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1.0 Description of the Procedure, Product, or Service

Dietary Evaluation and Counseling (Medical Nutrition Therapy) offers direction and guidance for specific nutrient needs related to a recipient's diagnosis and protocol. Individualized care plans provide for disease-related nutritional therapy and counseling.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Children through 20 Years of Age

Children through 20 years of age are eligible for dietary evaluation and counseling when they meet the medical necessity criteria listed in **Subsection 3.2.1**.

2.4 Pregnant and Postpartum Women

Pregnant and postpartum women are eligible for dietary evaluation and counseling when they meet the medical necessity criteria listed in **Subsection 3.2.2**.

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Medical Necessity Criteria

3.2.1 Children through 20 Years of Age

Medicaid covers dietary evaluation and counseling for children through 20 years of age when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management, including but not limited to the following:

- a. Inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth, or short stature
- b. Nutritional anemia
- c. Eating or feeding disorders that result in a medical condition such as failure to thrive, anorexia nervosa, or bulimia nervosa
- d. Physical conditions that have an impact on growth and feeding, such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy, and neural tube defects
- e. Chronic or prolonged infections that have a nutritional treatment component, such as HIV or hepatitis
- f. Genetic conditions that affect growth and feeding, such as cystic fibrosis, Prader-Willi Syndrome, or Down Syndrome
- g. Chronic medical conditions, such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies, and diseases of the immune system
- h. Metabolic disorders such as inborn errors of metabolism (PKU, galactosemia, etc.) and endocrine disorders (diabetes, etc.)
- i. Non-healing wounds due to chronic conditions
- j. Acute burns over significant body surface area
- k. Metabolic Syndrome/Type 2 diabetes
- l. Documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease, such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, and higher than ideal body weight

3.2.2 Pregnant and Postpartum Women

Medicaid covers dietary evaluation and counseling for pregnant women when the pregnancy is threatened by chronic, episodic, or acute conditions for which nutrition therapy is a critical component of medical management, and for postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period, including but not limited to the following:

- a. Conditions that affect the length of gestation or the birth weight, where nutrition is an underlying cause, such as
 1. Severe anemia (HGB < 10M/DL or HCT < 30)
 2. Pre-conceptionally underweight (<90% standard weight for height)
 3. Inadequate weight gain during pregnancy

4. Intrauterine growth retardation
5. Very young maternal age (under the age of 16)
6. Multiple gestation
7. Substance abuse
- b. Metabolic disorders, such as diabetes, thyroid dysfunction, maternal PKU, or other inborn errors of metabolism
- c. Chronic medical conditions, such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease
- d. Auto-immune diseases of nutritional significance, such as systemic lupus erythematosus
- e. Eating disorders, such as severe pica, anorexia nervosa, or bulimia nervosa
- f. Obesity when the following criteria are met:
 1. BMI > 30 in same woman pre-pregnancy and post partum
 2. BMI > 35 at 6 weeks of pregnancy
 3. BMI > 30 at 12 weeks of pregnancy
- g. Documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease, such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, and higher than ideal body weight

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Service Components

Dietary evaluation and counseling shall include all of the following service components:

- a. Review of medical management, an evaluation of medical and psychosocial history, and treatment plan as they impact nutrition interventions
- b. Assessment of living conditions related to nutrition evaluation such as possession of a working stove, refrigerator, and access to city water or tested well water
- c. Diagnostic nutritional assessment, which may include:
 1. Review and interpretation of pertinent laboratory and anthropometric data
 2. Analysis of dietary and nutrient intake
 3. Determination of nutrient–drug interactions
 4. Assessment of feeding skills and methods
- d. Development of an individualized nutrition care plan
 1. Recommendations for nutrient and calorie modification
 2. Calculation of a therapeutic diet for disease states such as diabetes, renal disease, and galactosemia
 3. Referral to other health care providers
- e. Counseling on nutritional/dietary management of nutrition-related medical conditions
- f. Consultation with the recipient's primary care provider
- g. Education on reading food labels

5.2 Service Setting

Dietary evaluation and counseling shall be provided as an individual, face-to-face encounter with the recipient or the recipient's caretaker.

5.3 Service Limitations

The initial assessment and intervention is limited to four units of service per date of service and cannot exceed four units per 270 days by the same or a different provider.

The re-assessment and intervention is limited to four units of service per date of service and cannot exceed 20 units per 365 days by the same or a different provider.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Medicaid-enrolled providers who employ or contract with licensed dietitians/nutritionists or registered dietitians (for example, local health departments, rural health centers, federally qualified health centers, physician or medical diagnostic clinics, outpatient hospitals and physicians) are eligible to bill for this service.

6.1 Provider Qualifications

Dietary evaluation and counseling provided in public agencies, private agencies, clinics, physician or medical diagnostic clinics, and physician offices shall be performed by

- a. a dietitian/nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable); OR
- b. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

6.2 Staff Qualifications

It is the responsibility of the provider agency to verify in writing all staff qualifications for their staff's provision of service. A copy of this verification (current licensure or registration) shall be maintained by the provider agency.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Medical Record Documentation

Medical record documentation shall be maintained for each recipient, for at least five years, and shall include, at a minimum:

- a. The date of service
- b. The presenting problem
- c. A summary of the required nutrition service components
- d. The signature of the qualified nutritionist providing the service
- e. The recipient's primary care or specialty care provider's order for the service

Documentation shall be maintained in the medical records of the recipient's primary care provider.

