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Documentation to Improve Medical Assessment Access and Reimbursement

Jessica A. Krenkel

Introduction

Nutrition and nutrition-related medical diagnoses are the basis for medical assessment and the administration of patient nutrition care. Standards of nutrition care are directed to quality treatment but reimbursement issues drive treatment access, and reimbursement is being closely tied to outcomes and costs versus benefits. The recent emphasis on evidence-based medicine and outcomes has stimulated the collection of data to reinforce the cost benefit for professional nutrition services, usually provided by a registered dietitian. Registered dietitians are currently the single identifiable group with the standardized education, clinical training, continuing education, and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy. Professional services may include counseling for preventing disease (primary prevention), for detecting asymptomatic disease or risk factors at early, treatable stages (secondary prevention), for disease treatment (tertiary prevention), and to promote normal growth and development.[1] The approach taken by the National Institute of Medicine (IOM) in making recommendations for future Medicare coverage included two nutrition service categories or levels: nutrition therapy and basic education or advice.[2] Nutrition therapy was identified by the IOM to include the assessment of nutritional status, evaluation of nutritional needs, intervention that ranges from counseling on diet prescriptions to the provision of enteral and parenteral nutrition, and follow-up care as appropriate. Since nutrition therapy is an intensive approach to the management of chronic diseases and requires significantly more training in food and nutrition science than is commonly provided in the curriculum of other health professions, the registered dietitian is the most common reimbursable provider, while basic nutrition could be provided by many health professionals.

The American Dietetic Association (ADA) uses the designation medical nutrition therapy (MNT) for assessment and interventions to treat illness and injury based on clinical research and experience. MNT involves the assessment and analysis of medical and diet history, blood chemistry lab values, and anthropometric measurements. Components of MNT include: 1) Diet modification and counseling and 2) specialized nutrition therapies

TABLE 28.1

Nutrition Diagnoses

260	Failure to thrive, kwashiorkor
261	Marasmus
263.8	Hypoalbuminemia with malnutrition
262-263.9	Mixed protein-kcalorie malnutrition and
263.0, 263.1	Malnutrition of mild to moderate degree
269.9	Nutritional deficiencies, unspecified
278	Obesity
281.9	Anemia, nutritional
646.1	Obesity/Pregnancy
646.8	Weight Loss/Pregnancy
733.1	Failure to thrive, child
783.1	Abnormal weight gain
783.2	Abnormal weight loss
733.0	Anorexia
307.1	Anorexia nervosa
783.6	Bulimia
307.50	Eating disorder, NOS

such as medical foods through food intake, enteral nutrition delivered via tube, or parental nutrition delivered via intravenous infusion.[3]

Nutrition Diagnosis

Medical diagnoses are officially coded by the International Classification of Diseases, Ninth Revision, Clinical Modification, ICD-9-CM, codes.[4] The codes identify the reasons services, equipment, or supplies are ordered. Diseases and injuries are arranged into 17 groups with 3 to 5 numeric descriptors. These include only a few codes specific to a nutrition diagnosis (Table 28.1) but many that are nutrition-related (Table 28.2) and therefore may require medical nutrition therapy as part of the treatment. A clinical modification of ICD-10-CM has been developed as a replacement for ICD-9-CM but has not been implemented yet.

There are 24 disease management protocols for the most common nutrition-related diagnoses provided by the ADA publication, Medical Nutrition Therapy across the Continuum of Care.[5] When coding the diagnosis for reimbursement, the code of choice should agree with the M.D.-identified diagnosis. For example, the ICD-9-CM codes for diabetes are very specific for complications and control (250.01 — diabetes mellitus without mention of complication, type 1; 250.02 — diabetes mellitus without mention of complication, type 2, uncontrolled). Familiar nutrition diagnoses are the codes related to malnutrition: failure to thrive, kwashiorkor (260), marasmus (261), hypoalbuminemia with malnutrition (263.8), mixed protein-calorie malnutrition (262-263.9), and malnutrition of mild to moderate degree (263, 263.1). There are suggestions for further clarification of malnutrition and weight loss diagnoses by describing body compartments: wasting (involuntary weight loss), cachexia (involuntary loss of body cell mass or fat-free mass when this compartment is reduced by little or no weight loss), and sarcopenia (involuntary loss of muscle mass). An increased degree of specificity for malnutrition may have value to increase the perception of nutrition as medical treatment for the future and to focus treatment on identified patient needs. Submitting codes to the American Medical

