Farela

The Audit-Ready MNT Documentation Standard

What a payer looks for in a nutrition note, the field-by-field reconciliation to run before you submit, and the wording that separates a defensible record from a clawback.

For registered dietitians billing medical nutrition therapy to commercial insurance and Medicare.

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BEFORE YOU START

How to use this

An audit does not ask whether you did good work. It asks whether the record proves you did the work you billed for.

Those are different questions, and the distance between them is where recoupment lives — money you earned, collected and spent, taken back months or years later because a note could not carry a claim. Nothing in this document is about being a better clinician. It is about making the record say what actually happened, clearly enough that a stranger reading it cold reaches the same conclusion you would.

Use it three ways:

- **While you write.** Keep §3 and §5 next to you until the elements are habit.
- **Before you submit.** Run §4 and §9 — that is the reconciliation that catches contradictions.
- **Backwards.** Pull five notes you have already billed and run §11 against them. This pass is the uncomfortable one, and it is the one that tells you where you actually stand.

> **The one thing to internalise first.** A clinically complete note does *not* prove a service is covered. Coverage, benefit limits, referral requirements, prior authorization, provider enrollment, diagnosis eligibility and telehealth rules all have to be verified separately for that patient's plan and that date of service. A perfect note and a denied claim coexist all the time. Keep the two questions apart.

Contents

This is general information for practice management. It is not legal, coding or billing advice, and it does not replace your payer contracts, state law, or your own professional judgment. Verify current payer policy for every date of service.

SECTION 1

Three questions that must never be collapsed

Almost every expensive billing mistake starts by treating these three as one question. They have different answers, different evidence, and different people responsible for them.

1. **Does the note support the service?**
   Answerable from the record alone. Did the documentation describe skilled nutrition work that actually happened, in enough detail to justify the code?

2. **Is the code consistent with the note?**
   Also answerable from the record. Initial vs. reassessment, individual vs. group, the units against the documented time, the diagnosis against what was addressed.

3. **Does this patient's plan cover it?**
   Not answerable from the note at all. Needs eligibility, benefit limits, referral and authorization status, provider enrollment, and the payer's policy for that date.

A note can be flawless and the claim still denied, because question 3 was never asked. And a claim can pay and still be recouped two years later, because question 1 was never really answered. Keep them apart in your head and in your workflow.

> **The fail-closed principle.** When a fact is missing, the record should say "not documented" — not a probable-sounding sentence that fills the gap. Better prose over a hole is worse than the hole, because it reads as an assertion. Make gaps visible.

SECTION 2

The four questions an auditor is answering

Everything in this document exists to answer one of these four.

1	**Who received care?**
2	**Why was nutrition therapy medically necessary for this patient, on this date?**
3	**What skilled nutrition services were actually provided?**
4	**Does the record support the procedure code, diagnosis codes, time, units, provider and place of service on the claim?**

If a note cannot answer all four on its own — without you standing beside it explaining — it is not audit-ready. That is the whole test.

SECTION 3

The 14 required note elements

	Element	Minimum defensible content
1	**Patient identity**	Name plus a second identifier (DOB or member ID), consistent with the claim and the chart.
2	**Encounter identity**	Date of service and the reason: initial evaluation, follow-up, reassessment, group, or other.
3	**Rendering clinician**	Full name and credentials, consistent with the rendering provider and NPI on the claim.
4	**Setting**	Practice or service location and place of service; office vs. telehealth, plus payer-required telehealth elements.
5	**Service and time**	CPT/HCPCS, start/stop or total direct service time, the unit calculation, and whether time was individual, group or synchronous.
6	**Diagnosis**	ICD-10-CM codes supported by the record and linked to the service. Nothing absent from or contradicted by the note.
7	**Assessment**	Anthropometric, biochemical, food and nutrition, medical, medication, activity, functional, behavioural, social.
8	**Nutrition diagnosis**	A supported statement connecting problem, cause and evidence, where appropriate.
9	**Medical necessity**	Why skilled MNT was needed *now*, which risks or impairments it addressed, and why self-directed general advice was insufficient.
10	**Intervention**	Specific education, counselling, food and nutrient recommendations, behaviour strategies, care coordination — with patient-specific rationale.
11	**Patient response**	Participation, understanding, teach-back, agreement or disagreement, readiness, confidence, questions.
12	**Monitoring**	What will be measured, how progress is judged, what would trigger a change of plan.
13	**Follow-up**	Timing and the clinical purpose of the next visit.
14	**Authentication**	Signature or compliant electronic authentication, with a date. Amendments preserve the original and identify author and date.

