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In This Issue

1
Feature Article

2
Letter from the Editor

10
Advances in Practice: Pica: An Important and Unrecognized Problem in Pediatric Dialysis Patients

15
Is Change Affecting You or Are You Effecting Change?

18
App: Kidney Diet

19
Calendar of Events

20
NKF Spring Clinical Meeting Updates

23
HOD Update

24
Public Policy Workshop Update

25
Renal Dietitians Chair Message

26
Recently Published

27
RPG Executive Committee

Maximizing Reimbursement in a Multidisciplinary Medical Practice: Navigating the Maze of Coverage Guidelines

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This article has been approved for 1.0 CPEU unit. The online CPEU quiz and certificate of completion can be accessed in the Members Only section of the RPG web site via the My CPEU link. This CPEU offering is available to current RPG members only and the expiration date is July 15, 2013.

Introduction

A sure-fire way of keeping registered dietitians (RDs) employed in a multidisciplinary medical practice (MDMP) is by third-party reimbursement for medical nutrition therapy (MNT) and diabetes self-management training (DSMT). Most insurers cover these services, but as most RDs and diabetes educators would confirm, coverage guidelines are confusing, complicated, convoluted, challenging and constantly changing! Let's clear things up with this article!

MNT is a therapeutic approach to treating and preventing medical conditions and their associated symptoms via the use of evidence-based protocols that include nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation (1,6,10). DSMT, also known as diabetes self-management education (DSME), is a collaborative patient/provider process through which patients with, or at risk for, diabetes gain the knowledge and skills needed to modify their behavior and successfully self-manage the disease and its related conditions (4,10).

Medicare Coverage

Billing and Coding

Medicare does reimburse select providers for these two services (2, 10). Table 1 summarizes coverage guidelines in key billing and coding categories. Table 2 outlines the procedure codes required by Medicare for MNT and DSMT. Table 3 presents the Centers for Medicare & Medicaid Services (CMS) guide to rounding the time spent face-to-face with patients when using 15-minute time-based current procedural terminology (CPT®) codes. These include the three codes used for MNT: 97802, 97804, and G0270. The specific diagnosis codes that Medicare requires on pre-dialysis renal MNT claims are provided in Table 4. These tables can be used as handy desk-top references.

Telehealth

MNT telehealth services have been reimbursed by Medicare for some time. This includes individual and group MNT (HCPCS codes G0270 and G0271 and CPT® codes 97802, 97803, and 97804). In January 2011, Medicare approved payment for DSME/T benefits when delivered via telehealth (HCPCS codes G0108 and G0109).

Telehealth services use a real-time audiovisual telecommunication system as a substitute for an inperson encounter between the Medicare beneficiary and the provider located at a different site (1,3,5,6). Medicare's specific telehealth coverage guidelines for billing and payment are summarized in Table 1 (see page 18). Additional information on Medicare MNT and DSME/T telehealth is available on the Academy of

– Continued on page 3.

Nutrition and Dietetics (the Academy) website at *http://www.eatright.org* and on the CMS web site at *http://www.cms.org*.

Private Payer and Medicaid Reimbursement for MNT and DSME/T

The RD, educator, and/or management personnel in the practice should contact each private payer in the local area and the state's Medicaid office to obtain their specific billing, coding, and payment guidelines. Best practice management requires that providers communicate the insurer's MNT and/or DSMT coverage policies to the patient ***before*** furnishing the benefit, including the payment rate and the patient's copayment amount. The patient has the right to this information to make an informed decision about whether to receive the benefit. Meeting this requirement can be a challenge because insurers typically have multiple insurance plans within their systems, such as a health maintenance organization or preferred provider organization. This information is also required to develop the procedures for furnishing the benefits; with Medicare, this includes obtaining the patient eligibility laboratory criteria and the physician's referral before the first visit.

Forty-six states and the District of Columbia have state laws that require private health insurance policy coverage for diabetes treatment and education for select subscribers. The specific coverage guidelines can be accessed at *http://www.ncsl.org/ default.aspx?tabid =14504*. The four states that do not have a mandate or insurance requirement are Alabama, Idaho, North Dakota, and Ohio.

