Program Memorandum
Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-059 **Date: MAY 1, 2002**

CHANGE REQUEST 2142

SUBJECT: Additional Clarification for Medical Nutrition Therapy (MNT) Services

This Program Memorandum (PM) clarifies information contained in Change Request 2046, Transmittal B-02-010, which was published on February 8, 2002. This PM obsoletes Change Request 2046. This revised PM contains two different effective dates depending on the whether the addition of new items is based on the final regulation or the recent national coverage determination (NCD). The original material still has an effective date of January 1, 2002.

NOTE: Updated information in this PM regarding MNT services is based on the final regulation published November 1, 2001, and the NCD of February 28, 2002. Although MNT is only billable to Medicare carriers, this PM also directs fiscal intermediaries (FIs) to do provider education.

This PM informs contractors of the coding, payment, claims processing, and enrollment requirements of §105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The effective date of this provision is January 1, 2002. *The italicized items in this PM are based on the final regulation and are effective January 1, 2002*. **The bolded items are from the NCD and are effective October 1, 2002.** The non-bolded, non-italicized wording was in CR 2046 and is still in effect. (The only exception is the information contained under the heading "Intermediaries", this is new information added for clarity.)

Intermediaries

No claims for MNT are to be paid by (FIs). This service is not billable to you. All claims for this benefit must be submitted by your providers to their local Medicare carrier on a Form HCFA-1500 or the appropriate electronic format. Until the July OCE is tested and installed into production in your standard system, FIs should assure that payment is not made for HCPCS codes 97802, 97803 or 97804 if billed by a provider on the UB92.

Fiscal intermediaries should post information on their web sites and in the next regularly scheduled bulletin to educate providers that claims for MNT services are not to be sent on a UB92 but only billed on a CMS-1500 or the appropriate electronic format to the local Medicare carrier. There is no separate facility payment for this new benefit.

This information for intermediaries is not a change in policy, only documentation of previous policy. Intermediaries should post the above information as soon as possible.

Background

Section 105 of BIPA permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861 (r) (l) of the Social Security Act (the Act). *Non-physician practitioners cannot make referrals for this service.* It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time.

The benefit will consist of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan. For purposes of coverage, the benefit

is defined as a maximum of 3 hours that may be reimbursed in the initial episode of care. In subsequent years, beneficiaries may receive 2 hours of MNT with a physician referral. The number of hours covered for diabetes is the same as the number of hours covered for renal disease.

For the purposes of this benefit, renal disease means chronic renal insufficiency; *end-stage renal disease when dialysis is not received; and the medical condition of a beneficiary for 36 months after a kidney transplant.* Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m^2). Diabetes is defined as diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency), Type 2 (familial hyperglycemia), *and gestational diabetes. Gestational diabetes is any degree of glucose intolerance with onset or first recognition during pregnancy.* The diagnostic criterion for a diagnosis of diabetes is a fasting glucose greater than or equal to 126 mg/dl. These definitions come from the Institute of Medicare 2000 Report, The Role of Nutrition in Maintaining Health in the Nation's Elderly.

Refer any complaints regarding the quality of services provided to the national or State organizations under which registered dietitians or nutrition professionals are certified, recognized, or licensed.

General Conditions of Coverage

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease as described in this PM. *A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.*

- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;

- Services may be provided either on an individual or group basis without restrictions;

- **For a beneficiary with a diagnosis of diabetes, Diabetes Self-management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis, or treatment as stated in 42 CFR 410.132(b)(5).**

- MNT services must be provided by a professional as defined below.

Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under §1881 of the Act.

- **A beneficiary may not receive MNT and DSMT on the same day.**

Referrals

Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined in this PM with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and any reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The UPIN number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. Return claims that do not contain the referring UPIN of the referring physician.

Additional Covered Hours for MNT Services

Additional hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a postpayment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (*they are not required to meet any other requirements)*; or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. *The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;*

- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and

- Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of the first two bullets of this section.

