ADA Diabetes Coverage Policy Statement

Registered Dietitians as Preferred Providers for Diabetes Care

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ADA Policy Statement:
Registered dietitians should be designated by third party payers as eligible providers of nutritional diagnostic, therapy and counseling services (Medical Nutrition Therapy) and other self-management education and training interventions for diabetes care. MNT is a cornerstone of diabetes management.

Executive Summary
The Institute of Medicine (IOM) identifies registered dietitians (RDs) as, "currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy"[1]. The American Dietetic Association affirms that registered dietitians are the qualified and preferred provider of nutritional diagnostic, therapy and counseling services (Medical Nutrition Therapy- MNT) and nutrition education for diabetes care. Other health organizations and diabetes groups also recognize the role of RDs and the outcomes achieved through RD-provided interventions for diabetes care[2, 3, 4, 5].

Generalist RDs are trained to provide diabetes MNT and counseling with the focus of improving diabetes outcome measures while delivering safe and effective quality care. RDs at the specialty and advanced level in diabetes care demonstrate expanded and specialized knowledge, skills, and competencies to provide additional diabetes services[6]. The *RD Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care* describe additional education, training and disease management services that RDs provide as a member of the patient's health care team. These tasks typically include:

- Suggesting recommendations to the physician/or healthcare team for adjustment of pharmacotherapy, based on integration of nutrition, physical activity, medication, blood glucose monitoring data and patient preferences, barriers and coping skills (psychological and social factors.
- Application of MNT and coordination of care in the management of the co-morbidities of diabetes.
- Coordination of care and counseling on the receipt of regular tests and screenings to prevent/delay disease progression, consistent with the American Diabetes Association's "Standards of Medical Care in the Treatment of Diabetes Mellitus."
- Selection of equipment and training on self-monitoring of blood glucose (including continuous glucose monitoring), interpretation of the data and recommendations for care plan adjustments.

• Interpretation of other key physical and biochemical health indicators for improved diabetes and co-morbidity management.
• Coordination and provision of ongoing diabetes care support.

RDs utilize a variety of activities to maintain and expand their diabetes expertise including individual or formal study programs, job experience, continuing education, mentoring, advanced practice, and additional certifications. Because of the importance of food choices and the distribution of food in the management of diabetes, and RDs' unique food and nutrition skills, provider qualifications for diabetes care should not be limited to specific certifications, such as the CDE (certified diabetes educator). The CDE credential identifies individuals, such as RDs, who have experience in diabetes care and education, yet this is only one venue that RDs use to demonstrate their expertise in diabetes care. ADA strongly recommends payers to include the Commission on Dietetic Registration credential, Registered Dietitian[7], as the designated provider qualification listed in coverage and payment policies for nutrition and nutrition-related services for diabetes and pre-diabetes care.

Supporting Information:
RD Effectiveness and Qualifications-- Clinical trials and outcomes research have provided evidence on the effectiveness and cost-effectiveness of MNT for diabetes care provided by RDs credentialed through the Commission on Dietetic Registration[2, 3.] RD involvement in diabetes care and education has increased substantially over the past 10 years, and RDs are recognized as integral members of the diabetes care team[3]. RDs providing MNT over an average of three visits for patients with either type 1 or type 2 diabetes mellitus resulted in 1% to 2% decreases in hemoglobin A1C[4, 8]. The Diabetes Prevention Program (DPP) showed that people at risk for developing diabetes can prevent or delay the onset of diabetes by losing a modest amount of weight through diet and exercise. DPP participants in the lifestyle intervention group reduced their risk of developing diabetes by 58 percent during the study[9]. Dietitians played a key role in the overwhelmingly positive DPP[10]. Other studies also describe the critical role that RDs play in achieving positive outcomes in diabetes care[11, 12, 13].

RDs provide high quality nutrition services based on their education, training, evidence-based practice and ongoing continuing education. RDs are uniquely qualified to provide nutrition services for individuals and groups of individuals with diabetes. Additionally, RDs provide wellness and preventive MNT and nutrition education services to delay or reduce the progression of diseases such as pre-diabetes. RDs use a variety of procedure (CPT) codes to report these services (see Attachment 1).

RD Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care-- To provide safe and effective quality diabetes care at the generalist, specialty, and advanced levels, RDs adhere to knowledge, skill and competency guidelines delineated in "The Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care"[6]. The Diabetes Care SOP presupposes that RDs use critical thinking skills and analytical abilities. The three levels of expertise in diabetes care are based on the RD's acquisition and development of diabetes-specific knowledge and skills. The diabetes SOP/SOPP generalist level of care identify RDs as qualified providers of MNT and self-

management skills for persons with diabetes, and identify members of a diabetes care team and benefits of team management.

RDs at the specialty and advanced level in diabetes care practice from both expanded and specialized knowledge, skills, competencies, and experience necessary for the RD to provide safe and effective quality diabetes care[6.] At these levels of practice, the RD has a deeper understanding of diabetes care and is able to apply these principles and modify practice according to the patient's situation. RDs at the specialty and advanced level of practice are uniquely qualified to provide nutrition services for individuals with diabetes utilizing continuous glucose monitoring (CGM) technology. The RD member of the diabetes care team possesses the unique education and practicum training, and reliance on evidence-based practice to assist in the evaluation of the CGM download data relating to the glucose response to meals/snacks to optimize glycemic control. Additionally, at the advanced level of practice, and in accordance with local scope of practice, state licensure, payer policies, and/or facility requirements, RDs may qualify to provide separate and complementary diabetes services to individuals such as training on insulin administration devices.

