TAKING ACTION:
Expanding MNT Insurance Coverage in Iowa

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MEET OUR SPEAKERS

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OBJECTIVES

01 **Summarize** the status of insurance coverage for medical nutrition therapy provided by registered dietitians practicing in Iowa.

02 **Discuss** how to speak with insurance companies about the barriers to nutrition care in Iowa.

03 **Identify** key skills, strategies, and action steps around enhancing insurance coverage for medical nutrition therapy provided by registered dietitians practicing in Iowa.

Foundational Information

Terms

- National Provider Identifier (NPI #)
- Electronic Health Record (EHR)
- The Council for Affordable Quality Healthcare (CAQH)
- International Classification of Diseases, Clinical Modification (ICD-10-CM)
- Clearinghouse

Concepts

Credentialing with Insurance Providers

- Hold RD/RDN Credential from CDR
- Hold Iowa License as RD/RDN
- NPI Number
- Liability Insurance?
- Background Check?
- CAQH vs Individual Insurance Providers

Electronic Billing

- Clearinghouse is an intermediary between the provider/practice and the insurer where the provider can electronically submit claims

Foundational Information

Diagnoses

ICD-10 Codes

- Medical Diagnosis
- Not within RDN scope to determine ICD-10 Code
- Documentation of this Code Needed

Z Codes

- Z codes are not diagnostic codes
- RDNs can use these codes independently of a physician referral.

Coding

- **97802**: Medical nutrition therapy; initial assessment and intervention, individual, face-to- face with the patient, each 15 minutes
- **97803**: reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
- **97804**: group (2 or more individual(s)), each 30 minutes
- **G0270**: Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, each 15 minutes
- **G0271**: group (2 or more individual(s)), each 30 minutes
- **G0108**: DSMT services, individual, per 30 minutes
- **G0109**: DSMT services, group session (2 or more),per 30 minutes
- **99401-04**: Preventive medicine counseling and/or risk factor reduction intervention(s)

other codes may be applicable, review ***The Complete Guide to Billing and Credentialing Essentials for RDNs* (available eatrightpro.org)

MNT in Iowa

Most Medical Nutrition Therapy (MNT) related services are covered by major insurance companies. (ICD-10 code)

- **Medicare**
  - Diabetes & CKD stage 3a +
- **Aetna, Cigna, United Health Care, Oscar, Medigold, Humana, etc.**
  - Cover mostly obesity
  - Other dx covered: diabetes, CKD, BMI + Z code, HLD, HTN.
- **Wellmark Blue Cross Blue Shield (BCBS)**: *out of network*
  - Diabetes, kidney disease, obesity (E code), HTN, HLD
  - Payment process is different
  - Private practice RDN v.s. larger healthcare system
- **Out of state BCBS**: depends...

Perspective from Private Practice

Credentialing:

- Longer process but resources available
- On average 3-4 months before accepting claims
- Proof of liability insurance required
- CAQH - platform used by all companies to access credentialing information

Coverage:

- Most companies are 80%-100% coverage of charged services
- HSA/FSA eligible
- Wellmark BCBS payments go to the patient

Claims:

- Filed through EHR (Simple Practice)
- Clearinghouse within EHR (responsible for denials, etc.)
- Staff to help with autofill & payments

Documentation needed for most companies.
Referrals needed for Medicare.
QUESTIONS???

Communication With Insurance Companies

Reasons to call insurance companies:

- Eligibility of services
- Prior authorizations?
- Verification of benefits
- Denials/claims
  - Sometimes r/t clearinghouse (claim error)
  - Sometimes r/t benefit coverage/code/etc.
- Credentialing
  - Typically a separate number to call on the website
  - Difficult to know *what* to ask

Most difficult…**getting to the right person**

Additional Perspectives

- Fair, just, accessible and transparent. Always ask yourself if this is happening with health benefit claims.
- Health insurance is heavily regulated by federal and/or state law
- Health insurance is a “product” and the policy is like a contract
- Legally, health plan coverage must be precisely described in a written document
- Certain requirements are mandated by law even if your health insurance policy says otherwise
- Your Plan document trumps an insurer’s internal policies
- The LAW trumps the Plan document :)

Plan terms MUST be set forth in a written document.

