Coding and Reimbursement Issues Related to Independently Performed Indirect Calorimetry Measurement Procedures Provided by Registered Dietitians

The following information is presented to help clarify coding and reimbursement issues for separately billed indirect calorimetry measurement services provided by registered dietitians (RDs). Because of the variability in coverage for indirect calorimetry as an independently billed service, RDs should provide full disclosure with their clients and advise them in advance that they may be responsible for payment of independently performed indirect calorimetry measurement.

When considering whether to bill for independently performed indirect calorimetry measurement services, each practitioner should inquire whether indirect calorimetry measurement, as an independent service, is a covered service within the private insurance plan. Independently performed indirect calorimetry measurements when provided by RDs are not covered under Medicare Part B, and private insurance plans may or may not cover these services. RDs may need to negotiate a revision to their contracts with the private insurance plan to add this additional service, or to clarify the coverage under the client’s plan. In particular, RDs should request a copy of the revised contract and keep a copy on file for future reference should any claim disputes arise.

For each private insurance plan where an RD has an existing contract for nutrition services, the RD should contact the insurance plan representative who was involved in establishing the original contract to discuss coverage and reimbursement for indirect calorimetry services. RDs who desire to establish a new contractual arrangement with an insurance plan may also contact the insurance plan’s provider relations department to discuss provider enrollment and/or contract provisions.

RDs may need to set up a system in their private practice, or discuss procedures with their facilities’ billing department, for gathering insurance and coverage information from their clients/patients. Ideally, the insurance coverage information should be obtained before scheduling the patient/client for the indirect calorimetry service. Although it is time-intensive on the RD’s part, practitioners should determine if the RD or the client will assume the responsibility to contact the patient/client’s insurance company to determine if independent indirect calorimetry measurement services are a covered service.

Medicare Covered Services: Medical Nutrition Therapy (MNT)
Medicare currently does not extend coverage to RDs for independently performed indirect calorimetry. Medicare does cover three hours of MNT for diabetes and non-
dialysis kidney disease in the first calendar year and two hours of MNT in subsequent years. Medicare will cover additional MNT in the same calendar year with a physician’s referral indicating the medical necessity for the additional MNT services. Medicare MNT includes both assessment and intervention components of the service.

While RDs cannot bill Medicare for indirect calorimetry measurement as an independent, separately billable service, RDs may choose to perform this measurement, using a variety of instruments, as part of the MNT nutrition assessment. Although use of any particular indirect calorimetry instrument is not separately covered under Medicare, all the steps of MNT, including the nutrition assessment, diagnosis, intervention and evaluation and monitoring are covered. Therefore, Medicare enrolled RDs should receive reimbursement for Medicare MNT services provided to qualifying beneficiaries with diabetes or non-dialysis kidney disease regardless of the technique used to determine the patient’s caloric requirements. Medicare enrolled RDs must accept the approved payment amount, determined by Medicare for MNT covered services, as the full reimbursement for the MNT service. Medicare RD providers are not able to bill the beneficiary for any amount over the reimbursement amount paid to the RD by Medicare.

Use of the indirect calorimetry device may extend the face-to-face billable time spent with the client and increase the units of MNT CPT code used during the first MNT visit when the initial MNT nutrition assessment occurs. (For additional Medicare MNT-related information, see Appendix 1).

**Frequently Asked Questions on Independently Performed Indirect Calorimetry Measurement Procedures Provided by Registered Dietitians**

Q. Can RDs bill Medicare for independently performed indirect calorimetry measurement services?

A. No, Medicare only covers and provides reimbursement to RDs for medical nutrition therapy services for diabetes and non-dialysis kidney disease, including post kidney transplants. Claims should not be sent to Medicare for indirect calorimetry measurement as an independent service provided by RDs. To the extent that indirect calorimetry measurement is performed as a part of a nutrition assessment when providing MNT for Medicare covered services, e.g. MNT for diabetes or non-dialysis kidney disease, reimbursement will likely be provided for the MNT service provided by the Medicare RD provider.

Q. What Current Procedural Terminology (CPT) codes could be used for indirect calorimetry services provided by RDs?
A. The American Dietetic Association has received feedback that some RDs are billing private insurance plans for independently performed indirect calorimetry measurement in addition to other nutrition services, such as MNT.

RDs should inquire whether independently performed indirect calorimetry measurement is a covered service with the private insurance plan. Additionally, RDs should check with the private insurance plan to determine the appropriate code to use for indirect calorimetry measurement. Request this information in writing from the insurance plan and keep this information on file in case you receive denied claims based on inappropriate code use from the plan.

For contract adjustments, RDs in private practice generally communicate with the private insurance plan provider relation’s staff that was involved in the preparation of the RDs’ original contract with the plan. RDs who are employed by a hospital should discuss with their outpatient nutrition department manager whether hospital outpatient nutrition services contracts exist with private insurance plans. Frequently the hospital’s finance, billing and/or nutrition departments are involved in contract negotiations for the facility and private insurance plans. If outpatient nutrition contracts exist, the RD or nutrition manager should inquire whether indirect calorimetry services can be added to the existing nutrition-related contracts.

