maximum number of medical nutrition therapy (MNT) CPT code units a registered dietitian (RD) can bill Medicare per visit?

**A:** The Centers for Medicare & Medicaid Services (CMS) regulations for Medicare MNT indicate that RDs who are Medicare providers are able to determine the amount of time spent (or number of units billed) for all MNT visits. Remember, one unit of the MNT CPT code 97802 (initial assessment and intervention, individual) equals 15 minutes; one unit of the CPT code 97803 (re-assessment and intervention, individual) equals 15 minutes; and one unit of the CPT code 97804 (group, 2 or more individuals) equals 30 minutes. For beneficiaries with diabetes or kidney disease, Medicare allows three hours of MNT in the first year and two hours in subsequent years. Up to two hours of additional services per year can be provided with a second referral for a change in diagnosis, medical condition or treatment regimen.

For best practice, the American Dietetic Association’s Evidence-based Nutrition Practice Guideline for Type 2 Diabetes Mellitus suggests 60 to 90 minutes for the initial patient-RD encounter and 30 to 45 minutes for subsequent encounters. To access the practice guideline and a companion toolkit, visit: www.adaevidencelibrary.com. Under CMS regulations, RDs who provide MNT services must follow evidence-based guidelines when providing care to Medicare beneficiaries with diabetes or kidney disease.

**Q:** When does an episode of care begin for Medicare Part B medical nutrition therapy (MNT) services for diabetes and renal disease?

**A:** According to the Centers for Medicare & Medicaid Services, “The episode of care begins with the patient’s visit to their managing or treating physician, who based upon the medical assessment, refers the Part B beneficiary for MNT as part of the treatment plan for that period of illness.” In other words, the physician referral is when the “clock” starts for MNT services (three hours in the first calendar year and two hours in subsequent calendar years). For more information, visit: www.cms.gov/transmittals/downloads/B0148.pdf.

**Diabetes-Related Services fact sheet revised**

A revised version of the Diabetes-Related Services fact sheet is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network. This fact sheet, which is designed to provide education on diabetes-related services, includes information on diabetes screening tests, diabetes self-management training, medical nutrition therapy, and covered supplies and other services for beneficiaries with diabetes. To download a copy of the fact sheet, visit: www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf.
Announcing the Diabetes Mellitus Toolkit

The American Dietetic Association (ADA) is happy to announce the availability a new ADA publication, the Diabetes Mellitus Toolkit. Available electronically or in print, the toolkit is a companion set of hands-on materials to help practitioners apply the Diabetes Type 1 and 2 Evidence-based Nutrition Practice Guideline in practice. The kit includes resources such as:

- Sample initial and follow-up progress notes
- An interactive progress note option for documenting electronically in a PDF file
- Case studies highlighting care by generalist, specialist and advanced registered dietitians
- An outline of the encounter process for patients/clients
- Sample forms for food recall, the encounter contract and the client agreement for care
- Forms to monitor outcomes that illustrate the progress of anthropometric, behavioral and biochemical outcomes

To purchase the toolkit or view the table of contents and sample documents, visit: www.adaevidencelibrary.com/store.cfm?category=1.

Key dates:

Month of November

American Diabetes Awareness Month
For diabetes related resources, visit: www.eatright.org/Members/content.aspx?id=7319
To view the ADA Diabetes Coverage Policy Statement, visit: www.eatright.org/Members/content.aspx?id=7702

Jan. 1, 2012

Accountable Care Organizations (ACOs) are scheduled to begin for Medicare
ACO background information, updates and discussion of the role of the RD in ACOs can be found at: www.eatright.org/Members/content.aspx?id=6442460362&terms=accountable+care+organizations

Standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010
Learn more about the transition to 5010 at: www.eatright.org/Members/content.aspx?id=6442465641

Oct. 1, 2013

ICD-10 code sets replace ICD-9-CM code sets
Resources to help guide RDs through the upcoming transition are located at: www.eatright.org/Members/content.aspx?id=6442465636

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