Some payers may also require other billing codes for MNT and DSME/T. In January 2006, the American Medical Association approved three new CPT® procedure codes that can potentially be used for nutrition education and training services (not MNT) provided by RDs and billed to private payers (Table 5) (10). Reimbursement is not only contingent on private payers' acceptance of these codes, but also on the RD's adherence to the payers' specific coverage guidelines for non- MNT nutrition services. Of note, these codes are not reimbursable by Medicare at this time. Therefore, RDs should not use them on claims sent to Medicare.

These codes are intended for use with education and training for patient self-management to treat established illnesses or diseases or to delay comorbidities. The purpose is to teach the patient (or caregivers) how to self-manage the patient's illnesses effectively in conjunction with the patient's professional health care team. An Academy task force developed a document that compares and contrasts the differences between MNT and nutrition education/ self-management training (http://www.eatright.org/mnt). Several other billing codes may be required or accepted by private payers and Medicaid plans that can be applied to MNT and DSME/T (Table 6).

Table 1. Medicare Coverage Guidelines

	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012	Individual and Group Diabetes Self-Management Training (DSMT) Initial and Follow-Up Episodes of Care: 2012
Coverage: In-Person	Diabetes type 1, type 2, gestational diabetes, predialysis renal disease, and for the period of 36 months following a successful kidney transplant.	Ten self-care topics included; nutrition is 1 of 10 presented as broad overview of basic concepts.
Allowed Settings	Outpatient settings that include hospital outpatient departments, private practices, federally qualified health centers, home health agencies, nursing homes, pharmacies, renal dialysis facilities, and rural health clinics.	Outpatient settings that include hospital outpatient departments, private practices, federally qualified health centers, home health agencies, skilled nursing homes pharmacies, and durable medical equipment companies.
Excluded Settings	Hospital inpatient and skilled nursing homes.	Hospital inpatient, nursing homes, renal dialysis facilities, and rural health clinics.
Utilization Limits and Format	Initial: 3 hours in first calendar year; can be repeated every 3 years. Follow-up: 2 hours in each subsequent calendar year. Cannot extend unused initial or follow-up hours into next calendar year. Format of Initial and Follow-up: Group or individual. Individualized meal and exercise plans with	Initial: 10 hours in 12 consecutive months, starting with date of first visit; once-in-a-lifetime benefit. Format of Initial: 9 of 10 hours must be provided in group, unless beneficiary meets criteria for individualized DSMT. 1 hour may be used for individual visit. Follow-up: 2 hours in each year following year in which DSMT completed.

Table 1. Medicare Coverage Guidelines - Continued

	extensive monitoring of outcomes to adjust plans and medications to meet targets. Individual visit to be minimum of 15 minutes because CPT codes 97802 and 97803 are 15-minute time-based codes. Group visit to be minimum of 30 minutes because CPT code 97804 is a 30-minute time-based code. Additional hours may be reimbursed if RD obtains documentation of medical necessity on another referral from treating physician and specific number of extra units of time is prescribed. Cannot be provided on same day as DSMT.	Format of Follow-up: Group or individual; learning barriers not required for individual follow-up DSMT. Cannot be provided on same day as MNT.
Billing Providers	*Individual providers:* Medicare provider RDs and nutrition professionals (latter has met same educational requirements as RD but has not taken national registration exam given by Commission on Dietetic Registration). Non-RD Medicare individual providers (e.g., physician) and entity Medicare providers (e.g., clinics, physician offices) may bill Medicare on behalf of Medicare provider RD, who has reassigned her/his reimbursement to practice entity. Only RD provider (or individual or entity Medicare provider billing on behalf of RD) can bill; benefit may not be subdivided for purposes of billing. Cannot be billed as "incidental to" physician's services.	*Individual* providers: RDs, qualified nutrition professionals, physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, clinical social workers, and clinical psychologists. *Entity providers:* Outpatient hospital, private health care practices, federally qualified health centers, home health agencies, pharmacies, skilled nursing homes, and durable medical equipment companies. Must be billing for other Medicare services and receiving payment. Only one individual or entity Medicare provider can bill for entire hours of training; benefit may not be subdivided for purposes of billing. Cannot be billed as "incidental to" physician's services.
	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012	**Individual and Group Diabetes Self-Management Training (DSMT) Initial and Follow-Up Episodes of Care: 2012**
Reimbursement	1. Must accept current geographically adjusted assigned reimbursement rate set by Medicare as payment in full. 2. Cannot bill beneficiary or secondary insurance for difference between RD's fee and Medicare payment. Text box on next page provides example.	*Non-participating* Medicare providers need not accept assignment: can bill beneficiary or his/her secondary insurance for difference between fee and Medicare's assigned reimbursement rate. However, fee is subject to Medicare's limiting charge. *Participating* providers, however, are required to accept assignment.
Beneficiary Co-Payment	Effective January 1, 2011, beneficiaries no longer required to pay MNT co-payment of 20%. Medicare pays 80% of adjusted allowed rate.	Beneficiaries are required to pay the 20% co-payment. Medicare pays 80% of adjusted allowed rate.

