Medical Nutrition Therapy (NCD 180.1)

Guideline Number: MPG204.08
Approval Date: January 12, 2022

Policy Summary

Overview
Section 1861(s)(2)(V) of the Social Security Act authorizes Medicare Part B coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease. Regulations for medical nutrition therapy (MNT) were established at 42 CFR §§410.130 – 410.134. The MNT national coverage determination (NCD) establishes the duration and frequency limits for the MNT benefit and coordinates MNT and diabetes outpatient self-management training (DSMT) as a national coverage determination.

Guidelines
Basic coverage of MNT for the first year a member receives MNT with either a diagnosis of renal disease or diabetes as defined in 42 CFR §410.130 is three hours of administration. Also, basic coverage in subsequent years for renal disease or diabetes is 2 hours. The dietitian/nutritionist may choose how many units are administered per day as long as all of the other requirements in the MNT NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception in 42 CFR §410.132(b)(5), additional hours are considered to be medically necessary and covered if a physician determines that there is a change in medical condition, diagnosis, or treatment regimen related to diabetes or renal disease that requires a change in MNT and orders additional hours during that episode of care.

If a physician determines that receipt of both MNT and DSMT is medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in the NCD and 42 CFR §§410.130-410.134 are met. Pursuant to the exception in 42 CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if a physician determines that there is a change in medical condition, diagnosis, or treatment regimen related to diabetes or renal disease that requires a change in MNT and orders additional hours during that episode of care.

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)(l) of the Act.
Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>97802</td>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
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<tr>
<td>97803</td>
<td>Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes</td>
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<tr>
<td>97804</td>
<td>Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes</td>
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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>G0270</td>
<td>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</td>
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<tr>
<td>G0271</td>
<td>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</td>
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Definitions

**DSMT**: Diabetes Self-Management Training; a program which educates members in the successful self-management of diabetes. Diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin dependent, and motivates patients to use the skills for self-management.

**MNT**: Medical Nutrition Therapy; MNT services are defined in statute as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional ... pursuant to a referral by a physician..."

References

**CMS National Coverage Determinations (NCDs)**

NCD 180.1 Medical Nutrition Therapy

Reference NCD: NCD 40.1 Diabetes Outpatient Self-Management Training

**CMS Benefit Policy Manual**

Chapter 15; § 300 Diabetes Self-Management Training Services

**CMS Claims Processing Manual**

Chapter 4; § 300-300.6 Medical Nutrition Therapy (MNT) Services

Chapter 9; § 70.5 Diabetes Self-Management Training (DSMT) and Medical Nutrition Services (MNT)

Chapter 18; § 80 Initial Preventive Physical Examination (IPPE), § 180.2/190.6/200.2 Institutional Billing Requirements
Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
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<tr>
<td>01/12/2022</td>
<td><strong>Policy Summary</strong>&lt;br&gt;Guidelines&lt;br&gt;Replaced references to “treating physician” with “physician”&lt;br&gt;Supporting Information&lt;br&gt;Updated References section to reflect the most current information&lt;br&gt;Archived previous policy version MPG204.07</td>
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</table>
These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.