

September 6, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1700-P  
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Re: File Code-CMS-1700-P; Medicare Program; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

Dear Administrator Brooks-LaSure:

The Academy of Nutrition and Dietetics (the “Academy”) is pleased to provide comments on File Code-CMS-1700-P published in the Federal Register on July 29, 2022. Representing more than 112,000 registered dietitian nutritionists (RDNs),<sup>1</sup> nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of nutrition and dietetics practitioners committed to accelerating improvements in global health and well-being through food and nutrition. RDNs independently provide professional services such as medical nutrition therapy (MNT)<sup>2</sup> under Medicare Part B and are recognized as Eligible Clinicians (ECs) and Qualified APM Participants (QPs) in Medicare’s Quality Payment Program. RDNs provide high quality, evidence-based care to patients and deliver substantial cost-savings to the health care system.

The Academy supports changes proposed in the payment policies under the Physician Fee Schedule and applauds continued efforts by CMS to work within their regulatory power to fine-tune policies that will support access to and delivery of safe, equitable and effective health care. With that in mind, the Academy offers specific comments on the following proposed rule items:

1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D)
2. Valuation of Specific Codes (Section II.E)
3. Request for Information:
  - a. (36) Medicare Part B Payment for Services Involving Community Health Workers (CHWs)
  - b. (38) Medicare Potentially Underutilized Services
4. Determination of Professional Liability Insurance (PLI) Relative Value Units (RVUs) (Section II.H.)
5. Chronic Pain Management (Section III.C.2.)
6. Updates to the Quality Payment Program (Section IV.)

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<sup>1</sup> The Academy has approved the optional use of the credential “registered dietitian nutritionist (RDN)” by “registered dietitians (RDs)” to more accurately convey who they are and what they do as the nation’s food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

<sup>2</sup> Medical Nutrition Therapy (MNT) is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. **Academy of Nutrition and Dietetics’ Definition of Terms list** updated February 2021. Accessed August 11, 2022.

## **1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D)**

### **a. Expiration of PHE Flexibilities for Direct Supervision Requirements**

The Academy continues to appreciate the work CMS has done to support both Medicare beneficiaries and providers during the public health emergency. In particular, the flexibilities related supervision requirements (direct supervision) during the PHE which allowed the supervising physician (or other supervising practitioner) the ability to be available through audio/video communications technology has been an undeniably crucial flexibility that allowed more beneficiaries to either gain or maintain access to care. We still echo CMS's rationale that confirms "individual practitioners were [and still are] in the best position to make decisions about how to meet the requirement to provide appropriate direct supervision based on their clinical judgment in particular circumstances."<sup>3</sup> The Academy believes this not only provided better access to care for beneficiaries but also supported the delivery of timely, cost-effective care. **The Academy is in support of CMS permanently allowing supervising physicians the ability to provide direct supervision via audio/video communication when necessary or clinically appropriate, as is the case when RDNs or other qualified health care providers deliver services such as the intensive behavioral therapy for obesity service.**

The 2010 NCD for intensive behavioral therapy (IBT) for obesity services is one important example of where this decision can achieve CMS's goal of continued access to high quality, cost-effective care while keeping patients and providers safe. Under CMS's current interpretation, RDNs must provide IBT for obesity under direct supervision of primary care providers in primary care settings. While RDNs providing IBT for obesity "incident to" remains a barrier, the flexibility that allowed for direct supervision through virtual presence greatly removed the burdensome requirement for real-time audio/video by physicians (who, in surveys and evidenced by the support of the American Medical Association, recognize RDNs should independently be providing these services) and ensures it will still be practicable for beneficiaries to access the full 22 sessions of the cost-effective and clinically-effective IBT services provided by RDNs. Access to direct supervision via audio/video communication has reduced barriers that limited beneficiary access to IBT for obesity services. This flexibility has also supported programs which in the past struggled to deliver services and meet the stringent supervision requirements. Academy member feedback reported improved compliance, improved patient satisfaction, and most importantly, they reported that beneficiaries had documented desirable weight loss.

## **2. Valuation of Specific Codes (Section II.E.4)**

### *(29) Caregiver Behavior Management Training (CPT codes 96X70 and 96X71)*

The Academy appreciates CMS's interest and recognition of the important role that caregivers play in supporting the health and well-being of Medicare beneficiaries. We are also in support of the RUC's work in developing the Caregiver Behavior Management Training CPT codes 96X70 and 96X71 as the rationale behind these codes is to support the necessary services that many beneficiaries require in order to improve clinical outcomes related to the primary diagnosis and care plan.

The Academy echoes comments submitted by the American Psychological Association (APA) that this code family primarily benefits the patients as they are necessary to report the behavioral management/modification training provided to multiple-family groups of parent(s)/caregiver(s) (without the patient present) of a patient with a mental or physical health diagnosis. These codes allow for reporting the physician/QHP work and/or time associated with the parent/caregiver training that are performed in tandem with the diagnostic and intervention services rendered directly to the "identified patient" that support the patient's optimal level of function.

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<sup>3</sup> Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021. <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>

We further align our comments through our shared belief that the interpretation of the Social Security Act at section 1862(a)(1)(A) is too narrow and we encourage CMS to acknowledge that there are scenarios where training, instruction or intervention is delivered to a beneficiary by way of caregiver who is able to adequately interpret and act upon the information in accordance with the clinical treatment plan. And, in the absence of such an individual, there is a risk that compliance to the treatment plan will be low, which will ultimately result in poor clinical outcomes.