TABLE 28.2

Nutrition-Related ICD-9 Diagnosis Code Examples

042	AIDS/HIV
693.1	Allergies — food related
626	Amenorrhea
429.2	ASCVD
239.6	Breast cancer
579.0	Celiac sprue
574	Cholelithiasis
558.9	Colitis/Ileitis
558.10	Colon cancer
428	Congestive heart failure
564	Constipation
555.9	Crohn's disease
250	Diabetes mellitus
250.91	Diabetes mellitus, I, complications
250.01	Diabetes mellitus, I, uncomplicated
250.90	Diabetes mellitus, II, complications
250.0	Diabetes mellitus, II, uncomplicated
648.8	Diabetes, gestational
251.0	Diabetic ketoacidosis
558.9	Diarrhea
271	Disorders of lipid metabolism
562.10	Diverticulitis
536.8	Dyspepsia
535.5	Gastritis
553.3	Hiatal hernia
272.03	Hypercholesterolemia
643.0	Hyperemesis gravidarum
272.1	Hyperglycemia
272.3	Hyperlipidemia
275.42	Hypercalcemia
276.7	Hyperkalemia
276.0	Hypernatremia
252.0	Hyperparathyroidism
275.41	Hypocalcemia
250.80	Hypoglycemia, diabetic, unspecified
251.2	Hypoglycemia, nondiabetic, unspecified
276.8	Hypokalemia
276.1	Hyponatremia
272.4	Hyperlipidemia
401-405	Hypertension
564.1	Irritable bowel
271.3	Lactose intolerance
579.9	Malabsorption syndrome
581.9	Nephrotic syndrome
733	Osteoporosis
239	Stomach cancer

Association and participating in the development of diagnosis codes related to nutrition are new roles for nutrition professionals. Whether the diagnosis codes or the more specific descriptors would improve reimbursement and outcomes is unknown. Ways to diagnose nutrition problems or diseases are only one part of a multidimensional concept needed for clinical nutrition practice today.

Care Standards

Clinical practice tools including practice guidelines, protocols, clinical pathways, care maps, and algorithms integrate clinical expertise and scientific evidence to reduce fragmentation of care, and to guide nutrition practice and nutrition-related diagnoses. The development of these tools begins with the most costly and frequent medical conditions. Professional organizations, insurance companies, government agencies, accrediting organizations, and corporation policies and procedures may establish standards of practice. Standards of practice are gaining importance for justifying treatment approaches for patients and for providing legal justification for time, billing, and counseling content.

Professional organizations that provide standards of practice include the American Dietetic Association, American Society for Parenteral and Enteral Nutrition, American Public Health Association, American Diabetic Association, and other professional associations and practice groups. Government agencies provide standards for various practice settings, which are published in the *Federal Register.* Additionally, interpretive guidelines and survey procedures provide additional sources for practice expectations. The Health Care Financing Administration (HCFA), with responsibility for Medicare, influences healthcare facility standards as well as the reimbursement system for private and public health plans. Additionally, the Agency for Health Care Policy and Research (AHCPR) was created by the U.S. Congress to enhance the quality, appropriateness, and effectiveness of clinical practice guidelines.[6] Accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), dictate expectations for quality nutrition care for many types of facilities. Corporations have relied on many published standards of practice to establish contracts, competencies, and policies and procedures for nutrition practitioners. Employer or professional liability may be determined by adherence to practice standards. Lawsuits related to practice guidelines in the medical profession have not permitted a lower standard for different rural communities, geographical areas, or resource availability, and this would be predicted to be the case for nutrition practice standards as well. Whether established practice guidelines will foster increased lawsuits against practitioners who fail to follow recommendations is unknown.[7]

Medical Assessment Access

Access to quality health care is important in order to eliminate health disparities and increase the quality and years of healthy life for all Americans.[1] Recent major changes in the U.S. health care system include welfare reform, an emphasis on market forces, the use of case management, and altered payment and delivery systems. Adequate access to nutrition care may increase use of these services and improve health outcomes. Conse-