> **The three that fail most often are 5, 9 and 14.** Most dietitians document clinical content well — elements 7 through 13 are usually strong. The failures cluster in the unglamorous ones: the time statement, the medical-necessity reasoning, and the signature.

If you deliver telehealth, six additions

- [ ] **Modality** — synchronous audio-video, audio-only, or another permitted mode.
- [ ] **Patient consent**, where law, payer or organizational policy requires it.
- [ ] **Patient location and provider location**, where required.
- [ ] **Identity verification** and emergency/contact procedure, where required.
- [ ] **Correct place of service and modifier** for that payer, on that date of service.
- [ ] **A statement** that the encounter met the same clinical documentation standard as in-person.

> **Do not memorise telehealth rules.** Place of service, modifiers, eligible providers, modality and location requirements all change. Check them per payer, per year, for the date of service — not from habit.

SECTION 4

Claim-to-note reconciliation

A contradiction is more serious than an omission, because it suggests the note and the claim describe two different services.

Run this field by field before submission.

Field	Compare	Pass condition
Patient	Name, DOB / member ID	Claim and chart identify the same patient.
Date	Date of service	Note, appointment, signature context and claim agree.
Provider	Rendering provider, NPI, credentials	Signer and rendering provider consistent, enrolled and eligible.
Service	CPT / HCPCS	Initial vs. reassessment, individual vs. group, description matches the documented work.
Diagnosis	ICD-10-CM and pointers	Record supports each diagnosis linked to the billed line. No unsupported diagnosis used only to obtain coverage.
Time / units	Total time and units	Arithmetic correct, time within payer rules, no overlap or duplicate billing.
Setting	POS, location, telehealth modifier	Note and claim describe the same location and modality.
Authorization	Prior auth / referral / order	Required documentation exists and covers the date, code, units and provider.
Benefit	Frequency and annual limits	Session does not exceed plan limits unless a documented exception applies.

Baseline checks for 97802 and 97803

97802	Initial individual MNT assessment *plus* intervention. Must clearly be the initial assessment for the applicable episode or payer definition.
97803	Individual MNT reassessment *plus* intervention. Must show prior care or an established plan, reassessment of progress or response, and intervention or modification.
Unit basis	Each code bills in 15-minute increments. **8 units = 120 minutes.** Do not assume a rounding methodology or an "8-minute rule" unless the payer's policy expressly applies it.
Delivery	Use the code and telehealth rules applicable to that payer and date. The documentation must accurately identify how the service was delivered.

Hard stops — do not submit if any of these is true

- [ ] **97802** billed, but the note states follow-up or reassessment, or documents prior MNT in the same episode without a payer-supported reason.
- [ ] **97803** billed, but there is no evidence of reassessment, progress review, response or plan modification.
- [ ] **8 units** billed, but the note documents less than 120 minutes, conflicting start/stop times, or overlapping services.
- [ ] In-office place of service billed, but the note states telehealth — or the reverse.
- [ ] A diagnosis on the claim is absent from, contradicted by, or unrelated to the documented intervention.
- [ ] The rendering provider on the claim differs from the authenticated clinician, without a supported billing arrangement.
- [ ] The note is unsigned, unauthenticated, or contains unresolved placeholders.
- [ ] The service appears copied from another patient, date or encounter.

SECTION 5

Medical necessity and the clinical story

Medical necessity is not a sentence you add at the end. It is visible throughout the note or it is not there at all.

It should appear in the reason for the encounter, the assessment findings, the diagnosis, the barriers, the intervention, the patient's response and the follow-up plan. A closing statement may summarise the story — it **cannot repair a note that otherwise lacks the facts**.

WEAK

"Patient wants to lose weight."

DEFENSIBLE

"Patient presents for follow-up MNT for obesity. Despite prior counseling, the patient reports persistent excessive energy intake, inconsistent meal timing, and schedule-related barriers that interfere with weight management. Skilled nutrition intervention remains necessary to reassess intake, address barriers, adjust the plan, and reduce cardiometabolic risk."

The four-step logic chain

Step	Requirement	Example
Finding	A current problem, risk, symptom, behaviour or objective measure.	"A1C remains above goal." "Meals are skipped on 3–4 workdays." "Weight regained after discontinuing tracking."
Clinical meaning	Why the finding matters, and how it relates to the billed diagnosis.	"Irregular intake contributes to late-day overeating and impairs glycemic consistency."
Skilled action	What you did that required clinical judgment.	"Reviewed intake pattern, identified triggers, adjusted carbohydrate distribution, developed a workday meal plan."
Expected monitoring	How the response will be measured.	"Monitor premeal glucose, meal timing adherence, and A1C at the next available interval."