Academy member feedback illustrated numerous times where the nutrition care was delivered to a beneficiary by way of a caregiver; below are two such vignettes:

*An evidence-based pediatric weight management program operating in a community-based setting includes a mixture of child/parent joint education and parent-only sessions. The parent-only sessions focus on topics that would be inappropriate or even harmful for the children to be present for such challenges that the parents face with affording healthy foods or safety concerns they have about the playgrounds in their neighborhood.*

*A dietitian and a speech language pathologist working in a neurology practice offer group education classes for caregivers of people who have suffered a stroke that resulted in chewing/swallowing difficulties. The classes focus on creating meals that comply with the International Dysphagia Diet Standardisation Initiative Framework for modified texture diets/liquids while also meeting the patient's nutritional needs to promote stroke recovery and prevent future strokes*

There are ample scenarios and evidence supporting the efficacy and effectiveness of direct intervention with the caregiver(s) of children, adolescents and adults to improve symptoms, functioning, adherence to treatment, and general welfare related to the patient's primary clinical diagnoses. As such, **we urge CMS to consider implementing payment for these important services under the PFS for CY 2023 and accept the initial RUC recommendations of a work RVU of 0.43 for CPT code 96X70 and a work RVU of 0.12 for CPT code 96X71.**

### **3. Request for Information**

#### *(36) Medicare Part B Payment for Services Involving Community Health Workers*

Whether an officially recognized position in the community or not, Community Health Workers (CHW) play an integral role in supporting communities health and wellbeing. In 2002, National Academy of Medicine (formerly the Institute of Medicine), stated that "community health workers offer promise as a community-based resource to increase racial and ethnic minorities' access to healthcare and to serve as a liaison between healthcare providers and the communities they serve."<sup>4</sup> The reports further recommended the use of CHWs among programs available to the medically underserved and racial and ethnic minority populations.<sup>5</sup>

CHWs are often an influential and trusted member of the community, they possess an understanding of the community culture and the challenges faced. Because of that level of camaraderie, community members in need of assistance (transportation, food security concerns, housing concerns) may be more open to questions about or accepting assistance from CHW versus a "traditional" health care provider. **The Academy believes that CHWs serve a vital role throughout the continuum of care and see their**

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<sup>4</sup> Smedley BD, Stith AY, Nelson AR eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, D.C.: Institute of Medicine; 2002.

<sup>5</sup> Anthony, S et al. Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council.. December 2009.

**value in supporting health equity, specifically as it relates to nutrition care.** Individuals living with nutrition-related chronic conditions do so in their own respective communities, not in a clinical or hospital-based setting.

In line with CMS's findings, Academy member feedback regarding the use of CHWs is highly varied as it relates to educational training and/or certification for CHWs, who employs CHWs, and what services are delivered by CHWs. There are however some commonalities among our member feedback as listed below.

### Scope

Member responses indicated that CHWs are used to conduct outreach on a variety of topics related to disease management and prevention. Many institutions have protocols where CHWs are able to place a referral to a health provider (e.g. RDNs and Licensed Clinical Social Workers). Other member feedback reported that CHWs were instrumental in vaccination efforts, accessing social services and assisting patient with following treatment plans. Conversely, there are also occurrences where CHWs are working beyond their professional scope. The Academy recognizes that without proper supervision, there may be frequent incidents where incorrect nutrition information and advice is provided that is detrimental to beneficiary health.

### Supervision

Overall member feedback showed agreement of the need for some level of supervision for CHWs. The supervision requirements appear more "general" in nature as the intent of the CHW service is to take place in the community and or home. However, Academy members also reported that CHWs had access to the health care provider via secure messaging. Some feedback did link direct supervision requirements with reimbursement, particularly as it related to direct oversight of treatment (e.g. administering medications such as metformin or insulin).

### Payment for Services and Certification

Adequate reimbursement for CHWs was a common challenge shared among many members. Of those who are submitting claims for CHW services, they report very low reimbursement which makes it difficult to maintain the service. Some programs have been able to utilize grant funding to support CHWs, but financial sustainability remains a concern. One commenter reported that a main barrier to billing for the service is that it is difficult to capture the breadth of services that CHWs are delivering as the available billing codes do not match the value of the service being provided.

Nearly all member feedback reported that the CHW must obtain some level of certification and training before working with patients. While no feedback spoke against this requirement, some did acknowledge that the cost of obtaining the certification is a barrier for some individuals as many CHWs or soon-to-be CHWs are facing the same health disparities challenges of those whom they are trying to help.

