MEDICAL NUTRITION THERAPY · COMMERCIAL BLUE PLANS

Billing Blue Cross Blue Shield as a dietitian

The codes, units, diagnoses, telehealth rules and BlueCard routing behind MNT claims that get paid — and what to check before the first visit.

Read this first

"Blue Cross Blue Shield" is about 33 independent companies. Each one sets its own coverage, visit limits and filing rules. Wherever this sheet says **verify**, it means it.

1 The three MNT codes

CODE	CPT DESCRIPTOR (SHORT)	UNIT	WHEN TO USE IT
`97802`	MNT, **initial** assessment and intervention, individual, face-to-face	15 min	The first visit with a new patient. Medicare uses it for the initial assessment only, then 97803. Many commercial plans also limit it (once per year or per episode is common) — **verify**.
`97803`	MNT, **re-assessment** and intervention, individual, face-to-face	15 min	Every follow-up, including a re-assessment after a change in condition or treatment.
`97804`	MNT, **group** (2 or more individuals)	30 min	Group classes. Each participant gets their own claim.

2 Units: count the minutes, not the appointment

Face-to-face minutes on this date of service

MINUTES	< 8	8–22	23–37	38–52	53–67	68–82	83–97	98–112
97802 / 97803	0	1	2	3	4	5	6	7

How the rule works. Under CPT's time rule, a unit counts once you pass its midpoint: 8 minutes for a 15-minute code. For `97804` (30-minute units): 16–45 min = 1 unit, 46–75 = 2. Most commercial payers follow CPT. Some plans cap units per visit or per day — **verify**.

Units come from this visit's documented minutes. Never copy the units from the last claim. We caught a 34-minute follow-up drafted with the 7 units of a 105-minute first visit. A payer might even pay that claim. An auditor won't accept it.

3 Diagnoses: what to put on the claim

`Z71.3` **Dietary counseling and surveillance.** Describes the counseling encounter. ICD-10-CM says to also code the underlying condition and the BMI (Z68.-) if known.

`Z68.xx` **BMI — secondary only.** Never first-listed and never alone. It needs an associated reportable diagnosis (such as overweight or obesity) documented by the patient's provider. The RD's own BMI measurement is fine. Not during pregnancy.

Medical diagnoses we see on MNT claims

`E66.811–.813`	Obesity, class 1 / 2 / 3 (new Oct 2024) · `E66.3` overweight
`R73.03`	Prediabetes · `E11.x` type 2 diabetes
`E78.x`	Hyperlipidemia · `I10` essential hypertension
`K58.x`	Irritable bowel syndrome · `E28.2` PCOS

Code only what is documented, to the highest specificity the record supports. Payers disagree on order: some want the medical condition first for medical necessity. Ask the plan (§6).

Preventive or medical benefit?

- **Preventive ($0 to the member in network).** Under the ACA, non-grandfathered plans must cover USPSTF "A/B" services without cost sharing. That includes healthy-diet counseling for adults with cardiovascular risk factors, intensive behavioral programs for adults with BMI ≥ 30, and programs for children 6 and older with high BMI.
- **The claim has to look preventive.** BCBS of Illinois lists 97802–97804 under those services. To process at the preventive level, a claim needs a preventive diagnosis *and* a preventive procedure code. Z71.3 is **not** on its preventive Diagnosis List 1 (R73.03 is).
- **Everything else is the medical benefit.** The diagnosis is the condition you treat, and the deductible, copay or coinsurance apply.

Plans decide which benefit applies. Ask during the benefits check. The USPSTF is being restructured in 2026. Current A/B recommendations still apply.

4 Telehealth: modifier + place of service must agree

WHERE THE PATIENT IS	POS	MODIFIER
At home, live video	`10`	`95` (some plans: `GT`)
Elsewhere, live video	`02`	`95` (some plans: `GT`)
In your office	`11`	None
Phone only	Often not covered for MNT. Where allowed: `93` or `FQ` — **verify first**	

- **Modifier 95** means live audio *and* video. 97802–97804 are on CPT's list of codes eligible for it.
- **BCBS of Illinois (RP033, Mar 2026):** telehealth on a CMS-1500 needs POS 02 or 10 *plus* a telehealth modifier. Asynchronous care (GQ) is not paid.
- **Licensure follows the patient.** Where your profession is licensed, you must be licensed in the state where the patient is during the visit.
- Each Blue plan writes its own telehealth policy. Check it before you default to video.

What got paid for us (one Illinois practice, BCBS of Illinois, 2025–2026)

- First visit `97802`, units by time (a 71-minute intake = 5 units); every later visit `97803`.
- Telehealth to the patient's home: modifier `95` + POS `10`.
- Dx `Z71.3` + a `Z68.xx` BMI code (Z71.3 alone was also paid). To follow coding guidelines strictly, add the weight diagnosis the provider documented (E66.x).
- This is one practice's pattern. It is not a promise: your plan and your contract decide.