TABLE 28.3

Major Classifications and Models of Managed Care Systems

Classification/Model	Characteristics
Health maintenance organization (HMO)	A managed care organization that provides or arranges for specific health care services for plan members for a fixed, prepaid premium or dollar amount.
Staff model	The HMO owns and operates all facilities needed for the care of plan members and directly hires providers to work in HMO facilities. Closed panel with tight control over practice and benefits.
Group model	The HMO contracts with physician groups to care for plan members instead of directly employing these physicians. These physician groups are managed independently from the HMO and are paid at negotiated, capitated rates.
Network model	The HMO contracts with several single- or multispecialty physician groups.
Independent practice association (IPA)	The HMO contracts directly with individual, independent physicians, who are paid on a capitated basis. These physicians work in their own offices and serve both HMO and non-HMO patients.
Mixed-model	A combination of the above four distinct HMO models and fee-for-service plans to accommodate the different preferences of providers and health plan members.
Preferred provider organization (PPO)	The HMO contracts with individual providers or networks of providers to provide health care, such as nutrition services or dental care, for plan members at discounted fee-for-service rates. Plan members are not matched with gatekeepers and can go to specialists without referrals.
Point-of-service (POS) plan	Plan members are coupled with primary care providers but can seek care directly from other providers for higher copayments.

quently, measures of nutrition access across a continuum of care are an important way to evaluate quality of care.

A significant measure of the trend of decreased access is the proportion of people who have health insurance. In 1997, 85% of persons under 65 years of age had health insurance. Health insurance may be either private or public health plans.[8] Private insurance includes fee-for-service (FFS) plans, single-service hospital plans, or coverage by managed care organizations. Managed care is divided into three major classifications (See Table 28.3): health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.[9,10] Public insurance includes Medicaid or other public assistance, Aid for Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Indian Health Service, Medicare, or military health plan coverage.

Medicare Part A (hospital insurance) covers inpatient hospital, home care, and hospice services, skilled nursing facility care, and end-stage renal disease services. Medicare is managed by the Health Care Financing Administration (HCFA) which contracts with 46 fiscal intermediaries who are private insurance companies to process claims. Under Medicare Part A there are no payments specifically for dietitian services, as facility reimbursement is related to complexity of care for different diagnoses and conditions. For hospitals, the HCFA classification scheme is called Diagnosis Related Groups (DRGs), while for skilled nursing facilities the classifications are called Resource Utilization Group (RUGs). The DRGs and RUGs provide the basis for a Prospective Payment System (PPS) or "bundled" approach for hospitals since 1983, skilled nursing facilities since 1998, and home health agencies as of October 2000.[11]

Medicare Part B (medical insurance) provides coverage for outpatient physician and hospital services, laboratory services, durable medical equipment, and other medical services. Part B professional services are administered by 33 carriers. Part B equipment and supplies are administered by four regional durable medical equipment carriers (DMERCs).[11] While there is not a benefit for nutrition counseling under Part B, this is the focus of current legislative efforts by the ADA.

Medicare Part C (Medicare + Choice) offers alternate health plan options in addition to the traditional fee-for-service plan. Medicaid is a federal–state matching entitlement program for certain individuals and families with low income and resources. State participation in the Medicaid program is optional as long as the state has a similar program for this population. Each state has varying coverage of nutrition services for Medicaid recipients.[11]

Although lack of health insurance is clearly a major factor impeding access to care, having health insurance does not guarantee that health care will be accessible or affordable. Managed care has become the dominant form of healthcare delivery in the U.S. replacing the traditional FFS or indemnity system.[12] Managed care shifts financial risk from employers, insurance companies, and self-paying patients to healthcare systems and providers. Providers are paid set or predetermined fees under capitation and bundled fee systems regardless of services ultimately rendered. Managed care attempts to control costs by preventing duplication of services, restricting choices of providers, and increasing efficiency. Access to service is provided by precertification, utilization review, and credentialing. Gatekeepers to the system vary, but the case manager has a key role in complex medical cases. Educating case managers to showcase the benefits of medical nutrition therapy, improved patient care, and cost containment is essential for improved nutrition service access. Nutrition professionals potentially impact preventive services, screening programs, health risk assessments, and case management if they become more knowledgeable about how the systems operate.

Reimbursement for some care settings over others causes an uneven distribution of access to service. Access sites should include the entire continuum of care: acute care, ambulatory care, home care, skilled nursing, and long-term care. While nutrition counseling is generally more effective outside the hospital setting, coverage for nutrition therapy in ambulatory settings is at best inconsistent, but most often nonexistent.[2] This lack of access is a significant barrier to improved patient outcomes associated with nutrition care.