The Academy's stance relating to Medical Nutrition Therapy is:

*“Medical nutrition therapy should only be provided by a registered dietitian nutritionist or by another evidence-based health care provider with knowledge and competencies commensurate to that obtained through the specialized education and training of registered dietitian nutritionists. Recognizing the inherent risk of harm when MNT is provided by unqualified or incompetent practitioners, nearly all state legislatures established minimum standards for obtaining a license to practice dietetics and nutrition and authorization to provide medical nutrition therapy. With notable exceptions, states only issue licenses authorizing the provision of MNT to individuals meeting either the exacting requirements for the RDN credential or a sufficiently rigorous combination of education, experience, and examination requirements; thus, most state-licensed dietitians and dietitian nutritionists can be deemed qualified to provide MNT.”*

Furthermore, “*certain health care professions, such as physicians, that have broad scopes of practice and an inherent legal authorization to provide medical nutrition therapy should recognize any limitations of their education and training relevant to nutrition care and defer to qualified providers as appropriate. With notable exceptions, these high-level practitioners, in addition to lay providers such as health or wellness coaches and other health care practitioners without the requisite education, experience and competencies, should refer patients and clients to an RDN for nutrition care services that might impact, treat or manage a disease or medical condition.*”

As such, **the Academy believes that with adequate training and under the supervision of qualified health care providers, such as an RDN, CHWs are capable of and should be utilized in the delivering a variety of services that support nutrition care.** The United States Agency for International Development released its “Community Health Worker Competency List for Nutrition Social and Behavior Change,”<sup>6</sup> addressing key areas of knowledge and skill that community workers with Nutrition Programs should possess. This just one example and the Academy urges CMS to consider establishing standardized qualifications for the essential service.

### *(38) Medicare Potentially Underutilized Services*

The Academy commends CMS’s actions aimed at looking for ways to increase utilization for the many high-value but vastly under-utilized Medicare benefits that not only promote beneficiary health and wellbeing but are also cost-effective. As we asserted in past comments,<sup>7,8</sup> a major barrier to many of these underutilized benefits is access. While lack of access is multi-factorial, benefit design is the common factor that affects access. Antiquated benefit design (e.g. benefit design that relies on outdated recommendations or overly strict supervision requirements) that restricts qualified health care professionals from delivering services and limits coverage to specific, finite settings interferes with a beneficiary’s ability to access high value services. In addition, team-based care is essential for delivering timely and effective person-centered health care and as such, it requires the expertise of a wide range of qualified physician and non-physician practitioners who are critical to achieve successful patient outcomes and control the progression of chronic disease. Practitioners, however, do not necessarily need to be located within the same physician office/suite setting in order to provide services as part of the patient-centered health care team.

The past two and a half years of the public health emergency has demonstrated that safe and effective care can not only be achieved by health care teams who are located outside of the same physician office setting, but also has allowed improved beneficiary access to much-needed services, in particular to beneficiaries with limited to access due to challenges related to transportation, long commutes to physician offices, inflexible work schedules and/or provider shortages. **The Academy remains concerned that coverage for services to prevent, manage, and treat chronic conditions such as diabetes, prediabetes, and obesity currently exist as a patchwork within CMS with persistent gaps**

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<sup>6</sup> USAID. Community Health Worker Competency List for Nutrition Social and Behavior Changes. June 2021. <https://www.advancingnutrition.org/resources/community-health-worker-competency-list-nutrition-social-and-behavior-change>. Accessed August 11, 2022.

<sup>7</sup> HHS-OS-2019-0015, Solicitation for Public Comments on Questions from the National Clinical Care Commission. Academy Urges HHS to Reduce Barriers to Nutrition Services. <https://www.eatrightpro.org/news-center/on-the-pulse-of-public-policy/regulatory-comments/academy-urges-hhs-to-reduce-barriers-to-nutrition-services>. Accessed August 10, 2022.

<sup>8</sup> Academy comments <https://www.eatrightpro.org/-/media/eatrightpro-files/news-center/on-the-pulse/regulatorycomments/feedback-to-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency.pdf?la=en&hash=1C3F5C335061EC8AF9E209D766B760BE81908B4E>. Accessed August 10, 2022

**and limitations related to the receipt of same-day service, referrals, coverage levels, payment and sites of service.**

The Academy offers comment on the following services:

*Intensive Behavioral Therapy for Obesity (IBT for Obesity)*

The goal of the Medicare IBT for Obesity benefit is to treat beneficiaries with obesity and reduce the rates of its comorbidities among older adults. As CMS has indicated, this benefit is not being utilized to its full potential, thus falling short of the goal.<sup>9</sup> As of 2019, only 2.16% of the more than 7.6 million Medicare FFS beneficiaries with obesity received the first-line of treatment for that disease.<sup>10</sup> The Academy believes that both the provider and location restrictions are barriers that prevent eligible beneficiaries from accessing the IBT for Obesity benefit.

Under current rules, IBT for Obesity can only be covered if Medicare beneficiaries receive the service from their physician or other primary care provider (PCP) in a primary care setting (such as a physician's office).<sup>11</sup> The service may also be provided by RDNs or other non-PCP professionals and billed incident-to the physician, but only if the service is still provided in the primary care setting and the physician is on-site to provide supervision, if needed. In theoretical practice, this looks like an RDN either co-locating in a primary care provider's office or working out of that office certain times of the week to see these patients.

Research has shown that PCPs report a variety of barriers when it comes to providing weight and related nutrition counselling including inadequate time, training, and office space.<sup>12</sup> A recent study published in Family Practice reported that 64% of family medicine departments within large academic health care systems in the southeastern United States did not have an RDN on site.<sup>13</sup> Primary care providers' offices simply do not have the additional functional space for an entirely new practitioner to set up a separate room for individual or group nutrition and behavioral counseling. Moreover, since private practice RDNs already have existing practices—of which Medicare beneficiaries may comprise merely a part—traveling back and forth from their own office to that of a primary care provider imposes incredible burdens and unnecessary expense. It also requires that the PCP office and the RDN enter into a financial employer-employee relationship that may not be desired by either party. **Limiting the IBT for Obesity benefit to the primary care setting is a barrier that prevents PCPs from referring their patients to providers, such as RDNs, who specialize in obesity treatment, as it will not be covered.** It also fails to reflect how modern primary care functions: by fostering an environment of collaboration and coordination without co-location that eases the burden of providing care and improves access to care for patients.

