Medicare Advantage Preferred Provider Organization Enhanced Benefit Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Nutritional Counseling Related to Approved Medical Conditions

Medicare Plus Blue℠
☒ Group
☐ Individual

Approval Date: 02/10/2026
Effective Date: 01/01/2026

Description

Nutritional counseling, or medical nutrition therapy, is comprised of significant, complex dietary instruction that is not available in the primary care physician's office or through community resources such as literature or interactive programs. It is a useful service for members who have significant diseases that affect their nutritional status and overall health. Nutritional counseling is performed by a registered dietician (RD) to provide members with dietary information that promotes health, prevents illness and reduces risk factors.

Medicare Coverage

Original Medicare covers medical nutrition therapy services for members with diabetes or kidney disease, or who've had a kidney transplant in the last 36 months, and their doctor refers them for services. Services may include:

- An initial nutrition and lifestyle assessment
- Individual and/or group nutritional therapy services
- Help managing the lifestyle factors that affect diabetes
- Follow-up visits to check on progress in managing diet

Policy Guidelines

Medicare Plus Blue is a Medicare Advantage Preferred Provider Organization (PPO) Plan, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

After searching the Medicare Coverage Database and other sources of conditions of coverage, it was determined that either Original Medicare does not provide coverage or has restrictions that have been modified or removed for the items/services found in this enhanced benefit policy.

Since Original Medicare limits coverage for nutritional counseling related to approved medical conditions, the scope of the benefit, reimbursement methodology, maximum allowable payment amounts and member cost sharing are determined by Blue Cross groups that select this benefit.

The following is applicable for this enhanced benefit policy:

CPT/HCPCS Codes

CPT/HCPCS Code(s):	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 individual(s)), 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 (two or more individuals), each 30 minutes
S9470	Nutritional counseling, dietitian visit

ICD-10 Codes

ICD-10 Code(s):	Code Description:
F50.00	Anorexia nervosa, unspecified
F50.010	Anorexia nervosa, restricting type mild
F50.011	Anorexia nervosa, restricting type, moderate
F50.012	Anorexia nervosa, restricting type severe
F50.013	Anorexia nervosa, restricting type, extreme
F50.014	Anorexia nervosa, restricting type, in remission
F50.019	Anorexia nervosa, restricting type, unspecified
F50.020	Anorexia nervosa, binge eating/purging type, mild
F50.021	Anorexia nervosa, binge eating/purging type, moderate

F50.022	Anorexia nervosa, binge eating/purging type, severe
F50.023	Anorexia nervosa, binge eating/purging type, extreme
F50.024	Anorexia nervosa, binge eating/purging type, in remission
F50.029	Anorexia nervosa, binge eating/purging type, unspecified
F50.20	Bulimia nervosa, unspecified
F50.21	Bulimia nervosa, mild
F50.22	Bulimia nervosa, moderate
F50.23	Bulimia nervosa, severe
F50.24	Bulimia nervosa, extreme
F50.25	Bulimia nervosa, in remission
F50.9	Eating disorder, unspecified
Z71.3	Dietary counseling and surveillance

Conditions for payment

The table below specifies payment conditions for nutritional counseling related to approved medical conditions.

Conditions for Payment	
Eligible Provider	No provider limitations
Payable Location	No restrictions
Frequency Limits	No restrictions
CPT/HCPCS Code Restriction	97802, 97803, 97804, G0270, G0271, S9470
Diagnosis Restrictions	F50.00, F50.010 – F50.019, F50.020 – F50.029, F50.20 – F50.25, F50.9, Z71.3
Age Restrictions	No restrictions

Medicare Plus Blue Reimbursement

Medicare Plus Blue plan's maximum payment amount for the nutritional counseling related to approved medical conditions benefit is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed amount or the provider's charge, minus the member's cost share. When there is no rate available under Original Medicare, visit our provider portal, Availity Essentials™. Within Secure Provider Resources, click on Medicare Plus Blue PPO Enhanced Benefit Fee Schedule under the Fee

Schedules tab and follow the instructions. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- Medicare Plus Blue providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat-dollar copayment, a percentage coinsurance or a deductible.
- Providers can only collect the appropriate Medicare Plus Blue cost sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the non-covered service.
- Providers may not have members sign an Advance Beneficiary Notice of Noncoverage to accept financial responsibility for noncovered items. If there is any question about whether an item is covered, seek a coverage determination from Medicare Plus Blue before providing the item to the member. If a provider issues a noncovered item to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost-share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. *Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim form.*
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Send your electronic and paper claims to your local Blue Cross plan.
6. Use electronic billing:
    a. **Michigan Providers:** Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835Companion Documents) are available on the Blue Cross website under the reference library section at bcbsm.com/providers/help/edi/.
    b. Providers outside Michigan should contact their local Blue Cross plan.
7. Send paper claims to:
    a. Michigan Providers:

        Blue Cross Blue Shield of Michigan
        Imaging and Support Services
        P.O. Box 32593
        Detroit, MI 48232-0593
    b. Providers outside of Michigan should contact their local Blue Cross plan.

Government Regulations

National:

NCD 180.1: Medical Nutrition Therapy

Local:

Not Applicable

(The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services (CMS) are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, please refer to CMS.gov website.)

References

1. *Medicare Benefit Policy Manual*
    - *Not applicable*
2. *Medicare.gov*
    - *Medical nutrition therapy services*
3. *Medicare Claims Processing Manual*
    - *Chapter 4, section 300 – Medical Nutrition Therapy (MNT) Services*
4. *Related internal Medical Policy*
    - *Not applicable*

Important Reminder

Medicare Advantage Enhanced Benefit Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Enhanced Benefit policies are created when permitted by applicable laws, reviewed regularly, and may be revised periodically. BCBSM/BCN Enhanced Benefit Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation supporting billed claims, including but not limited to applicable medical records.

Disclaimer: This Enhanced Benefit Policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in this Enhanced Benefit Policy. Enhanced benefit policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The Enhanced Benefit Policy is not intended to replace independent medical judgment for treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	BCBSM/BCN Approval Date	Comments
01/01/2026	02/10/2026	Updated diagnosis codes to include F50.010 – F50.019, F50.020 – F50.029, F50.20 – F50.25 effective 01/01/2026. Removed U of M from the title as this is now a group benefit effective 01/01/2026.
01/01/2026	12/09/2026	Transitioned to new template. Approval date reflects date approved by Medicare Advantage Medical Director and/or delegated clinician. No changes made to benefit and payment conditions.