Getting Started with Insurance
Billing for CHIP
The following guide is for U.S. physicians and dietitians seeking to bill Medicare and insurance providers for their running of Complete Health Improvement Program (CHIP) with patients. This guide serves as a framework on how insurance providers can potentially be billed for CHIP, but is not a guarantee that insurance providers will pay for the program.

It is also important to note that physicians and dietitians bill different ways.

This publication is a general summary that explains certain aspects of the medical billing process; however, this is not a legal document and does not grant rights or impose obligations. The Lifestyle Medicine Institute LLC will not bear any responsibility or liability for the results or consequences of using this summary guide. This document was current as of the date of publication; nevertheless, we encourage users to review the specific laws, regulations and rulings for up-to-date detailed information. Providers are responsible for the correct submission of claims and response to any remittance advice in accordance with current laws, regulations and standards.
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The Process

Becoming a credentialed provider

1. Assess/ensure compliance with HIPAA

2. Get NPI

   - Enroll with Medicare using PECOS at: https://pecos.cms.hhs.gov
     To do this you’ll need your username and password you created when applying for your NPI. You will also need to know who your MAC contractor is.

3. Identify the major health plans in your state

4. Contact each major health insurance organization in your state and request a provider enrollment packet

5. Once accepted, sign up for EFT

6. Complete required forms and submit. Applications can take up to 8 weeks to process

   - Some plans will only credential providers in a multi-specialty practice. If this is the case you will need to identify the MD or DO you work with.
Billing insurance for CHIP programs - Dietitians

Document the nature and content of each session thoroughly. CHIP session summaries can be used to document topics covered.

After determining eligibility, have the patient sign a form acknowledging that if insurance does not cover the cost, they are personally responsible for covering the applicable rates outlined in the form.

Is the patient eligible for billing through Medicare or a private health plan?

- Medicare

- Private health plan

Unlike Medicare, Private health plans do not limit billing to just patients with diabetes and chronic kidney disease using the MNT codes (97802, 97803, 97804). Most plans now pay for preventive care, which includes “Diet Behavioral Counseling.” The number of units may or may not be limited.

Patients with diabetes or chronic kidney disease can be billed using the MNT codes (97802, 97803, 97804). They can be billed for 12 units in the first year and 8 units each subsequent year. Has the patient reached their unit limit?

- No

- Yes

Continue billing with these codes

Medicare will pay for more units each year if the HCP provides a new referral request and billing codes G0270 or G0271 are used.

Following submission of claim, legal requirements in each state determine the acceptable timeline for prompt payment of medical claims. Check health plan provider manuals to determine payment requirements.
Billing insurance for CHIP programs - Physicians

Document the nature and content of each session thoroughly. CHIP session summaries can be used to document topics covered.

After determining eligibility, have the patient sign a form acknowledging that if insurance does not cover the cost, they are personally responsible for covering the applicable rates outlined in the form.

Will you be billing using MNT, Preventative Care or E/M codes?

E/M

MNT

Preventive Care

See Billing - Dietitians

Note that these codes are subject to deductible and copay. Since counseling represents more than 50% of the time spent for a CHIP session the code you choose depends on the time you literally spend with the participant. You must document the total face-to-face time and the nature of the counseling including CHIP activities. Is time the determinant for your billing?

Yes

No

Then choose the code which represents the time spent with the patient to bill: 99212 (10min); 99213 (15 min); 99214 (25 min)

Then 2 out of 3 elements of History (1 – 3 HPI elements), Examination (1 or 6 elements) and Decision Making are needed.

Most health plans will accept billing to Preventive Care codes 99401, 99402, 99403, 99404, 99411 and 99412. These codes are not subject to deductible or copay.

Following submission of claim, legal requirements in each state determine the acceptable timeline for prompt payment of medical claims. Check health plan provider manuals to determine payment requirements.
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance

Covered entities (in this case this is a healthcare provider) and business associates must protect the privacy and security of Personal Health Information (PHI) in electronic formats across all systems and technologies to prevent breaches. Before initiating electronic transfer of protected health information, it is necessary to ensure that both covered entities and business associates comply with the Health Insurance Portability and Accountability Act (HIPAA).

Any HIPAA business associate can be held accountable for a data breach and penalized for noncompliance.