Table 1. Medicare Coverage Guidelines - Continued

Facility Fee	No Medicare facility fee allowed, except if furnished as telehealth.	No Medicare facility fee allowed, except if furnished as telehealth.
Quality Standards	Regulations state: *"RDs and nutritionists must use nationally recognized protocols, such as those developed by the Academy."* Also known as evidence-based nutrition practice guidelines and available at: www.nutritioncaremanual.org	Program must have accreditation from AADE or recognition from ADA; status based on program meeting the 10 National Standards for Diabetes Self-Management Education and meeting application requirements.
Beneficiary Entitlement	*Initial MNT:* Has Medicare Part B insurance and has not received initial MNT in previous 3 years. Medicare carriers now in process of meeting new requirement to allow provider access to history of beneficiary's claims. Beneficiary can call Medicare to obtain own history (1-800-MEDICARE). *Follow-Up MNT:* Has Part B insurance.	*Initial DSMT:* Has Medicare Part B insurance and has not received initial DSMT ever. *Follow-Up DSMT:* Has Medicare Part B insurance.
Allowed Referring Providers	Treating physicians who are MDs and DOs only. Qualified non-physician practitioners cannot refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).	Treating physician (MDs and DOs) and qualified non-physician practitioners can refer (i.e., nurse practitioners, physician assistants, clinical nurse specialists).
Beneficiary Eligibility: Referral	Must establish medical necessity by RD obtaining written referral for MNT from treating physician for initial and again for follow-up MNT. Referral must include diagnosis of diabetes or 5-digit diabetes ICD-9-CM diagnosis code, physician's NPI number, and other data.	Must establish medical necessity of program by obtaining written referral for DSMT from provider for both initial and again for follow-up DSMT. Referral must include diagnosis of diabetes or 5-digit diabetes ICD-9-CM diagnosis code and other data.
Beneficiary Eligibility: Diagnostic Laboratory Criteria	Documentation of 1 of 3 in chart maintained by RD for type 1/type 2 diabetes mellitus: 1) Fasting blood glucose ≥126 mg on 2 different occasions.* 2) 2-hour post glucose challenge test ≥200 mg on 2 different occasions. 3) Random blood glucose test ≥200 mg for person with symptoms of uncontrolled diabetes. *Documentation in chart maintained by RD for predialysis renal MNT: estimated glomerular filtration rate of 13 to 50 mL/min/1.73m^2	Same. * Cannot be obtained from home-based or inpatient (bedside) blood glucose meter

Table 1. Medicare Coverage Guidelines - Continued

	Individual and Group Medical Nutrition Therapy (MNT) Initial and Follow-Up Episodes of Care: 2012
Coverage: Telehealth (4)	Individual and group MNT and DSMT (initial and follow-up) can be provided as telehealth services. Telehealth services use a real-time audiovisual telecommunication system as a substitute for an in-person encounter between the Medicare beneficiary and the provider, who are at different sites. Medicare's specific telehealth coverage guidelines for billing and payment are: 1) The beneficiary must be at an "originating site" at the time the service is being furnished. 2) Originating sites must be located in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. a. However, entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. 3) The originating sites authorized by law are: a. Offices of physicians or qualified non-physician practitioners b. Hospitals c. Critical Access Hospitals (CAHs) d. Rural Health Clinics e. Federally Qualified Health Centers f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites) g. Skilled Nursing Facilities h. Community Mental Health Centers 4) The provider is at a "distant site" at the time the service is being furnished. 5) An interactive audio and video telecommunications system must be used that permits real-time communication between the provider at the distant site and the beneficiary at the originating site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. a. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii. 6) Claims for telehealth services are submitted using the appropriate CPT or HCPCS code along with the telehealth modifier GT "via interactive audio and video telecommunications system" (e.g., 97802 GT). By using the GT modifier, the distant site provider certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. a. In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, providers use the telehealth modifier GQ "via asynchronous telecommunications system" (e.g., 97802 GQ). 7) For DSMT telehealth services, a minimum of 1 hour of in-person instruction in the self-administration of injectable drugs training must be furnished in-person during the year following the initial DSMT service, if the beneficiary is prescribed this type of drug therapy. The injection training may be furnished through either individual or group DSMT services. 8) Providers at the distant site can bill either the Medicare Carrier or the Part A/Part B Medicare Administrative Contractor (MAC) for telehealth MNT and DSMT. Reimbursement rates are the same as when MNT and DSMT services are delivered face to face. 9) In addition, the originating site that owns the specialized audiovisual equipment can bill the Medicare Carrier or A/B MAC a facility fee, as described by HCPCS code Q3014 (telehealth originating site facility fee). Facility fee is a separately billable Part B payment. Providers paid according to applicable payment methodology for facility or location; usual Medicare deductible and coinsurance policies apply to this code. In 2010 to 2011, the average facility fee was $24.00.

RD's usual and customary fee: $60 for one 30-minute unit of group MNT (CPT code 97804). Medicare's geographically adjusted reimbursement rate: $15 per 1 unit. RD must accept $15 as payment in full; cannot bill beneficiary directly or beneficiary's supplemental insurance for difference between $60 fee and Medicare's payment rate of $15. Does not mean, however, that RD should make usual and customary fee the same as Medicare reimbursement rate. Fees determined by compiling and analyzing several factors, including Medicare reimbursement rate, but not solely on that rate. *Legend: HCPCS: Healthcare Common Procedure Coding System; CPT: Current Procedural Terminology, copyright American Medical Association; AADE: American Association of Diabetes Educators; ICD-9-CM: International Classification of Diseases, 9th Ed, Clinical Modifications; DSMT: Diabetes Self- Management Education/Training; EMR: Electronic Medical Record; the Academy: Academy of Nutrition and Dietetics; ADA: American Diabetes Association; NPI: National Provider Identification number.

Table 2. Procedure Codes Required by Medicare for Billing MNT and DSMT

HCPCS or CPT® Code	Description	Utilization Limits in Initial Episode of Care and Provision of Hours	Utilization Limits in Follow-Up Episode of Care and Provision of Hours
G0108	Diabetes outpatient self-management training services (DSMT): individual visit, face-to-face with the patient, each 30 minutes of training. DSMT program must be accredited as meeting 10 National Standards of DSME by either the ADA or AADE.	10 hours in first consecutive 12 months upon written referral by physician (MD or DO) or qualified non-physician practitioner; 9 hours to be in group, unless: • Barriers that hinder group learning documented by referring provider. • No DSMT program scheduled within 2 months of referral date. • Referring provider orders additional insulin training.	2 hours in subsequent calendar years, starting with calendar year following year in which beneficiary completed initial 10 hours of DSMT, upon another written referral by physician (MD or DO) or qualified non-physician practitioner. 2 hours may be individual or group; documentation of learning barriers not required in order to provide individual follow-up DSMT.
G0109	DSMT: group session (2 to 20 individuals*), face-to-face with patients, each 30 minutes. *Note: 2 to 20 individuals must be patients; not all patients need be Medicare beneficiaries.		
97802	MNT: individual, initial assessment and intervention, face-to-face, each 15 minutes. ***See Table 3: CMS' Guide for Fifteen-minute Time-based CPT Codes***	3 hours in initial episode of care (initial assessment and intervention) in first calendar year upon referral from treating physician (MD or DO).	2 hours in follow-up episode of care (reassessment and intervention) in subsequent calendar years upon another written referral by treating physician.
97803	MNT: individual reassessment and intervention, face-to-face, each 15 minutes.		
97804	MNT: group initial assessment and intervention, and reassessment and intervention, face-to-face, group (≥2 individuals), each 30 minutes.		
G0270	MNT: reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, individual, face-to-face, each 15 minutes.	No limit* for additional hours >3 initial hours and >2 follow-up hours if RD obtains: • Documentation of medical necessity for specific number of additional hours. • Another physician's referral for specific number of additional hours plus documentation of medical necessity. *To date, no limit specified by Medicare for additional hours.	
G0271	MNT: reassessment and subsequent intervention(s) following 2nd referral in same year for change in diagnosis, medical condition, or treatment regimen, group (≥2 individuals), each 30 minutes.		