Both beneficiary need and demand are high for obesity management services; to compound matters further, the U.S. is still grappling with a PCP shortage. A 2020 study from the Association of

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<sup>9</sup> Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2017. Data.cms.gov. <https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Provider-Utilization-and-Payment-Data-Phy/fs4p-t5eq>. Accessed July 30, 2020.

<sup>10</sup> Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2019. Data.cms.gov. <https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-geography-and-service/data>. Accessed August 9, 2022.

<sup>11</sup> Obesity Screening Coverage. Medicare.gov. <https://www.medicare.gov/coverage/obesity-behavioral-therapy>. Published 2020. Accessed August 23, 2022.

<sup>12</sup> Jacobs M, Harris J, Craven K, Sastre L. Sharing the 'weight' of obesity management in primary care: integration of registered dietitian nutritionists to provide intensive behavioural therapy for obesity for Medicare patients. Fam Pract. 2020. Doi:[10.1093/fampra/cmaa006](https://doi.org/10.1093/fampra/cmaa006)

<sup>13</sup> Sastre LR and Van Horn LT. Family medicine physicians report strong support, barriers and preferences for Registered Dietitian Nutritionist care in the primary care setting. Fam Pract 2020 1-7 doi:[10.1093/fampra/cmaa099](https://doi.org/10.1093/fampra/cmaa099).



American Medical Colleges predicted shortage of 21,400 to 55,200 primary care physicians by 2033.<sup>14</sup> The concept of RDNs providing IBT for obesity services to Medicare beneficiaries is not new and is currently happening through often cumbersome incident-to billing arrangements. There is consensus among physicians who agree that RDNs are qualified providers of IBT for Obesity.<sup>15</sup> Research conducted by the Academy of Nutrition and Dietetics in 2018 found that RDNs who reported billing services “incident to” a physician were overwhelmingly billing for individual (75%) and group (19%) IBT for obesity incident to PCPs.<sup>16</sup> Mandating that services can only be provided “incident to” under direct supervision presents another barrier and is impracticable. This requirement creates unnecessary administrative burden on the PCP and office staff as it requires meeting the supervision requirements for health care professionals who, outside of this Medicare benefit, are regularly considered independent providers of such services by scope of practice and state licensure laws.<sup>17</sup> It also often requires initiation and management of contractual agreements between the RDN and PCP as it is less common for a PCP practice to directly employ an RDN. This same research reported adult overweight/obesity as the second most common diagnosis for which RDNs received reimbursement from third party payers, including payers outside of Medicare.<sup>18</sup>

**In summary, the Academy believes that allowing RDNs to serve as direct providers for the IBT for Obesity benefit, with the ability to see these patients in their own offices upon referral from a physician but without direct oversight from one, would greatly improve beneficiary access to this highly effective and evidence-based service.**

#### *Medical Nutrition Therapy*

MNT provided by RDNs is a widely recognized component of medical guidelines for the prevention and treatment of heart disease, diabetes, renal disease, obesity, cancers and many other chronic diseases and conditions, as well as in the reduction of risk factors for these conditions. MNT is clearly proven to reduce chronic disease risk, delay disease progression, enhance the efficacy of medical/surgical treatment, reduce medication use, and improve patient outcomes including quality of life.<sup>19</sup> The Academy appreciates the actions CMS took in last year’s final rule<sup>20</sup> that focused on increasing beneficiary utilization of the Part B MNT Benefit. We realize the existing statutory limitations may limit CMS’s ability to expand access and coverage of MNT by RDNs through regulations; however we still believe that CMS can exercise its authority to do more to further improve access to MNT.

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<sup>14</sup>The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. 2020. Washington, D.C.: Association of American Medical Colleges. Available at: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>

<sup>15</sup>Bleich S, Bennett W, Gudzone K, Cooper L. National survey of US primary care physicians’ perspectives about causes of obesity and solutions to improve care. *BMJ Open*. 2012;2(6):e001871. doi:10.1136/bmjopen-2012-001871

<sup>16</sup>Jortberg BT, Parrott JS, Schofield M, et al. Trends in Registered Dietitian Nutritionists’ Knowledge and Patterns of Coding, Billing, and Payment. *J Acad Nutr Diet*. 2020;120(1):134-145.e133.

<sup>17</sup>42 CFR §410.26(b); 42 CFR §410.32(b)(3)(iii); 42 CFR §410.26(b)(5)

<sup>18</sup>Parrott JS, White JV, Schofield M, et. Al. Current coding practices and patterns of code use of registered dietitian nutritionists: The Academy of Nutrition and Dietetics 2013 coding survey. *J Acad Nutr Diet*. 2014;114:1619-1629.

<sup>19</sup>Grade 1 data. Academy Evidence Analysis Library, <http://andevidencelibrary.com/mnt>. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, “Good evidence is defined as: “The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power.”