Outcomes

Analysis of the effectiveness of the practice guidelines for medical nutrition therapy is a focus of outcomes research. The outcomes determine reimbursement for clinical practice in our health care system as evidence-based medicine is becoming a controlling factor in determining the distribution of healthcare dollars.[13] The outcome is the result of a process of healthcare that weighs options as to cost and effects. The two major categories of outcomes are health and cost. Outcomes data provide health care payers information on the effectiveness of care to help them "1) reduce health care costs, 2) prioritize care and make reimbursement decisions, 3) establish guidelines, and 4) make purchasing decisions."[14] Decisions such as which tests to run first, or whether to try enteral or parenteral feeding, require knowledge of the evidence which supports nutrition decisions. Acceptance of clinical nutrition by the plan practitioners may be enhanced by the realization that cost-effective medical practice is optimized by wider application of nutrition principles to health maintenance and patient care.[15]

Health outcomes include clinical outcomes such as lab results and length of stay, functional outcomes such as quality of life, and general outcomes such as patient satisfaction and interventions.[14] Clinical research, as well as continuous quality improvement (CQI) or other in-house quality measurements, utilize health outcomes to determine results.[16] These need to be coupled with the cost outcomes of cost-effectiveness, cost-benefit, and charges. Cost-effectiveness is a ratio measure of the number of dollars spent for the

TABLE 28.4

Types of Outcomes

Clinical Outcomes

Primary	*Secondary*
Anatomic or Anthropometric — weight, height, % body fat, etc.	Morbidity
Physiologic —	Mortality
Biochemical labs, such as albumin, hemoglobin, cytokines	Length of stay
Healing, such as pressure ulcers, wounds, burns	Rates of infection
Metabolic rate	Re-admissions
Study or Disease Specific	Drug utilization
Such as stool analysis in cystic fibrosis, or residuals in enteral feeding studies	Number of doctor visits
	Home health care nursing visits

General Outcomes	*Functional Outcomes*
Patient satisfaction and expectations	Quality of life
Learning outcomes — enrollment, knowledge, behavioral change, improvements	Activities of daily living
	Mental/emotional health
Interventions — type, frequency or usage, acceptance by patient, timeliness	Family interaction
Acceptance of recommendations — M.D., interdisciplinary team, patient	Self-assessed health care status
Meal, food, nutrient intake	Pain

Economic Outcomes

Costs — cost-benefit, cost-effectiveness
Revenue
Reimbursement

improvement in an outcome (e.g., dollars spent for a therapy/HbA1c improvement), whereas cost-benefit is a ratio of the dollars spent on a therapy or program service to the number of dollars saved by implementing the program. In Congress, a cost-benefit (COB score) estimates the cost of legislation over a five-year period.[17] Medicare reimbursement is being considered for diseases where there are estimates for economically significant benefits to beneficiaries and reduced Medicare program health care expenditures. A lack of systems to track quality and cost of nutrition care has resulted in increased involvement of the ADA in collecting outcome data.[24] National outcome data for a larger range of medical conditions and preventive care will allow providers and administrators to identify nutrition services and populations that are in need of improved delivery and funding.

Quantification of patient satisfaction and quality of life is difficult, but these outcomes are of importance to the National Committee on Quality Assurance (NCQA) that accredits health maintenance organizations. The NCQA publishes a Health Plan Employer Data Information Set (HEDIS). The 3.0 version had 8 domains with 71 total performance measures to help employers and consumers compare managed care organizations.[18] Patient satisfaction is domain 3, and increased satisfaction has been associated with positive clinical outcomes.[19]

Reimbursement

The value of the dietitian is determined by income generation and by contribution to the goals of the organization in the private and public sectors of society. A lack of reimburse-

ment is a specific barrier to more consistent delivery of diet counseling and to employment of nutrition professionals.