7.3 WIC Program

All individuals categorically eligible for the Women, Infants, and Children (WIC) Program shall be referred to that program for routine nutrition education and food supplements.

Note: For agencies that also administer a WIC Program, the nutrition education contacts required by that program shall be provided prior to billing Medicaid for dietary evaluation and counseling. Staff time utilized to provide a Medicaid-reimbursable nutrition service may not be charged to WIC program funds.

Dietitians/nutritionists providing dietary evaluation and counseling are encouraged to refer eligible clients to the Maternity Care Coordination or Child Service Coordination programs as appropriate.

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 2001

Revision Information:

Date	Section Revised	Change
1/1/08	Section 6.0	Providers eligible to bill for the services were expanded to include outpatient hospital clinics, physician and medical diagnostic clinics, and physician's office effective with date of service 4/1/07 as approved by CMS on 10/1/06.
1/1/08	Attachment A, item B	ICD-9-CM diagnosis codes 278.00, 278.01, 783.7, and 783.41 were added to the policy.
1/1/08	Attachment A, item D	RC 942 was added as a covered code for hospital outpatient clinic providers.
7/1/09	Throughout	Updated language to DMA's current standard.
7/1/09	Section 6.0	Added a paragraph that shows DMA's standard language for provider qualifications.
7/1/09	Section 7.1	Added this section on compliance and renumbered subsequent sections.
7/1/09	Attachment A	Deleted specific instructions in Claim Type (standard language is sufficient); added full descriptions to Diagnosis Codes; clarified billing instructions for item 3 in Billing Units.
10/27/09	Attachment A , Section B	Added statement that Children 0-20 years of age are not limited to the diagnosis list below. Added the words "pregnant or postpartum" before the word recipient.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

Children 0-20 years of age

Children 0-20 years of age are not limited to the diagnosis list below.

Pregnant and Postpartum Women

One of the primary diagnosis codes listed below must be used when the pregnant or postpartum recipient is 21 years of age or older.

ICD-9-CM Code	Description
V22.0	Normal pregnancy; supervision of normal first pregnancy
V22.1	Normal pregnancy; supervision of other normal pregnancy
V22.2	Normal pregnancy; pregnant state, incidental
V23.0	Supervision of high-risk pregnancy; pregnancy with history of infertility
V23.1	Supervision of high-risk pregnancy; pregnancy with history of trophoblastic disease
V23.2	Supervision of high-risk pregnancy; pregnancy with history of abortion
V23.3	Supervision of high-risk pregnancy; grand multiparity
V23.4	Supervision of high-risk pregnancy; pregnancy with other poor obstetric history
V23.5	Supervision of high-risk pregnancy; pregnancy with other poor reproductive history
V23.7	Supervision of high-risk pregnancy; insufficient prenatal care
V23.81	Other high-risk pregnancy; elderly primigravida
V23.82	Other high-risk pregnancy; elderly multigravida
V23.83	Other high-risk pregnancy; young primigravida
V23.84	Other high-risk pregnancy; young multigravida
V23.89	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy
V24.2	Postpartum care and examination; routine postpartum follow-up
278.00	Overweight and obesity; obesity, unspecified
278.01	Overweight and obesity; morbid obesity
783.41	Lack of expected normal physiological development in childhood; failure to thrive
783.7	Adult failure to thrive

C. Procedure Code(s)

CPT Code	Description
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

D. Revenue Codes

Hospital outpatient clinics bill for services using RC 942.

E. Modifiers

Providers are required to follow applicable modifier guidelines.

F. Billing Units

1. CPT code 97802
 - a. Each 15 minutes of service equals 1 billing unit.
 - b. Service is limited to a maximum of 4 units per date of service.
 - c. Service cannot exceed 4 units per 270 days.
2. CPT code 97803
 - a. Each 15 minutes of service equals 1 billing unit.
 - b. Service is limited to a maximum of 4 units per date of service.
 - c. Service cannot exceed a maximum of 20 units per 365 days.
3. Revenue Code 942
 - a. Each 15 minutes of service equals 1 billing unit.
 - b. Service for an initial assessment and intervention is limited to 4 units per date of service, and the maximum allowed is 4 units per 270 days.
 - c. Service for a reassessment and intervention cannot exceed 4 units per date of service, with a maximum of 20 units per 365 days.

G. Place of Service

Dietary evaluation and counseling shall be provided in hospital outpatient clinics; public agencies such as health departments, federally qualified health centers, and rural health clinics; private agencies; physician or medical diagnostic clinics; and physician offices.

H. Co-Payments

Co-payments are not required for dietary evaluation and counseling when provided to pregnant and postpartum women or to children 0 through 20 years of age.

I. Reimbursement

Providers shall bill their usual and customary charges. All agencies shall bill the same fee for all recipients who receive the same service.