- Generally summarized in a “summary plan description” or “certificate of coverage”
- **Participant has the right to obtain the plan document from their employer or the plan administrator**
- Plan document dictates the most important terms, including:
- Coverage
- Exclusions
- Definitions of essential requirements for coverage
- Services requiring pre-authorization
- Out-of-network benefits calculations
- Patient’s cost-share formula
- Appeal rights

An **explanation of benefits (EOB)** tells you what happened with your claim submission. It may include, among other things, information about:

- The type of service provided and the date of service.
- The amount a plan provider billed for the service.
- Any discount the participant or beneficiary received for using an in-network provider.
- The amount the plan paid.
- The amount the participant or beneficiary owes.
- The amount applied toward the plan's deductible.
- If approved or denied - and why!
- Available review or appeals procedures.

Common Denial Reasons

- Not medically necessary
- Experimental/ investigational
- Experimental/investigational for a clinical trial
- Experimental/investigational for a rare disease
- Out-of-network and the health plan proposed an alternate in-network service
- Out-of-network referral
- Formulary Exception
- Not Covered Benefit

Identifying a Wrongful Denial

- **Understand the reasons** for the denial and the plan term on which the administrator is relying
- Pay attention if the denial notice is missing mandated information or is overly vague
- If coverage is denied orally during Peer Review, **ask follow-up questions** to ensure you have this information.
- If you are notified of the denial in writing, **carefully read** the Explanation of Benefit (EOB) and/or denial letter to identify the denial reason(s).

General Questions

- Where does the patient get their insurance from?
- What is the date of the denial?
- Why was this denied?
- Was decision made within mandated time frame?
- Does the notice provide sufficient detail on reason?
- Are the facts correct?
- Is the health plan following the law, or relevant guidelines?
- What is the deadline for filing the appeal/review?
- Do you have a signed HIPAA?
- What documents do you need from the health plan?
- What documents do you need to support the appeal?
- Did you get your requested documents?

Medical Necessity Denial Questions

- What is the medical necessity definition?
- Is this experimental/investigational treatment?
- If so, is there any data to support it yet?
- What will happen if the patient does not obtain care?
- Has a peer review been conducted?
- If so, has any documentation been provided?
- What medical documentation exists? (letters from providers, imaging, charts, etc.)
- Is there medical support showing course of treatment is necessary given the patient's circumstances?

The Appeal Letter

Step 1	Look at your EOB and make sure the information is correct.
Step 2	If you feel this is an urgent issue than in large letters write URGENT EXPEDITED APPEAL on top of your page.
Step 3	Clearly write Patient name, Insurance ID#, Claim # (found on your EOB), Provider name, date of service.
Step 4	Look at your COC and find the definition of medical necessity(or denial reason).
Step 5	Explain, using facts, quotes and documents: What was denied? The exact reason given for the denial Why you disagree and think the proposed treatment meets the policy definition. What will happen if the treatment is not received in a timely manner.
Step 6	Specify any laws, regulations or guidelines that you think were not followed.
Step 7	Request copies of guidelines and records used to make the decision.

Submission Checklist

- ❑ Copy of most recent denial letter
- ❑ Signed HIPAA authorization form
- ❑ Physician statement supporting medical necessity of treatment and why the plan determination is wrong
- ❑ Advocacy letter

Request for Entire Claim File and any other information used in making the determination

- ❑ Relevant rules, medical guidelines or articles
- ❑ Highlight parts of policy that are relevant to the denial
- ❑ Copy of medical records .
- ❑ Copies to send to Regulatory Agent or Congressional
- ❑ Save complaint copy
- ❑ Input pertinent information into tracking systems

Most plans fail to comply and should be tracked and reported

Why Your Voice Matters in Policy and Regulation

What is a Regulation?

- **Definition**: A regulation is a rule or directive made and maintained by a government agency. Unlike laws passed by Congress, regulations are created by agencies to guide how laws will be implemented in real life.
- **Example**: Regulations determine how health insurance must cover eating disorder treatments under laws like the Mental Health Parity and Addiction Equity Act (MHPAEA).

Key Message: Advocacy is not just about treating patients; it's about shaping the policies that govern their care.

- **Why it matters**: Proposed regulations can directly impact the accessibility and quality of care for individuals with eating disorders.
- **How you can help**: By participating in public comment periods for proposed regulations, you can share your expertise and real-world experiences to inform better policy decisions.

How Your Comments Can Make a Difference

Case Example: Mental Health Parity Act – The inclusion of clearer rules for eating disorder treatment was influenced by advocates sharing personal and professional feedback.

