Medical Policy

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

Policy Number: OCA 3.66
Version Number: 17
Version Effective Date: 12/01/19

Product Applicability

- All Plan+ Products

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Well Sense Health Plan</td>
<td>✓ MassHealth ACO</td>
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<tr>
<td></td>
<td>✓ MassHealth MCO</td>
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<tr>
<td></td>
<td>✓ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
</tr>
<tr>
<td></td>
<td>✓ Senior Care Options ◊</td>
</tr>
</tbody>
</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers medical nutrition therapy to be medically necessary for specified medical conditions up to the time/unit recommendations listed in the Medical Policy Statement section. One (1) individual initial assessment and intervention and one (1) individual re-assessment and intervention of medical nutrition therapy per calendar year do not require prior authorization. Prior authorization is required for additional visits or units of medical nutrition therapy.
It will be determined during the Plan’s prior authorization process if additional visits or units of medical nutrition therapy are considered medically necessary for the requested indication. See the Plan’s *Medically Necessary* medical policy, policy number OCA 3.14, for the product-specific definitions of medically necessary treatment. Review the Plan’s *Tube Fed Enteral Nutrition Products Supplied and Billed by Home Infusion Providers* medical policy, policy number OCA 3.37, for guidelines related to tube fed enteral nutrition.

**Description of Item or Service**

**Medical Nutrition Therapy (MNT):** The American Dietetic Association defines MNT as nutritional diagnostic, therapy, and counseling services for the purpose of disease management; services are furnished by a registered dietitian or nutrition professional. MNT consists of an initial, in-depth and individualized assessment of nutritional status followed by additional, planned visits for dietary interventions (including duration and frequency of care) to prevent or treat medical illness. The member is referred to a registered dietitian or nutrition professional for MNT by a treating physician (i.e., medical doctor [MD], doctor of osteopathy [DO], or doctor of naturopathic medicine [ND]) or a licensed practitioner (such as an advanced practitioner registered nurse or physician assistant when operating within the scope of the practitioner’s license).

MNT is a specific type of nutrition care; one of the key distinguishing characteristics between MNT and the other nutrition services is that MNT always involves an in-depth, comprehensive assessment and an individualized care plan. Assessment provides the foundation for the nutrition diagnosis and includes the review of dietary intake for factors that affect health conditions and nutrition risk that include but is not limited to the following components: (1) Evaluate health and disease condition for nutrition-related consequences; (2) evaluate psychosocial, functional, and behavioral factors related to food access, food selection, food preparation, physical activity, and understanding of the individual’s health condition; (3) evaluate the individual’s knowledge, readiness to learn, and potential for changing behaviors; (4) identify standards by which data will be compared; and (5) identify possible problem areas for making nutrition diagnoses. The applicable nutrition diagnoses describe alterations in the individual’s nutritional status, including pathophysiological, psychosocial, situational, developmental, cultural, and/or environmental cause(s), risk factors, and related factors. The individualized treatment plan is based on the nutrition assessment and includes patient-focused nutrition interventions for each applicable nutrition diagnosis. The purpose of nutrition monitoring and evaluation is to determine the degree to which progress is being made to meet desired goals as a result of targeted nutrition interventions. Nutrition counseling for MNT includes setting priorities, establishing goals, and creating individualized action plans which acknowledge and foster responsibility for self-care. (*Source: American Dietetic Association.*)
Medical Policy Statement

For BMC HealthNet Plan pediatric members (i.e., members under age 21 on the date of service), medical nutrition therapy considered medically necessary when criteria are met for EITHER early intervention services (according to Massachusetts regulations) or criteria are met in this Medical Policy Statement section, as specified below. For Well Sense Health Plan pediatric members (i.e., members under age 21 on the date of service), prescribed medical nutrition therapy (for the calendar year therapy is provided) is considered medically necessary when criteria are met for EITHER EPSDT services (according to New Hampshire regulatory guidelines) or criteria are met in this Medical Policy Statement section, as specified below.

