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March 22, 2024

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Attention: Gift Tee, Director, Division of Practitioner Services

Subject: Re: Coverage for Medical Nutrition Therapy (MNT) Services in Hospital Outpatient Departments

Dear Mr .Tee:

I am responding to CMS' request for more information regarding the obstacles encountered when billing for Part B Medical Nutrition Therapy (MNT) in hospital outpatient departments (HOPDs).

The Academy of Nutrition and Dietetics (the Academy) thanks you for your time in reviewing this letter and commends the efforts by your team and all of CMS for pivoting at the onset of the public health emergency to remove barriers and support billing practices, which facilitated the provision of essential services via telehealth while ensuring beneficiary safety. However, these changes have underscored an ongoing issue affecting the utilization of MNT and Diabetes Self-Management Training (DSMT) services, particularly in the HOPD setting.

Section 105 of the Benefit and Improvement Act (BIPA) of 2008[1] authorized Medicare Part B coverage for MNT services.[2] The Social Security Act designated registered dietitians (RD) or other qualified nutrition professionals as eligible practitioners for independent billing of MNT.[3] The current Part B MNT benefit covers MNT services for beneficiaries with diabetes, non-dialysis chronic kidney disease or for those that have had a kidney transplant in the last 36 months.[4] Since 2006, MNT has been included on the list of Medicare approved telehealth services and RDs have been on the list of qualified distant site providers.[5]

The CDC's National Diabetes Statistics Report estimates that almost 30% of Americans aged 65 or older have diabetes (diagnosed and undiagnosed)[6] and 33.7% of adults aged 65 or older have chronic kidney disease.[7] It is also well known that medically underserved communities as well as non-white communities bear a larger burden of diabetes prevalence. A 2023 study from the American Hospital Association showed that Medicare

[1] Pub L. No. 106-554. The Benefits Improvement and Protection Act of 2000
[2] 42 CFR § 410.132
[3] CMS Manuel: List of Medicare Telehealth Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R790CP.pdf. Accessed: August 21, 2023
[4] 42 CFR § 410.132
[5] 42 CFR, §410.134
[6] https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed March 13, 2024
[7] https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html, Accessed March 13, 2024

patients who receive care in a hospital outpatient department are more likely to come from a medically underserved population and be sicker and more complex to treat than Medicare patients treated in a professional, non-facility setting.[8]

Medical Nutrition Therapy is administered in diverse settings, including HOPDs, both in person and via telehealth. The Academy acknowledges the billing complexity for Part B services like MNT in facility settings. Prior to the COVID-19 Public Health Emergency, billing practices for MNT in HOPDs were characterized by uncertainty and inconsistency.

Providers and billers must navigate a complex path of cross-referencing numerous documents to understand Medicare policies, requirements, and guidelines. The myriad of practical questions faced when trying to set up delivery of care and billing systems and the challenges in trying to find answers to those questions came to the forefront at the onset of the COVID-19 PHE when the need for telehealth flexibilities became apparent. While MNT services have been on the list of Medicare approved telehealth services for a long time, instructing HOPDs to bill for Part B MNT telehealth services the same as in-person services was problematic as facilities did not know how to bill for it as in-person services.

The Academy is concerned that this lack of clarity as to how to bill for MNT in the HOPD has led hospitals to cap services and layoff RDs or restrict provider access, despite high demand for such services. Ultimately, inadequate billing instruction and procedures for MNT services in HOPDs has left many departments with limited options to support necessary providers like RDs, thus impeding beneficiaries' access to this defined benefit and necessary care. Despite the evident need, billing procedures for MNT services in HOPDs remain unclear. This absence of definitive guidance has resulted in disjointed and inconsistent billing practices, thereby exacerbating the underutilization of MNT services.[9]

In our annual feedback to the Medicare Physician Fee Schedule, the Academy consistently seeks clarification regarding provider enrollment billing for MNT, whether provided in person or via telehealth in the HOPD (under the Medicare Physician Fee Schedule using both the CMS 1500 and the UB-04 forms). Regrettably, our inquiries have often resulted in references to passages and citations from the Medicare Claims Manual, which fail to adequately address the issue. Additionally, attempts to obtain guidance from the Medicare Administrative Contractors have yielded limited clarity or direction.

Over the years, we have identified several factors that we believe contribute to these billing challenges.

Ambiguity Relating to Billing Documentation Requirements:

- Place of Service (POS) codes (11, 19, 22)
- National Provider Identifier (NPI) assignment/reassignment
- Revenue codes
- Type of Bill (TOB), with implications for POS coding
- Differentiation between provider based and HOPD clinics, and their relevance to billing under the Medicare Physician Fee Schedule versus the Outpatient Prospective Payment System (OPPS).

[8] https://www.aha.org/press-releases/2023-03-27-new-study-reveals-hospital-outpatient-departments-treat-sicker-lower-income-patients-other-sites

[9] 86 FR 39259 through 39261: MNT participation remains under 2 percent of eligible beneficiaries. Based on an analysis of Medicare claims data from 2018, 2019, 2020, we identify the utilization rate of MNT services among eligible beneficiaries to be between 1.5 and 1.8 percent.

