


Contracting with Medicare and MediCal Managed Care


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What is Medicare? Who is eligible?

Federal health care program for people (beneficiaries) 65 yrs. and older, certain younger people and people with End Stage Renal Disease (ESRD)




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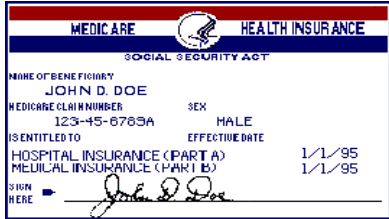
Medicare Program

<ul style="list-style-type: none"> • Part A- "Hospital Insurance" <ul style="list-style-type: none"> ○ Aged insured ○ Disabled insured ○ ESRD insured- on dialysis 	<ul style="list-style-type: none"> • Part B- "Medical Insurance" <ul style="list-style-type: none"> ○ Coverage of physician and non-physician services, diagnostic tests, durable medical equipment and ambulance transportation ○ Voluntary program for which the insured must pay a monthly premium
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Medicare Card




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Providers Eligible to Independently Bill Medicare Part B

- Physicians
- Nurse practitioners
- Physical Therapists
- Registered Dietitians or Nutrition Professional

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Medicare MNT Benefit and RDs Options for Participation

Enroll

- Practitioners can enroll at any time
- Enrollment application forms available from the local state Medicare carriers or Medicare Administrative Contractors (MACs).
- Current California carrier is Palmetto GBA
website: <http://www.palmettogba.com>

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Enrollment Process

- RD must obtain a national provider number (NPI) before enrolling in Medicare
Website: <http://nppes.cms.hhs.gov>
Toll free number: 800-465-3203
- Medicare Forms to use
 - CMS855I- form for individual provider enrollment
 - CMS855R- form to reassign benefits to employer, facility
 - CMS855B- form for group practices



Practice Tip

Medicare provider status
will be deactivated
if no claims are submitted
over 12 months



Medicare MNT Benefit Regulations



Medicare MNT Benefit Requirement

Medicare RD Provider must use nationally recognized protocols– e.g. ADA MNT Evidence-Based Guides for Practice

- Links the best scientific evidence about nutrition care to a specific health problem
- It includes research, national guidelines, policies, expert opinion and quality improvement data.
- When research data is lacking, apply expert knowledge via consensus statements



Steps of MNT The Nutrition Care Process

- In-depth nutrition assessment
- Determine nutrition diagnosis (the nutrition problem)
- With client input, determine nutrition intervention(s)
- Follow-up over time with beneficiary
- Monitor and evaluate progress over time
- Document progress and outcomes



Frequency and Duration of Medicare MNT Services

- Basic coverage (year 1)= 3 hours
“...additional hours are considered to be medically necessary and covered if the treating physician determines there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.”
- Follow-up (year 2 and subsequent years) = 2 hours

Source: CMS National Coverage Determination



Medicare RD Providers Must Use MNT CPT Codes

- **97802**
 - MNT, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
 - Used only for the initial MNT visit
- **97803**
 - Re-assessment and Intervention, individual, face-to-face with the patient, each 15 minutes
- **97804**
 - Group -- 2 or more individuals, each 30 minutes
- **Multiple units of codes are used**
- **List code & number of units on claim form (CMS1500 form or UB-04)**



Additional Medicare MNT Codes

- **G0270**
 - MNT, re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.
- **G0271**
 - MNT, re-assessment and subsequent intervention(s), following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
- **Multiple units of codes are used**
- **List code & number of units on claim form.**



Medicare MNT Provided in FQHCs

- A Federally Qualified Health Center includes primary care and preventative services by an MD, or by a nurse practitioner, physician assistant, clinical psychologist, clinical social worker or a qualified provider of medical nutrition therapy services
- The facility must agree to meet certain other conditions of the Medicare program



FQHC Regulations

- CMS covers individual MNT and diabetes self management training (DSMT) services as core Federal Qualified Health Center (FQHC) services
- Claims sent to fiscal intermediaries
- Prior to this change, MNT was bundled into the services available at FQHCs, but separate payments for MNT provided by RDs were not allowed.



Medicare MNT and FQHCs


- MAC will make payment directly to the FQHC using the all-inclusive payment rate.
 - \$117.41 in urban areas or \$100.96 in rural areas (2008 calendar year FQHC inclusive rate)
- FQHC prepares claims on CMS1450 (UB-04)

CMS transmittal 1426 accessible at:
<http://www.cms.hhs.gov/transmittals/downloads/R1426CP.pdf>



RD Enrollment Considerations


- A Registered Dietitian may be employed or contracted by the FQHC
- By law, FQHC services are payable only to the FQHC. (Staff/contracted personnel are paid by the FQHC)
- No reassignment allowed, Medicare enrollment not required of RD employed in FQHC.



Medicare Resources

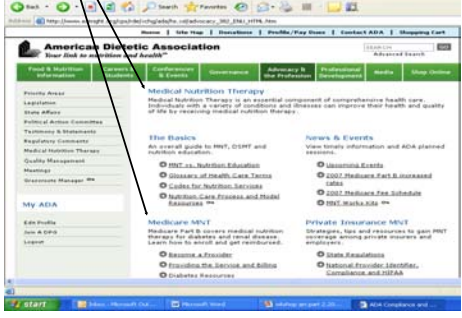
- CMS
- Medicare MACs/Carrier/FI
- ADA resources
- Medicare fee schedule for RDs
www.eatright.org/feeschedule
- State and DPG reimbursement representatives
- Medicare publications (ADA and others)

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Medicare MNT ADA Web resources

www.eatright.org/mnt




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Contracting with Medicaid (MediCal) Managed Care

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Medicaid programs are funded jointly by individual states and the federal government

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They help to pay for the medical care of:

- Eligible low-income families with children
- The aged, blind, and disabled
- People eligible to receive federally assisted income maintenance payment

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Medicaid programs in California do not cover MNT like Medicare

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**RD's can negotiate contracts
with Medicaid HMO's
in California**



**Medicaid HMO's are private payers
contracted with states
to handle Medicaid medical claims
processing, case management,
utilization review, and customer
service**



**Medicaid fee-for-service model
is quickly moving into
managed care**



**As of 2001 –
57% of the Medicaid population
was under managed care**



Alameda Alliance Card

