Eli's Rehab Report

2002 Medicare Fee Schedule Addresses Medical Nutrition Therapy, Incident To

CMS issued its new fee schedule on Nov. 1, 2001, with important changes affecting the way rehab practices will bill for services in 2002. The most notable change: Medicare now allows payment for the nonreimbursable medical nutrition therapy (MNT) codes that were introduced in 2001. The following outlines these Medicare policy changes, as well as other new information applicable to PM&R practices.

Medical Nutrition Therapy

PM&R coders probably remember the MNT services codes (97802-97804) being introduced in CPT 2001, with the understanding that Medicare would not reimburse for the codes since no relative value units (RVUs) had been established. All of that changed in January, however, when Medicare began paying claims for these services.

"As of Jan. 1, 2002, these codes were approved by Medicare for reimbursement to cover patients with diabetes (250.0-250.9) and renal disease (581-587)," says **Dorothy Michalczyk,** manager of communications for the American Dietetic Association. "The codes are only covered when referral for the therapy is made by the patient's treating physician. A referral must be documented for each episode of MNT."

The **Fee Schedule** defines MNT as "nutritional diagnostic, therapy, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing disease" and makes clear that only the patient's treating physician (the doctor managing the patient's diabetes or renal disease) can refer for MNT. This means that a physiatrist working as the patient's primary care physician in rehabilitation facilities will be able to refer for MNT, although some private practice physiatrists may not.

For example, an internal medicine specialist managing a patient's diabetes fails to refer the patient for MNT. The patient presents to her physiatrist for treatment of rheumatoid arthritis (714.0). The physiatrist notes that the patient would benefit from education and counseling on nutrition therapy, so he refers her for MNT. Most carriers would not approve, because the physiatrist is not managing the patient's diabetes as carefully as the internist.

Suppose the physiatrist saw the patient for postsurgical rehabilitation following amputation of her left foot due to complications from diabetes. The physiatrist notes that the patient has not been referred for MNT and discusses this with the patient. In this case, the physiatrist may be able to refer for MNT because he is working with the patient's other physicians who are managing the diabetes. If this is an option, the physiatrist should phone the insurer ahead of time to ensure that his referral will be acceptable; if not, the physiatrist should discuss his recommendation with the patient's internist, who can make the final decision regarding referral.

MNT codes include:

1. 97802 medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
2. 97803 ... re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
3. 97804 ... group (2 or more individual[s]), each 30 minutes.

CMS states that these codes are for the use of nonphysician healthcare professionals, specifically "registered dietitians

and nutrition professionals." CMS does not explain who qualifies as a "nutrition professional," however, leaving this decision to state licensing regulations and Medicare carrier designations.

Dietitians, including those working within rehab facilities, should code MNT services using their own provider numbers. Physicians are not qualified to bill for MNT services on their own, unless they meet all licensing requirements designating them registered dietitians as well as physicians. This means that MNT codes cannot be billed "incident to" and that any nutritional counseling between physiatrist and patient should continue to be included in the physician's own E/M billing codes.

Numerous Modules in Therapy

CMS mentions occupational therapy (OT) services in the fee schedule: "Some of the OT codes contain several pieces of very expensive equipment called environmental modules. Because it is unclear how many of these modules would typically be used for each service, we are only including one module for each code that might use this equipment."

The fee schedule also notes that the phrase "one module and some smaller equipment" qualifies for:

4. 97530 therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

5. 97535 self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

6. 97537 community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes.

Therapists reading the fee schedule were confused because they are normally free to use an unlimited number of modules in their therapy.

According to **Judy Thomas, MGA,** director of reimbursement and regulatory policy at the American Occupational Therapy Association (AOTA) in Bethesda, Md., CMS considers the number of modules used when setting RVUs because these modules and their expenses are factored into costs associated with running a practice. "This information has no effect on billing or coding," Thomas says. "All of these discussions with the AMA and CMS are related to underlying parts of the formula used to compute the **Medicare Fee Schedule** amounts. AOTA wants to ensure that payment is fair and that the greater medical community better understands the work and expenses involved with providing good therapy."

Thomas says that the statements in the fee schedule about modules relate to data AOTA submitted to the Practice Expense Advisory Committee (PEAC) regarding clinical staff time, clinical supplies and equipment needed to provide services associated with each code. AOTA contends that the cost of providing some of the services should include "environmental modules" (such as freestanding simulated kitchens, bedrooms, bathrooms and offices) that the clinics purchase.

"These modules are expensive," Thomas says, "but for successful occupational therapy with individuals who have a number of conditions and who wish to return to work, it is essential that treatment take place in an environment that simulates the circumstances and activities necessary for each patient to regain the requisite capabilities."

Clarification of Incident To Billing

CMS uses the new fee schedule to alleviate any confusion surrounding the incident to issue raised in the following example:

Dr. Smith orders physical therapy services for a patient with multiple sclerosis (340). The physical therapist (who is

employed by the practice) performs 30 minutes of therapeutic exercises 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) as well as 15 minutes of gait training 97116 (... gait training [includes stair climbing]) on the patient. Because Smith is on vacation, the therapist works under the supervision of Dr. Jones (a partner in the practice). Does the therapist bill her incident to services under the ID number of Smith (who ordered the therapy) or Jones (who supervised it)?

The fee schedule notes that the incident to services (two units of 97110 and one unit of 97116) should be billed under the ID number of the physician who supervised the services, that is Jones. Although this policy does not represent a change from any previous incident to rules, it does clarify an issue that had not been clearly addressed in the past.

Note: Access the 2002 Medicare Physician Fee Schedule at http://www.hcfa.gov/medicare/pfsmain.htm. Click on "2002 National Physician Fee Schedule Relative Value File," click on file RVU02-a.zip and follow the prompts to download it. The easiest format in the zip package for viewing the fee schedule is pprrvu02.xls, which requires Excel or an Excel viewer. Other files in the zip package include the appendix, which explains the meaning of each indicator.