

## §410.110

(c) *Plan of treatment.* (1) The service must be furnished under a written plan of treatment that—

(i) Is established and signed by a physician before treatment is begun; and

(ii) Prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals.

(2) The plan must be reviewed at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy and speech-language pathology services by a facility physician or the referring physician who, when appropriate, consults with the professional personnel providing the services.

(3) The reviewing physician must certify or recertify that the plan is being followed, the patient is making progress in attaining the rehabilitation goals, and the treatment is having no harmful effects on the patient.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8841, Mar. 1, 1991; 72 FR 66400, Nov. 27, 2007]

## Subpart E—Community Mental Health Centers (CMHCs) Providing Partial Hospitalization Services

### §410.110 Requirements for coverage of partial hospitalization services by CMHCs.

Medicare part B covers partial hospitalization services furnished by or under arrangements made by a CMHC if they are provided by a CMHC as defined in §410.2 that has in effect a provider agreement under part 489 of this chapter and if the services are—

(a) Prescribed by a physician and furnished under the general supervision of a physician;

(b) Subject to certification by a physician in accordance with §424.24(e)(1) of this subchapter; and

(c) Furnished under a plan of treatment that meets the requirements of §424.24(e)(2) of this subchapter.

[59 FR 6577, Feb. 11, 1994]

## Subpart F [Reserved]

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### Subpart G—Medical Nutrition Therapy

SOURCE: 66 FR 55331, Nov. 1, 2001, unless otherwise noted.

#### §410.130 Definitions.

For the purposes of this subpart, the following definitions apply:

*Chronic renal insufficiency* means the stage of renal disease associated with a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 13–50 ml/min/1.73m<sup>2</sup>).

*Diabetes* means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

*Episode of care* means services covered in a 12-month time period when coordinated with initial diabetes self-management training (DSMT) and one calendar year for each year thereafter, starting with the assessment and including all covered interventions based on referral(s) from a physician as specified in §410.132(c). The time period covered for gestational diabetes extends only until the pregnancy ends.

*Medical nutrition therapy services* means nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or a renal disease.

*Physician* means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section of 1101(a)(7) of the Act).

*Renal disease* means chronic renal insufficiency, end-stage renal disease when dialysis is not received, or the medical condition of a beneficiary for 36 months after kidney transplant.

*Treating physician* means the primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.

[66 FR 55331, Nov. 1, 2001, as amended at 68 FR 63261, Nov. 7, 2003]

**§ 410.132 Medical nutrition therapy.**

(a) *Conditions for coverage of MNT services.* Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by the treating physician. Except as provided at § 410.78, services covered consist of face-to-face nutritional assessments and interventions in accordance with nationally-accepted dietary or nutritional protocols.

(b) *Limitations on coverage of MNT services.* (1) MNT services based on a diagnosis of renal disease as described in this subpart are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.

(2) A beneficiary may only receive the maximum number of hours covered under the DSMT benefit for both DSMT and MNT during the initial DSMT training period unless additional hours are determined to be medically necessary under the national coverage determination process.

(3) In years when the beneficiary is eligible for MNT and follow-up DSMT, the beneficiary may only receive the maximum number of hours covered under MNT unless additional hours are determined to be medically necessary under the national coverage determination process.

(4) If a beneficiary has both diabetes and renal disease, the beneficiary may only receive the maximum number of hours covered under the renal MNT benefit in one episode of care unless he or she is receiving initial DSMT services, in which case the beneficiary would receive whichever is greater.

(5) An exception to the maximum number of hours in (b)(2), (3), and (4) of this section may be made when the treating physician determines that there is a change of diagnosis, medical condition, or treatment regimen related to diabetes or renal disease that

requires a change in MNT during an episode of care.

(c) *Referrals.* Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease as defined in this subpart with documentation maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and any additional assessments or interventions required by a change of diagnosis, medical condition, or treatment regimen during an episode of care.

[66 FR 55331, Nov. 1, 2001, as amended at 72 FR 66400, Nov. 27, 2007]

**§ 410.134 Provider qualifications.**

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means an individual who, on or after December 22, 2000:

(a) 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 accredited by an appropriate national accreditation organization recognized for this purpose.

(b) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(c) 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 of paragraphs (a) and (b) of this section.

(d) *Exceptions.* (i) A dietitian or nutritionist licensed or certified in a State as of December 21, 2000 is not required to meet the requirements of (a) and (b) of this section.

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(ii) A “registered dietitian” in good standing, as recognized by the Commission of Dietetic Registration or its successor organization, is deemed to have met the requirements of (a) and (b) of this section.

[66 55331, Nov. 1, 2001; 67 FR 20684, Apr. 26, 2002]

### Subpart H—Outpatient Diabetes Self-Management Training and Diabetes Outcome Measurements

SOURCE: 65 FR 83148, Dec. 29, 2000, unless otherwise noted.

#### §410.140 Definitions.

For purposes of this subpart, the following definitions apply:

*ADA* stands for the American Diabetes Association.

*Approved entity* means an individual, physician, or entity accredited by an approved organization as meeting one of the sets of quality standards described in §410.144 and approved by CMS under §410.141(e) to furnish training.

*Deemed entity* means an individual, physician, or entity accredited by an approved organization, but that has not yet been approved by CMS to furnish and receive Medicare payment for the training. Upon being approved by CMS under §410.141(e) to furnish training, CMS refers to this entity as an “approved entity”.

*Diabetes* means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

*NSDSMEP* stands for the National Standards for Diabetes Self Management Education Programs.

*Organization* means a national accreditation organization.

*Rural* means an area that meets one of the following conditions:

(1) Is not urbanized (as defined by the Bureau of the Census) and that is des-

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ignated by the chief executive officer of the State, and certified by the Secretary, as an area with a shortage of personal health services.

(2) Is designated by the Secretary either as an area with a shortage of personal health services or as a health professional shortage area.

(3) Is designated by the Indian Health Service as a health service delivery area as defined in §36.15 of this title.

*Training* means outpatient diabetes self-management training.

[65 FR 83148, Dec. 29, 2000, as amended at 68 FR 63261, Nov. 7, 2003]

#### §410.141 Outpatient diabetes self-management training.

(a) *General rule.* Medicare Part B covers training defined in §410.140 if all of the conditions and requirements of this subpart are met.

(b) *Conditions for coverage.* The training must meet the following conditions:

(1) *Training orders.* Following an evaluation of the beneficiary’s need for the training, it is ordered by the physician (or qualified nonphysician practitioner) (as defined in §410.32(a)) treating the beneficiary’s diabetes.

(2) *Plan of care.* It is included in a comprehensive plan of care established by the physician (or qualified nonphysician practitioner) treating the beneficiary for diabetes that meets the following requirements:

(i) Describes the content, number of sessions, frequency, and duration of the training as written by the physician (or qualified nonphysician practitioner) treating the beneficiary.

(ii) Contains a statement specified by CMS and signed by the physician (or qualified nonphysician practitioner) managing the beneficiary’s diabetic condition. By signing this statement, the physician (or qualified nonphysician practitioner) certifies that he or she is managing the beneficiary’s diabetic condition and the training described in the plan of care is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage the beneficiary’s diabetes. The physician’s (or qualified nonphysician practitioner’s) statement must identify the beneficiary’s specific medical conditions