Priority Health	BILLING POLICY No. 204
Nutrition Counseling, Education and Therapy	
Date of origin: 07/26	**Review dates: MM/YY**

DEFINITION

This policy outlines billing and payment requirements associated with nutrition counseling, education, and therapy.

- Nutrition education/counseling is defined as general education classes or counseling provided in-home or in an outpatient setting by a registered dietitian.
- Medical Nutrition Therapy (MNT) is a form of treatment that uses nutrition education and counseling provided by registered dietitian nutritionists (RDNs) or Registered dietitians (RDs) to prevent or manage health conditions.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Nutrition counseling, education and therapy visit coverage

There is no longer a six-visit limit for preventive dietitian visits. Members can have more than six visits covered in full as a preventive health care guideline; deductible does not apply. This change applies to FF and SF groups.

Medicare and commercial coverage

Nutrition education/counseling benefit:

- Provided in-home or in an outpatient setting by a registered dietitian
- Available to members with diabetes or renal disease diagnosis

Medical Nutrition Therapy (MNT) benefit:

- Three hours of total administration for the first year a beneficiary receives nutrition education/counseling, with either a diagnosis of renal disease or diabetes. Basic coverage in subsequent years for renal disease or diabetes is two hours. The registered dietitian/nutritionist may choose how many units are administered per day as long as all of the other requirements are met. Additional hours are medically necessary and covered if the physician determines that there's a change in medical condition, diagnosis or treatment regimen that requires a change in nutrition education/counseling and orders additional hours during that episode of care.
- Limited to people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by the physician

For Medicare, nutrition education/counseling is a supplemental benefit separate from the covered medical nutrition therapy preventive services benefit.

Note: Medical nutrition therapy allowed units per benefit year is cumulative to additional conditions that are outlined in the policy for diabetes education programs.

Nutrition counseling, education and therapy visit authorizations

Members across all lines of business must be referred by the physician overseeing their diabetes care.

Nutrition counseling, education and therapy billing

Payable when billed by:

- Participating hospitals/facilities: Report with revenue code 0942 on the UB04.
- Participating home care agencies: Report with revenue code 0589 on the UB04.
- Registered dietitians billing under the supervising physician in the provider office setting: Report with the AE modifier.
- Health departments

Medical nutrition therapy (MNT) must be provided by a registered or licensed dietitian.

Coding specifics

For fully funded, self-funded and MyPriority® commercial members and for Priority Health Choice (Healthy Michigan Plan and Medicaid) members, these codes are accepted for medical nutrition therapy, nutrition education, and nutrition counseling.

For Medicare, these codes are accepted for medical nutrition therapy only.

- 97802: Initial one-on-one with the patient, 15 minutes
- 97803: Follow-up one-on-one with the patient, 15 minutes
- 97804: Group session, 30 minutes or more
- G0270: 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: 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 (2 or more individuals), each 30 minutes

For Medicare, these codes are accepted for nutrition education/counseling:

- S9452: Nutrition classes, non-physician provider, per session
- S9470: Nutritional counseling, dietician visit

One unit is payable per date of service when S codes are billed.

Units billed

Units billed should total the time spent. Example: For 30-minute visits, bill 2 units.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Resources

- PH Provider Manual- Nutrition counseling, education and therapy

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
July 2026	Billing policy created from PH Provider Manual Page.