Reimbursement issues have become a barrier for clinical nutrition in hospitals, clinics, and educational and other settings that have begun to operate their clinics with more of a business approach. Reimbursement has been poor to variable, with a wide range of experience expressed nationwide. The Health Care Financing Team at ADA has encouraged registered dietitians to develop skill understanding medical nutrition therapy coding and the coverage issues that surround reimbursement.[20] Recent efforts by ADA offer potential for increased reimbursement. The ADA has had three MNT current procedural terminology (CPT) codes accepted by the American Medical Association and published in the 2001 CPT Code.[21] Under HCFA's coding system, CPT codes are considered Level I HCPCS codes (acronym for HCFA's Common Procedure Coding System). These represent levels of service for individual new (97802) and established (97803) patients and group (97804) that may be used in the private sector (e.g., with third party payers); however, they have not been assigned relative value units (RVU). The RVUs will determine possible payment for MNT levels of service by Medicare and HCFA. The RVU represent a fair and reasonable fee structure based on geographical location, work required/resources consumed to perform service, other operating expenses, and other related factors. The AMA Health Care Professional Advisory Committee (HCPAC) has not accepted ADA's recommended work values which were based on practitioner data collected in March 2000, due to their unfamiliarity with the content and complexity of nutrition services. ADA has notified the AMA and HCFA that the Association will extend development of codes by seeking additional codes and reformatting the present codes to separate the tasks of assessment and intervention. Similar problems have occurred with the codes and RVUs being used for diabetes counseling, as the time needs and complexity are unfamiliar to the AMA. The acceptance of AMA codes and RVU for nutrition provider services is crucial in obtaining reimbursement from Medicare. Medicare decisions set precedents often followed by insurance companies, and add to the credibility of nutrition professionals as providers. The CPT codes and RVUs specific for recognized nutrition providers would be expected to become the basis of reimbursement for Medicare and insurance companies.[22]

Recent bills before congressional committees, the Medical Nutrition Therapy Act of 1999 (H.R. 1187/S.660) and the Medicare Wellness Act of 2000 (S.2225/H.R. 3887), which include some preventive services for Medicare beneficiaries, demonstrate a climate of change for Medicare reimbursement. The Medical Nutrition Therapy Act provides coverage for medical nutrition therapy under Medicare Part B furnished by registered dietitians and qualified nutrition professionals. A compromise is being considered that would be a five-year demonstration project for Medicare coverage of diabetes and renal disease.[23] The major reforms, including prescription drugs, will delay consideration of the controversial Medicare Wellness Act until at least 2001. These bills have gained momentum due to the study of the National Academy of Sciences Institute of Medicine, The Role of Nutrition in Maintaining Health in the Nations Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population, which recommends that medical nutrition therapy — with physician referral — be a covered benefit under the Medicare program.[2]

Presently, numerous CPT codes are used for clinical nutrition services.[10,24,25] Codes and reimbursement vary from state to state, among the various payors, and in different care settings, but commonly used codes include physician codes for new patients (99201 series), established patient or follow-up (99211 series), and consultation codes (99241 series). There is considerable controversy about the use of these codes by non-physician providers with and without "incident to" a physician billing. "Incident to" a physician billing requires supervision by the physician and billing under his tax ID, and is primarily used in states without dietitian licensure. Legal opinion has questioned the use of this billing practice

by non-physicians for Medicare patients except at the lowest level of service and payment.[26] Health insurance companies with provider agreements continue to accept "incident to" billing. Hospital-based outpatient clinics bill under the hospital tax ID instead of the physician or the licensed dietitian certified provider ID.

Other codes such as the new MNT codes (97802, 97803, and 97804), or preventive medicine codes (99381, 99391, and 99401 series) are available but may often have low reimbursement, as the RVU are minimal to none. Group counseling for preventive counseling (99411 and 99412) is seldom reimbursed, and also has RVU minimal to none. There has been some progress with the use of G-codes (G0108, G0109) for diabetes counseling, but numerous criteria must be met to bill when using these codes, including the need for services to be provided "incident to" a physician's services and under the physician's supervision. The G codes are provisional codes for a new benefit.[10] The HCPCS Level II manual includes a series of temporary national non-Medicare S codes and descriptors: S9465 — Diabetic management program, dietitian visit, S9470 — Nutritional counseling, dietitian visit.[27]

Articles and previously published information about which codes to use may not meet legal challenge and claims of fraud, as there has not been an easily understandable definition of how dietitians should use the codes. "Practice" does not mean that Medicare will accept the coding if investigated. This has recently been emphasized with Medicare's vigorous monitoring for fraud and abuse,[28] although thus far dietitians have not faced prosecution. Requests for clarification from Medicare are often verbal, and there has been resistance to putting interpretations in writing that are not in the published standards. These numerous inconsistencies and the increasing legal environment emphasize the need to have professional organizations such as the ADA involved in coding issues and supporting bills to clarify services.

