NUTRITION SERVICES PROTOCOL

A. Nutrition Assessment

1. Is the request for an initial assessment after enrollment in the waiver or after an interval of *at least* 12 months since the last Nutrition Services assessment?

   If **YES**, skip to Question #3.

   If **NO**, proceed to Question #2.

2. Is a new Nutrition Services assessment needed because the service recipient was discharged from services by a dietitian/nutritionist who withdrew from participation as a waiver services provider?

   If **YES**, proceed to Question #3.

   If **NO**, skip to Question #5.

3. Is there sufficient information in the Individual Support Plan (ISP) and/or supporting documentation to document that:

   a. There is an order for the Nutrition Services assessment by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **AND**

   b. The service recipient:

      (1) Has a medical condition or diagnosis:

         (a) For which a special therapeutic diet or dietary plan has been ordered by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **OR**

         (b) Which has resulted in the service recipient's inability to maintain adequate hydration or nutrition; **OR**

         (c) Which involves pressure ulcers or non-healing skin lesions or wounds; **OR**

      (2) The service recipient is obese as indicated by a body mass index or BMI of 30 or greater (*see below for calculation of BMI); **OR**

(3) The service recipient has had unplanned weight gain or loss of 10% or more of body weight during the past 6 months?

If **YES** ***to both*** criteria specified in "3.a" and "3.b" above, proceed to Question #4.

If **NO** to either the criterion specified in "3.a" or to all three of the criteria specified in "3.b" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If the denial is based in any part on the lack of an order from a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist), the following must be specified in the denial letter: State law says you must have a doctor's order to get a nutrition assessment [Tennessee Code Annotated 63-25-105 *"No therapeutic dietary regimen may be developed unless pursuant to the appropriate orders and/or referral of licensed practitioners of medicine, osteopathy, chiropractic, dentistry or podiatry when incidental to the practice of their respective professions."*]

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

4. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical condition or diagnosis, obesity, or weight gain or loss as specified in "3.b" above, the service recipient's nutritional needs cannot be adequately determined without a *new* Nutrition Services assessment?

If **YES**, skip to Question #7.

If **NO,** stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

5. Is there sufficient information in the Individual Support Plan (ISP) to document that:

a. There is an order for the Nutrition Services assessment by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **AND**

b The service recipient:

(1) Has a new medical diagnosis or condition for which a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist) has ordered a special therapeutic diet (e.g., diabetic diet, renal

diet, low fat/low cholesterol diet) or dietary plan which can not be appropriately followed without a new Nutrition Services assessment; **OR**

(2) Has experienced a significant change in health status that affects the ability to maintain adequate hydration or nutrition, after having been discharged from Nutrition Services by the dietitian/nutritionist; **OR**

(3) Has experienced a significant exacerbation of a pre-existing medical condition (e.g., unstable diabetes), after having been discharged from Nutrition Services by the dietitian/nutritionist?

If **YES** ***to both*** of the criteria specified in "5.a" and "5.b" above, proceed to Question #6.

If **NO** ***to*** either the criterion specified in "5.a" or to all three of the criteria specified in "5.b" above, stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If the denial is based in any part on the lack of an order from a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist), the following must be specified in the denial letter: State law says you must have a doctor's order to get a nutrition assessment [Tennessee Code Annotated 63-25-105 *"No therapeutic dietary regimen may be developed unless pursuant to the appropriate orders and/or referral of licensed practitioners of medicine, osteopathy, chiropractic, dentistry or podiatry when incidental to the practice of their respective professions."*]

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

6. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical condition or diagnosis, significant change in health status, or significant exacerbation of a pre-existing medical condition as specified in "5.b" above, the service recipient's nutritional needs cannot be adequately determined without a *new* Nutrition Services assessment?

If **YES**, proceed to Question #7.

If **NO**, stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

7. Has the waiver limit of three (3) Nutrition Services assessments per year per provider been exceeded for the current program year?

If **YES**, stop and deny as a **non-covered service** based on the waiver service limit of three (3) assessments per service recipient per provider per program year.

If **NO**, stop and approve the Nutrition Services assessment.

