Clinical Policy: Dietary Evaluation and Counseling and Medical Lactation Services

Reference Number: WNC.CP.210
Last Review Date: 08/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Dietary Evaluation and Counseling offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease-related dietary evaluation and counseling.

Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover dietary evaluation and counseling for beneficiaries when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management, including **any one** of the following:

- A. Inappropriate growth or 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 (phenylketonuria (PKU), galactosemia) and endocrine disorders such as diabetes;
- I. Non-healing wounds due to chronic conditions;
- J. Acute burns over significant body surface area;
- K. Metabolic Syndrome; **or**
- L. Documented history of a relative of the first degree with cardiovascular disease 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.

II. WellCare of North Carolina® shall cover 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 **any one** of 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 [Hemoglobin (HgB) less than 10m/dl or Hematocrit (Hct) less than 30].
   2. Preconceptionally underweight (less than 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; **or**
   7. Substance use.

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. Body Mass Index (BMI) greater than 30 in same woman pre-pregnancy and postpartum.
   2. BMI greater than 35 at 6 weeks of pregnancy; **or**
   3. BMI greater than 30 at 12 weeks of pregnancy. **OR**

G. Documented history of a relative of the first degree with cardiovascular disease 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.

III. WellCare of North Carolina® shall cover a lactation evaluation and breastfeeding counseling when the breastfeeding infant has a chronic, episodic, or acute condition for which medical lactation services are a critical component of medical management.
These services include an individualized assessment and counseling when the breastfeeding infant:

A. Has latch-on difficulties;

B. Is premature;

C. Is a multiple birth;

D. Requires breastmilk and the mother-infant dyad needs assistance in the continuation of breastfeeding;

E. Is a special-needs infant (such as Down Syndrome, cleft lip or palate or other congenital deformity affecting feeding);
F. Jaundice;
G. Dehydration and difficulty with weight gain; **or**
H. Inadequate weight gain or inappropriate weight loss.

IV. WellCare of North Carolina® **shall not** cover group medical lactation services under this policy.

Background[1]

The *Dietary Evaluation and Counseling* initial assessment and intervention for a beneficiary 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**. Dietary evaluation and counseling must be provided as an individual, face-to-face encounter with the beneficiary or the beneficiary's caretaker.

Medical Lactation services are limited to a maximum of **six (6) units per day** with a **maximum of thirty-six (36) lifetime units**. This service must be provided as an individual, face-to-face encounter with the mother-infant dyad. Billing shall be applied to the infant.

I. Provider Qualifications
A. Dietary evaluation and counseling services
1. Dietitian or Nutritionist, currently licensed by the N.C. Board of Dietetics and Nutrition (provisional license is not acceptable);
2. Registered Dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable);
B. Medical lactation services
1. Physicians, Certified Nurse Midwives (CNMs), Nurse Practitioners (NPs), Physician Assistants (PA's); **or**
2. International Board-Certified Lactation Consultant (IBCLC) consultants who are either employed or contracted by the physician or physician group or have a referral for an IBCLC consult in another medical practice.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes - All Telehealth Eligible Services	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
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

HCPCS ®* Codes	Description
No applicable codes.	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
See https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/dietary-evaluation-and-counseling-and-medical-lactation-services-clinical-coverage-policy for a list of applicable diagnosis codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	05/21
Reviewed CPT codes.	09/21	11/21
Annual review. CPT codes verified.	09/22	09/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. CPT codes reviewed.	08/23	08/23

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1-I Dietary Evaluation and Counseling and Medical Lactation Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published December 1, 2020. Accessed June 1, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid 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.

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.

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: https://medicaid.ncdhhs.gov/

Provider(s) 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 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.

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 NC Medicaid'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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, 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.
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.

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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.