Payment for MNT

Payment will be made under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self-management training benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

Pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department. (**NOTE:** This payment language change is to be implemented on July 1, 2002 as originally stated in CR 2046).

Payment will be made under the following codes:

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (NOTE: This CPT code must only be used for the initial visit.)

97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Group (2 or more individual(s)), each 30 minutes

Instructions for Use of the Medical Nutrition Therapy Codes

97802 This code is to be used only once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent Group Visits are to be billed as 97804.

97803 This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).

97804 This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

NOTE: The above codes can only be paid if submitted by a registered dietitian or nutrition professional who meets the specified requirements. These services cannot be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietitian or nutrition professional.

General Claims Processing Information

Registered dietitians and nutrition professionals must accept assignment. These providers should be treated the same as those listed in the Medicare Carriers Manual, (MCM), §17001.1 E. This section will be updated in the future adding these new practitioners to the list. If a claim is submitted as unassigned, you must change the claim to assigned. Since these new providers must accept assignment, the limiting charge does not apply.

Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in item 24k of Form CMS-1500.

As stated under "General Conditions of Coverage," this benefit is payable for beneficiaries who have diabetes or renal disease. You are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, §2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, §§3-6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under §1862(a)(1)(A) of the Act.

Enrollment of Dietitians and Nutritionists

Registered dietitians and nutrition professionals are paid for MNT services through local carriers. In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. The new specialty code for "dietitians/nutritionists" is 71. Treat the enrollment process for these new providers as you

would any other supplier/provider. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location, but not before January 1, 2002.

You must establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT. As stated above the specialty code is 71 and the credentials are MNT. For further instructions, see the MCM, Part 4, Professional Relations §1000. Do not release UPINs to registered dietitians/nutrition professionals at this time. Release their provider identification numbers only. For additional information see MCM, Part 4, Professional Relations, §1006.

Carriers are required to include the following language in their newsletters/bulletins and on Web sites to inform registered dietitians and nutrition professionals of the new benefit.

> "Beginning January 1, 2002, Medical Nutrition Therapy is a covered Medicare service when provided by a qualifying registered dietitian or nutrition professional. Other types of providers do not qualify for reimbursement for this service.
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> If you are a registered dietitian or nutrition professional and want to become a Medicare provider, please see http://www.hcfa.gov/Medicare/enrollment to determine the local carrier for your area. The carrier will require you to submit a completed Form CMS-855."

Medicare Summary Notice (MSN) and Explanation of Medicare Benefits (EOMB) Messages

Use the following MSN and/or EOMB messages where appropriate. If you locate a more appropriate message, then you should use it.

> If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 or EOMB 17.25. (This service was not covered by Medicare at the time you received it.) The Spanish version is 'Este servicio no estaba cubierto por Medicare cuando usted lo recibio.'
>
> If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 or EOMB 17.26. (This item or service is not covered when performed or ordered by this provider.) The Spanish version is 'Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.'

Remittance Advice Messages

Use the appropriate remittance advice messages when denying claims. Use the following message when denying claims with dates of service before January 1, 2002: ANSI X12-835 claim adjustment reason code 26, "Expenses incurred prior to coverage" at the line level.

Use the following message when denying claims submitted by a provider that does not meet the criteria: ANSI X12 –835 claim adjustment reason code 52. (The prescribing provider is not eligible to perform the service billed.)

Note Regarding the Common Working File (CWF)

The CWF is tracking the number of hours allowed for MNT. Another instruction will be issued pertaining to the national editing that will be done in CWF. CWF will edit the number of hours allowed for MNT and the follow up hours. No CWF action is needed for this instruction.

The effective and implementation date for the bolded material is October 1, 2002.

The effective date for the italicized material is January 1, 2002 and the implementation date is October 1, 2002.

Contractors do not have to reopen any claims unless brought to their attention.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2003.

Questions can be directed to the appropriate regional office.