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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 beneficiary's diagnosis and protocol. Individualized care plans provide for disease-related nutritional therapy and counseling.

### 1.1 Definitions

None Apply.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term "Specific" found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

#### b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

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

### **2.2.2 EPSDT does not apply to NCHC beneficiaries**

### **2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

### **2.2.4 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**.

### **2.2.5 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**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

## 3.2 Specific Criteria Covered

### 3.2.1 Specific criteria covered by both Medicaid and NCHC

#### Children through 20 Years of Age

Dietary evaluation and counseling is covered for children through 20 years of age receiving Medicaid and for children receiving NCHC ages 6 through 18 years 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 Medicaid Additional Criteria Covered

#### 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.

**Note:** If eligible, NCHC beneficiaries, ages 6 through 18 years of age, who become pregnant and have been transferred to another appropriate Medicaid eligibility category that includes pregnancy coverage are eligible for this service.

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

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

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **4.1 Specific Criteria Not Covered**

#### **4.1.1 Specific Criteria Not Covered by both Medicaid and NCHC**

None Apply.

#### **4.1.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.1.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

### **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### **5.1 Prior Approval**

Medicaid and NCHC shall not require prior approval for dietary evaluation and counseling.

#### **5.2 Prior Approval Requirements**

##### **5.2.1 General**

None Apply.

##### **5.2.2 Specific**

None Apply.

#### **5.3 Other Requirements or Limitations**

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.
- d. Counseling on nutritional/dietary management of nutrition-related medical conditions.
- e. Consultation with the beneficiary’s primary care provider.
- f. Education on reading food labels.

### **5.3.1 Service Setting**

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

### **5.3.2 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 calendar 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 calendar 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 the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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 and NCHC-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 and Occupational Licensing Entity Regulations**

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

- 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

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

### 7.2 Medical Record Documentation

Medical record documentation shall be maintained for each beneficiary, in the medical records of the beneficiary's primary care provider for at least six (6) 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 beneficiary's primary care or specialty care provider's order for the service.

### 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 shall not be charged to WIC program funds.

Dietitians/nutritionists providing dietary evaluation and counseling are encouraged to refer eligible clients to the Pregnancy Care Management (PCM) or CC4C 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.
7/1/10	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
3/12/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1I under Session Law 2011-145 § 10.41.(b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**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 beneficiary is 21 years of age or older.

ICD-10-CM Code(s)		
E66.01	O09.11	O09.513
E66.9	O09.12	O09.521
R62.51	O09.13	O09.522
R62.7	O09.211	O09.523
Z33.1	O09.212	O09.611
Z34.01	O09.213	O09.612
Z34.02	O09.291	O09.613
Z34.03	O09.292	O09.621
Z34.81	O09.293	O09.622
Z34.82	O09.31	O09.623
Z34.83	O09.32	O09.891
Z34.91	O09.33	O09.892
Z34.92	O09.41	O09.893
Z34.93	O09.42	O09.91
Z39.2	O09.43	O09.92
E66.9	O09.511	O09.93
O09.02	O09.512	R62.51
O09.03		

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code

Hospital outpatient clinics bill for services using RC 942.

CPT Code(s)
97802
97803

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

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 calendar 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 calendar days.
3. Revenue Code 942 (Hospital Outpatient clinics bill for services using RC 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 calendar days.
  - c. Service for a reassessment and intervention cannot exceed 4 units per date of service, with a maximum of 20 units per 365 calendar days.

**F. 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.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html).

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

All agencies shall bill the same fee for all beneficiaries who receive the same service.