Calling to Verify Insurance Benefits

Call the customer service number on the back of your card and have your card ready with your customer #. Explain that you are calling to verify "Nutritional Counseling" or "Medical Nutrition Therapy" benefits. Ask the following questions:

1. Is Dr. Mary Friesz (NPI #1790833929) covered under my plan? If not, what are my out-of-network nutrition benefits?
2. Does my policy cover any of the following CPT Codes?
   (These are some of the most common CPT Codes that Dr. Mary Friesz uses):
   a. • Evaluation/Assessment (first appointment) = CPT Code 97802
   b. • Follow-up Sessions = CPT Code 97803
   c. • Group Sessions = CPT Code 97804

3. Do I need a referral or a pre-authorization from my primary doctor for any of the CPT codes above? ***Ask specifically** if you are covered for the diagnosis code **Z71.3**, which is preventative nutrition, if you do not have a medical diagnosis.
4. If I do have coverage, is there a limit on the number of visits allowed per year?
5. Is Nutrition Counseling covered when provided via Telehealth?
6. Do I have a deductible for Nutritional Counseling services? If yes, how much is it and how much has been met so far?
7. Is there a copayment for each visit or what is the percentage of coverage?
   (Dr. Friesz is considered a Specialist, so you will often be responsible for your Specialist copayment.)
8. Are there any restrictions and/or limitations to my coverage? In other words, does my plan cover preventative "medically necessary" visits or does it only cover Medical Nutrition Therapy with a primary diagnosis, such as Diabetes, Hypertension, Chronic Kidney Disease, Hyperlipidemia, Obesity/Morbid Obesity, etc?
9. If you have a medical condition and your plan only covers nutrition for a specific diagnosis, below are some of the most common ICD-10 diagnosis codes related to Medical Nutrition Therapy. However, when you make an appointment with Dr. Mary Friesz, she will be able to determine the appropriate codes prior to your session.

Type 2 Diabetes = E11.9
Type 1 Diabetes = E10.6
Gestational Diabetes = O24.41
Hypertension/High Blood Pressure = I10
Hyperlipidemia/High Cholesterol = E78.5
Prediabetes = R73.03 or Impaired Fasting Glucose = R73.01

Obesity and Morbid Obesity (this is coded at various levels of obesity)
  Obesity (BMI over 30 but under 40) = E66.9 and Z68.3
  Morbid Obesity (BMI over 40) = E66.01 or Z68.4
  Childhood Obesity (Over 95th percentile for age) = Z68.54

Note: Be sure to write down the date and reference number for your call, as you will be responsible for any visits your insurance carrier denies payment.

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 discount.

Out-of-Network - Services from health care providers who don't have a contract with your plan will usually cost you more than those received from an in-network provider.

Deductible - The amount you pay for eligible services during a benefit period before your plan begins to pay. For example, if your deductible is $1000, your plan won't cover anything until you've met your $1000 deductible for covered health care services subject to the deductible. 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).

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. You pay coinsurance plus any deductibles you owe. 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.

Plan's Maximum - This is the specific deductible, coinsurance, or out-of-pocket amount for your plan, and what you may owe cannot exceed these amounts. This does not include copayments or non-covered services.

Out of Pocket - The total amount of coinsurance that you will pay during a policy period before your plan begins to pay at 100% of the allowed amount. This limit typically does not include your premium, copayments, deductibles, charges over allowed amounts, or services that are non-covered. Charges that are applied to your out-of-network coinsurance are credited to your in-network out-of-pocket maximum. However, charges applied to your in-network coinsurance are not credited to your out-of-network out-of-pocket maximum.