RDs Provide Diabetes MNT and Nutrition Education-- RDs provide MNT services for individuals with diabetes, as well as nutrition education in independently organized diabetes programs, or as a component of recognized and accredited diabetes self-management training (DSMT) programs. Under the revised National Standards for Diabetes Education (DSME), RDs may serve as the solo program instructor to provide all the program educational content. The Standards specify that the instructors may provide the program content if they "have recent educational and experiential preparation in education and diabetes management…"[14]. The national diabetes standards affirm the RD's role in providing MNT and diabetes education based on their experience base and training as an individual credentialed through the Commission on Dietetic Registration, not other credentials such as the Certified Diabetes Educator. Additional documents also verify the role of the RD as the member of the healthcare team who provides nutrition therapy.

According to the American Diabetes Association's *Standards of Medical Care in Diabetes—2008*, "Achieving nutrition-related goals requires a coordinated team effort that includes the active involvement of the person with pre-diabetes or diabetes. Because of the complexity of nutrition issues, it is recommended that a registered dietitian who is knowledgeable and skilled in implementing nutrition therapy into diabetes management and education be the team member who provides MNT"[3]. Similarly, a registered dietitian is recommended to be the team member who provides the nutrition education component of the DSMT curriculum[15].

RDs Recognized as Providers of Billable MNT Services-- Many third party payers, including Medicare, identify the RD as the qualified provider for MNT services for diabetes. CMS' regulations delineating "Professional Standards for Dietitians and Nutritionists"[16] indicate:
For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

• Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
• Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
• Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

Conclusion

Based on the evidence listed above, the ADA believes the CDE credential should not be required for RDs to receive reimbursement for their services. RDs play a crucial role in the management of diabetes as well as in the prevention of diabetes. RDs adhere to the SOP/SOPP in diabetes care, and apply evidence-based nutrition interventions to ensure a continued, high level of performance and quality of care. The education and training and attainment of the RD credential, verified by successful completion of the RD credentialing examination, should serve as the basis for dietitian provider qualifications for MNT and other diabetes education services by payers.

[1] IOM, The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population. Jan. 1, 2000.
[2] American Diabetes Association. Standards of Medical Care in Diabetes-2009. Diabetes Care 2009; 32(Suppl 1):S13-S61.
[3] American Diabetes Association. Standards of Medical Care in Diabetes-2008. Diabetes Care. 2008; 31(Suppl 1):S12-S54.
[4] Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med. 1993; 329(14):977-986.
[5] Pastors JG, Franz MJ, Warshaw H, Daly A, Arnold MS. How effective is medical nutrition therapy in diabetes care? J Am Diet Assoc. 2003; 103(7):827-831.
[6] Kulkarni K, Boucher JL, Daly A, Shwide-Slavin C, Silvers BT, O'Sullivan Maillet J, Pritchett E, American Dietetic Association. American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care. J Am Diet Assoc. 2005;105(5):819-824.
[7] In addition to the RD credential, applicable state licensure or certification designations apply for payer provider credentialing criteria for MNT and diabetes education services.
[8] ADA Evidence Analysis Library; MNT effectiveness for diabetes. Accessed at: http://www.adaevidencelibrary.com/conclusion.cfm?conclusion_statement_id=250190.
[9] Knowler WC, Barrett-Connor E, Fowler SE, Hamman RF, Lachin JM, Walker EA, Nathan DM; Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002;346(6):393-403.
[10] Wylie-Rosett J, Delahanty L. An Integral Role of the Dietitian: Implications of the Diabetes Prevention Program. J Am Diet Assoc 2002;102(8):1065-1068.
[11] Delahanty L, Simkins S, Camelon K, The Expanded Role of the Dietitian in the Diabetes Control and Complications Trial (DCCT): Implications for Clinical Practice. J Am Diet Assoc.1993; 93:758-764, 767.
[12] Delahanty L, Halford B, The Role of Diet Behaviors in Achieving Improved Glycemic Control in Intensively Treated Patients in the Diabetes Control and Complications Trial (DCCT): Diabetes Care. 1993; 16(11):1453-1458.
[13] Delahanty LM, Nathan DM. Research Navigating the Course of Clinical Practice in Diabetes. J Am Diet Assoc. 2004; 104:1846-1853.
[14] Funnell MM, Brown TL, Childs BP, Haas LB, Hosey GM, Jensen B, Maryniuk M, Peyrot M, Piette JD, Reader D, Siminerio LM, Weinger K, Weiss MA. National standards for diabetes self management education. Diabetes Care. 2007;30(6):1630-37.
[15] American Dietetic Association Diabetes White Paper – Defining the delivery of nutrition services in Medicare MNT versus Medicare DSMT programs, accessed from: www.eatright.org/adadmwhitepaper.
[16] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual: Chapter 4–Part B Hospital, Section 300. http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf.

Attachment 1

Frequently used CPT codes by RDs for diabetes services

Medical Nutrition Therapy

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

Diabetes Self-Management Training

G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Education and Training

98960 - Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

98961 - Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients

98962 - Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients

Continuous Glucose Monitoring

95250 - Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording