PROVIDER POLICIES & PROCEDURES

MEDICAL NUTRITION THERAPY

The primary purpose of this document is to assist providers with the information needed to support a medical necessity determination for medical nutrition therapy (MNT). By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Medical nutrition therapy (MNT) is a form of treatment that uses nutrition-based education and behavioral counseling to prevent or manage an acute or chronic medical condition.

Note:

- MNT must be provided by a dietitian-nutritionist who is enrolled in the Connecticut Medical Assistance Program (CMAP) and certified by the Connecticut Department of Public Health (CT DPH).
- Coverage of MNT is limited to three (3) hours per calendar year per HUSKY Health member. The initial assessment (CPT code 97802) is included in these three (3) hours.
- ***Prior authorization is only needed for MNT services beyond the initial three (3) hours per calendar year.***

Please refer to the Connecticut Department of Social Services (DSS) Provider Bulletin *PB 2025-18: New Coverage of Medical Nutrition Therapy (MNT) f*or additional details on coverage requirements for medical nutrition therapy provided by certified dietitian-nutritionists.

CLINICAL GUIDELINE

Coverage guidelines for MNT services are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

An additional three (3) hours (for a maximum of (6) six hours total) per calendar year of MNT services (CPT Codes 97803, 97804) may be considered medically necessary when:

A. The services will be provided by a CMAP enrolled, CT DPH certified dietitian-nutritionist; and
B. A CMAP enrolled physician or other licensed practitioner* has ordered/referred the individual for MNT services; and
C. The individual has a diagnosis on *Table 26: List of Diagnosis Codes for MNT Services* on the DSS Fee Schedule Instructions; and
D. One of the following scenarios is present:
    1. The individual is experiencing an exacerbation or worsening of symptoms related to the diagnosis that meets *criteria point C* above; or

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

2. The individual has had a recent hospitalization or readmission related to nutritional status; or
3. The individual has a cognitive disorder that delays processing of information related to their diagnosis and/or nutritional intake; and

E. There is a documented plan of care listing problems, measurable goals, and interventions; and
F. Visit notes indicate the interventions performed at each visit and progress towards goals; and
G. There is documentation in the medical records supporting the need for an additional three (3) hours of MNT.

*Licensed practitioner: an advanced practice registered nurse (APRN), certified nurse midwife (CNM), or physician assistant (PA)

Not Medically Necessary
MNT for conditions other than those on *Table 26: List of Diagnosis Codes for MNT Services* on the DSS Fee Schedule Instructions are not medically necessary.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of MNT services beyond the initial three (3) hours per calendar year is required. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for MNT services:

1. Fully completed authorization request via fax;
2. Fully completed *Medical Nutrition Therapy Services Prior Authorization Request Form;*
3. Referral/order from a CMAP enrolled physician or other licensed practitioner* written within the past three (3) months*;*
4. Plan of care that includes measurable, short- and long-term goals, and interventions;
5. Notes from all previous visits documenting interventions performed at each visit and patient response; and
6. A signed and dated clinical note from the certified-dietitian nutritionist supporting the medical necessity of MNT as outlined in the *Clinical Guideline* section of this policy.

*Licensed practitioner: an advanced practice registered nurse (APRN), certified nurse midwife (CNM), or physician assistant (PA)

EFFECTIVE DATE

This policy for the prior authorization of MNT services for individuals covered under the HUSKY Health

Program is effective November 1, 2025.

LIMITATIONS
N/A

CODES:

Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; reassessment 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

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her

medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

- Connecticut Department of Social Services (DSS) Provider Bulletin PB 2025-11: Certified Dietitian-Nutritionist Enrollment Criteria
- Connecticut Department of Social Services (DSS) Provider Bulletin PB 2025-18: New Coverage of Medical Nutrition Therapy, dated June 2025.

PUBLICATION HISTORY

Status	Date	Action Taken
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