The Plan considers outpatient medical nutrition therapy (MNT) to be medically necessary when provided by a practitioner functioning within the scope of practice and adhering to state licensing guidelines (e.g., dietician) and when Plan medical criteria are met and documented in the adult or pediatric member’s medical record. Prior authorization must be obtained (when necessary), as specified below in item 1 (for initial assessment) or item 2 (for continuing service or a new condition):

1. **Initial Assessment:**

   One (1) initial, medical nutrition therapy assessment and intervention and one (1) medical nutrition therapy re-assessment and intervention per calendar year are considered medically necessary **WITHOUT prior authorization up to 60 minutes per visit**, as appropriate per applicable CPT/HCPCS code and as specified below in item a or item b:

   a. Up to four (4) 15-minute units per visit; OR

   b. Up to two (2) 30-minute units per visit; OR

2. **Continuing Service or New Condition:**

   Medical nutrition therapy (MNT) for continuing services or services for a new condition in the same calendar year as prior MNT services do **REQUIRE prior authorization**, as specified below in items a through c:

   a. The service is beyond one (1) initial assessment and intervention and one (1) re-assessment and intervention per calendar year and therefore requires prior authorization; AND

   b. Even when the requested number of visits/units are within the Plan’s condition-specific recommendations specified below in the Medical Nutrition Therapy Table, the service does require prior authorization; AND

   c. Requests for visits/units in excess of the recommendations specified below in the Medical Nutrition Therapy Table require medical necessity review by a Plan Medical Director.

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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**Important Note for Well Sense Health Plan Members:**
For Well Sense Health Plan adult and pediatric members, medical nutrition therapy must be prescribed by a treating, licensed independent practitioner (i.e., medical doctor [MD], doctor of osteopathy [DO], doctor of naturopathic medicine [ND]), physician assistant, or advanced practice registered nurse who is operating within the scope of the practitioner’s license). The prescribed medical nutrition therapy must be provided in the same calendar year that the provider has prescribed the medical nutrition therapy.

**Medical Nutrition Therapy Table:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommended # of Visits per Calendar Year</th>
<th>Recommended # of Billed Units per Calendar Year (at Four [4] 15-Minute Units per Visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease risk factor modification (including but NOT limited to hypertension and cholesterol management)</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Congestive heart failure (CHF)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Diabetes Type 1</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Diabetes Type 2</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Eating disorders (including but NOT limited to anorexia and/or bulimia)</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Enteral feeding support or total parenteral nutrition (TPN)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Failure to thrive or malnutrition</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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<thead>
<tr>
<th>Condition</th>
<th>Recommended # of Visits per Calendar Year</th>
<th>Recommended # of Billed Units per Calendar Year (at Four [4] 15-Minute Units per Visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal (GI) conditions including altered absorption/metabolism of nutrients (including but NOT limited to celiac disease, Crohn’s disease, gastroparesis, irritable bowel syndrome, short bowel syndrome, liver dysfunction, and/or swallowing or chewing difficulties resulting in impaired nutrition status)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>High risk premature infants and children with special health care needs impacting nutritional status (including but NOT limited to low birth weight, premature birth, malabsorption, or other medical condition)</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>High risk prenatal care</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>HIV/AIDS - adult member with moderate to severe symptoms</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>HIV/AIDS - pediatric member with moderate to severe symptoms</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Hyperemesis gravidarum</td>
<td>3</td>
<td>12</td>
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<tr>
<td>Illness or injury resulting in member being unable to meet daily nutritional requirements using traditional foods alone</td>
<td>3</td>
<td>12</td>
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</tbody>
</table>

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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## Medical Nutrition Therapy Table (cont.): 

