Medical Nutrition Therapy (MNT)

Medicare provides coverage of Medical Nutrition Therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

The MNT benefit allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement.

The MNT benefit is a completely separate benefit from the Diabetes Self-Management Training (DSMT) benefit.

For the purpose of disease management, covered MNT services include the following:

- An initial nutrition and lifestyle assessment,
- Nutrition counseling,
- Information regarding diet management, and
- Follow-up sessions to monitor progress.

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on 2 different occasions,
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions, or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Renal Disease

For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 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^2).

Coverage Information

Medicare provides coverage of MNT services when the following general coverage conditions are met.

- The beneficiary has diabetes or renal disease.
- The treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. A treating physician means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease (non-physician practitioners cannot make referrals for this service).
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.
- MNT services may be provided either on an individual or group basis without restrictions.

Stand Alone Benefit

The MNT benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

- MNT services must be provided by a registered dietitian, or a nutrition professional who meets the provider qualification requirements, or a "grandfathered" dietitian or nutritionist who was licensed as of December 21, 2000. (See the Professional Standards for Dietitians and Nutrition Professionals section later in this chapter.)
- For a beneficiary with a diagnosis of diabetes, 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 the 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.

This benefit provides three hours of one-on-one MNT services for the first year and two hours of coverage each year for subsequent years. Based on medical necessity, additional hours may be covered if the treating physician orders additional hours of MNT based on a change in medical condition, diagnosis, or treatment regimen.

MNT and DSMT Separate Billable Services

The MNT and DSMT benefits can be provided to the same beneficiary in the same year but **may not** be provided on the same day. They are different benefits and require separate referrals from physicians.

Medicare provides coverage of MNT as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Social Security Act.
- A beneficiary may not receive MNT and DSMT services on the same day.

Referrals for MNT Services

Medicare provides coverage for three hours of MNT in the beneficiary's initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT and the beneficiary only uses two hours in November, the calendar year ends in December and, if the third hour is not used, it cannot be carried over into the following year. The following year, a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year, a beneficiary must have a new referral for follow-up hours.

A referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

The referring physician must maintain documentation in the beneficiary's medical record. Referrals must be made for each episode of care and for reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The referring physician's provider number must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The carrier/AB Medicare Administrative Contractor (carrier/AB MAC) or Fiscal Intermediary/AB MAC (FI/AB MAC) may return claims that do not contain the provider number of the referring physician.

NOTE: Medicare may cover additional covered hours of MNT services 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 an episode of care that makes a change in diet necessary.

A physician must prescribe these services and renew the referral yearly if continuing treatment is needed into another calendar year.

Telehealth

Telehealth services include coverage for individual MNT as described by Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes G0207, 97802, and 97803 (as well as 97804 for dates of service on or after January 1, 2011). In addition, certified registered dietitians and nutrition professionals may furnish and receive payment for a telehealth service.

All eligibility criteria, conditions of payment, payment, or billing methodology applicable to Medicare telehealth services apply to MNT provided with telehealth. Originating sites must be located in either a non-Metropolitan Statistical Area (MSA) county or rural health professional shortage area and can only include a physician's or practitioner's office, hospital, Critical Access Hospital (CAH), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). An interactive audio and video telecommunications system must be used that permits real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the beneficiary must be present and participating in the telehealth visit. The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for telehealth services when asynchronous store-and-forward technology is used.

Professional Standards for Dietitians and Nutrition Professionals

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means an individual who meets one of the following sets of criteria.

An individual is a "registered dietitian or nutrition professional" if, on or after December 22, 2000, the individual:

- 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 (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 stated above).

However, even an individual who does not meet the criteria listed above may be a "registered dietitian or nutrition professional:"

- A "grandfathered" dietitian or nutritionist licensed or certified in a state as of December 21, 2000, is not required to meet the criteria listed above.
- A registered dietitian in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the criteria above.

Enrollment of Dietitians and Nutrition Professionals

The following qualifications must be met for the enrollment of dietitians and nutrition professionals.