<sup>20</sup>Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2022. <https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>

**Update the definition of diabetes in § 410.130 Definitions to include HbA1c  $\geq$  6.5% as recommended in national standards of medical care for diabetes.** As is the case with classification and diagnostic guidelines for kidney disease, the definition of diabetes for the purposes of the MNT benefit has not been updated since the original NCD. HbA1c testing has been accepted among the clinical community as a diagnostic test for abnormal glycemic status for at least 10 years. Both the United States Preventive Services Task Force<sup>21</sup> and the American Diabetes Association Standards of Care<sup>22</sup> recommend use of any of three testing methods to screen for abnormal blood glucose: fasting plasma glucose, HbA1c and two-hour plasma glucose.

**Further expand the definition of renal disease in § 410.130 Definitions to include G Stage 1 Kidney Damage with normal kidney function (GFR 90 ml/min/1.73m<sup>2</sup> or higher), G Stage 2 Mild CKD (GFR 60-89 ml/min/1.73m<sup>2</sup>) and G Stage 5... to include the full breadth of non-dialysis dependent chronic kidney disease.**<sup>23</sup> Section 1861(s)(2)(V)(ii) of the Social Security Act allows for MNT for a “beneficiary with ... renal disease who...is not receiving maintenance dialysis.” Medicare expenditures increase dramatically from stages 1-2 to stages 4-5.<sup>24</sup> Covering MNT for these earlier stages of CKD is a low-cost intervention proven to slow or prevent CKD progression.<sup>25, 26</sup> Also, some G Stage 5 patients with a GFR below 15 ml/min/1.73m<sup>2</sup> may not yet be on dialysis and so not receiving nutrition services under the ESRD benefit. Such patients would benefit from MNT services under the Part B benefit. Of note, the ICD-10 code file associated with the MNT NCD (180.1) and issued by CMS to the Medicare Administrative Contractors for claims processing purposes includes the ICD-10 codes for all stages of CKD.<sup>27</sup> To address potential concerns about risk of fraudulent billing, the Academy suggests **CMS create a modifier code to be appended to claims for Part B MNT services to indicate when a Medicare beneficiary with Stage 5 CKD is not receiving dialysis.**

### *Diabetes Self-management Training*

The Academy echoes both the concerns and recommendations noted in comments submitted by the Diabetes Advocacy Alliance (DAA), of which the Academy is a member. **The Academy recommends that CMS allow DSMT and MNT to be delivered on the same day.** This limitation creates an unnecessary burden for beneficiaries attempting to access critically important and distinct services related to managing diabetes care. We also urge CMS to standardized and simplify the required data collection processes to ensure consistency across DSMT programs so that all relevant partners, including claims adjudicators follow a consistent approach throughout the audit and oversight processes to ensure better alignment with the purpose and scope of high-quality DSMT programs of all types and sizes. Additionally, we support the following recommendations, recognizing that some require congressional action:

- Allow the initial 10 hours of DSMT to remain available beyond the first 12 months from diagnosis until fully utilized.

<sup>21</sup> Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. U.S Preventive Services Task Force. October 26, 2015. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-abnormal-blood-glucose-and-type-2-diabetes>. Accessed August 17, 2021.

<sup>22</sup> Classification and Diagnosis of Diabetes: *Standards of Medical Care in Diabetes—2021*. American Diabetes Association. Diabetes Care Jan 2021, 44 (Supplement 1) S15-S33; DOI: 10.2337/dc21-S002.

<sup>23</sup> National Kidney Foundation. Estimated Glomerular Filtration Rate (eGFR). <https://www.kidney.org/atoz/content/gfr>. Accessed August 17, 2022.

<sup>24</sup> United States Renal Data System. Chapter 6: Healthcare Expenditures for Persons with CKD. <https://adr.usrds.org/2020/chronic-kidney-disease/6-healthcare-expenditures-for-persons-with-ckd>. Accessed August 17, 2022.

<sup>25</sup> de Waal D, Heaslip E, Callas P. Medical Nutrition Therapy for Chronic Kidney Disease Improves Biomarkers and Slows Time to Dialysis. *J Ren Nutr*. 2016; 26(1): 1-9.

<sup>26</sup> Kramer H, Yakes Jimenez E, Brommage D, et al. Medical Nutrition Therapy for Patients with Non-Dialysis-Dependent Chronic Kidney Disease: Barriers and Solutions. *J Acad Nutr Diet*. 2018; 118(10): 1958-1965.

<sup>27</sup> <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR12027.zip> Accessed August 17, 2022.



- Allow for six additional hours (instead of two hours) of DSMT, if necessary.
- Eliminate copays and deductibles (cost sharing) for DSMT.
- Expand the types of physician providers who can refer for DSMT (for example, podiatrists, specialists treating diabetes-related complications, and emergency medicine physicians).
- Allow community-based sites to provide DSMT.

**The Academy firmly believes that access to many of the underutilized Part B benefits will increase if CMS uses its authority, where possible, to loosen restrictions pertaining to delivery of these essential services so that they are not exclusively tied to location requirements (e.g. benefits that must be physically provided in primary care offices) and removes limits placed on qualified clinicians from practicing at the top of their practice (e.g. RDNs independently providing IBT for Obesity services).**

#### **4. Determination of Professional Liability Insurance (PLI) Relative Value Units (RVUs) (Section II.H.)**

The Academy appreciates and agrees with the American Medical Association’s (AMA) comment relating to the CMS CY2023 proposed annual PLI premium for specialty code 76 [*sic*] *Registered Dietitian/Nutrition Professional* appears to be and outlier. Furthermore, we support AMA’s recommendation that if CMS and ARC are unable to find any premium data for Registered Dietitian/Nutrition Professionals, a crosswalk should be used to another non-MD profession with similar PLI costs. Additionally, we support CMS’s proposal to phase in the reduction in MP RVUs over a 3-year period. Lastly, we would like to call attention to the specialty code used to signify Registered Dietitian/Nutrition Professionals in the AMA comments is listed as Specialty code 76. Registered Dietitian/Nutrition Professionals are Specialty code 71.

#### **5. Chronic Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Section III.C.)**

##### *New Care Management Codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI)*

The Academy supports the development of Chronic Pain Management (CPM) HCPCS codes GYYY1 and GYYY2 and appreciate CMS’s recognition of the value of services provided to beneficiaries who are dealing with pain management. Chronic pain can greatly impact nutrition status and conversely, nutrition interventions can have a significant effect on pain reduction<sup>28</sup>. Chronic pain can negatively impact weight status and contributes to poor/low dietary intake which, subsequently can lead to malnutrition (both over and under) and contribute to progression and severity of chronic disease. For example, pain can negatively impact many Activities of Daily Living (ADLs), such as one’s ability to ambulate, grocery shop and participate in food preparation. RDN intervention, in this case may include referrals to community meal programs or recommendations for supplemental nutrition to facilitate improved overall nutrient intake. In another example, RDNs closely monitor food and drug interactions of beneficiaries who take multiple medications. A common side effect of medication, especially in instances of polypharmacy is GI distress manifesting as nausea, cramping, constipation and/or diarrhea. Nutrition care by RDNs is often an integral part of managing not only GI complications but also ensuring nutritional

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<sup>28</sup> International Association for the Study of Pain. *Nutrition and Chronic Pain*. <https://www.iasp-pain.org/resources/factsheets/nutrition-and-chronic-pain/#:~:text=Nutrition%20interventions%20have%20a%20significant,quality%20%5B2%3B%20%5D>. Accessed August 15, 2022.

adequacy of diet. **RDNs are an important part of the care team to support the holistic care required by beneficiaries by providing MNT and helping to mitigate the impact pain has on nutrition status.**

The Academy received feedback from members emphasizing the importance of nutrition care for individuals dealing with pain-related issues and suggested the inclusion of provisions for both nutrition screening and nutrition therapy in the codes descriptions. We support these suggestions and look forward to continuing to explore opportunities to support beneficiaries managing pain.

## **6. Updates to the Quality Payment Program (Section IV.)**

The Academy is appreciative of CMS's continued efforts to make participation in the Quality Payment Program more meaningful for clinicians while also continuing to reduce barriers for successful participation. We also remain supportive and appreciative of CMS' ongoing focus to address issues surrounding health equity and social determinants of health.

Many RDNs continue to face significant barriers to participating in the QPP, mainly that many practices continue to rely on manual reporting and data collection which can make it difficult to near impossible to participate in quality reporting. Our member feedback continues to show that while there is interest in participating in the QPP, the complexities of the program prove to be too burdensome. In addition to technology barriers, many RDNs have expressed concerns when selecting which measures to report and meeting participation thresholds. **The Academy continues to encourage CMS to provide financial support (e.g., grants) and continued technical assistance to all provider types that they can actively and meaningfully participate.**

### *MIPS Value Pathway (MVPs)*

The Academy continues to support the rationale and merit behind development of MVPs and believes they will support CMS's goal of strengthening the QPP as a value-based program. The Academy also recognizes that as health care continues to shift towards value-based payments there is an even greater opportunity and need for team-based care. Medical Nutrition Therapy provided by RDNs is recognized as a key component to management of chronic diseases, including conditions beyond diabetes and renal disease. The Academy remains concerned that, like the overall design of the QPP, it is being done through the lens of physician-providers only and non-physician eligible clinicians, such as RDNs, who are active participants on health care teams and routinely contribute to improving beneficiary health outcomes, are at a disadvantage when it comes to understanding how their discipline will meaningfully participate in MVPs.

Of the 13 potentially available MVPs (7 previously finalized and 5 proposed), RDNs could potentially participate in 10 of the proposed MVPS, to include: Advancing Rheumatology Patient Care MVP; Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP; Advancing Care for Heart Disease MVP; Optimizing Chronic Disease Management MVP; Improving Care for Lower Extremity Joint Repair MVP; Advancing Cancer Care MVP; Optimal Care for Kidney Health MVP; Optimal Care for Neurological Conditions; Supportive Care for Cognitive-Based Neurological Conditions; and Promoting Wellness. However, in their current state, there appears to be limited available measures for qualified non-physician providers. The Academy remains concerned that MVPs continue to rely heavily on measures that are not applicable or available to many of the MIPS eligible clinicians who provide care to beneficiaries. Similar to our comments to the CY 2022 Fee Schedule, the Academy acknowledges that with the newness of the MVPs, the focus rests primarily on the major types of participating eligible clinicians. **Given the desire for increasing participation of all MIPS eligible**

**clinicians, the Academy asks CMS to further define how MIPS eligible clinicians, who are also non-physician providers, such as RDNs are to participate in MVPs**

**Lastly, we ask that CMS confirm our understanding that the scoring of the foundational layer consisting of both Promoting Interoperability and Population Health will be reweighted for MIPS eligible clinicals who are not yet able to report under either category.** Many RDNs who could potentially see Medicare beneficiaries may be doing so in their own solo practice and/or may not be part of a multidisciplinary groups. This could mean that they would not meet the MVP foundational layer requirements of the population health measures or promoting interoperability performance category. The Academy acknowledges that while CMS has stated that these measures would be excluded from scoring (and the reweighting policies will align with those of traditional MIPS) we remain concerned about any unintended consequences, specifically that this policy may have a negative impact on the potential for such MIPS eligible clinicians to achieve positive payment adjustments.