The American Medical Association CPT [Current Procedural Terminology] 2005 book lists the following CPT code for this procedure:

94690 Oxygen uptake, expired gas analysis, rest, indirect (separate procedure)

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While the AMA CPT book does not specifically define the healthcare professionals who are legitimately able to provide indirect calorimetry measurement services, AMA’s code database indicates that a wide variety of physician and non-physician (e.g., nurse practitioners etc.) specialty groups use the code.

Q. How should I discuss payment for indirect calorimetry measurement services with my clients?

A. Full disclosure to your clients/patients is highly recommended. Payment by private insurance plans for independently performed indirect calorimetry measurement provided by RDs varies depending on the client’s insurance benefits. If you are not sure if the private insurance plan will cover indirect calorimetry measurement, it is a good business practice to inform the client of the possibility that self-pay for the service will be required. Or, if you are a recognized provider under a particular plan and direct bill the plan for MNT and other services, but are not certain the private insurance plan will cover indirect calorimetry measurement, inform the client of this uncertainty and the client’s responsibility to pay if the plan denies the claim.
RDs may wish to develop a form that explains the uncertainty of insurance coverage for independently performed indirect calorimetry measurement and the client’s responsibility to pay for the service where coverage is denied. Prior to delivering the service, clients should be asked to sign the form to acknowledge their understanding of their liability to pay for the service if the insurance company will not pay for indirect calorimetry. (Note: a Medicare Advanced Beneficiary Notice (ABN) form is not appropriate to use in this case- see question below.)

Q. Can a Medicare Advanced Beneficiary Notice (ABN) form used for independently performed indirect calorimetry measurement services?

A. No, an ABN form should not be used with indirect calorimetry measurement services provided by RDs. ABNs are used solely with Medicare services when there is uncertainty that a covered Medicare service will be reimbursed. Since indirect calorimetry measurement provided by an RD is not covered within Medicare, an ABN form should not be used.

The following example describes when an ABN form would be used with a Medicare beneficiary. For example, a Medicare beneficiary with the diagnosis of diabetes has attended 3 Medicare MNT visits in the calendar year. The patient's condition has consistently and progressively improved as evidenced by a change in A1C values from 9.5% to 8.0%. The referring physician's evaluation is that with an additional one or two MNT visits, the patient will improve their A1C goal to closer to 7%. The RD receives this referral for an additional two MNT visits. Medicare may not cover these visits since the Medicare patient has met the initial MNT duration and frequency requirements of the benefit. Therefore the RD must tell the patient, in advance and in writing, that Medicare may not cover the service. The patient receives the ABN from the RD and is requested to sign and date the statement. With this advance notice, the patient knows that he/she will have to pay the RD for the additional MNT visits should Medicare deny payment. (See Appendix 1 for more Medicare ABN information.)

As an alternative, if the patient has Medicare Part B coverage, and the patient is interested in receiving the independently performed indirect calorimetry service provided by the RD, the RD can use the Notice of Exclusions from Medicare Benefits (NEMB) form. This form can be used to explain that Medicare will not pay for the independently performed indirect calorimetry measurement provided by the RD, and the Medicare patient will be required to pay for the service. The RD should provide the Medicare patient with the NEMB prior to delivering the indirect calorimetry service.
Appendix 1

Medicare and indirect calorimetry:
Medicare has not authorized coverage of indirect calorimetry hand held devices, eg MedGem, for indirect calorimetry services.

Respiratory therapists may perform indirect calorimetry measurement as part of the pulmonary services they provide. “Respiratory therapy is defined in section 230.10 of the Skilled Nursing Facilities Manual as those services that are prescribed by the attending physician to access, treat, manage and monitor patients with deficiencies and abnormalities of cardiopulmonary function. The use of Indirect Calorimetry is not a covered respiratory therapy service when used to assess nutritional status.”

“Medicare normally does not cover screening procedures for asymptomatic patients. This is because the Medicare law, at section 1862(a)(1)(A) of the Social Security Act (the Act), generally permits coverage only for those services that are considered reasonable and necessary for diagnosing or treating an illness, injury, or other impairment that has already manifested itself. The only exception under existing law with regard to screening procedures are those specifically authorized by the law itself, such as screening mammographies and pap smears (see section 1862 (a)(1)(F) (of the Act).”

Medicare MNT:
“Section 1861(s)(2)(V) of the Social Security Act authorizes Medicare part B coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease, effective for services furnished on or after January 1, 2002. Regulations for medical nutrition therapy (MNT) were established at 42 CFR §§410.130 – 410.134. This national coverage determination establishes the duration and frequency limits for the MNT benefit and coordinates MNT and diabetes outpatient self-management training (DSMT) as a national coverage determination.”

“The following chart outlines the duration and frequency coverage for MNT for both renal disease and diabetes. The only restriction imposed in this decision is regarding the number of hours of basic coverage per year. The referring physician will be free to determine the exact length and number of the visits as long as the yearly limit is not exceeded.