<table>
<thead>
<tr>
<th>Condition</th>
<th>Visits</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney disease when member has impaired nutrition status related to the condition (including but NOT limited to non-dialysis dependent kidney disease, conditions requiring dialysis, chronic renal failure, or after kidney transplant)</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Oncology at risk (including but NOT limited to chemotherapy, radiation, and/or surgery)</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Pressure ulcer management</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Weight management (including but NOT limited to obesity and/or bariatric surgery)</td>
<td>8</td>
<td>32</td>
</tr>
</tbody>
</table>

## Limitations

1. Plan Medical Director review is required to determine the medical necessity for requests for visits/units in EXCESS of the recommendations specified in the Medical Nutrition Therapy Table in the Medical Policy Statement section of this policy. Conditions NOT specified in the Medical Nutrition Therapy Table also require Plan Medical Direction review for authorization of medical nutrition therapy. ALL of the following documented clinical information is required for Plan Medical Director review for medical nutrition therapy (MNT), as specified below in items a through d:

   a. There is likelihood that the member will benefit from additional MNT; AND

   b. Individualized and measurable goals have been established for the treatment provided during those additional MNT visits/units; AND

   c. There is a plan for coordination of care with other health care providers; AND
d. If applicable, the member meets Diagnostic and Statistical Manual of Mental Disorders™ (DSM) criteria for an eating disorder, and the member is either unable to maintain adequate body weight or continues to show eating disorder symptoms.

2. ANY of the following services is NOT considered medically necessary within this Medical Nutrition Therapy medical policy, as specified below in items a through c:

a. Nutrition counseling/services offered as a component of commercial diet programs, commercial weight management programs (where criteria in the Medical Policy Statement section are NOT met for medical nutrition therapy for weight management), and/or gym-based programs, including any food products or services related to any of these programs.

b. Nutrition counseling/services offered by health resorts, recreational programs, camps, wilderness programs, outdoor skill programs, relaxation or lifestyle programs, and/or holistic programs, including any food products or services related to any of these programs.

c. Nutrition counseling/services provided by a practitioner when the service is NOT related to the scope of practice (e.g., nutrition counseling/services as a component of physical therapy).

Refer to the following medical policies for information regarding services requested in the home setting: Home Health Care medical policy, policy number OCA 3.719, for a BMC HealthNet Plan member; Home Health Care Services for an Acute Episode of Care medical policy, policy number OCA 3.720, for a Well Sense Health Plan member; and Home Health Care for Maintenance Services medical policy, policy number OCA 3.730, for a Well Sense Health Plan member.

Definitions

Early Intervention Services for BMC HealthNet Plan Members: (Source: Massachusetts Department of Public Health. Early Intervention Operational Standards. July 2013.) Early Intervention services include the following, as specified below in items 1 through 5:

1. Developmental services designed to meet the needs of each eligible infant or toddler and the needs of the family related to enhancing the infant or toddler’s development in the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development; AND

2. Determined in collaboration with the family in accordance with the Individualized Family Service Plan (IFSP); AND

3. Provided by qualified personnel as defined by these standards; AND
4. Subject to the Early Intervention Operational Standards, DPH contracting, and Part C requirements (of the Massachusetts Department of Public Health Early Intervention Operational Standards, July 2013); AND

5. Available to all eligible infants and toddlers including Indian infants and toddlers, homeless infants and toddlers, and infants and toddlers who are wards of the state.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services for Well Sense Health Plan Members:** The EPSDT benefit is a comprehensive health benefit that helps meet children’s health and developmental needs. Covered benefits include age-appropriate medical, dental, vision, and hearing screening services at specified times, commonly referred to as well-child checkups, and when health problems arise or are suspected. In addition to screening, EPSDT services include all medically necessary diagnostic and treatment services to correct or improve a child’s physical or mental illness or condition. This is particularly important for children with special health care needs and disabilities. The Plan covers EPSDT services for members under the age of 21 years, except for applied behavioral analysis (ABA) services which are covered by New Hampshire Medicaid. Prior authorization from the Plan is NOT required for EPSDT screenings. However, some treatment services do require a prior authorization from the Plan by the requesting provider.