* Body mass index (BMI) equals body weight divided by the square of the height. BMI may be obtained from standard reference charts or it may be calculated by one of the following methods:

- BMI is calculated by dividing the weight in kilograms (kg) by the height in meters squared (m^2). Since height is commonly measured in centimeters, divide height in centimeters by 100 to obtain height in meters.

$$\text{BMI equals } \frac{\text{weight in kilograms}}{(\text{height in meters})^2}$$

- BMI may also be calculated by dividing weight in pounds (lbs) by the height in inches squared (in^2) and multiplying by 703.

$$\text{BMI equals } \frac{\text{weight in pounds}}{(\text{height in inches})^2} \text{ times 703}$$

B. *Initial* Nutrition Services (excluding assessment)

(NOTE: This section applies to service recipients who are **not** currently approved for Nutrition Services through the waiver.)

1. Medical necessity review questions:

   a. Is there an order for the Nutrition Services by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that:

      (1) The service recipient has a medical condition or diagnosis:

         (a) For which a special therapeutic diet or dietary plan has been ordered by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **OR**

         (b) Which has resulted in the service recipient's inability to maintain adequate hydration or nutrition; **OR**

         (c) Which involves pressure ulcers or non-healing skin lesions or wounds; **OR**

      (2) The service recipient is obese as indicated by a body mass index or BMI of 30 or greater (*see below for calculation of BMI); **OR**

      (3) The service recipient has had unplanned weight gain or loss of 10% or more of body weight during the past 6 months; **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation to conclude that the service recipient's dietary and nutritional needs cannot be adequately met unless Nutrition Services are provided by a licensed dietitian/nutritionist (i.e., paid and unpaid

caregivers would not otherwise be able to adequately meet the specified functional or treatment needs); **AND**

d. Is there sufficient documentation in the ISP and/or supporting documentation to conclude that the provision of Nutrition Services can be reasonably expected to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems; **AND**

e. Are there clearly defined measurable Nutrition Services goals in the ISP and/or supporting documentation which are reasonable and appropriate given the person's current age and health status?

If **YES** ***to all five*** of the criteria specified in "1.a" through "1.e" above, proceed to Question #2.

If **NO** to ***any*** criterion specified in "1.a" through "1.e" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "1.a" through "1.e" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If the denial is based in any part on the lack of an order from a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist), the following must be specified in the denial letter: State law says you must have a doctor's order to get a nutrition assessment [Tennessee Code Annotated 63-25-105 *"No therapeutic dietary regimen may be developed unless pursuant to the appropriate orders and/or referral of licensed practitioners of medicine, osteopathy, chiropractic, dentistry or podiatry when incidental to the practice of their respective professions."*]

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

2. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Nutrition Services requested *consistent with* and not *in excess of* the amount of services needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems as specified in "1.b" above?

NOTE: To the maximum extent possible and appropriate, Nutrition Services by a licensed dietitian/nutritionist should be utilized to develop a special dietary plan and to provide education and counseling so that such plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across settings in order to achieve the maximum therapeutic benefit. Periodic services by the licensed dietitian/nutritionist should be authorized *only* as necessary to support the ongoing implementation of the special dietary plan, or to modify the plan in response to the changing nutritional needs of the service recipient.

If **YES**, stop and approve the amount of Nutrition Services requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Nutrition Services continue to be medically necessary. Such determination shall be based on current medical records provided by the licensed dietitian/nutritionist and/or the licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist) in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Nutrition Services requested that is *consistent with* the amount of Nutrition Services needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems as specified in "1.b" above. Deny as **not medically necessary** that portion of the total amount of Nutrition Services requested that is *in excess of* the amount of services needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems as specified in "1.b" above. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If Nutrition Services are approved for lesser duration of service than requested, include the following in the denial letter: "Based on the medical records we have now, we can only tell that you need this care for ___ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ___ days? Before the ___ days are over, you can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ___ days, you can appeal.

C. *Continuation* of Nutrition Services (excluding assessment)

(NOTE: This section applies to service recipients who are *currently* approved for Nutrition Services through the waiver and who request *continuation* of Nutrition Services or an *increase* in services.)

1. Medical necessity review questions for *continuation* of the *currently* approved level of Nutrition Services plus any requested *increase* in such services, as applicable:

   a. Is there an order for the Nutrition Services by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that:

      (1) The service recipient has a medical condition or diagnosis:

         (a) For which a special therapeutic diet or dietary plan has been ordered by a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist); **OR**

         (b) Which has resulted in the service recipient's inability to maintain adequate hydration or nutrition; **OR**

         (c) Which involves pressure ulcers or non-healing skin lesions or wounds; **OR**

      (2) The service recipient is obese as indicated by a body mass index or BMI of 30 or greater (*see below for calculation of BMI); **OR**

      (3) The service recipient has had unplanned weight gain or loss of 10% or more of body weight during the past 6 months; **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation to conclude that the service recipient's dietary and nutritional needs *still* cannot be adequately met unless Nutrition Services are provided by a licensed dietitian/nutritionist (i.e., paid and unpaid

caregivers would *still* not otherwise be able to adequately meet the specified functional or treatment needs); **AND**

d. Is there sufficient information in the ISP and/or supporting documentation to demonstrate:

(1) Progress toward defined treatment goals in terms of measurable improvements in the service recipient's medical condition or symptoms or quality of life; or

(2) Continuing medical need for Nutrition Services in order to prevent the imminent development of serious nutrition-related medical problems; **AND**

e. Are clearly defined measurable Nutrition Services goals as specified in the ISP and/or supporting documentation *still* reasonable and appropriate given the person's current age and health status?

If **YES *to all*** of the criteria specified in "1.a" through "1.e" above for some or all of the requested Nutrition Services, proceed to Question #2.

If **NO to *any*** criterion specified in "1.a" through "1.e" above, stop and deny as **not medically necessary**. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If the denial is based in any part on the lack of an order from a licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist), the following must be specified in the denial letter: State law says you must have a doctor's order to get a nutrition assessment [Tennessee Code Annotated 63-25-105 *"No therapeutic dietary regimen may be developed unless pursuant to the appropriate orders and/or referral of licensed practitioners of medicine, osteopathy, chiropractic, dentistry or podiatry when incidental to the practice of their respective professions."*]

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

2. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of *continued* Nutrition Services requested plus any requested increase in such services, as applicable, *consistent with* and not *in excess of* the amount of services *still* needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems?

To the extent that the request includes any increase in the frequency, amount, or duration of Nutrition Services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient's needs have changed and/or the previously approved frequency, amount, or duration of Nutrition Services is no longer sufficient to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems?

NOTE: To the maximum extent possible and appropriate, Nutrition Services by a licensed dietitian/nutritionist should be utilized to develop a special dietary plan and to provide education and counseling so that such plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across settings in order to achieve the maximum therapeutic benefit. Periodic services by the licensed dietitian/nutritionist should be authorized *only* as necessary to support the ongoing implementation of the special dietary plan, or to modify the plan in response to the changing nutritional needs of the service recipient.

If **YES**, stop and approve the *continuation* of Nutrition Services and any *increase* as requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Nutrition Services continue to be medically necessary. Such determination shall be based on medical records provided by the licensed dietitian/nutritionist and/or the licensed health care practitioner (i.e., a physician, physician assistant, nurse practitioner, chiropractor, podiatrist, or dentist), in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Nutrition Services requested that is *consistent with* the amount of Nutrition Services needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems.

- If the request for Nutrition Services was submitted as an ISP amendment or as an annual update of the ISP, deny as **not medically necessary** that portion of the total amount of Nutrition Services requested that is *in excess of* the amount of Nutrition Services needed to (1) achieve measurable improvements in the service recipient's medical condition or symptoms or quality of life; or (2) prevent the imminent development of serious nutrition-related medical problems; **OR**

- If the protocol was used for a DMRS-initiated review of an ISP and cost plan (i.e., rather than review of an ISP amendment or annual ISP update), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved Nutrition Services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the reduction/termination of Nutrition Services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved Nutrition Services pending resolution of the appeal, in which case such previously approved Nutrition Services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If *continuation* of Nutrition Services is approved for a lesser duration of service than requested, include the following in the denial letter: "Based on the medical records we have now, we can only tell that you need this care for ___ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ___ days? Before the ___ days are over, you can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ___ days, you can appeal.