- In order to file claims for MNT, a registered dietitian or nutrition professional must be enrolled as a Medicare provider and meet the requirements outlined above. MNT services can be billed with the effective date of the Medicare provider's license and the establishment of the practice location.
- The Medicare carrier/AB MAC will enroll registered dietitians and nutritional professionals as a provider of MNT services using the National Provider Identifier (NPI).
- Registered dietitians and nutrition professionals must accept assignment, and the limiting charge will not apply.

Documentation

Medical record documentation must show that all coverage requirements were met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The following HCPCS/CPT codes, listed in Tables 12 and 13, must be used to report MNT.

Table 12 – HCPCS/CPT Codes for MNT

HCPCS/CPT Code	Code Descriptor
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
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	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

Table 13 – Instructions for Use of the MNT Codes

HCPCS/CPT Code	Instructions for Use
G0270 & G0271	These codes are to be used when additional hours of MNT services are performed beyond the number of hours typically covered, when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.
97802	This code is to be used 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.
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: Medicare will make payment for the above codes only if a registered dietitian or nutrition professional who meets the specified requirements under Medicare submits the claim. These services cannot be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietitian or nutrition professional.

NOTE: Telehealth modifiers -GT (via interactive audio and video telecommunications system) and -GQ (via synchronous telecommunications system) are valid when billed with HCPCS/CPT codes G0270, 97802, and 97803.

Diagnosis Requirements

MNT services are available for beneficiaries with diabetes or renal disease. The treating physician must make a referral and indicate an International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code of diabetes or renal disease. For further guidance, contact the local Medicare Contractor.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB MACs

When physicians and qualified non-physician practitioners submit claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding ICD-9-CM diagnosis code in the X12 837 Professional electronic claim format.

The referring physician's provider number must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. Non-physician practitioners cannot make referrals for this service.

Registered dietitians and nutrition professionals can be part of a group practice. In that case, the provider identification number of the registered dietitian or nutrition professional who performed the service must be entered on the claim form.

NOTE: In those cases where a supplier qualifies for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, Form CMS-1500 may be used to submit these claims on paper. All providers must use Form CMS-1500 (08-05) when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act (ASCA) Claims Requirements

The ASCA requires that claims be submitted to Medicare electronically to be considered for payment, with limited exceptions. Claims are to be submitted electronically using the X12 837-P (Professional) or 837-I (Institutional) format as appropriate, using the version adopted as a national standard. For more information on these formats, visit http://www.cms.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Billing and Coding Requirements When Submitting Claims to FIs/AB MACs

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837 Institutional electronic claim format.

MNT services can be billed to FIs/AB MACs when performed in an outpatient hospital setting. Hospital outpatient departments can bill for MNT services through the local FI/AB MAC if the registered dietitians or nutrition professionals reassign their benefits to the hospital. If the hospitals do not get the reassignments, either the registered dietitians or nutrition professionals must bill the local carrier/AB MAC under their own provider number or the hospital must bill the local carrier/AB MAC. Registered dietitians and nutrition professionals must obtain a Medicare provider number before they can reassign their benefits.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bill (TOBs) for FIs/AB MACs

The FI/AB MAC will reimburse for MNT services when submitted on the following TOBs and associated revenue codes, listed in Table 14.

Table 14 – Facility Types, TOBs, and Revenue Codes for MNT*

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	0942
Skilled Nursing Facility Outpatient (SNF)	23X	0942
Home Health Agency (HHA) (not under an HHA plan of care)	34X	0942
Critical Access Hospital (CAH)	85X	0942
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011**	77X	052X

***NOTE:** Separate payment to RHCs (TOB 71X) is precluded as these services are not within the scope of the Medicare-covered RHC benefits.

****NOTE: For dates of service prior to January 1, 2011,** FQHCs may qualify for a separate visit for payment for MNT services in addition to any other qualifying visit on the same date of service, as long as the services provided were individual services and billed with the appropriate site of service revenue code in the 052X series on a 77X TOB. Group services do not meet the criteria for a separate qualifying encounter.