EPSDT means a program, pursuant to 42 CFR 440.40, designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Title XIX eligible individuals under age 21, as specified below in items 1 through 5:

1. EPSDT screening services:

   Comprehensive and age-appropriate medical assessments and screenings of the child’s physical and mental status provided according to the March 2000 periodicity schedule entitled “Recommendations for Preventive Pediatric Health Care” of the American Academy of Pediatrics including the following, as specified below in items a through l:

   a. Comprehensive health and developmental history; AND

   b. Comprehensive unclothed physical examination; AND

   c. Developmental and behavioral assessment; AND

   d. Measurements of the child’s height and weight, head circumference, and blood pressure; AND

   e. Appropriate immunizations; AND

   f. Appropriate laboratory tests will include of the following, as specified below in item (1) and item (2):

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(1) Testing for lead toxicity for EPSDT eligible children at 12 and 24 months of age; AND

(2) Testing for lead toxicity for EPSDT eligible children between 36 and 72 months of age, if not previously screened for lead poisoning; AND

g. Appropriate vision testing; AND

h. Appropriate hearing testing; AND

i. Assessment of nutritional status; AND


k. Health education about the benefits of healthy lifestyles and practices; AND

l. Anticipatory guidance about child safety and injury prevention.

2. EPSDT diagnostic and treatment services, if medically necessary as a result of assessment and screening, include the following specified below in items a through f:

a. Urinalysis; AND

b. Sickle cell screening; AND

c. Tuberculin testing; AND

d. Blood testing for hematocrit and/or hemoglobin levels; AND

e. Immunizations provided according to the 2006 issue of the “Recommended Childhood and Adolescent Immunization Schedule, United States 2006” jointly approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians; AND

f. Any other Title XIX services as specified in He-W 522 through He-W 589, to treat conditions discovered during a screen.
3. Any services not listed in He-W 522 through He-W 589 as covered services shall be given independent review by the department for coverage based on medical necessity in accordance with He-W 546.06.

4. Transportation services, pursuant to He-W 574, 42 CFR 43.153, and 42 CFR 441.62, shall be covered for EPSDT-eligible children.

5. Services in excess of the service limits in He-W 530 shall be covered for EPSDT-eligible children, if medically necessary, in accordance with the requirements in He-W 546.

**Nutritional Counseling:** A supportive process to set priorities, establish goals, and create individualized action plans which acknowledge and foster responsibility for self-care.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

See the Plan’s applicable reimbursement policies for payment guidelines related to medical nutrition therapy. Reimbursement policies are posted on the Plan’s websites (i.e., available at [www.bmchp.org](http://www.bmchp.org) for services rendered for BMC HealthNet Plan members and posted at [www.wellsense.org](http://www.wellsense.org) for services rendered for Well Sense Health Plan members).

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Clinical Background Information

There are many diseases associated with dietary factors that contribute to the cause of illness. Scientific evidence has identified diet as a contributing factor to coronary artery disease, some types of cancer, and stroke. Links have also been found between diet and diabetes mellitus, Crohn’s disease, hypertension, osteoporosis, diverticulitis, and/or arteriosclerosis. Medical nutrition therapy (MNT) may improve overall health survival in infants, children, and adults at nutritional risk with the following conditions: HIV/AIDS, developmental disabilities, eating disorders, obesity, malabsorption syndromes, pre and post bariatric surgery, metabolic syndromes, multiple and severe food allergies, liver and kidney disease, congestive heart failure, chronic lung disease, and/or malnutrition states.

MNT is provided by a registered dietitian or a nutrition professional and involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk; this includes review and analysis of medical and diet history, laboratory values, and body measurements. Based on the nutritional assessment, modalities most appropriate to manage the condition or treat the illness or injury are chosen and include the following:

1. Diet modification, counseling, and education leading to the development of a personal diet plan to achieve nutritional goals and desired health outcomes.