Evidence that can support necessity

Ongoing symptoms or functional limitations · abnormal or worsening labs · clinically significant weight change · chronic disease or risk requiring nutrition intervention · medication effects, including GLP-1 therapy · nutritional deficiencies · food insecurity or resource constraints · inadequate or excessive intake · GI symptoms · disordered eating within scope · behavioural barriers, limited readiness, low confidence, relapse risk · the need for ongoing education because the patient has not demonstrated the skills to self-manage safely.

Diagnosis cautions

> **E66.9 and Z71.3 may describe the encounter accurately without establishing coverage.** Their presence does not mean a payer covers 97802 or 97803. Verify covered diagnoses and benefit policy separately. For **Medicare**, national MNT coverage is limited to qualifying diabetes or renal disease — obesity-only or dietary-counseling-only patterns must never be used as a Medicare template.

- [ ] Do not add a disease diagnosis merely because it would improve claim acceptance.
- [ ] Do not convert patient-reported history into a confirmed diagnosis unless the record and coding rules permit it.
- [ ] Do not assume a more specific code is supported without documentation of the required specificity.
- [ ] When **Z71.3 is the only diagnosis**, treat it as a review trigger: check payer policy and whether the note documents a condition, risk or benefit category establishing necessity.
- [ ] When **E66.9** is used, make sure the note supports obesity management and the relevant clinical risk — and still treat coverage as payer-specific.

SECTION 6

Time, units and signatures

Verify both the arithmetic *and* the clinical plausibility. Documented work should reasonably reflect the duration claimed.

Check	Requirement
Arithmetic	Verify total documented time, start/stop where available, and the exact unit conversion the payer requires. For 15-minute codes, 8 units = 120 minutes.
Service time	Confirm what the payer counts: direct individual time only, synchronous telehealth time, or other components. **Do not include documentation, scheduling or administrative time.**
No overlap	Check for overlapping appointments, concurrent services, group time billed as individual, and duplicate claims for the same patient, date and time.
Scope of work	A longer visit should show broader assessment, individualised education, counselling, goal setting, response and planning — **not repeated boilerplate**.
Benefit limit	Verify annual or episode limits, and any additional-hours order or exception, before billing an extended session.

> **Connection time is not billable time.** The length of a video call, a recording, or a scheduled appointment slot is not the same as documented direct service time — and several payers say so explicitly. If you bill time-based units, the note has to state the time.

Extra scrutiny for 120-minute visits

- [ ] Start and stop times, or another reliable contemporaneous time source, are available.
- [ ] The session was genuinely individual MNT and did not overlap another billable service.
- [ ] Assessment and intervention are comprehensive and individualised enough to explain the duration.
- [ ] The note documents patient participation and is not mostly copied education text.
- [ ] The payer permits that number of units on one date, and the patient has remaining benefits or a valid exception.
- [ ] The diagnosis and service meet the payer's coverage requirements.
- [ ] The attestation states the actual time and units, rather than restating the claim.

Authentication

- [ ] The rendering clinician reviews and authenticates the final note.
- [ ] Where a scribe is used — **including AI** — CMS states the responsible clinician signs the entry to authenticate the document and the care provided.

- [ ] Software should never auto-apply a signature, signature date or attestation.
- [ ] Electronic signature systems should protect against modification and keep an audit trail.

A missing signature is a critical pre-bill defect. Treat an unsigned note as not billable. A later signature attestation is permitted in some Medicare situations, but it must never be the routine workflow.

Units are arithmetic. Arithmetic is what software is for.

Farela derives the units from the session it recorded and shows the calculation, so the number on the claim traces back to something rather than to a habit.

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SECTION 7

Corrections, amendments and late entries

This is the section that turns a documentation problem into a credibility problem if you get it wrong. Electronic records carry metadata and audit trails; edits are visible.

- [ ] Never overwrite or silently replace original signed content.
- [ ] Clearly label the amendment, correction or late entry as such.
- [ ] Identify the date, time, author and reason for the change.
- [ ] Preserve the original content and show what changed.
- [ ] Do not add clinical facts after an audit request unless they are legitimate, clearly identified late entries supported by contemporaneous evidence.
- [ ] **Never backdate** a signature, encounter, order or plan of care.

> **If a payer has already requested records, stop and think before touching anything.** Editing a note at that moment is the single fastest way to convert a billing question into an allegation about the integrity of your records. If a correction is genuinely warranted, label it as a late entry with its own date, leave the original intact, and send both.

Retention

Keep the signed note and supporting records per federal, state, payer, contract and professional rules. In Medicare contexts covered by 42 CFR 424.516(f), CMS guidance requires records to be maintained **seven years** from the date of service and made accessible on request. If a telehealth vendor or an employer holds the record, that does not remove your responsibility to be able to produce it.

