Impact and components of the Medicare MNT benefit

Next January, Medicare beneficiaries and RDs will be able to participate in a new benefit program for medical nutrition therapy (MNT) services. This focused nutrition program, which recognizes RDs and nutrition professionals as qualified Medicare providers has never before existed. Consumers will have access to MNT for diabetes and kidney disease (non-dialysis)—two diseases where evidence-based MNT Guides for Practice have demonstrated positive outcomes and significant cost savings.

Over the last decade, ADA members have lobbied Congress to create MNT legislation for the Medicare population. Work simultaneously occurred to recognize medical nutrition therapy in the private sector within the physician fee schedules overseen by the American Medical Association. Last year, ADA members achieved success with the enactment of the Medicare MNT legislation and the Centers for Medicare and Medicaid Services (CMS) recognition of MNT codes.

Under the Medicare, Medicaid and SCHIP Benefits Improved and Protection Act of 2000, CMS has been charged with establishing regulations for the Medicare MNT benefit. The agency's proposed regulations were published Aug. 2 in the *Federal Register*. ADA, its members and the public were able to provide comments to the proposed regulations through Oct. 1. Members can review ADA's comments to CMS through the association Web page (*www.eatright.org/gov*). At press time, the final regulations were not released; however, the following information describes the proposed components of the new Medicare MNT benefit, effective Jan. 1, 2002.

Proposed policy definitions

CMS has defined MNT as nutritional diagnostic therapy and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing disease. The benefit covers Medicare beneficiaries who have diabetes or renal disease, and CMS has defined both diseases according to definitions from the Institute of Medicine's report, *The Role of Nutrition in Maintaining Health in the Nation's Elderly* (1). CMS also indicated that the benefit for chronic renal insufficiency excludes Medicare individuals who are receiving maintenance dialysis. In ADA's comments to CMS, the Association suggested CMS broaden its definitions of diabetes and renal disease so that patients with all states of the disease have Medicare coverage. A change of this nature would mean individuals with kidney stones or with gestational diabetes also could receive the benefit.

Conditions of coverage

Medicare MNT must be ordered by the individual's "treating physician" to ensure that the physician establishing the need for MNT is actually treating the individual for diabetes or renal disease, and to ensure coordinated care among the RD and MD providers. ADA suggested CMS more clearly define and consistently use the term treating physician in the regulation. Physicians involved in the patient's care should be able to order MNT services. ADA felt it would undermine patient treatment if access to MNT services were restricted by limiting physicians who order the service.

CMS has used a National Coverage Determination (NCD) process to establish the frequency of MNT service available to Medicare individuals with diabetes or renal disease. Through this process, CMS conducted an evidence-based analysis of the research for MNT frequency and duration, and also discussed nationally recognized protocols with groups such as ADA, the American Diabetes Association, American Association of Diabetes Educators and National Kidney Foundation. The regulation explicitly requires that nationally recognized guides be used for MNT services. Members can meet this requirement by implementing ADA's *MNT Evidence-Based Guides for Practice* (available online by January 2002) (2). The guides provide a set of steps that clearly define the level, content and frequency of nutrition care that is appropriate for diabetes and renal disease.

ADA's recommendations for MNT frequency and duration were provided to CMS through the *MNT Evidence-Based Guides for Practice* for renal disease and type 1 and type 2 diabetes. The research-based guides suggest a minimum of 4.5 hours of MNT for individuals with diabetes and a minimum of 5.5 hours of MNT for individuals with non-dialysis renal disease.

CMS also proposed guidelines for the coordination of care among the MNT benefit and services available through the Medicare Diabetes Self-Management Training (DSMT) program. The proposed regulations said MNT would only be covered if the individual had not started a DSMT program within the past 12 months, unless: (1) the need for a reassessment had been documented by the referring physician, or (2) the beneficiary had been diagnosed with both diabetes and renal disease. If an individual diagnosed with diabetes was referred for both follow-up DSMT services and MNT, he or she would only receive the total amount of hours covered under either follow-up DSMT services or MNT, whichever was greater. Additionally CMS proposed, "if a beneficiary has both diabetes and renal disease..., the beneficiary may receive both MNT and DSMT, but coverage in any 12-month period would be limited to the number of hours the beneficiary would receive under either the MNT benefit or the DSMT benefit for that period, whichever is greater."

In the event that DSMT and MNT benefits overlapped, CMS proposed to not allow the number of hours covered under the MNT benefit to exceed the hours covered if the individual was only receiving DSMT. Here the agency created an exception: If a beneficiary receiving initial DSMT subsequently was diagnosed with renal disease or if there was a change

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in diagnosis or medical condition that occurred during an episode of care, the agency would allow additional hours. CMS also would allow additional hours of coverage for patients with renal disease and diabetes because MNT for renal disease is more complex than MNT for diabetes alone. ADA acknowledged that there is some overlap between MNT and DSMT benefits. If a patient was eligible for both DSMT and MNT, ADA recommended a slight reduction in total MNT services.

Providers

CMS has identified providers as a registered dietitian or nutrition professional who meet the following criteria:

- Holds at least a bachelor's degree from a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose.
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed, or, if a state does not provide for licensure or certification, meets other criteria established by the U.S. Secretary of Health and Human Services.
- Individuals who were licensed as nutrition professionals as of December 21, 2000, qualify as providers even if the other education and experience requirements are not met.

Payment and codes

CMS has been willing to recognize the MNT current procedural terminology codes for MNT services. According to the law, the payment will be set at the lesser of 80 percent of the actual charge for the services or 85 percent of the amount determined under the physician fee schedule for the same services if such services had been furnished by a physician. The agency suggests Medicare co-payments and deductibles would apply for the MNT services. The MNT codes, the proposed code relative value units, and the proposed payment amount for one hour of service are listed in the Figure below.

Payment levels are a continuing frustration for health care professionals participating in Medicare. Without exception, professionals feel that their reimbursement under the program is too low. Dietetic professionals reacted similarly when CMS published proposed rates for Medicare MNT. ADA mounted a nationwide campaign to underscore how CMS' proposed rates were too low, and the association made the case that Medicare MNT would not serve beneficiaries well if the reimbursement were discounted to a level that qualified professionals would not choose to provide the service. ADA strongly feels the potential of MNT will be reduced if CMS fails to recognize the distinct character and value of MNT services and fails to provide adequate resources.

Next steps

CMS will release the final regulations for the Medicare MNT benefit in November. ADA will inform members directly and through postings on the Web. During the October Food and Nutrition Conference and Exhibition, three sessions will detail information on the benefit, the provider application process, and compliance factors among Medicare.

Also this autumn, ADA launches an MNT campaign to increase awareness of the Medicare benefit among members, other health care providers and the public. The campaign message will emphasize the Medicare public's new access to MNT services provided by RDs. Not only will the public benefit from this new program, but RDs will gain provider status and heightened recognition within the healthcare profession and community.

References

1. National Academy of Science, Institute of Medicine. "The Role of Nutrition in Maintaining the Health in the Nation's Elderly", 2000, pg. 118-119.
2. American Dietetic Association Medical Nutrition Therapy Evidence-Based Guides for Practice, www.eatright.org/qm.

MNT code	Proposed total relative value unit	Proposed CMS 85% value for 60-minute MNT (approx. $)
97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes	0.48	$62.44
97803 Re-assessment and intervention, individual, face-to-face with patient, each 15 minutes	0.35	$45.53
97804 Group (2 or more individuals), each 30 minutes	0.15	$ 9.76 (per patient)

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