To help minimise risk of breaches, use the following good practice:

- Encrypt PHI on device and when sending
- Only access PHI via connections, cloud services, apps and web portals that are secure
- Make use of unique IDs, role based permissions, auto time out, screen lock and strong passwords
- Have firewalls and antivirus software installed on all devices
- Provide/attend regular HIPAA training
- Put in place a risk mitigation plan
- If you use a BYOD system, keep track of these devices
- Conduct regular audits and risk assessments

In addition to basic good practice, a Business Associate Agreement (BAA), a contract between a HIPAA covered entity and a HIPAA business associate is required. The contract protects PHI in accordance with HIPAA guidelines and explicitly states how a business associate will report and respond to any data breaches, including those that may be caused by subcontractors of a business associate. A BAA should also outline how a business associate will respond to any Office of Civil Rights (OCR) investigation.

A sample/template BAA can be found at:
http://www.chiphealth.com/Shop-CHIP/Facilitator-Supplies/FacilitatorResources/
Getting Started

Applying for a National Provider Identifier (NPI)

1. The first step in billing any entity is getting a NPI, this is your unique identifier as a healthcare provider in the United States. It is one number you will need for the rest of your career and will follow you from location to location.

2. Apply for an NPI online at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

To complete the application, ensure you have the following information available:

<table>
<thead>
<tr>
<th>Information Required for Individual Providers</th>
<th>Information Required for Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider Name</td>
<td>• Organization/Business Name</td>
</tr>
<tr>
<td>• SSN</td>
<td>• Employer Identification Number (EIN) (if you have one registered with the IRS)</td>
</tr>
<tr>
<td>• Provider Date of Birth</td>
<td>• Name of Authorized Official for the Organization</td>
</tr>
<tr>
<td>• Country of Birth</td>
<td>• Phone Number of Authorized Official for the Organization</td>
</tr>
<tr>
<td>• State of Birth (if Country of Birth is U.S.)</td>
<td>• Organization Mailing Address</td>
</tr>
<tr>
<td>• Provider Gender</td>
<td>• Practice Location Address and Phone Number (you cannot use a PO Box or Residential Address unless it is your Practice address)</td>
</tr>
<tr>
<td>• Mailing Address</td>
<td>• Taxonomy (Provider Type) (Note: RDs should select the provider type “Registered Dietitian - 133V00000X”)</td>
</tr>
<tr>
<td>• Practice Location Address and Phone Number (you cannot use a PO Box or Residential Address unless it is your Practice address)</td>
<td>• State License Information (Your license number from the NC Board of Dietetics)</td>
</tr>
<tr>
<td>• Taxonomy (Provider Type) (Note: RDs should select the provider type “Registered Dietitian - 133V00000X”)</td>
<td>• Contact Person Name</td>
</tr>
<tr>
<td>• State License Information (Your license number from the NC Board of Dietetics)</td>
<td>• Contact Person Phone Number and Email</td>
</tr>
<tr>
<td>• Contact Person Name</td>
<td>• Contact</td>
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<tr>
<td>• Contact Person Phone Number and Email</td>
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</tbody>
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3. Once an application has been submitted, you’ll be emailed a NPI within 10 days (usually it is within minutes).
Notes on Medicare Enrollment

1. An explanation of Medicare enrollment processes can be found at your Medicare Administrative Contractor’s (MAC) website. That would be the website of the company responsible for Medicare in your area. For example, in the Boston area MAC is NHIC Corp for MAC jurisdiction 14. They are responsible for Medicare part A and B for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. You can see a list of the MAC contractors and their respective areas at this website: http://www.en-tnet.org/content/websites-medicare-administrative-contractors

2. Select the Medicare part B section of the website and look for Provider Enrollment Information. There will be instructions and steps to complete the enrollment process. Once you have all your information completed enrollment usually takes up to 60 days to be processed.

General Steps for Medicare Enrollment

1. You may complete the Medicare provider application using Medicare Provider Enrollment, Chain, and Ownership System (PECOS). To do this, you’ll need the username and password you created when you applied for your NPI. You will also need to know who your MAC contractor is. Go to PECOS at: https://pecos.cms.hhs.gov

2. Print, sign and return all certification and other required documentation.

When you have been enrolled, you will be sent your Provider Transaction Access Number (PTAN) and your official enrollment date. This is your official account number with your MAC. If you have to reapply to Medicare in the future, you will be assigned a new PTAN. You need a PTAN to speak with a customer representative about your account, however, when you do billing you always refer to yourself with your NPI. You are able to bill Medicare for services provided after your official enrollment date.