2. Specialized nutrition therapies including supplementation with medical foods for those unable to obtain adequate nutrients through food intake only; this may include enteral nutrition delivered via tube feeding into the gastrointestinal tract for those unable to ingest or digest food, and/or parenteral nutrition delivered via intravenous infusion for those unable to absorb nutrients.

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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MNT is appropriate only for the management of certain diseases and illnesses that place the individual at nutritional risk and where the nutritional intervention has been proven to result in positive health outcomes and are essential for the prevention or treatment of a medical illness.

At the time of the Plan’s most recent policy review, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 180.1 includes medically necessary indications for MNT for a beneficiary with a diagnosis of renal disease and/or diabetes according to CMS established criteria based on duration of treatment, episode of care, date of service, and number of units administered per day. As stated in NCD 180.1, additional treatment may be considered medically necessary and covered if the treating physician determines that there is a change in the beneficiary’s medical condition, diagnosis, and/or treatment regimen that requires a change in MNT and the physician orders additional MNT during that episode of care. Verify CMS criteria in the applicable NCD, local coverage determination (LCD), and/or coverage guidelines in effect on the date of the prior authorization request for a Senior Care Options member.

Services related to MNT may or may not include enteral and parenteral nutrition therapy, behavioral therapy for obesity, and/or bariatric surgery. For enteral and parenteral nutritional therapy, see CMS NCD 180.2 for medically necessary indications for therapy and review applicable CMS documentation for administrative guidelines related to required equipment and supplies (e.g., Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and the Stage 2 Critical Elements for Tube Feeding Status form CMS–20093).

According to CMS NCD 210.12, CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², for the prevention or early detection of illness or disability. Intensive behavioral therapy for obesity consists of the following: (1) Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²); (2) dietary (nutritional) assessment; and (3) intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. Additional administrative guidelines for covered behavioral therapy for obesity are included in NCD 210.12.

CMS NCD 100.1 includes the following clinical guidelines for bariatric surgery for the treatment of morbid obesity for Medicare beneficiaries and specifies that type 2 diabetes mellitus is an applicable comorbidity: “…Open and laparoscopic Roux-en-Y gastric bypass (RYGBP), open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and laparoscopic adjustable gastric banding (LAGB) are covered for Medicare beneficiaries who have a body-mass index ≥ 35, have at least one comorbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity. These procedures are only covered when performed at facilities that are: (1) certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center...; or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence.” See the Plan medical policy, Bariatric Surgery (policy number OCA 3.49), for additional Plan guidelines related to bariatric surgery.

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Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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### Policy History

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<tr>
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<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Original Policy Approved by</th>
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<td>Regulatory Approval: N/A</td>
<td>07/01/07 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)</td>
<td>Q&amp;CMC, QIC, and UMC</td>
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<td>Internal Approval: 03/13/07: Utilization Management Committee (UMC) 04/10/07: Quality Improvement Committee (QIC) 05/01/07: Quality and Clinical Management Committee (Q&amp;CMC)</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for the Senior Care Options Product(s): 01/01/16

### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tr>
<td>03/11/08</td>
<td>Procedure review: Added reimbursement language to the grid above to include the recommended number of billed units per visit.</td>
<td>Version 2</td>
<td>03/11/08: MPCTAC 03/25/08: UMC 04/15/08: QIC</td>
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<td>03/24/09</td>
<td>No changes to clinical criteria. Updated references.</td>
<td>Version 3</td>
<td>03/24/09: MPCTAC 03/24/09: UMC 04/17/09: QIC</td>
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<tr>
<td>03/01/10</td>
<td>Updated coding. No changes to clinical criteria.</td>
<td>Version 4</td>
<td>03/23/10: MPCTAC 04/28/10: QIC</td>
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<td>02/01/11</td>
<td>No changes to criteria, clarified clinical guideline statement, and updated references.</td>
<td>Version 5</td>
<td>03/16/11: MPCTAC 04/27/11: QIC</td>
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<tr>
<td>02/01/12</td>
<td>No changes to criteria. Updated references and coding.</td>
<td>Version 6</td>
<td>02/28/12: MPCTAC 03/28/12: QIC</td>
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<td>08/01/12</td>
<td>Off cycle review. Revised Summary statement, reformatted Medical Policy Statement, revised Limitations statement. Review of entire policy conducted.</td>
<td>Version 7</td>
<td>08/17/12: MPCTAC 09/06/12: QIC</td>
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<tr>
<td>10/01/12</td>
<td>Revised title to specify services in an outpatient setting. Updated references. Reformatted Medical Policy Statement section and referenced applicable Plan</td>
<td>Version 8</td>
<td>10/17/12: MPCTAC 11/28/12: QIC</td>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Action Description</th>
<th>Effective Date</th>
<th>Version</th>
<th>Reviewer</th>
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<tr>
<td>08/01/13</td>
<td>Review for effective date 12/01/13. Updated language in Applicable Coding section.</td>
<td>12/01/13</td>
<td>Version 9</td>
<td>08/21/13: MPCTAC</td>
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<td>09/19/13: QIC</td>
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<td>09/01/14</td>
<td>Revised Summary section, Clinical Background Information section, and introductory paragraph in Applicable Coding section. Updated references. Added CPT code 97804 to applicable code list.</td>
<td>11/01/14</td>
<td>Version 10</td>
<td>09/17/14: MPCTAC</td>
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<td>10/08/14: QIC</td>
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<td>09/01/15</td>
<td>Review for effective date 01/01/16. Updated list of applicable products, including the removal of Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Updated Description of Item or Service, Definitions, and References sections. Criteria updated in the Medical Policy Statement and Limitations sections. Administrative changes made to Medical Nutrition Therapy Table without changing criteria.</td>
<td>01/01/16</td>
<td>Version 11</td>
<td>09/16/15: MPCTAC</td>
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<td>10/14/15: QIC</td>
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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Revised language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>Version 12</td>
<td>11/25/15: MPCTAC</td>
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<td>12/09/15: QIC</td>
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<tr>
<td>09/01/16</td>
<td>Review for effective date 11/01/16. Updated Description of Item or Service, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Clarified Medical Policy Statement section without changing criteria. Added Plan note to Applicable Coding section without changing the applicable code list.</td>
<td>11/01/16</td>
<td>Version 13</td>
<td>09/21/16: MPCTAC</td>
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<td>10/12/16: QIC</td>
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<tr>
<td>09/01/17</td>
<td>Review for effective date 10/01/17. Updated References, Other Applicable Policies, and References to Applicable Laws</td>
<td>10/01/17</td>
<td>Version 14</td>
<td>09/20/17: MPCTAC</td>
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* Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
<th>Version</th>
<th>Authorizing Entity</th>
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<tbody>
<tr>
<td>02/01/18</td>
<td>Review for effective date 05/01/18. Revised criteria in the Medical Policy Statement section. Administrative changes made to the Definitions, Applicable Coding, References, and Other Applicable Policies sections.</td>
<td>05/01/18 Version 15</td>
<td>02/21/18: MPCTAC</td>
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<td>09/01/18</td>
<td>Review for effective date 12/01/18. Administrative changes made to the References and Other Applicable Policies sections. Criteria updated in the Medical Policy Statement and Limitations sections.</td>
<td>12/01/18 Version 16</td>
<td>09/19/18: MPCTAC</td>
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<td>09/01/19</td>
<td>Review for effective date 12/01/19. Removed code from the Applicable Coding section because it is no longer payable for any of the Plan’s products. Administrative changes made to the References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.</td>
<td>12/01/19 Version 17</td>
<td>09/18/19: MPCTAC</td>
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**Last Review Date**