#### *Merit-based Incentive Payment System (Traditional MIPS)*

The Academy appreciates the agency's recognition of the continued impact of COVID-19 on the ability of MIPS eligible clinicians to complete data submission as they focus on caring for patients. We also appreciate CMS's continued efforts to facilitate greater participation by small practices.

#### Quality Performance Category

##### *Nutrition/Dietician Measure Set:*

**The Academy requests that CMS add the MNT CPT codes (97802, 97803, 97804, G0270, G0271) to the denominator criteria of the measure specification for Depression Screening (NQF#0418/Quality#134) and subsequently add to the Nutrition/Dietician Measure Set.**

**Rationale:** Depression continues to be a major public health concern and all Medicare providers should be doing their part to address the issue. Depression, particularly in older adults, has been linked to malnutrition and food insecurity,<sup>29</sup> both of which are issues RDNs actively address to not only provide guidance and intervention but also assist in the coordination of care with other appropriate subspecialties.

Screening for depression is often a routine part of the comprehensive nutrition assessment performed by RDNs as nutrition status is closely linked to mental health and optimizing the nutrition status of an individual with mental illness has been shown to improve both cognitive and emotional functioning.<sup>30</sup> RDNs use various tools and resources, including practice guidelines from federal associations such as the National Institutes of Health and other professional organizations, to guide nutrition care.<sup>31</sup> The Nutrition Care Process<sup>32</sup> and the Academy's Standards of Professional Practice for RDNs in Mental Health and Addiction<sup>33</sup> guide RDNs to assess and consider other factors affecting intake, nutrition, and health status (e.g., cultural, ethnic, religious, lifestyle influencers, psychosocial and social determinants of health). RDNs work with beneficiaries to create a nutrition care plan which includes developing and prioritizing

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<sup>30</sup> Academy of Nutrition and Dietetics: Revised 2018 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Mental Health and Addictions. *J Acad Nutr Diet* October 2018, Volume 118, Number 10.

<sup>31</sup> Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. *J Acad Nutr Diet*, January 2018 Volume 118 Number 1.

<sup>32</sup> The Nutrition Care Process (NCP) is defined as systematic method to providing high-quality nutrition care based on evidenced-based nutrition research, critical thinking and decision-making. Nutrition Care Process and Model: An Academic and Practice Odyssey. *J Acad Nutr Diet*, December 2014 Volume 114 Number 12.

goals based on individual needs and evidenced based best practice, provide nutrition counseling and make referrals to appropriate resources and programs when needed. Beyond MNT services, RDNs may perform depression screens as recognized providers of the Annual Wellness Visit (AWV). Given the RDN Scope of Practice, it would be appropriate to add this measure to the Nutrition/Dietician Measure set.

**The Academy requests that CMS add the MNT CPT codes (97802, 97803, 97804, G0270, G0271) to the denominator criteria of the measure specification for: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented Quality#317) and subsequently add to the Nutrition/Dietician Measure Set.**

**Rationale:** Elevated high blood pressure is a major public health concern and all eligible Medicare providers should be addressing within their professional competency. In 2020, high blood pressure accounted for or contributed to more than 670,000 deaths in the U.S. and it continues to be a leading risk factor of both heart disease and stroke according to the CDC National Center for health Statistics<sup>33</sup>. Lifestyle management is often a first line of therapy for the both the prevention and treatment of hypertensive individuals<sup>34</sup>. As such, RDNs working in community and clinical settings often screen for elevated blood pressure as routine part of the comprehensive nutrition assessment. RDNs providing nutrition care to beneficiaries in either the wellness/prevention environment or to beneficiaries with chronic conditions (e.g. heart disease, diabetes, obesity or renal disease) are actively applying evidence-based practice guidelines and utilizing clinical judgment to address health promotion and wellness, and prevention, delay, or management of acute or chronic diseases and conditions. The Scope of Practice for Registered Dietitian Nutritionists guides RDNs to perform and/or interpret test results related to nutrition status [to include] blood pressure, anthropometrics, etc”<sup>30</sup>. Beyond MNT services, RDNs may perform blood pressure screening as recognized providers of the Annual Wellness Visit (AWV). Given the Scope of Practice, it would be appropriate to add this measure to the Nutrition/Dietician Measure set.

#### Improvement Activities Performance Category

In continued efforts to improve health equity and equality, CMS has proposed two new improvement activity measures: “Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients” and “Create and Implement a Language Access Plan” to be added for the 2023 Performance Year.

*Proposed Activity ID: IA\_AHE\_XX Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients*

As indicated by the Improvement Activity, there is both need and opportunity to support the health care needs of beneficiaries who are members of the LGBTQ+ community and provide long-overdue training to clinicians and staff caring for these beneficiaries. Research has shown that LGBTQ community has unique challenges when it comes to accessing safe and inclusive health care, and those challenges may be contributing factors to many of the nutrition-related concerns and conditions that affect this community

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<sup>33</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. About Multiple Cause of Death, 1999–2020. CDC WONDER Online Database website. Atlanta, GA: Centers for Disease Control and Prevention; 2022. Accessed August 8, 2022.