MHPAEA Final Regulation- September 23, 2024

[110] The proposed rules and these final rules refer to benefits for "nutrition counseling." The Departments acknowledge several commenters who noted that other terminology may be more appropriate, such as "medical nutrition therapy" or "medical nutrition therapy provided by a dietitian" using specific CPT codes. The Departments intend that references to nutritional counseling for eating disorders be interpreted broadly to include these and other appropriate types of treatment for eating disorders.

Provider Takeaways

- Be informed about the applicable laws and implications for patients
- Help patients identify advocates who can assist with the process
- Inform patients of their rights to appeal and help them through the process
- Allow patients to be part of the process
- Don’t accept how the claim was first processed
- Counsel patients to be the squeaky wheels
- If claims remain unresolved or a patient has been denied necessary, life-saving care, seek help.

Academy of Nutrition & Dietetics: Resources

MNTWorks Toolkit

Provide RDNs and fellow partners with a step-by-step playbook for advocating for improved access and coverage of MNT to stakeholders, such as: Commercial Payers, Employers and Benefits Consultants, Hospital Administrators, Primary Care Providers

Join Affinity Calls

Reimbursement and Payment Affinity Group

- Meets the fourth Tuesday of every month, 1-2 p.m. (Central time)

MNT Expansion Affinity Group

- Meets the first Tuesday of every month from 2:30-3:30 p.m. (Central time)

MNT Provider

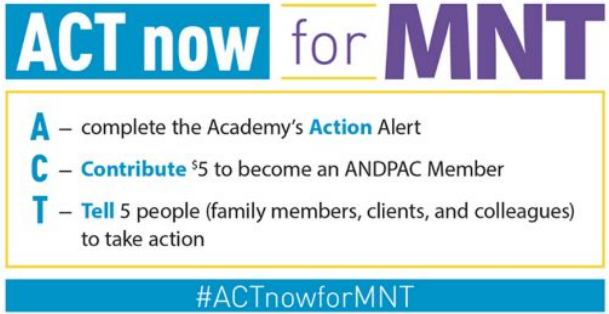
A newsletter, on topics such as billing, coding and coverage, CMS updates and releases, practice and business management, health care reform, Medicare, Medicaid and private insurance reimbursement

Call to Action: National

Medical Nutrition Therapy Act

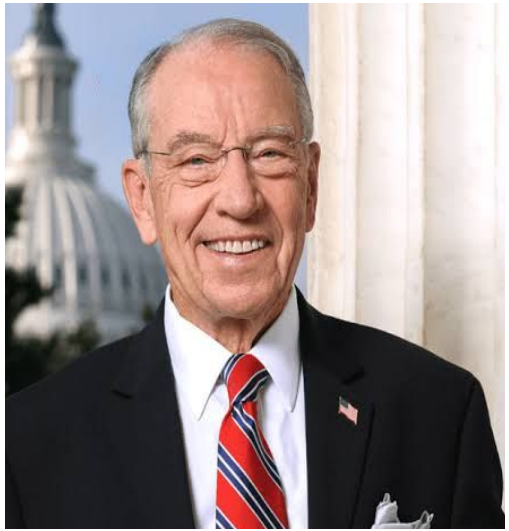
The Medical Nutrition Therapy Act allows Medicare beneficiaries to access the care they need by providing Medicare Part B coverage for MNT for:

- Prediabetes
- Obesity
- Hypertension
- Dyslipidemia
- Malnutrition
- Eating disorders
- Cancer
- Gastrointestinal diseases including celiac disease
- Cardiovascular disease
- HIV/AIDS
- Any other disease or condition causing unintentional weight loss



Call to Action: National

Senator, Joni Ernst



Senator, Chuck Grassley

ACT now for MNT

A – complete the Academy's **Action** Alert

C – **Contribute** $5 to become an ANDPAC Member

T – **Tell** 5 people (family members, clients, and colleagues) to take action

#ACTnowforMNT

Call to Action: State

“We want to hear from you!”

-Iowa Academy of Nutrition & Dietetics-Public Policy Team

If you or a patient has a testimonial regarding access to Nutrition Services in Iowa, please share your story with us.

https://forms.gle/JGbQZaVU4hNtWbkb6
(link in the chat)

Questions?

policyeatrightiowa@gmail.com

Survey Link for CEU

https://forms.gle/yY8iBFoN7tbKE3Q46