09/01/19

**Next Review Date**

07/01/20

**Authorizing Entity**

MPCTAC

**Other Applicable Policies**

- Medical Policy - *Medically Necessary*, policy number OCA 3.14
- Medical Policy - *Home Health Care for Maintenance Services*, policy number OCA 3.730 for Well Sense Health Plan Members
- Medical Policy - *Home Health Care Services for an Acute Episode of Care*, policy number OCA 3.720 for Well Sense Health Plan Members
- Medical Policy - *Private Duty Nursing Services*, policy number OCA 3.715

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Medical Policy - Tube Fed Enteral Nutrition Products (Supplied and Billed by Home Infusion Providers) and Digestive Enzyme Cartridges, policy number OCA 3.37
Reimbursement Policy - Adult Medical Day Care, policy number WS 4.10
Reimbursement Policy - Chronic Maintenance Dialysis performed in Freestanding Dialysis Clinics, policy number 4.95
Reimbursement Policy - Diabetes Self-Management Training (DSMT)/Medical Nutrition Therapy (MNT), policy number 4.32
Reimbursement Policy - Diabetes Self-Management Training (DSMT)/Medical Nutrition Therapy (MNT), policy number WS 4.32
Reimbursement Policy - Dialysis, policy number WS 4.13
Reimbursement Policy - End-Stage Renal Disease - Dialysis, policy number SCO 4.95
Reimbursement Policy - General Billing and Coding Guidelines, policy number 4.31
Reimbursement Policy - General Billing and Coding Guidelines, policy number SCO 4.31
Reimbursement Policy - General Billing and Coding Guidelines, policy number WS 4.17
Reimbursement Policy - General Clinical Editing and Payment Accuracy Review Guidelines, policy number 4.108
Reimbursement Policy - General Clinical Editing and Payment Accuracy Review Guidelines, policy SCO 4.108
Reimbursement Policy - General Clinical Editing and Payment Accuracy Review Guidelines, policy number WS 4.18
Reimbursement Policy - Home Health, policy number 4.7
Reimbursement Policy - Home Health Care and Private Duty Nursing, policy number WS 4.19
Reimbursement Policy - Home Infusion Including Parenteral/Tube Fed Enteral Nutrition Therapy, policy number 4.121
Reimbursement Policy - Home Infusion Including Parenteral/Tube Fed Enteral Nutrition, policy number WS 4.22
Reimbursement Policy - Hospice, policy number 4.8
Reimbursement Policy - Hospice policy number SCO 4.8
Reimbursement Policy - Hospice, policy number WS 4.20
Reimbursement Policy - Hospital, policy number WS 4.21
Reimbursement Policy - Non-Participating Provider, policy number WS 4.5
Reimbursement Policy - Non-Reimbursed Codes, policy number 4.38
Reimbursement Policy - Non-Reimbursed Codes, policy number WS 4.38
Reimbursement Policy - Non-Waivered and Waivered Services, policy number WS 4.36
Reimbursement Policy - Outpatient Hospital, policy number 4.17
Reimbursement Policy - Outpatient Hospital, policy number SCO 4.17
Reimbursement Policy - Outpatient Hospital, policy number 4.17
Reimbursement Policy - Personal Care Attendant, policy number WS 4.26
Reimbursement Policy - Physician and Non Physician Practitioner Services, policy number 4.608
Reimbursement Policy - Physician and Non-Physician Practitioner Services, policy number 4.608
Reimbursement Policy - Physician and Non Physician Practitioner Services, policy number SCO 4.608
Reimbursement Policy - Physician and Non Physician Practitioner Services, policy number WS 4.28

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number SCO 4.610
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number WS 4.29

**Reference to Applicable Laws and Regulations**


130 CMR. Code of Massachusetts Regulations. Division of Medical Assistance.

211 CMR 52.00. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers.


Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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Disclaimer Information:

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Medical Nutrition Therapy in the Outpatient Setting or Office Setting

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