Contracts with insurance companies and health maintenance organizations may closely follow Medicare guidelines or may be negotiated for acceptable codes and reimbursement/billing rates. Working with the clinic personnel responsible for these contracts has been beneficial compared to spending time calling each company to get approval for individual patients or to become a provider. The provider forms for dietitians are usually the same as for physicians, but many of the questions are not applicable, and dietitians are not credentialed the same as physicians, especially in states without licensure. Nutrition provider or credentialing information for contracts and provider agreements varies between health insurance companies, and within the same company there may be different benefits, interpretations, and provider agreements by region. A negative complication to payment for nutrition services is the idea of health insurance companies approving professionals for "access." The nutrition professionals on the list are recommended but the health insurance company does not provide payment, and the insured have to self-pay.

The billing level does not reflect the reimbursement level. It is important to have a set fee for any code that is being used, no matter what the reimbursement level. If rates are set at the expected level of payment the reimbursement will most likely be disappointing, as most schedules are discounted by payors. Published fees cannot be varied for different payors, but the fee schedule can be discounted at a set amount for ability to pay or cash payment. A good practice is to keep track of all patients seen, diagnosis, referring physician, and charges or amount billed for future use. Certainly the collectibles are only part of services billed, and nutrition services should be documented to justify diagnosis codes used on reimbursement claims and provide support for medical necessity.[10,11]

Key staff in insurance, billing, or information systems can help track billing and code results and develop procedures to maximize reimbursement. Private practice nutrition professionals may want to contract out insurance and billing tasks until they become more familiar with these systems. Claim forms and processing are integral to reimbursement. Physician offices and some individual certified hospital providers submit claims using

HCFA-1500 and electronic filing. Hospital clinics typically use the HCFA 1450 (UB-92) form for hospital-employed providers, and most hospital outpatient programs use HCFA 1450 form.

Data on the payor mix is important for assessing contracts, marketing, and reimbursement potential. Cost data analysis helps evaluate if your claims are 80 or 30 cents on the dollar. A streamlined approach to analysis in a large center with many payors would be to start with Medicare and the other top four payors.[29] Reimbursement may not always cover costs, but this is important information for decision making and to lobby for changes in rates. Knowing ahead of time that the dietitian costs are not being covered, such as in capitated contracts, allows time to present evidence to clinic or facility administrators that consults are saving physician time or preventing hospitalization and therefore reducing overall costs.

Conclusion

Medical assessment of nutrition contributes to the diagnosis and interventions that improve the quality of health care for patients. Access to nutrition care by the patient and reimbursement of the nutrition professional are inexorably tied to quality outcomes with cost effectiveness. Nutrition professionals need to actively communicate that medical assessment and nutrition care are essential components of quality health care with a low cost versus substantial benefit worthy of healthcare dollars.

Terminology

Capitated Fee — A fixed sum of money per enrollee, paid in advance, for a specified period of time.

Continuum of care — The array of health services and care settings that address health promotion, disease prevention, and the diagnosis, treatment, management, and rehabilitation of disease, injury and disability. Included are primary care and specialized clinical services provided in community and primary care settings, hospitals, trauma centers, and rehabilitation and long-term care facilities.

Managed care — According to the Institute of Medicine, "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing decisionmaking through case-by-case assessments of the appropriateness of care prior to its provision."

Primary care — According to the Institute of Medicine, "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Primary prevention — Measures such as health care services, medical tests, counseling, and health education designed to prevent the onset of a targeted condition. Routine immunization of healthy individuals is an example of primary prevention.

Secondary prevention — Measures such as health care services designed to identify and treat individuals who have a disease or risk factors for a disease but who are not yet experiencing symptoms of disease. Pap tests and high blood pressure screening are examples of secondary prevention.

Tertiary prevention — Preventive health care measures or services that are part of the treatment and management of persons with clinical illnesses. Examples of tertiary prevention include cholesterol reduction for patients with coronary heart disease and insulin therapy to prevent complications of diabetes.

Providers — Those providing health care — both individuals (physicians and other health care providers) and the entities that employ them (hospitals, outpatient clinics, physician practices, durable medical equipment suppliers).

Payors — Those assuming the financial risk of health claim losses and/or administering reimbursement for health care claims.

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