SECTION 8

Common failure patterns, with corrected wording

Failure	Weak pattern	Correction
Necessity only as a conclusion	“MNT is medically necessary.”	Describe current findings, risk, barriers, skilled actions and monitoring throughout the note.
Generic intervention	“Discussed diet and exercise.”	Identify the specific topic, the patient-specific rationale, the method, the goal and the response.
Unsupported time	“120 minutes” with a brief, repetitive note.	Document the actual time and comprehensive individualised work; verify benefit and unit rules.
No continuity	Each follow-up repeats the initial history.	Reference prior goals, adherence, barriers, response and plan changes.
Judgmental language	“Noncompliant.” “Lazy.”	Use objective, attributed facts; quantify behaviour where possible.
Diagnosis disconnected from care	Claim lists a diagnosis the note never discusses.	Show how the assessment and intervention address each billed diagnosis — or remove the code.
Copied-forward contradictions	Old weight, medication, goal or family detail remains.	Update or remove stale content; keep only relevant prior facts, with attribution.
Coverage assumed from the note	A complete note treated as proof of eligibility.	Verify policy, referral, authorization, enrollment, limits and diagnosis eligibility separately.

Four rewrites worth stealing

WEAK

“Patient is noncompliant with the plan.”

DEFENSIBLE

“Patient reports following the breakfast plan on three of seven days. Barriers included early work shifts and lack of prepared food. The plan was simplified to two portable breakfast options.”

WEAK

“Reviewed protein.”

DEFENSIBLE

“Reviewed current protein intake and explained the role of protein in satiety and lean-mass retention. Patient selected two breakfast options providing approximately 25–30 g protein and verbalized how to assemble them.”

WEAK

“Continue current plan.”

DEFENSIBLE

“Continue the meal structure that improved afternoon hunger. Modify the evening snack to include protein and fiber because the patient reports persistent hunger at 9 PM. Monitor evening hunger and snack frequency for two weeks.”

WEAK

“Patient understands.”

DEFENSIBLE

“Patient accurately described the plate method using a typical dinner and identified one change to make this week.”

SECTION 9

High-risk situations that deserve a second look

None of these is wrong on its own. Each is a pattern that draws attention, so each deserves a deliberate check before you submit.

- [ ] **Six or more units on one date**, especially for follow-up MNT.
- [ ] A counseling code or an unspecified diagnosis as the **only** diagnosis on a time-intensive claim.
- [ ] A payer or plan you have not billed before.
- [ ] A claim at or near the patient's annual benefit limit.
- [ ] A telehealth claim missing location, consent, modality, POS or modifier data.
- [ ] A note with substantial copied text, minimal patient response, or generic necessity language.
- [ ] A note signed late or amended after the claim was submitted — or after a records request.
- [ ] Repeated identical unit counts and note structures across many patients.
- [ ] A mismatch between appointment duration, connection logs and billed time.
- [ ] A diagnosis or service changed **solely because an earlier code was denied**.

> That last one is worth sitting with. Changing a code after a denial is legitimate when the record supports the new code and payer policy allows it. It is not legitimate when the only thing that changed is that the first attempt did not pay.

SECTION 10

The audit-defense package

If a records request arrives, this is what a complete response looks like. Assembling it once, for a single claim, is the fastest way to find out what you are missing.

- [ ] The final signed and dated note, including amendment history.
- [ ] The CMS-1500 / 837P claim and the remittance or ERA.
- [ ] Eligibility and benefit verification evidence.
- [ ] The referral or order, and prior authorization, if either was required.
- [ ] The payer policy in effect *on the date of service*.
- [ ] Prior signed notes needed to show continuity and response.
- [ ] Appointment and time evidence, including the telehealth log where relevant.
- [ ] Relevant labs, medication list, correspondence and coordination-of-care records.
- [ ] Rendering provider enrollment or credential evidence, if requested.

> **Send exactly what was requested — no more.** Extra dates of service, other patients' information, or a whole chart when one note was asked for all widen the review rather than closing it. Deadlines vary by payer and state, and extensions are commonly granted if you ask in writing before the deadline.