FQHC TOB

For dates of service on or after April 1, 2010, all FQHC services must be submitted on a 77X TOB. For dates of service prior to April 1, 2010, all FQHC services were submitted on a 73X TOB.

For dates of service on or after January 1, 2011, the professional component of MNT is a covered FQHC service when provided by an FQHC. FQHCs receive the all-inclusive encounter rate for MNT services billed under the appropriate HCPCS/CPT code on a 77X TOB with revenue code 052X.

Reimbursement Information

General Information

Medicare provides coverage of MNT as a Medicare Part B benefit. Both the coinsurance or copayment and the Medicare Part B deductible apply. For dates of service on or after January 1, 2011, both the coinsurance or copayment and deductible are waived.

Payment is made for MNT services attended by the beneficiary and documented by the Medicare provider. Payment is made for beneficiaries that are not inpatients of a hospital, SNF, hospice, or nursing home.

Reimbursement of Claims by Carriers/AB MACs

When the provider bills the carrier/AB MAC, Medicare reimburses MNT under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all MNT services.

Medicare Physician Fee Schedule (MPFS) Information

For more information about MPFS, visit http://www.cms.gov/PhysicianFeeSched on the CMS website.

Reimbursement of Claims by FIs/AB MACs

When the provider bills the FI/AB MAC, Medicare reimbursement for the MNT depends on the type of facility providing the service. Table 15 lists the type of payment that facilities receive for MNT.

Table 15 – Facility Payment Methodology for MNT*

Facility Type	Basis of Payment
Hospital Outpatient	Medicare Physician Fee Schedule (MPFS)
Skilled Nursing Facility (SNF) Outpatient	MPFS
Home Health Agency (HHA) (not under an HHA plan of care)	MPFS
Critical Access Hospital (CAH)**	Reasonable cost
Federally Qualified Health Center (FQHC) for dates of service on or after January 1, 2011	All-Inclusive Encounter Rate

***NOTE:** For MNT paid under the MPFS, payment is the lesser of the actual charge or 85 percent of the MPFS.

****NOTE:** For CAHs, if the distant site is a CAH that has elected Method II and the physician or non-physician practitioner has reassigned his/her benefits to this CAH, the CAH should bill its regular FI/AB MAC for the professional telehealth services provided using revenue codes 096X, 097X, or 098X. In addition, all requirements for billing distant site telehealth services apply.

Additional Reimbursement Information for RHCs and FQHCs

RHCs or FQHCs may choose to become accredited providers of MNT services. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements and services must be provided by a registered dietitian or nutrition professional. In addition, the medical evidence reviewed by CMS suggests that the MNT benefit for diabetic beneficiaries is more effective if provided after completion of the initial DSMT benefit.

While Medicare does not make separate payment for this service to RHCs, similar services may be covered when furnished by, or "incident to," an RHC professional. Payment is included in the all-inclusive encounter rate when covered. RHCs should include the charges on the claims for future inclusion in encounter rate calculations.

For dates of service prior to January 1, 2011, FQHCs that are certified providers of MNT services can receive per-visit payments for covered services rendered by registered dietitians or nutrition professionals. These services are included under the FQHC benefit as billable visits. **For dates of service on or after January 1, 2011, the professional component of MNT is a covered FQHC service when provided by an FQHC. FQHCs receive the all-inclusive encounter rate for MNT services.**

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of MNT services:

- The beneficiary is not qualified to receive this benefit.
- The individual provider of the MNT services did not meet the provider qualification requirements.

