Academy of Nutrition and Dietetics
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April 23, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar and Administrator Verma:

The Academy of Nutrition and Dietetics (the "Academy") commends you for the steps taken thus far to exercise the authority granted to you by Congress and the President under the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security (CARES) Act to "temporarily waive or modify application of certain Medicare requirements with respect to telehealth services furnished during certain emergency periods." Representing more than 107,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of nutrition and dietetic professionals in the United States. Our members provide essential medical and professional services in the clinical and community settings that improve the nutritional status of Americans and help prevent and manage chronic conditions that place them at high risk during this pandemic.

The current national emergency and mandates to practice social distancing and shelter at home exacerbate previously existing concerns, as well as create new ones, around Medicare beneficiary access to safe, effective nutrition care services provided by RDNs. We propose for your consideration the following recommendations that conform with current health care practices and existing federal recommendations by facilitating telehealth and the streamlined provision of care without expanding covered services or increasing costs. They align with current efforts to put patients over paperwork, to help the U.S. healthcare system address the COVID-19 patient surge, and to keep patients safe and healthy at home.

<u>Facilitate Access to Care in FQHCs</u>

Allow FQHCs to deliver and receive payment for group services (such as diabetes self-management training) **via telehealth**. Existing regulations[1] exclude group diabetes self-management training (DSMT – G0109) as a qualifying service for new or established patients. During this public health emergency, when FQHCs are dealing with potential

[1] https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf.

provider shortages, any effort to introduce efficiencies in the delivery of care will reduce burden on the already strained healthcare system. Also, the ability to offer group services via telehealth may improve the mental health for seniors isolated at home.

Allow FQHCs to bill separately from their qualifying visit HCPCS codes for new and established patients for medical nutrition therapy (MNT) and DSMT services provided on the same day as another billable visit. Existing regulations[2] do not allow these qualified FQHC visits to be billed if these services are furnished on the same day as an otherwise billable visit. As care for FQHC patients shifts to the home setting and some FQHC practitioners may also be shifting their location of service to their homes, such temporary flexibility would reduce the administrative burden for FQHCs to track services being furnished on the same day for billing purposes.

Allow phone-only telehealth when audio/video telehealth is not possible
For the duration of this public health emergency, allow all services on the list of Medicare telehealth services to be delivered via audio only (e.g., via phone) rather than audio/video if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met. While audio/video remains the optimal method for delivering telehealth, this requirement can pose a barrier in rural areas where limited internet bandwidth may not accommodate audio/video communication and for any seniors who are practicing social distancing and cannot independently operate audio/video technologies. Without such flexibility, seniors are losing access to benefits to which they are entitled. A precedent has already been set under current waivers for counseling and therapy services provided as part of opioid treatment programs.

Clarify supervision requirements for certain limited incident-to billing
To enable Medicare beneficiaries' continuing access to the 26 sessions of intensive behavioral therapy for obesity, clarify requirements for real-time audio-video supervision by the billing physician. Section U.3. of CMS-1744-IFC[3] published on March 30, 2020 notes, "to the extent NCDs and LCDs require a physician or physician specialty to supervise other practitioners, professionals or qualified personnel, the chief medical officer of the facility can authorize that such supervision requirements do not apply during the PHE for the COVID-19 pandemic." We believe this provision would remove the burdensome requirements of real-time audio/video supervision by physicians (who recognize RDNs should independently be providing these services) and ensures it will still be practicable for beneficiaries to continue to access the cost-effective and clinically effective IBT services they receive from RDNs that conform to the manner in which these services are provided. We ask CMS to confirm our interpretation of this provision for both the facility and non-facility (i.e., primary care provider office) settings.

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[2] https://www.govinfo.gov/content/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec405-2463.pdf
[3] https://www.cms.gov/files/document/covid-final-ifc.pdf

Don't penalize patients for not receiving care during a public health emergency
Under current law, services such as intensive behavioral therapy (IBT) for obesity and diabetes self-management training (DSMT) covered under Medicare Part B include clear timeframes in which beneficiaries must receive services and meet weight loss goals to remain eligible for continued services. For DSMT services, hours for the first year of service currently expire one year from the date of the first encounter. For IBT for obesity services, Medicare beneficiaries are required to lose 3 kg (6.6 lbs.) during the first 6 months of treatment to be eligible to continue services for the next 6 months. **For the duration of this public health emergency, CMS should allow "pauses" in DSMT and IBT for obesity services initiated as of March 15, 2020 and flexibilities in eligibility criteria for continuation of services consistent with the temporary changes granted for the Medicare Diabetes Prevention Program**.

Add G2071 to the list of Medicare telehealth services
The current list of Medicare telehealth services[4] includes:

- CPT code 97802 – Medical nutrition therapy, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- CPT code97803 – Medical nutrition therapy, re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- CPT code97804 – Medical nutrition therapy, group (two or more individuals), each 30 minutes
- HCPCS code G0270 – Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen, individual, face-to-face with the patient, each 15 minutes

Absent from this list is HCPCS code G0271 for group medical nutrition therapy reassessment and subsequent intervention(s) for a change in diagnosis, medical condition, or treatment regimen, which is analogous to CPT code 97804. We request HCPCS code G0271 be added to the list of approved Medicare telehealth services to achieve alignment across the family of codes.

Specifically include all Medicare providers in guidance for use of communication technology-based services
In guidance[5] and FAQs[6] released by CMS on telehealth waivers, registered dietitians and nutrition professionals are not specifically listed as Medicare providers for use of G2061-3 (online assessment and management services) and 98966-8 (telephone assessment and management services). We believe the agency's intent when listing eligible Medicare providers was to highlight those providers who are not eligible to provide telehealth services but can provide these communication technology-based services. However, stakeholders (including administrators and billing staff) are interpreting the information

[4] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
[5] https://www.cms.gov/files/document/covid-final-ifc.pdf
[6] https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

published by CMS quite literally and are mistakenly believing that they cannot bill for these services when provided by a registered dietitian. A comprehensive list of eligible providers for these codes would provide much-needed clarity.

Clarify that MNT and DSMT services billed by hospitals for outpatients are included in the 1135 waivers

MNT and DSMT services are included in the list of Medicare telehealth services. Pre-COVID-19, hospital outpatient clinics (Place of Service codes 19 and 22) had been billing and receiving payment from CMS for such services (in-person and via telehealth) under the Medicare Physician Fee Schedule. While there is a lot of information concerning the CMS 1500 and professional fee services, there is minimal information about submitting institutional billing for such services. This lack of previous guidance is now creating confusion under the current waivers. **We urge CMS to issue clear guidance indicating these services are covered under the 1135 waivers when delivered by approved distant site providers and specific instructions on how to submit claims on a UB-04 form.** Medicare beneficiaries with diabetes have been disproportionately affected by the coronavirus. Access to MNT and DSMT via telehealth by all originating and distant site providers is crucial to keeping these individuals healthy and out of over-burdened emergency rooms and hospitals.

Thank you for your careful consideration of the Academy's recommendations to ensure continued access by Medicare beneficiaries to cost-effective nutrition care provided by RDNs via telehealth during this public health emergency. These solutions are designed to meet the Administration's goals and address the health needs of this population. Please do not hesitate to contact Jeanne Blankenship at 312-899-1730 or jblankenship@eatright.org or Marsha Schofield at 312-899-1762 or mschofield@eatright.org with any questions or requests for additional information. Thank you for your efforts to rapidly issue necessary guidance during this unprecedented time.

Sincerely,

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