SECTION 11

Three checklists

Before you sign

- [ ] The note accurately reflects what occurred, with **no invented, assumed or copied-forward fact** that was not verified.
- [ ] Patient, date, service type, provider, setting, diagnosis, time and units are correct.
- [ ] The assessment contains relevant current facts, and clearly attributes patient-reported and prior-record information.
- [ ] Medical necessity is demonstrated throughout the clinical story.
- [ ] The intervention is specific, skilled, individualised and linked to the assessment and diagnosis.
- [ ] The patient's response, understanding, readiness and goals are documented where known.
- [ ] Monitoring and follow-up are clear.
- [ ] Prior goals and progress are addressed, in follow-up notes.
- [ ] Time and units are accurate and supported.
- [ ] The note is internally consistent and free of stale names, pronouns, dates, weights or diagnoses.
- [ ] Any correction or late entry is properly labelled and traceable.
- [ ] You have signed and dated the final note.

Before you submit the claim

- [ ] The signed note supports every claim line and diagnosis pointer.
- [ ] The CPT/HCPCS matches initial vs. reassessment, individual vs. group, and the actual service delivered.
- [ ] The unit calculation and time source are correct; there is no overlapping or duplicate billing.
- [ ] Place of service and telehealth modifier match the note and the payer's rules.
- [ ] The rendering provider is credentialed and enrolled, and matches the claim.
- [ ] The diagnosis is supported by the note and eligible under payer policy.
- [ ] Any required referral, order or prior authorization exists and covers the date, code, units and provider.
- [ ] Eligibility and benefit limits are checked; remaining units are sufficient, or a valid exception exists.
- [ ] The claim is **not** being changed solely to bypass a denial without supporting facts and payer authority.

The final read-through

Ask these as if you were the auditor, about a note you cannot explain in person.

- [ ] Can I identify who received care?

- [ ] Can I understand why MNT was medically necessary?
- [ ] Can I identify the skilled services actually provided?
- [ ] Does the note support every code, diagnosis, unit and claim field?
- [ ] Is the assessment complete and relevant?
- [ ] Are the interventions specific to this encounter?
- [ ] Does the note objectively describe progress, response and barriers?
- [ ] Does the record tell a cohesive story across visits?
- [ ] Is the follow-up plan documented?
- [ ] Does the record reasonably support the time and units?
- [ ] Is the note authenticated and internally consistent?
- [ ] Is separate evidence available for coverage, authorization, referral, enrollment and benefit limits?

SECTION 12

Sources

This standard is informed by current CMS and HHS OIG materials. Your payer contracts, state law and current plan policies must also be consulted — they govern where they differ.

R1	**Complying With Medical Record Documentation Requirements** (MLN909160) — CMS, Dec 2024. Insufficient documentation, medical necessity, signatures, claim support, recovery of overpayments.
R2	**Complying With Medicare Signature Requirements** (MLN905364) — CMS, Jul 2025. Authentication, electronic signatures, signature logs and attestations, AI and scribe documentation.
R3	**Medical Record Maintenance & Access Requirements** (MLN4840534) — CMS, Jan 2026. Seven-year maintenance and access, macros, telehealth entity access, record authenticity.
R4	**NCD 180.1 — Medical Nutrition Therapy** — CMS, effective Jan 1 2022. Medicare MNT qualifying conditions, basic annual hours, additional-hours requirements.
R5	**Additional Documentation Request** — CMS, accessed Jul 2026. Medical review and supporting-document requests.
R6	**Medicare Program Integrity Manual**, Pub. 100-08 — CMS. Medical review, signatures, amendments, coverage and coding determinations, statistical sampling, recovery audit.
R7	**Medicare Home Health Agency Provider Compliance Audit: VNS Health** — HHS OIG, 2026. Overpayment findings, refund recommendations, strengthening documentation review controls.

Keep going — the deep dives

Each of these expands one section of this document. All free, no signup.

How to Audit-Proof Your Nutrition Claims
The full method, and what to do when a records request lands. → farela.ai/blog/audit-proof-nutrition-claims

Your Payer Requested Your Chart Notes
What to send, what not to send, and how to tell an audit from a records retrieval.

Charting for Medical Necessity
Expands §5 — the language that carries the claim.

The 8-Minute Rule for Dietitians
Expands §6 — how documented minutes become billable units.

How to Appeal a Denied Nutrition Claim
The appeal ladder, the deadlines, and the evidence that wins.

Why Nutrition Claims Get Denied
The common denial reasons for MNT, and the fix for each.

All 63 articles

Billing, audits, credentialing, documentation, software, practice growth. → farela.ai/blog

Who made this, and why it's free

Farela is insurance billing software for independent registered dietitians. We wrote this standard because we work these claims every day — coding, submission, denials and appeals — and because the two best-known audit resources in this field both sit behind a paywall. A document this basic should not cost anyone anything.

If the billing side is what's eating your evenings: Farela records the session, drafts the chart, derives the codes and the units, files the claim under your NPI, and reads the insurer's remittance so you stop reconciling by hand.

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