<table>
<thead>
<tr>
<th>Type of MNT (Any Covered Diagnosis)</th>
<th>Number of Hours Covered per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial MNT</td>
<td>3</td>
</tr>
<tr>
<td>Follow-up MNT</td>
<td>2</td>
</tr>
</tbody>
</table>

Pursuant to the exception at 42 CFR 410.32(b)(5), additional hours are considered to be medically necessary and covered if the treating physician determines there is a change in
Appendix 1, continued

**Medicare MNT:**
medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

In addition, if the treating physician determines that receipt of both services [DSMT and MNT] is medically necessary, Medicare will cover both DSMT and MNT in initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same dates of service.” Source: CMS Web page at: http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=180.1&ncd_version=1&basket=ncd%3A180%2E1%3A1%3AMedical+Nutrition+Therapy, and http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=53.

**Medicare MNT payment**
Although RDs’ usual and customary fees may be set at a higher amount than the Medicare approved payment rate, practitioners may only receive reimbursement for the Medicare approved rate for the MNT services. Under the Medicare MNT benefit, RDs must accept assignment, whereby the RD agrees that the approved amount determined by the Medicare carrier for the MNT covered service shall be the full charge for that service.

CMS determined the payment amount for Medicare MNT as the lesser the actual charge for the services or 85% of the physician fee schedule amount. Of this amount, Medicare pays 80% of the amount and the Medicare beneficiary pays a 20% co-payment amount. The Medicare beneficiary is also responsible for the Medicare deductible payment. RDs can access current Medicare payment rates from the Medicare carrier's Web page or CMS’ Web page. When reviewing the 2005 Physician Fee Schedule from the carrier's Web page, RDs need to remember to take 85 percent of the "par amount" (the participating provider amount) listed for each of the MNT codes — 97802, 97803 and 97804.

**Medicare Advanced Beneficiary Notice Information:**
An Advanced Beneficiary Notice (ABN) is a written notice used by Medicare providers and suppliers to notify Medicare beneficiaries, before the service is provided, of the following:

- That Medicare will probably deny payment for the service/supply,
- The reason why the provider expects Medicare to deny the payment, and
- The Medicare beneficiary is personally and fully responsible for payment if Medicare denies payment.

In addition to the above items, the ABN must also describe the service, include the patient's name, billing account, Medicare number, patient's signature, date, and if needed include space for a witness' signature and date. The intent of ABNs is to empower Medicare beneficiaries to be active participants in their own health care treatment decisions.
Appendix 1, continued

A properly executed ABN serves as notice to a Medicare beneficiary, the patient, that the beneficiary is responsible for the payment if Medicare denies payment. ABNs are **used with Medicare covered services only** and the form should be used when the RD or provider is **unsure that a service is will be considered medically necessary or may exceed the frequency and duration of the covered service.** If the provider is **certain that Medicare does not cover a service, then an ABN is not needed.** If items or services are always non-covered under the Medicare program, (e.g. MNT for other diagnosis besides diabetes and non-dialysis kidney disease), the patient must pay the full bill and an ABN notice from the provider is not necessary. There is nothing that prevents providers from using ABNs, however in cases where Medicare does not cover the service, the ABN is not needed and the provider can state with certainty that the Medicare beneficiary will have to pay for the services. According to the Medicare Carriers Manual, giving ABNs for all claims or services is not an acceptable practice. (CMS Web page at: [http://www.cms.hhs.gov/medicare/bni/](http://www.cms.hhs.gov/medicare/bni/) and the CMS MedLearn Network ABN resources at: [http://www.cms.hhs.gov/medlearn/dpinfo.asp](http://www.cms.hhs.gov/medlearn/dpinfo.asp).)

**Notice of Exclusion for Medicare Benefits**
Practitioners may use the *Notice of Exclusions from Medicare Benefits* (NEMB) form with patients to inform them that Medicare will **not pay** for certain services, e.g. independently performed indirect calorimetry measurement provided by the RD, and that the Medicare patient will be required to pay for the service. The form should be reviewed and signed by the patient before the non-covered service is performed. A sample *Notice of Exclusion for Medicare Benefits* form is available from CMS’ Web page at: [http://www.cms.hhs.gov/medicare/bni/20007_English.pdf](http://www.cms.hhs.gov/medicare/bni/20007_English.pdf).

**Additional indirect calorimetry measurement references:**
Certain companies may have created reimbursement reference materials to assist practitioners who use their products. When reviewing industry-produced materials, carefully read the document to determine how the information may apply to government programs, e.g. Medicare and/or Medicaid, and private insurance plans. Do not assume reimbursement by third party insurers for this procedure.

**For Additional Coverage and Reimbursement Information:**
Access Medicare and Private Insurance information from ADA’s member only Web page at: [http://www.eatright.org/Member/83_12954.cfm](http://www.eatright.org/Member/83_12954.cfm)

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