Incorrect and Inconsistent Information:

Medical Nutrition Therapy Incorrectly Treated as Therapy Services

In the July 2020 Interim Final Rule (IFC) (CMS-5531-IFC), CMS erroneously grouped MNT and DSMT services under therapy services. Doing so led to further error with CMS stating that the Medicare laws do not have a benefit category that "would allow registered dietitians [sic] the ability to directly bill Medicare for their services."[10] Outpatient therapy services are a distinct benefit category under Medicare Part B. Prior to the PHE, outpatient therapy services were not on the list of Medicare approved telehealth services such that physical therapists, occupational therapists, and speech language pathologists were not recognized as distant site providers for telehealth services. While CMS loosely addressed this issue in the CY 21 Fee Schedule, [11] we believe that initially placing MNT and DSMT with outpatient therapy services[12] during the public health emergency further contributed to confusion as to whether both MNT and DSMT should be paid under the Medicare Physician Fee Schedule or Outpatient Payment Prospective System. To date, the Hospitals and Critical Access Hospitals Frequently Asked Questions (dated June 26, 2023)[13] still lists MNT (CPT Codes 97802, 87903, 97804) and DSMT (G0108 and G0109) as examples of hospital outpatient therapy.

Medical Nutrition Therapy is Captured in Hospital Payments

The Academy would like to address a longstanding concern regarding the interpretation of the Conditions of Participation for Hospitals outlined in Title 42 of the Code of Federal Regulations[14]. Specifically, there appears to be a misconception that Medical Nutrition Therapy (MNT) services, provided by dietitians, are inherently included within the requirements outlined in these conditions.

Upon reviewing the federal code, it has become evident that the language primarily pertains to food service and oversight of therapeutic diets, rather than specifically addressing the provision of MNT. Despite this, there has been a prevailing assumption that MNT services are encompassed within these regulations[15], leading to complications in billing for Part B MNT services within hospital outpatient departments (HOPDs). This misinterpretation has resulted in challenges for healthcare providers seeking reimbursement for essential MNT services provided to Medicare and Medicaid beneficiaries. It is imperative to clarify the distinction between the oversight of food service and the provision of specialized MNT services, which are crucial for managing various medical conditions and promoting optimal health outcomes.

Recommendations:

While the proposed extension of coverage for telehealth services until 2024 is a positive step, the Academy remains concerned about the lack of clear guidance for hospitals billing for MNT and DSMT services provided by institutional employees in HOPDs.

Here are four instances illustrating the provision of Medical Nutrition Therapy (MNT) within a facility-based outpatient department. The Academy is seeking clarity on the billing requirements for MNT in each scenario (under the Medicare Physician Fee Schedule using both the CMS 1500 and the UB-04 forms).

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[10] CMS-5531-IFC

[11] CMS-1734-F

[12] Example of Hospital Outpatient Therapy, Counseling and Education Services that May be furnished to a Beneficiary in the Hospital by Remote Hospital Clinical Staff Using Telecommunication Technology During the COVID-19 Public Health Emergency. **https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers**. Accessed March 21, 2024.

[13] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf. Accessed March 21, 2024

[14] § 482.28 Condition of participation: Food and dietetic services. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482. Accessed, March 21, 2024

[15] CMS-1751-P

- **Scenario 1:** Registered dietitian (RD) is employed by the hospital in the Nutrition Services Department. The Department operates an outpatient clinic.
- **Scenario 2:** RD is employed by the hospital in the Nutrition Services Department. The Department has an arrangement with the hospital's outpatient Diabetes Center to provide an RD 3 days/week to see outpatients. Billing for MNT provided by the RD is done through the Diabetes Center.
- **Scenario 3:** RD provides MNT services through an endocrinology clinic. RD is an employee of the clinic. Clinic is provider-based. Clinic bills for RD services.
- **Scenario 4:** RD provides MNT services through an endocrinology clinic. RD is an employee of the clinic. Clinic is a "free-standing clinic" located on hospital premises. Clinic bills for RD services.

The Academy believes that both, MNT and DSMT services should be consistently paid for under the Medicare Physician Fee Schedule and regulated under 1834(m) when delivered via telehealth from the HOPD setting. We believe the mechanism for achieving this lies in issuing sub-regulatory guidance to specify the components that must be submitted to the Medicare Administrative Contractor (MAC) to ensure compliance with the requirements of 1834(m).

In conclusion, the Academy appreciates and applauds CMS's efforts to expand access to telehealth services and improve reimbursement policies However, further clarification and guidance are necessary to tackle the longstanding billing challenges associated with MNT and DSMT services, especially when delivered in person or via telehealth within HOPDs, to guarantee beneficiary access and utilization. We respectfully request CMS to provide explicit instructions and clarification to address these challenges and ensure equitable access to MNT and DSMT services for Medicare beneficiaries.

We look forward to continued collaboration with CMS to enhance access to high-quality nutrition care for Medicare beneficiaries. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at jblankenship@eatright.org or Carly Léon at 312-899-1773 or by email at cleon@eatright.org with any questions or requests for additional information. Thank you for considering our comments on this critical issue.

Sincerely,

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