



Nutritional Counseling

I. Policy

University Health Alliance (UHA) will reimburse Nutritional Counseling for members when determined to be medically necessary and within the medical criteria guidelines (subject to limitations and exclusions) indicated below.

In all circumstances, the intent of this policy is to permit the nutritional counselor to function as a consultant to evaluate the member and coordinate ongoing care with the referring provider.

II. Criteria/Guidelines

- A. UHA considers nutritional counseling for chronic disease states medically necessary when these criteria are met:
 - 1. Dietary adjustment has a therapeutic role; and
 - 2. Dietetic services are known to be effective in improving health outcomes; provided that:
 - a. Effectiveness is determined first by scientific evidence;
 - b. If no scientific evidence exists, then by professional standards of care; and
 - c. If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
 - 3. Nutritional counseling services provided are cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price; and
 - 4. When it is prescribed by a physician or other UHA recognized provider who will continue oversight and coordination of individualized treatment plan and document medical condition reviews, summary of disciplines/treatment modalities requested, goals status, and further treatment plan coordination; and
 - 5. When it is furnished by a registered dietician, Certified Nutrition Specialist, or Certified Diabetes Educator; and
 - 6. Nutritional counseling services are limited to the number of visits and length of time per session as outlined in Section IV below. Additional visits or time requires prior authorization and provider's documentation must provide justification as to how additional visits will benefit this member.
- B. Medically Necessary nutritional counseling for chronic medical conditions may include but are not limited to the following:
 - 1. Eating disorders: to include Anorexia, Bulimia, Nutritional marasmus
 - 2. Unspecified protein-calorie malnutrition
 - 3. Disorders of lipid metabolism
 - 4. Convulsions/Seizures
 - 5. CVD (Cardiovascular Disease): to include Atherosclerosis, Chronic total occlusion of coronary artery, other forms of chronic ischemic heart disease

6. Diabetes: to include Diabetes mellitus, Pre-diabetes, special nutritional screening, Impaired Fasting Glucose, Impaired glucose tolerance test (oral), other abnormal glucose
 7. HTN (Hypertension)
 8. Renal Disease: to include CKD - non dialysis (Chronic Kidney Disease) and ESRD (End Stage Renal Disease)
 9. Gastrointestinal disorders: to include IBS (Irritable Bowel Disease), Acute gastric ulcer, Regional enteritis, Ulcerative colitis, and pancreatitis
 10. Colostomy and enterostomy complications
 11. Oropharynx Squamous Cell cancer
 12. Obstructive sleep apnea (adult) (pediatric)
 13. Maternity pre-natal nutrition counseling services for diet regulation
 14. Pre and post operative nutritional counseling services for members undergoing bariatric surgery
 15. Pediatric Overweight and Obesity (BMI >95%). For pediatric members, weight *maintenance* is generally recommended. Weight loss may be recommended when the child's BMI is > 95% and/or when the child has additional risk factors.
 16. Nutritional counseling for obese adults (as defined by a BMI ≥ 30 kg/m²)
 - a. Six months after initial nutritional counseling a reassessment of obesity and a determination of the amount of weight loss should be performed. To determine the medical necessity of additional nutritional counseling services, members must have achieved a reduction in weight of at least 3kg (6.6 lbs). This determination must be documented in the physician office records.
- C. UHA considers nutritional counseling of unproven value for conditions that have not been shown to be nutritionally related, including but not limited to asthma, attention-deficit hyperactivity disorder, and chronic fatigue.

III. Limitations/Exclusions

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Administrative Guidelines

- A. Prior Authorization is **not** required.
 1. In all circumstances, the intent of this policy is to permit the nutritional counselor to function as a consultant to evaluate the member and coordinate ongoing care with the referring physician.

2. Additional visits beyond the suggested number of visits per year (see table, below) may be denied without adequate documentation of medical necessity.
3. Additional visits will be considered based on documented progress towards goals, adherence, and motivation. If patient is not progressing towards goal, provider's documentation must provide justification as to how additional visits will benefit this member. Whenever possible, the member should be transitioned to group therapy or support groups (Example: Weight Watcher's).
4. Maximum time allowable for therapy sessions:
 - a. Individual therapy: 45 minutes per session
 - b. Group Therapy: 1 hour per session
5. Services must be rendered by a CDE, CNS, or RD with experience in the condition being treated.
6. For eating disorder, patient must be referred by a UHA recognized provider or psychologist AND continue under the care of the provider or psychologist while receiving nutrition counseling AND include a team (Mental Health & Dietician/Nutritionist) with experience treating eating disorders.
7. For conditions other than eating disorder, patient must be referred by a physician.
8. Patients with multiple co-morbidities may be approved to receive nutrition counseling services under the condition with the most number of visits per year.
9. Pediatric Weight Management (6 to 17 years, BMI >95%). Intensive treatment phase over at least 3 months or until initial weight management goals are achieved may be approved. Suggested frequency: weekly office visits for a minimum of 8 to 12 weeks; monthly visits thereafter are recommended to maintain new behaviors). Initial 12 visits may be approved. Subsequent 6 visits will require another prior authorization review.

