BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

# Medical Nutrition Therapy in the Outpatient Setting or Office Setting

**Policy Number:** OCA 3.66
**Version Number:** 20
**Version Effective Date:** 12/01/21

## Product Applicability

☒ **All Plan[+] Products**

**WellSense Health Plan**
☒ NH Medicaid
☒ NH Medicare Advantage

**Boston Medical Center HealthNet Plan**
☒ MassHealth ACO
☒ MassHealth MCO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

## 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 Clinical Criteria 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.

## Clinical Criteria

For BMC HealthNet Plan and WellSense New Hampshire pediatric members (i.e., members under age 21 on the date of service), medical nutrition therapy is considered medically necessary when criteria are met for EPSDT services or Plan criteria are met.



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The Plan considers outpatient medical nutrition therapy 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 Plan medical criteria are met and documented in the adult or pediatric member's medical record. Criteria must be met in item 1 for the 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 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 for continuing services or services for a new condition in the same calendar year as prior medical nutrition therapy **REQUIRE prior authorization** according to guidelines 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.

Note: For WellSense New Hampshire Medicaid 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.



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**Medical Nutrition Therapy Table:**

| Condition | Recommended # of Visits per Calendar Year | Recommended # of Billed Units per Calendar Year at Four (4) 15-Minute Units per Visit |
|---|---|---|
| Cardiac disease risk factor modification<br><br>(including but NOT limited to hypertension and cholesterol management) | 6 | 24 |
| Chronic obstructive pulmonary disease (COPD) | 4 | 16 |
| Congestive heart failure (CHF) | 4 | 16 |
| Cystic fibrosis | 4 | 16 |
| Diabetes Type 1 | 8 | 32 |
| Diabetes Type 2 | 8 | 32 |
| Eating disorders<br><br>(including but NOT limited to anorexia and/or bulimia) | 12 | 48 |
| Enteral feeding support or total parenteral nutrition (TPN) | 4 | 16 |
| Failure to thrive or malnutrition | 5 | 20 |
| Gastrointestinal (GI) conditions including altered absorption/ metabolism of nutrients<br><br>(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) | 4 | 16 |
| Gestational diabetes | 7 | 28 |
| High-risk premature infants and children with special health care needs impacting nutritional status<br><br>(including but NOT limited to low birth weight, premature birth, malabsorption, or other medical condition) | 5 | 20 |



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**Medical Nutrition Therapy Table (cont.):**

| Condition | Recommended # of Visits per Calendar Year | Recommended # of Billed Units per Calendar Year (at Four [4] 15-Minute Units per Visit) |
|---|---|---|
| High risk prenatal care | 3 | 12 |
| HIV/AIDS - adult member with moderate to severe symptoms | 6 | 24 |
| HIV/AIDS - pediatric member with moderate to severe symptoms | 12 | 48 |
| Hyperemesis gravidarum | 3 | 12 |
| Illness or injury resulting in member being unable to meet daily nutritional requirements using traditional foods alone | 3 | 12 |
| Kidney disease when member has impaired nutrition status related to the condition<br><br>(including but NOT limited to non-dialysis dependent kidney disease, conditions requiring dialysis, chronic renal failure, or after kidney transplant) | 8 | 32 |
| Oncology at risk<br><br>(including but NOT limited to chemotherapy, radiation, and/or surgery) | 5 | 20 |
| Pressure ulcer management | 4 | 16 |
| Weight management<br><br>(including but NOT limited to obesity and/or bariatric surgery) | 8 | 32 |

## Limitations and Exclusions

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 Clinical Criteria section. Conditions NOT specified in the Medical Nutrition Therapy Table also require Plan Medical Direction review for authorization of medical nutrition therapy. ALL documented clinical information in items a through d are required for Plan Medical Director review:



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a. There is likelihood that the member will benefit from additional medical nutrition therapy; AND

b. Individualized and measurable goals have been established for the treatment provided during those additional medical nutrition therapy 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 services listed in items a through c is NOT considered medically necessary:

a. Nutrition counseling/services offered as a component of commercial diet programs, commercial weight management programs (where criteria in the Clinical Criteria 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).

## Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HOM members, including but not limited to national coverage determinations (NCCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 180.1 includes guidelines for medical nutrition therapy. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or WellSense Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

## 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



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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 Clinical Criteria and Limitations and Exclusions sections, 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. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

| **CPT Codes** | **Description: Codes Covered When Medically Necessary** |
|---|---|
| 97802 | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes |
| 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 |
| **HCPCS Codes** | **Description: Codes Covered When Medically Necessary** |
| 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 |

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## Policy History

| Original Approval Date | Original Effective Date* and Version Number | Policy Owner | Original Policy Approved by |
|---|---|---|---|
| Regulatory Approval: N/A<br><br>Internal Approval:<br>03/13/07: Utilization Management Committee (UMC)<br>04/10/07: Quality Improvement Committee (QIC)<br>05/01/07: Quality and Clinical Management Committee (Q&CMC) | 07/01/07<br>Version 1 | Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) | Q&CMC, QIC, and UMC |

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12



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*Effective Date for the WellSense Health Plan New Hampshire Medicaid Products: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

## Policy Revisions History

| Review Date | Summary of Revisions | Revision Effective Date and Version Number | Approved by |
|---|---|---|---|
| 03/11/08 | Procedure review: Added reimbursement language to the grid above to include the recommended number of billed units per visit. | Version 2 | 03/11/08: MPCTAC<br>03/25/08: UMC<br>04/15/08: QIC |
| 03/24/09 | No changes to clinical criteria. Updated references. | Version 3 | 03/24/09: MPCTAC<br>03/24/09: UMC<br>04/17/09: QIC |
| 03/01/10 | Updated coding. No changes to clinical criteria. | Version 4 | 03/23/10: MPCTAC<br>04/28/10: QIC |
| 02/01/11 | No changes to criteria, clarified clinical guideline statement, and updated references. | Version 5 | 03/16/11: MPCTAC<br>04/27/11: QIC |
| 02/01/12 | No changes to criteria. Updated references and coding. | Version 6 | 02/28/12: MPCTAC<br>03/28/12: QIC |
| 08/01/12 | Off cycle review. Revised Summary statement, reformatted Medical Policy Statement, revised Limitations statement. Review of entire policy conducted. | Version 7 | 08/17/12: MPCTAC<br>09/06/12: QIC |
| 10/01/12 | Revised title to specify services in an outpatient setting. Updated references. Reformatted Medical Policy Statement section and referenced applicable Plan policies. Updated language in Applicable Coding section. | Version 8 | 10/17/12: MPCTAC<br>11/28/12: QIC |
| 08/01/13 | Review for effective date 12/01/13. Revised Summary section, Clinical Background Information section, and introductory paragraph in Applicable Coding section. Updated references. Added CPT code 97804 to applicable code list. | 12/01/13<br>Version 9 | 08/21/13: MPCTAC<br>09/19/13: QIC |
| 09/01/14 | Review for effective date 11/01/14. Updated Summary and References sections. Revised introductory paragraph in the Applicable Coding section without | 11/01/14<br>Version 10 | 09/17/14: MPCTAC<br>10/08/14: QIC |



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| Policy Revisions History | | | |
|---|---|---|---|
| | changing the code list. Revised text in the Medical Policy Statement and Limitations sections without changing medical criteria. | | |
| 09/01/15 | 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. | 01/01/16<br>Version 11 | 09/16/15: MPCTAC<br>10/14/15: QIC |
| 11/25/15 | Review for effective date 01/01/16. Revised language in the Applicable Coding section. | 01/01/16<br>Version 12 | 11/25/15: MPCTAC (electronic vote)<br>12/09/15: QIC |
| 09/01/16 | 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. | 11/01/16<br>Version 13 | 09/21/16: MPCTAC<br>10/12/16: QIC |
| 09/01/17 | Review for effective date 10/01/17. Updated References, Other Applicable Policies, and References to Applicable Laws and Regulations sections. | 10/01/17<br>Version 14 | 09/20/17: MPCTAC |
| 02/01/18 | 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. | 05/01/18<br>Version 15 | 02/21/18: MPCTAC |
| 09/01/18 | 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. | 12/01/18<br>Version 16 | 09/19/18: MPCTAC |



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| Policy Revisions History | | | |
|---|---|---|---|
| 09/01/19 | 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. | 12/01/19 Version 17 | 09/18/19: MPCTAC |
| 07/01/20 | Review for effective date 08/01/20. Updated the Clinical Background Information, References, and Other Applicable Policies sections. | 08/01/20 Version 18 | 07/15/20: MPCTAC |
| 08/01/21 | Review for effective date 09/01/21. Administrative changes made to the Medical Policy Statement, Limitations, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. | 09/01/21 Version 19 | 08/27/21: MPCTAC (electronic vote) |
| 11/01/21 | Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections. | 12/01/21 Version 20 | 11/17/21: MPCTAC |

## Next Review Date

07/01/22

## Authorizing Entity

MPCTAC

**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



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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.



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