<sup>34</sup> 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular disease. *Circulation*. 2019;140:e596–e646. DOI: 10.1161/CIR.0000000000000678

such increased risk of food insecurity, obesity, heart disease, cancer and eating disorders<sup>35,36</sup>. Additionally, health care professionals trained and competent on issues specific to the LGBTQ community, to include older adults,<sup>37</sup> results in LGBTQ patients experiencing fewer acts of discrimination by health care workers. **We commend CMS for recognizing the challenges faced by the LGBTQ+ community when seeking equitable health care as well as providing an avenue for MIPS eligible clinicians to report on this critical area of care.**

*Proposed Activity ID: IA\_AHE\_XX : Create and Implement a Language Access Plan*

A beneficiary's ability to understand their medical condition as well as the care plan, is reliant on many factors, however, language can often times be one of the biggest barriers to an individual's ability to truly understand health related information provided. Considering the impact that low health literacy coupled with language barriers can have on health outcomes, the provision of both culturally and linguistically appropriate language services is critical to not only improving health outcomes but also reducing health disparities. We support the use of language access plan to address communication barriers for individuals with limited English proficiency and agree that the plan should align with national standards set forth in Culturally and Linguistically Appropriate Services (CLAS).

### **MIPS Quality Performance Category Health Equity (Request for Information)**

The Academy firmly believes that nutrition services, from pre-conception through end of life, are an essential component of comprehensive health care. As such, we believe that access to nutrition care must be included as part of the conversation when discussing nutrition access and equity issues related to health care. There are harsh consequences of food insecurity, such as malnutrition or the development of or exacerbation of chronic diseases,<sup>38</sup> which are compounded by one's limited access to and availability of health care, that negatively impact health outcomes. We believe that health care must be patient-centered, and therefore it is absolutely crucial that beneficiaries dealing with food insecurity and nutrition-related chronic conditions have access to nutritionally adequate and appropriate foods and appropriate nutrition care to maintain or improve their health.

While the Academy supports endeavors that address social determinants of health issues such as food security, we also remind CMS that the underlying etiology of individuals who are struggling with food security issues is multifactorial and will require referrals to appropriate providers such as RDNs and social workers to facilitate appropriate tailored interventions that address the issues and support the beneficiary within their own community. **The Academy supports CMS's continued dedication to addressing healthy equity and looks forward to partnering with CMS to support the development of health equity measures as it relates to the quality payment program.**

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<sup>35</sup> Joy, P, et al. Moving Dietetics Forward with Queer Pedagogy: A Post-structural Qualitative Study Exploring the Education and Training Experiences of Canadian Dietitians for LGBTQ Care. Journal of the Academy of Nutrition and Dietetics, February 2022 DOI: <https://doi.org/10.1016/j.jand.2022.02.011>

<sup>36</sup> Wellington, C et al. Gender Identity: A Culture with Unique Nutrition Concerns. Journal of the Academy of Nutrition and Dietetics, September 2012 Suppl 3—Abstracts Volume 112 Number 9

<sup>37</sup> Higgins A. Pedagogical principles and methods underpinning education of health and social care practitioners on experiences and needs of older LGBT+ people: Finding from a systematic review. Nurse Education in Practice. Vol (40). 2019.

<sup>38</sup> Ahmed T, Haboubi, N. Assessment and management of nutrition in older people and its importance to health. Clin Interv Aging. 2010; 5: 207–216.

## Patient Access to Health Information Measure (Request for Information)

The Academy appreciates CMS continued interest in supporting patient access to protected health information as we believe that improved access will also lead to improved coordination of care, especially if there are interoperability challenges between health care systems present. For example, a beneficiary who is newly diagnosed with diabetes and is discharged from an inpatient hospital stay may live many miles from the original hospital system. That patient may elect to receive care from an RDN located closer to home who may work in a different hospital system or private practice. In this scenario, it may be necessary for the beneficiary to easily access their health in a way that is both expeditious and secure so that the new provider has as much medically appropriate information as necessary to treat the beneficiary. However, our members report that barriers remain from some beneficiaries when there is a need to utilize electronic communications for both access to care and information. These barriers include apps that are not compatible with mobile devices (the application requires or is easier to use with a desk/laptop computer), non-English speaking language barriers and continued struggles with technology and broadband services. We have also received feedback that patients, particularly those who are older, prefer to communicate in person and report feeling not comfortable using the health system applications. Similarly, members report that while electronic applications have improved scheduling and improved attendance to visits, utilization overall remains relatively low. For example, feedback suggested that there is often an increase in time needed to train beneficiaries on how to use applications, increasing provider burden.

Thank you for your careful consideration of the Academy's comments on the proposals for the CY 2023 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Please do not hesitate to contact Jeanne Blankenship by phone at 312-899-1730 or by email at [jblankenship@eatright.org](mailto:jblankenship@eatright.org) or Carly Léon at 312-899-1773 or [cleon@eatright.org](mailto:cleon@eatright.org) with any questions or requests for additional information. The Academy looks forward to continued opportunities to work with CMS to design a health care delivery and payment system that improves the health of the nation and meets the needs of all stakeholders.

Sincerely,



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