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# Program Memorandum Carriers

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Department of Health and  
Human Services (DHHS)  
Centers for Medicare &  
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CHANGE REQUEST 1776

**SUBJECT: Medical Nutrition Therapy Services for Beneficiaries with Diabetes or Renal Disease**

This Program Memorandum (PM) informs contractors of the coding, payment, 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. This PM also contains additional claims processing information with respect to this benefit.

## **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) (1) of the Social Security Act (the Act). 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 will be defined as a maximum number of hours that may be reimbursed in an episode of care. The maximum number of hours covered will be provided in a future PM when that requirement has been finalized. We will further define ‘intervention’ in the national coverage determination process. Note that the number of hours covered for diabetes may be different than the number of hours covered for renal disease.

For the purposes of this benefit, renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months. 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<sup>2</sup>). Diabetes is defined as diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency) and Type 2 (familial hyperglycemia). 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;
- The number of hours covered in an episode of care may not be exceeded;
- Services may be provided either on an individual or group basis without restrictions;
- When follow-up Diabetes Self-management Training (DSMT) and MNT services are provided within the same time period, hours from both benefits are counted toward the maximum number of covered hours allowed during the episode of care; and
- 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.
- If a beneficiary has both renal disease and diabetes, they may receive only the number of hours covered under this benefit for either renal disease or diabetes, whichever is greater.
- A beneficiary cannot receive MNT if they have received initial DSMT within the last 12 months, unless:
  - The need for a reassessment and additional therapy has been documented by the referring physician as a result of a change in diagnosis or medical condition; or
  - The beneficiary receiving DSMT is subsequently diagnosed with renal disease.
- If a beneficiary diagnosed with diabetes has been referred for both follow-up DSMT and MNT services, the number of hours the beneficiary may receive is limited to the number of hours covered under either follow-up DSMT or MNT services annually, whichever is greater.

## **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 HCFA-1500 claim form 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 Reassessments and Interventions**

Additional reassessments and interventions may be covered beyond the number of hours typically covered under an episode of care. The exact amount of hours that will be covered will be provided in a future PM. Additional MNT reassessments and interventions are only covered within an episode of care when the referring physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary.

### **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; 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;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; 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.

Make payment based on the lesser of the physician fee schedule amount provided on the physician fee schedule database or the actual charge. Apply coinsurance after determining the Medicare allowance using this methodology. As required by statute, use this same methodology for services provided in the hospital outpatient department.

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.

### **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 HCFA-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 websites 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.

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 HCFA-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 will track the number of hours allowed for MNT beginning early next year. Another instruction will be issued pertaining to the number of hours allowed for MNT and the national editing that will be done in CWF. No CWF editing is needed for this instruction.

**DISCLAIMER: These instructions are tentative and will be revised to reflect any changes that are published in the final rule.**

**The *effective date* for this Program Memorandum (PM) is January 1, 2002.**

**The *implementation date* for this PM is January 1, 2002.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after September 30, 2002.**

**Questions should be directed to the appropriate regional office.**