Your MAC will also have a provider portal where you can look up the status of claims and eligibility status online. You can find this portal on the MAC website and register (using your PTAN) to get a username and password. It may take a couple weeks after you signup to get officially registered for the online portal.
Insurance Billing

Health Insurance Credentialing (becoming a credentialed provider)

Becoming a credentialed healthcare provider with the major health plans in your state will provide you with an economic advantage as you deliver Medical Nutrition Therapy (MNT) and Therapeutic Lifestyle Change. Some billing companies (businesses that do the billing for you) will charge a significant amount of money to facilitate your credentialing process. However, it’s very easy to do it yourself. By the time you complete all the forms and provide all the information to someone else to submit, you might as well have done the whole process yourself. *Be prepared for the credentialing process to take up to 6 months in a worst case scenario. Insurance providers can take up to 60 days to review an application and if any information is missing or incorrect, the application may be denied and take longer. Time frames insurers are allowed to take to process applications vary from state to state.*

1. The first step is to identify the major health plans in your state. If you have a relationship with an active medical practice, they will be able to tell you what health plans patients most often use in their practice. You can also go on your states insurance board website and identify the major health plans. If they don’t have an obvious list, you can call and ask for one.

2. Contact each major health insurance organization in your state and request a provider enrollment packet. Most of the time an enrollment packet will be available online within the provider section of the website. If you are unable to find it there, call customer service and request it. They will send it to you or direct you to the online resources. Some plans will only credential providers in a multi-specialty practice. Therefore you will need to find out if that is their policy. Then to be credentialed you will need to identify the MD or DO you work with to qualify you in a multi-specialty practice.

UnitedHealthcare is an example of a nationwide health plan that may require its providers to be in a multi-specialty practice. If you are not in a multi-specialty practice UnitedHealthcare will offer credentialing through its alternative medicine network OptumHealth, which is a discount program that requires patients to pay out-of-pocket.

There are provider networks you may also want to join that health plans often contract with to identify qualified providers in your area. Two examples of these are American Specialty Health Network [www.ashcompanies.com](http://www.ashcompanies.com) and the MultiPlan Network [www.multiplan.com/providers](http://www.multiplan.com/providers).

3. Complete the required forms with your information and return them. Most states have a general insurance credentialing form so that if you complete one, you can make copies and return it
to all companies. Each company will have one or two additional forms they may want you to submit in addition to a copy of your state license and malpractice/liability insurance policies. Just like the state general credentialing form, some payers will subscribe to a free online service. You complete the forms online; submit additional documentation and then this information will be available to all subscribing companies for which you are applying.

One such online service is CAQH Universal Provider DataSource. The following link will provide easy access https://upd.caqh.org/oas. The health plan will tell you what online service to use if they are using one.

4. Each plan will contact you with information about your credentialing status as they process your application. It could take up to 8 weeks. If you have questions about your application, call provider customer service.

5. When accepted, some plans will assign you a specific provider relations person. As a credentialed provider you will be listed in the health plan’s provider directory within 30 days. Check it periodically for accuracy. If not accepted, find out if they are credentialing anyone at this time. It may be that they only use ‘out-of-network’ dietitians for MNT. You’ll just have to ask.

6. Finally, sign-up for EFT (electronic funds transfer, where payments are directly deposited into your checking account). Each health plan will have their own application.
Determining Eligibility for Services (nutrition and preventive care counselling)

1. Collect copies of the patient’s health plan ID card or ask for the information through the enrollment process. The enrollment process starts with the physician providing you the referral form. This form should have the health plan name, ID number and the patient’s phone number. You may call the patient and ask them to complete an online enrollment form. Ask them for their email address and let them know that you will be contacting them again to explain the results of your eligibility determination.

2. Go to the health plan provider portal and download your patient’s health plan eligibility documentation. This will have important information such as copays, deductible requirements, as well as basic plan enrollment data. Store this in patient’s record. Office Ally also offers a free eligibility look-up service online with your Office Ally account www.officeally.com.

3. Call the health plan and confirm eligibility for the treatment codes you intend to use (such as, 97802, 97803, 97804, G0447, 99404 or 99412). You will be asked for your name, call-back phone number, tax ID number with corresponding NPI and finally the name and address of your office. You will then be asked for the patient’s health insurance number, their name and date of birth. You will usually get an automated attendant first, in this case go to medical provider eligibility. The automated attendant may ask you for the patient’s insurance ID before you reach a live person.

We can also ask if the policy will cover a 99404 provided by a Registered Dietitian or Health Educator. This is general preventive care counseling for anything. Dietitians are not usually listed as a valid provider of this code. But, a physician may have the RD provide this code as an “incidence to” service. MD must be in the office for RD to provide an “incidence to” appointment.