Condition	Total # of Visits Per Year	Initial Assessment (Max. 75 minutes each)	Individual or Group Therapy (Max. 45 minutes individual and 1 hr Group/each session)
Eating disorder: Anorexia/Bulimia/Nutritional marasmus/Malnutrition/Disorders of lipid metabolism	8	1	7
CKD (non-dialysis)	6	1	5
Convulsions			
CVD/Atherosclerosis/Chronic total occlusion of coronary artery/Chronic ischemic heart disease/	4	1	3
Diabetes mellitus, special screening	No limit		
Other specified complication, antepartum/ Abnormal maternal glucose tolerance, complicating pregnancy/Abnormal maternal glucose tolerance, antepartum			
HTN	3	1	2
ESRD (pre-dialysis)	6	1	5
IBS/Gastric ulcer/Regional enteritis/Ulcerative colitis/Colostomy and enterostomy complications	3	1	2
Gout	2	1	1

Obesity (BMI > 35)	6	1	5
Obstructive sleep apnea	No limit		
Post-Bariatric Surgery	8	1	7
Pediatric Weight Management (2 to 5 years old)	6	1	5
Pediatric Weight Management (6 to 17 years old)	18	1	17

B. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed.

CPT Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face to face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face to face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
G0270	Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) individual, face to face with the patient, each 15 minutes
G0271	Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group, each 15 minutes. (2 or more individuals), each 30 minutes
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes self-management training services, group session (2 or more), per 30 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
S9470	Nutritional counseling, dietitian visit

HCPCS Code	Description
S9449	Weight management classes, non-physician provider, per session
S9452	Nutrition classes, non-physician provider, per session

V. Policy History

Policy Number: MPP-0106-140401

Current Effective Date: 01/29/2019

Original Document Effective Date: 04/01/2014

Previous Revision Dates: 12/01/2017

PAC Approved Date: 04/01/2014

References:

1. American Dietetic Association. Position of the American Dietetic Association: Medical nutrition therapy and pharmacotherapy. J Am Diet Assoc. 1999;99:227-230.
2. American Dietetic Association. Position of the American Dietetic Association: Cost-effectiveness of medical nutrition therapy. J Am Diet Assoc. 1995;95:88-91.

3. American Dietetic Association. Nutrition recommendations and principles for people with diabetes mellitus. *J Am Diet Assoc.* 1994;94:504-506.
4. Becker AE, Grinspoon SK, Klibanski A, et al. Eating disorders. *N Engl J Med.* 1999;340(14):1092-1098.
5. Bakx JC, Stafleu A, van Staveren WA, et al. Long-term effect of nutritional counseling: A study in family medicine. *Am J Clin Nutr.* 1997;65(6 Suppl):1946S-1950S.
6. Dodge RE. Nutritional counseling and the physician. *Am J Prev Med.* 1997;13(2):73.
7. American Dietetic Association. Position of the American Dietetic Association: Integration of medical nutrition therapy and pharmacotherapy. *J Am Diet Assoc.* 2003;103(10):1363-1370.
8. Anderson JV, Palombo RD, Earl R. Position of the American Dietetic Association: The role of nutrition in health promotion and disease prevention programs. *J Am Diet Assoc.* 1998;98(2):205-208.
9. U.S.. Preventive Services Task Force. Behavioral counseling in primary care to promote a healthy diet: Recommendations and rationale. *Am J Prev Med.* 2003;24(1):74-100.
10. Olendzki B, Speed C, Domino FJ. Nutritional assessment and counseling for prevention and treatment of cardiovascular disease. *Am Fam Physician.* 2006;73(2):257-264.
11. American Dietetic Association. Position of the American Dietetic Association: Nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *J Am Diet Assoc.* 2006;106(12):2073-2082.
12. Baldwin C, Weekes CE. Dietary advice for illness-related malnutrition in adults. *Cochrane Database Syst Rev.* 2008;(1):CD002008.
13. Herpertz-Dahlmann B, Salbach-Andrae H. Overview of treatment modalities in adolescent anorexia nervosa. *Child Adolesc Psychiatr Clin N Am.* 2009;18(1):131-145.
14. Consensus Statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition) Jane V. White, PhD, RD, FADA1; Peggy Guenter, PhD, RN2; Gordon Jensen, MD, PhD, FASPEN3; Ainsley Malone, MS, RD, CNSC4; Marsha Schofield, MS, RD5 *Journal of Parenteral and Enteral Nutrition* Volume 36 Number 3 May 2012 275-283.