How to Check your Nutrition Benefits

A STEP-BY-STEP GUIDE

We are unable to directly bill your insurance for nutrition services; you will need to pay for your nutrition and wellness coaching session at the time of service. A "superbill" (an itemized invoice) can be provided that you may submit to your insurance company for reimbursement. Reimbursement is based on your policy's standards. Please call your insurance company's member services number to verify how reimbursement works under your insurance policy.

The information below will walk you through the steps to see if your insurance will cover the cost of nutrition counseling visits.

Call the 800 number (member services) on the back of your insurance card and explain to them that you need to verify "out-of-network nutritional counseling in office benefits". Ask the following questions:

1. Do I have nutritional counseling coverage on my insurance plan? (Linda is out-of-network)
    a. If the insurance company asks for a CPT code, provide them with the following codes: 97802 (evaluation/assessment- first session) & 97803 (follow up sessions).
    b. If you do not have coverage using those codes, ask them to check your coverage for codes: 99401, 99402, 99403, or 99404.

2. How many visits do I have per calendar year?
    a. The number of covered visits can range from 0 to unlimited depending on medical need.

3. Is pre-certification necessary for any of the above CPT codes?

4. Do I have a deductible for nutritional counseling services? If yes, how much is it and how much has been met so far?

5. Do I have a copay for each visit or what is the percentage of coverage?
    a. Most insurance companies consider dietitian a specialist. Your specialist copay is likely applicable. If your insurance considers nutritional counseling to be preventative counseling, the copay may not be applicable. Linda is an out-of-network provider.

6. Is this benefit limited to a specific medical diagnosis (such as diabetes or other diagnosis) in order for me to use the nutritional benefit? If so, what is included?
    a. What, if any medical diagnosis, is specifically listed as excluded from my nutrition benefit?
    b. Another way to ask this: are there any restrictions or limitations to my coverage- does my plan cover preventative "medically necessary" visits, or does it also allow and cover services such as a primary diagnosis?
    c. Does my plan cover eating disorder diagnosis? (f50) *(if applicable)*

7. Can I use my insurance for telehealth and what is my copay for telehealth?

Practice Information:
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Call Notes:

Rep Name		Copay/deductible	
Reference #		Nutrition benefit	
Date of call			

What is a superbill and how does it work?

A superbill is a detailed document that allows you to bill your insurance company directly. It includes information similar to an insurance claim form, such as the date of the service provided, procedure codes, diagnosis code, and a total balance due.

Payment for the session is due at the time of service. You can then use the superbill to try to get reimbursed for the session by your insurance company if your plan offers out-of-network benefits for the services you've received. If you do have out-of-network coverage, the amount you paid for your services may either get applied to your deductible or reimbursed and sent to you by check. Whether or not you get reimbursed depends on the type of coverage you have.

In Iowa, diagnosing patients is out of the scope of practice for an RDN. This means the RDN will need a referral with diagnosis from your primary care physician. Our practice will ask you to sign a release form so we can contact your physician on your behalf and gather the required information prior to your first visit. Without the referral and diagnosis, we cannot create a superbill for you.

Here is a list of helpful definitions:

In-Network - Doctors, hospitals, clinics, and other health care providers who have a contract with your insurance carrier to provide services to you at a contracted rate.

Out-of-Network - Services from health care providers who don't have a contract with your plan. Linda is an out-of-network provider.

Deductible - The amount you pay for eligible services during a benefit period before your plan begins to pay. The deductible does not include copayments, member coinsurance, charges in excess of the allowed (contracted) amount, and expenses for non-covered services.

For example, if your deductible is $1000, your plan won't pay anything until you've paid $1000 for covered health care services (after the copay, coinsurance, and contracted discounts are applied). The deductible may not apply to all services. This means you may be able to pay a copayment rather than the full amount (check your policy for details).

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Note: Your plan may have different deductible amounts for services in and out of the provider network. Deductible types include Individual Deductible and Family Deductible - If you have dependents on your policy, each person may have an individual deductible that is applied toward a total family deductible.

Family Deductible - Most family health insurance policies have both individual deductibles and family deductibles. Each time an individual within the family pays toward his or her individual deductible, that amount is also credited toward the family deductible. Under most family health insurance policies, coverage begins for each individual member as soon as his or her individual deductible is met. Once the family deductible is met, post-deductible coverage is provided for everyone in the family, even if their individual deductibles are not met.

Copayment (copay) - The fixed-dollar amount which is due and payable by the member at the time a covered service is provided. (Example $25) There is usually a specialist and a primary care copay amount listed on the front of the card. Some services fall under a copay while others may fall under the coinsurance.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service after all deductibles have been met. You pay coinsurance plus any deductibles you owe. Some policies have a coinsurance maximum – the maximum amount of coinsurance that the patient is obligated to pay for covered services per calendar year/benefit period.

For example, if your plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. Your plan pays the rest of the allowed amount. Also, once you reach your coinsurance maximum, your plan will pay 100% for covered services for the rest of the benefit period.

Out of Pocket Maximum - The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits. It typically includes your deductible, coinsurance, and copays, but this can vary by plan. The out-of-pocket limit typically doesn't include: your monthly premium, services that are non-covered, out of network care & services, charges over allowed amounts.

Preventative Care – Certain preventative care services don't require a deductible, copay, or coinsurance under the affordable care act. You won't pay for things like preventative (non-diagnostic) services like mammograms, physicals, vaccines, etc. In these instances, insurance typically pays at 100%.