AADE =American Association of Diabetes Educators; ADA = American Diabetes Association; CPT® = Current Procedural Terminology, copyright American Medical Association; DSME = diabetes self-management education; DSMT = diabetes self-management training; HCPCS = Healthcare Common Procedure Coding System; MNT = medical nutrition therapy; Adapted from: 1) Indian Health Service. Step-by-step guide to Medicare medical nutrition therapy (MNT) reimbursement 2nd ed. http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/CKDNutrition/MNT_Reimburse_Guide_508c.pdf.; 2) American Association of Diabetes Educators. Diabetes education services, reimbursement tips for primary care practice. http://www.diabeteseducator. org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf. Accessed November 15, 2011.

Table 3. CMS' Guide for Fifteen-minute Time-based CPT® Codes*

1 unit =	> 8 minutes to <23 minutes	5 units =	>68 minutes to <83 minutes
2 units =	>23 minutes to <38 minutes	6 units =	>83 minutes to <98 minutes
3 units =	>38 minutes to <53 minutes	7 units =	>98 minutes to <113 minutes
4 units =	>53 minutes to <68 minutes	8 units =	>113 minutes to <128 minutes

*Includes medical nutrition therapy codes 97802, 97803, and G0270.
From: Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, Rev. 2160.

Table 4. Diagnosis Codes for Billing Predialysis Renal Medical Nurtrition Therapy to Medicare

ICD-9-CM Diagnosis Code	Classification of Renal Disease	Glomerular Filtration Rate Value
585.1	I	90
585.2	II (mild)	60 to 89
585.3	III (moderate)	30 to 59
585.4	IV (severe)	15 to 29
585.5	V (dialysis)	15
585.9	CKD, unspecified	

Adapted from: International Classification of Diseases, 2009 Revision, Clinical modifications, World Health Organization. http://www.cdc.gov/nchs/icd/icd9cm.htm

Table 5. Patient Education and Self-Management CPT® Codes*

98960	Education and training for patient self-management by a qualified, non-physician healthcare professional using a standardized curriculum, face-to-face with a patient (could include caregiver/family) each 30 minutes, individual patient.
98961	Group education and training, 2 – 4 patients
98962	Group education and training, 5 – 8 patients
Follow-up education and training: education and training related to subsequent reinforcement or due to changes in patient's condition or treatment plan reported in same manner as original education and training.	

*Not for Medicare use.
Note: CPT codes, descriptions and material only are copyright © 2006 of the American Medical Association. All Rights Reserved.

Table 6. Potential Billing Codes for Medical Nutrition Therapy and Diabetes Self-management Education/Training (14)

S9140	Diabetes management program, follow-up visit to non-MD provider
S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)
S9455	Diabetic management program, group session
S9465	Diabetic management program, dietitian visit
S9470	Nutritional counseling, dietitian visit

From: American Association of Diabetes Educators. Diabetes Education Services – Reimbursement Tips for Primary Care Practice. http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf

Summary

Reimbursement can be confusing and challenging. However, in today's changing health care environment of shrinking dollars, compressing organizational charts, and the trend of paying non-nutrition clinicians for nutrition and diabetes education services, it is vital for RDs to become experts in this area.

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Resource List

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Online Interactive Tool

The Academy's Reimbursement Community of Interest (COI) is an interactive online tool that offers a private and secure area for the Academy's members to connect. The COI is available to Academy members who desire to learn more about coverage for medical nutrition therapy (MNT) and exchange best practices to help advance coverage of nutrition services with health plans, employers and third party payers.

More information about the COI: ***http://www.eatright.org/Members/content.aspx?id=7490***