Medicare Contractor Contact Information

Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Medicare providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. Refer to the most current listing of these codes at http://www.wpc-edi.com/Codes on the Internet. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice (RA) Information

For more information about the RA, visit http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Other Diabetes Services

Medicare provides coverage of the following services for beneficiaries with diabetes:

- Foot care;
- Hemoglobin A1c tests;
- Glaucoma screening;
- Influenza and pneumococcal immunizations;
- Routine costs, including immunosuppressive drugs, cell transplantation, and related items and services for pancreatic islet cell transplant clinical trials; and
- Retinal eye exams for diabetic retinopathy.*

*Retinal eye exams for diabetic retinopathy may be covered as a medically necessary diagnostic exam furnished to beneficiaries diagnosed with diabetes.

Details regarding Medicare's coverage of glaucoma screening services and influenza and pneumococcal vaccinations are described in this Guide. For specific information regarding other diabetes services, refer to relevant Centers for Medicare & Medicaid Services (CMS) documentation.

Diabetes Supplies and Services Not Covered by Medicare

Medicare Part B may not cover all supplies and equipment for beneficiaries with diabetes. The following may be excluded:

- Insulin pens,
- Insulin* (unless used with an insulin pump),
- Syringes,
- Alcohol swabs,
- Gauze,
- Orthopedic shoes (shoes for individuals whose feet are impaired, but intact),
- Eye exams for glasses (refraction),
- Weight loss programs, and
- Injection devices (jet injectors).

*Insulin not used with an external insulin pump and certain medical supplies used to inject insulin are covered under Medicare prescription drug coverage.

For more information on coverage exclusions, contact the local Medicare Contractor.

Diabetes-Related Services

Resources

American Association of Diabetes Educators
http://www.diabeteseducator.org/ProfessionalResources/accred

American Diabetes Association
Information on diabetes prevention, nutrition, research, etc., is available in both English and Spanish.
http://www.diabetes.org

American Diabetes Association's DiabetesPro: Professional Resources Online Website
http://professional.diabetes.org

American Dietetic Association
Website provides food and nutrition information and a national referral service to locate registered nutrition practitioners.
http://www.eatright.org

Centers for Disease Control and Prevention (CDC) Diabetes Data and Trends
http://apps.nccd.cdc.gov/DDTSTRS

CDC Diabetes Public Health Resource
http://www.cdc.gov/diabetes/consumer

IHS Division of Diabetes Treatment and Prevention
http://www.ihs.gov/MedicalPrograms/Diabetes

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

National Diabetes Education Program
http://www.ndep.nih.gov

National Diabetes Information Clearinghouse (NDIC)
Information on diabetes treatment and statistics is available in both English and Spanish.
http://diabetes.niddk.nih.gov

NDIC National Diabetes Statistics
http://diabetes.niddk.nih.gov/dm/pubs/statistics

Diabetes Screening

CMS Diabetes Screening Web Page
https://www.cms.gov/DiabetesScreening

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 90
http://www.cms.gov/manuals/downloads/clm104c18.pdf

USPSTF Recommendations
This website provides the USPSTF written recommendations for type 2 diabetes mellitus in adults.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsdiab.htm

DSMT

CMS Diabetes Self-Management Web Page
https://www.cms.gov/DiabetesSelfManagement

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15, Section 300
http://www.cms.gov/manuals/Downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 120
http://www.cms.gov/manuals/downloads/clm104c18.pdf

MLN Matters® Article 6510, "Diabetes Self-Management Training (DSMT) Certified Diabetic Educator"
http://www.cms.gov/MLNMattersArticles/Downloads/MM6510.pdf

MNT

American Dietetic Association Information on Medical Nutrition Therapy
http://www.eatright.org/HealthProfessionals/content.aspx?id=6877&terms=mnt

CMS Medical Nutrition Therapy Web Page
http://www.cms.gov/MedicalNutritionTherapy

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 4, Section 300
http://www.cms.gov/manuals/downloads/clm104c04.pdf

National Kidney and Urologic Diseases Information Clearinghouse
http://kidney.niddk.nih.gov

National Kidney Disease Education Program
http://nkdep.nih.gov

More informational websites are available in References C and E of this Guide.
Beneficiary-related resources are available in Reference F of this Guide.