5 BlueCard: out-of-state Blue members

- **File with your local Blue plan**, not the member's home plan. Your plan routes the claim to theirs through the BlueCard program and pays you at your contracted rate.
- **The 3-character prefix is the routing key.** It sits at the start of the member ID and can mix letters and numbers. Enter the ID exactly as printed, prefix included (up to 17 characters). Never guess a prefix or copy one from another card.
- **Eligibility:** check it through your local plan's portal (Availity for many Blues) or call the BlueCard Eligibility line, **1-800-676-BLUE (2583)**.
- **Exceptions — follow the back of the card:** FEP IDs start with "R" and have no prefix. Blue Medicare Advantage and Medicaid plans often have their own payer ID and rules. Canadian Blue Cross is not BlueCard.
- **Timely filing** comes from your local plan and your contract. Example: BCBS of Illinois gives participating PPO professionals 180 days from the date of service. Other Blues and some employer groups differ.
- **What worked for us:** an Illinois practice files Texas and California Blue members to BCBS of Illinois (payer ID 00621) and gets paid. A New York practice filed Florida Blue members to its local Blue and was paid 4 of 4.

6 Before the first visit: the benefits check

Portal or phone. Write the answers in the chart.

- ☐ **Which Blue?** The prefix, and whether it's commercial, FEP, Medicare Advantage or Medicaid.
- ☐ **In network?** Are you credentialed with your local Blue, under your individual NPI?
- ☐ **Covered codes:** 97802 / 97803 (and 97804) when a registered dietitian provides them?
- ☐ **Which benefit:** preventive or medical? Which diagnoses qualify? Is Z71.3 accepted?
- ☐ **Limits:** visits or units per year? Calendar or plan year? Shared with other providers?
- ☐ **Member cost:** deductible, copay, coinsurance. Is preventive care $0?
- ☐ **Gatekeeping:** PCP referral (common in HMOs) or prior authorization?
- ☐ **Telehealth:** is it covered to the home (POS 10 + modifier 95)?
- ☐ **97802 frequency:** how often can the initial code be billed?
- ☐ **Proof:** rep's name, date and call reference number, saved in the chart.

7 Top denials and how to fix them

Codes are X12 claim adjustment reason codes (CARC) on your ERA

DENIAL	USUAL CAUSE	FIX
31 · Patient can't be identified as insured	ID keyed without its prefix, wrong subscriber, DOB mismatch	Copy the ID from the *current* card, prefix included. Patient isn't the policyholder? Add subscriber and relationship.
16 · Missing info or billing error	Empty diagnosis slot, a line pointing to a blank diagnosis, missing NPI	Every service line points to a filled diagnosis. Our clearinghouse rejected exactly this one.
11 / 167 · Diagnosis inconsistent or not covered	Z68 listed first or alone, or a diagnosis outside the plan's list	Z68 is always secondary. Lead with a diagnosis the policy covers.
4 / 5 · Modifier or place of service inconsistent	Video visit without 95, 95 with POS 11, or POS 02 when the patient was home	Match the table in §4: home = POS 10 + 95.
50 / 96 / 204 · Not medically necessary or not covered	MNT isn't in the benefit, or the diagnosis doesn't support it	Run the benefits check first. Appeal with the note and the referral.
119 · Benefit maximum reached	Yearly visits used up, sometimes by another provider	Ask how many visits remain. Track them per patient.
197 · Authorization absent	HMO referral or prior authorization not on file	Get it before the visit. It is rarely granted after.
B7 · Provider not eligible	Not credentialed yet, or a rendering NPI that isn't the RD who saw the patient	Finish credentialing with your local Blue. The rendering NPI must be the RD who signed the note.
29 · Filing time limit expired	Claims batched monthly or left in drafts	Submit weekly. Know your plan's limit (§5).
Wrong date of service	Software that stamps evening visits with the next day's UTC date	The DOS is the visit's local date, the same as on the note. We found and fixed this in our own claims.

8 Documentation that survives an audit

- **Time:** start and stop times, or total face-to-face minutes. The billed units must match.
- **Telehealth:** audio-video modality, the patient's location (home or other), and consent where your state requires it.
- **Referral or order**, and the diagnosis it names, when the plan requires one.
- **Medical necessity:** the plan of care clearly tied to the diagnosis you billed.
- **Nutrition Care Process (ADIME):** Assessment (height, weight, BMI, labs, intake, history), nutrition Diagnosis as a PES statement, Intervention, and Monitoring & Evaluation with measurable goals.
- **Signature:** RD name, credentials and NPI, signed and dated. Sign the note before you submit the claim.
- **Consistency:** the diagnosis, date and minutes agree across the note, the referral and the claim.

Sources: AMA CPT® 97802–97804 descriptors, CPT time rule and Appendix P (modifier 95). ICD-10-CM Official Guidelines FY2026, §I.B.14 and §I.C.21.c.3 (BMI), plus the Z71.3 tabular notes. BCBS of Illinois reimbursement policies RP033, Telemedicine & Telehealth (eff. 3/27/2026), and RP006, Preventive Services (eff. 4/1/2026). BCBSIL BlueCard Program page and timely filing notice (10/28/2024). Independence Blue Cross, *Quick guide to Blue member ID cards*. USPSTF recommendations: adult obesity (2018), healthy diet & physical activity with CVD risk factors (2020), children and adolescents with high BMI (2024). ACA §2713 and *Kennedy v. Braidwood* (U.S. 2025). X12 Claim Adjustment Reason Codes. Academy of Nutrition and Dietetics, Nutrition Care Process. Farela's de-identified claims experience, 2025–2026.