Medical Nutrition Therapy Payment Policy

Policy

The Plan will reimburse for covered Medical Nutrition Therapy (MNT) services provided by licensed professionals who are participating through a contracted entity and are within the legal scope of their practice.

For Navicare and Fallon Medicare Plus, the Plan will reimburse for up to 3 total visits of one-on-one counseling each year for all members (Medicare-covered and non-Medicare covered diagnoses). The services must be provided by a registered dietician or other nutrition professional in the network.

Definitions

Medical Nutritional Therapy (MNT) is nutritional therapy and counseling services for the purpose of management of a medical condition.

This policy applies to the payment for MNT services furnished by a non-MD licensed professional such as: Registered Dietitian (RD), Licensed Medical Nutrition Therapist (LMNT), Certified Nutritionist (CN), Registered Diabetic Educator (RDE), Licensed Dietician/Nutritionist (LDN), or other licensed health-care providers with specific training in the provision of nutritional counseling.

Each state is responsible for mandating and enforcing specific requirements for licensure and for defining the legal scope of practice.

Reimbursement

The Plan's payment for MNT services provided by non-physician professionals is 85 percent of the applicable physician fee schedule amount, or as per contract.

Diabetes Self-Management Education and Training (DSME/T) services will not be reimbursed if provided on the same day as MNT services.

Referral/notification/prior authorization requirements

A PCP referral is not required for medical nutrition. Prior authorization is not required for medical nutrition therapy.

Fallon Health Weinberg model of care is based on patient care coordination; therefore, we encourage referring providers to contact the member's designated care coordinator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

The referring physician's name and NPI number must be submitted.

The following codes should be used:

97802	Medical Nutrition Therapy (MNT) Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	MNT reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	MNT group, 2 or more individuals, each 30 minutes.
G0270	MNT; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen,

	individual, face-to-face with the patient, each 15 minutes.
G0271	MNT; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, group, each 30 minutes.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	07/21/04
Previous revision date(s):	02/02/05, 07/06/05, 05/23/07, 09/12/07
	05/01/09 – Added to the list of professionals who perform the service, edited the billing/coding section to clearly state that if these professional services are submitted on UB-04 rather than CMS-1500 claim forms, they will deny as “Reject - bill on CMS-1500 form”, and removed code S9470 – Nutritional counseling, dietician visit from the list of CPT codes that should be used because it is a non-covered code.
	March 2011 – Removed requirement to submit services on CMS-1500 claim forms.
	05/01/2015 - Added language stating that MNT and DSME/T services will not be reimbursed if provided on the same date of service.
	01/01/2016 - Updated to new template.
	09/01/2016 - Annual review.
Connection date & details:	July 2017 – Annual review.
	July 2018 – Annual review, no updates
	July 2019 – Annual review, no updates.
	January 2021 – Updated policy section for Fallon Medicare Plus and NaviCare; updated Referral /notification/prior authorization requirements section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.