

# CMS Manual System

## Pub 100-04 Medicare Claims Processing

Transmittal 673

Department of Health &  
Human Services  
Center for Medicare and  
&  
Medicaid Services

Date: SEPTEMBER 9,  
2005

Change Request 3955

*NOTE: Transmittal 650, dated August 12, 2005, is rescinded and is replaced with Transmittal 673, dated, September 9, 2005 because a strike out was inadvertently left in §300.4 (Payment for MNT Services) of the manual portion of the instruction. All other information in the revision remains the same.*

**SUBJECT: Manual Update on Medical Nutrition Therapy (MNT) Services - Manualization**

**I. SUMMARY OF CHANGES:** This instruction manualizes sections in the current Internet Only Manual (IOM) for Medical Nutrition Therapy Services (Pub 100-04, Sections 300 through 300.6). The definition for diabetes mellitus has been changed based on the 2003 Medicare Physician Fee Schedule Regulation. Also, material that was excluded from the new IOM has been added.

### MANUALIZATION

**EFFECTIVE DATE : NON-APPLICABLE**

**IMPLEMENTATION DATE : NON-APPLICABLE**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	4/Table of Contents
R	4/300/Medicare Nutrition Therapy (MNT) Services
N	4/300.1/General Conditions and Limitations on Coverage
N	4/300.2/Referrals for MNT Services
N	4/300.3/Dietitians and Nutritionists Performing MNT Services

N	4/300.4/Payment for MNT Services
N	4/300.5/General Claims Processing Information
N	4/300.6/Common Working File (CWF) Edits

**III. FUNDING:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

**IV. ATTACHMENTS:**

Business Requirements

Manual Instruction

*\*Unless otherwise specified, the effective date is the date of service.*



Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
3955.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X		X					

**IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

**A. Other Instructions: N/A**

X-Ref Requirement #	Instructions

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## V. SCHEDULE, CONTACTS, AND FUNDING

<p><b>Effective Date*:</b> N/A</p> <p><b>Implementation Date:</b> N/A</p> <p><b>Pre-Implementation Contact(s):</b> for Part A issues, Taneka Rivera at <a href="mailto:taneka.rivera@cms.hhs.gov">taneka.rivera@cms.hhs.gov</a> or 410-786-9502; for Part B issues, Yvette Cousar at <a href="mailto:yvette.cousar@cms.hhs.gov">yvette.cousar@cms.hhs.gov</a> or (410) 786-2160</p> <p><b>Post-Implementation Contact(s):</b> Appropriate Regional Office (RO)</p>	<p><b>No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.</b></p>
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# Medicare Claims Processing Manual

## Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

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*(Rev.673, 09-09-05)*

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## 300 - Medical Nutrition Therapy (MNT) Services

*(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)*

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (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 Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists 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.

*Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.*

For the purposes 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 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>). *Effective January 1, 2004, CMS updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two 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.*

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service *for the same beneficiary.*

### ***300.1 General Conditions and Limitations on Coverage***

*(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)*

#### ***A. General Conditions on 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 above, a treating physician means the primary care physician or specialist coordinating care for 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 and;*
- *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).*

### ***B – 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 Act.*
- *A beneficiary may not receive MNT and DSMT on the same day.*

### ***300.2 Referrals for MNT Services***

***(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)***

*Medicare covers 3 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 3 hours of MNT but a beneficiary only uses 2 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 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.*

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

*Documentation must be maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and 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. The Carrier or FI shall return claims that do not contain the referring UPIN of the referring physician.*

**NOTE:** *Additional covered 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 post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132 (a).*

### **300.3 Dietitians and Nutritionists Performing MNT Services**

**(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)**

#### **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 stated above.*

## **B – Enrollment of Dietitians and Nutritionists**

- *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. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location.*
- *The carrier shall establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.*
- *Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.*

## **300.4 Payment for MNT Services**

***(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)***

*The contractor shall pay for MNT services 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 (DSMT) 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.*

*The contractor shall 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.*

## **A – Payable Codes for MNT with Applicable Instructions**

- *97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (NOTE: This HCPCS code must only be used for the initial visit.)*
  - *This code is to be used only once for the initial assessment of a new patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as 97803. The provider shall bill all subsequent group visits as 97804.*
- *97803 – Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

- *The provider shall bill this code for all 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 – Group (2 or more individual(s)), each 30 minutes*
  - *The provider shall bill this code for 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 be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid “incident to” physician services.*

***B – HCPCS Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)***

*The following HCPCS codes shall be used when there is a change in the beneficiary's condition:*

- *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.*

**NOTE:** *These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).*

### **300.5 General Claims Processing Information**

**(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)**

*This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors 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, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 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 Section 1862(a)(1)(A) of the Act.*

#### **A. Special Requirements for Carriers**

- *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 on the claim form.*

*- The specialty code for “dietitians/nutritionists” is 71*

#### **B. Medicare Summary Notices (MSNs)**

- *Use the following MNT 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 (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 (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.’*

#### **C. FI Special Billing Instructions**

*MNT Services can be billed to FIs when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the local Medicare carrier under their own provider number or the hospital will have to bill the local Medicare carrier.*

***NOTE: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.***

*The only applicable bill types are 13X, 14X, 23X, 32X, and 85X.*

### ***300.6 Common Working File (CWF) Edits***

***(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)***

*The CWF edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen, and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.*

#### ***Advance Beneficiary Notice (ABN)***

*The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.*

*An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professions who are qualified to render the service in their state but who have not obtained Medicare provider numbers.*