Have on hand the following information:
• Health plan phone number
• Your provider tax ID number and NPI
• The patient’s full name, health insurance ID number (HIN) and date of birth
• The procedural code and the patient’s diagnosis

Ask the following questions:
A) Does the patient have a Medical Nutrition Therapy or diet behavioral counselling benefit? The code is 97802 or 97803. It will be for a diagnosis of [name of diagnosis] (provide the ICD10 code). If yes, then ask; Are there any limits on the number of visits or units provided?

B) Do they consider Medical Nutrition Therapy as Preventive care (and therefore eligible for no
co-pay or deductible) if this is for a cardiovascular risk condition such as hyperlipidemia, hypertension or diabetes as recommended by the USPSTF Preventive Services Guidelines? If they are not sure you may have to submit a predetermination request.

C) Finally ask, if a Registered Dietitian is included in the provider type eligible to provide this service? If yes, then ask: Must the provider be in-network or can they be out-of-network? (Confirm that you are in their network if you don’t know)

4. Finally document the eligibility status in your electronic record management system under the patient’s insurance information, include the date and call reference number from the health plan and designate a status term such as:
   - Approved
   - Not approved
   - Pending
   - Questionable
   - To be determined (default)

**Eligibility Checklist**

- Health plan provider website
- Health plan phone number
- Provider’s EIN and NPI and your call-back number
- Patient’s identification (Name, plan ID, and date of birth) and phone number
- Patient’s diagnosis and MNT codes
- Do they have an MNT benefit and nutrition counseling not excluded?
- Are there any limits on number of visits or units?
- Is your CHIP facilitator a qualified provider?
- Is this a “Grandfathered plan” (plan before 9/2010)?
- Ask if all preventive care services are 100% no copay or deductible and that includes “Diet behavioral counseling”?
- Asked if services for Diabetes are subject to copay and deductible?
- Conversation documented for future reference (includes call reference #)

**After Eligibility Determination List**

- Call patient and make an appointment (explain any insurance issues as needed)
- Document patient’s email address and inform them we will need forms completed preferably online if they are able and have computer/Internet access.
- Send email invitation to complete online survey forms.
- 48 - 24 hours before appointment, check if they completed online survey forms
- 24 hours before appointment, call patient remind them of appointment and to do survey forms if not yet completed.
CHIP Reimbursement

To facilitate reimbursement from the various health plans you must create the appropriate documentation and submit accurate and justifiable billing for each session. These processes may be implemented through your own EMR, billing and services software. One such tool is the MNT Assistant (a software tool developed by Lifestyle Medicine Group). This tool has been successfully used for CHIP in the Northwest. The MNT Assistant is also used to create the required communications to a participant’s healthcare provider (HCP). To get more information and access to MNT Assistant call the Lifestyle Medicine Group on (503) 652-5070.

You can submit electronic claims for the maximum number of sessions allowed by the health plan, and will come closest to the value charged to self-paying participants. Claims can then be submitted through a clearinghouse such as “Office Ally” or “InstatMed.” CHIP session visits may be billed as group or shared visits depending on the code you choose to use. A credentialed healthcare provider such as a physician, registered dietitian nutritionist, nurse practitioner, or physician’s assistant may submit claims. However, successful billing will depend on the provider being a qualified and participating “in-network” provider for the health plan.

Dietitians:

Using Medical Nutrition Therapy (MNT) Codes (97802, 97803, 97804)

When using the MNT codes, Medicare will only pay for treating diabetes or chronic kidney disease. Medicare’s rules dictate that they pay for up to 12 units for the first year of MNT and 8 units in each subsequent year. They will pay for more units each year if the HCP provides a new referral request and billing codes G0270 or G0271 are used.

Private health plans may have fewer limitations. They will pay for more than just diabetes and chronic kidney disease. Most plans now pay for preventive care, which includes “Diet Behavioral Counseling.” The number of units may or may not be limited. For example Regence BlueCross and BlueShield of Oregon will pay for 6 hours of MNT each year, whereas Aetna may have no limit. **Although these codes were designed for dietitian/nutritionists, most commercial health plans (not UnitedHealthcare) will allow physicians to use these codes.**

Physicians:

Using Evaluation and Management (E/M) Codes [99212 (10min); 99213 (15 min); 99214 (25 min)]

Since counseling represents more than 50% of the time spent for a CHIP session the code you choose depends on the time you literally spend with the participant. You must document the total face-to-face time and the nature of the counseling including CHIP activities. If time is not the determinant, then you need 2 out of 3 elements of History (1 – 3 HPI elements), Examination (1 or 6 elements) and decision making. **It is not appropriate for dietitian/nutritionists to use these codes. These codes will obligate patients to pay their deductible and copay.**