

MEDICAL NUTRITION THERAPY · AETNA COMMERCIAL PLANS

Billing Aetna as a dietitian

The codes, units, diagnoses, telehealth rules and preventive routing behind MNT claims to Aetna, and what to check before the first visit.

Read this first

Aetna's clinical policy (CPB 0049) says when counseling is medically necessary. The member's plan decides whether it is a benefit, how many visits she gets and what she pays. Wherever this sheet says **verify**, it means it.

1 The codes Aetna lists for nutritional counseling

CPB 0049, reviewed March 10, 2026

CODE	DESCRIPTOR (SHORT)	UNIT	WHEN TO USE IT
97802	MNT, initial assessment and intervention, individual, face-to-face	15 min	The first visit with a new patient. Plans can limit how often it is billed — verify .
97803	MNT, re-assessment and intervention, individual, face-to-face	15 min	Every follow-up visit.
97804	MNT, group (2 or more individuals)	30 min	Group classes. Each participant gets their own claim.
G0270/71 G0447 G0473 S9470	MNT after a second referral; obesity behavioral counseling; dietitian visit	varies	Also in CPB 0049. G0270/G0271 are Medicare's extra-hours codes (Aetna Medicare Advantage). Bill the others only if your contract asks; most RDs bill 97802 / 97803 by time.

2 Units: count the minutes, not the appointment

Face-to-face minutes on this date of service

MINUTES	< 8	8–22	23–37	38–52	53–67	68–82	83–97	98–112
97802 / 97803	0	1	2	3	4	5	6	7

How the rule works. A 15-minute unit counts once you pass its midpoint, 8 minutes (CPT's time rule; CMS's 8-minute counting gives the same table for one code). 97804 : 16–45 min = 1 unit, 46–75 = 2. Plans can cap units — **verify**.

Units come from this visit's documented minutes, never from the last claim: a 34-minute follow-up is 2 units even if the first visit was 7. Bill a long first visit all as 97802; splitting it with 97803 invites CO-97.

3 Diagnoses: what CPB 0049 covers

E66.x	Obesity (E66.01–E66.2, E66.811–E66.9), adults and children: a preventive indication.
E66.3	Overweight (adult BMI over 25) only with a CVD risk factor : hypertension, dyslipidemia, impaired fasting glucose or metabolic syndrome. Code it too.
Z68.xx	BMI, secondary only : Z68.30–Z68.45, Z68.25–Z68.29 (with CVD risk only), pediatric Z68.53 / Z68.54. Never first or alone.
E11 · N18 · F50	Diabetes, kidney disease, hypertension, eating disorders, GI disorders and other conditions where diet treats the disease: the medical indication.
Z71.3	Describes the encounter. Not a covering diagnosis in CPB 0049: pair it with the condition, never alone.

Preventive or medical benefit?

- **Preventive (\$0 in network).** Under the ACA, non-grandfathered plans cover USPSTF "A/B" services without cost sharing: healthy-diet counseling for adults with CVD risk factors, and intensive behavioral programs for adults with BMI ≥ 30.
- **CPB 0049's preventive indications:** obesity in children and adults, and overweight adults with CVD risk factors.
- **Everything else is the medical benefit:** the condition you treat is the diagnosis, and the deductible, copay or coinsurance apply.

Which diagnoses route to preventive is a plan-level question: ask on the benefits check (\$6). Unproven per CPB 0049: asthma, ADHD, chronic fatigue (J45.x, F90.x, R53.82).

REPORTED · NOT VERIFIED

September 2026: preventive changes reported for Aetna commercial plans

- **Reported as no longer preventive on their own:** Z71.3 alone, BMI codes Z68.xx, family history Z82.49, and overweight (BMI 25–29.9).
- **Reported as still preventive:** obesity E66.x with BMI ≥ 30, or an adult chronic condition: E78.0–E78.5, I10, E08–E13.
- **Source:** a clinician's meeting with Aetna and a third-party Fall 2026 reimbursement sheet. As of Sep 29, 2026 we found **no public Aetna policy** saying this; CPB 0049 still lists overweight with CVD risk as preventive.
- **Confirm with Aetna or your provider rep** before you change your coding. If it holds, those visits process under the medical benefit.

4 Telehealth: modifier + place of service must agree

WHERE THE PATIENT IS	POS	MODIFIER
At home, live video	10	95 (or GT)
Elsewhere, live video	02	95 (or GT)
In your office	11	None
Phone only	Not paid under Aetna's policy (93 / FQ)	

- **Aetna's telemedicine payment policy** lists 97802–97804 and G0270 for live audio-video with 95 or GT; audio-only and asynchronous (GQ) aren't paid. Its public copy dates from 2021: ask which POS the plan wants for home.
- **Licensure follows the patient:** you must be licensed where the patient is during the visit.
- **Medicare Advantage** follows CMS: home telehealth through Dec 31, 2027.

Where to check a member: Availity (Aetna's provider portal) for eligibility, benefits and claim status; then the Provider Contact Center, 1-888-632-3862 for commercial plans or 1-800-624-0756 for Medicare Advantage (Aetna provider manual). The number on the member's card wins.

5 Visit limits, referrals and plan types

- **CPB 0049 sets no visit number.** The weight-reduction policy, CPB 0039, considers up to **26 individual or group visits per 12 months, combined across all providers**, medically necessary for adults with BMI ≥ 30. Other numbers you see online (such as 10 diet-counseling visits) are plan-specific: confirm the member's own.
- **Weight-control exclusions.** CPB 0039 warns that many Aetna plans exclude services for obesity or diet and weight control. A plan exclusion wins over the clinical policy.
- **Referral:** some plans require one (CPB 0049 says so; HMO-style plans are the usual case). Keep it on file with the diagnosis it names. **Prior authorization** is not described for routine counseling. Ask anyway.
- **Self-funded employer plans** administered by Aetna follow the employer's plan document, which can add or remove nutrition benefits.
- **Aetna Medicare Advantage** follows Medicare MNT at a minimum: diabetes, non-dialysis kidney disease or a kidney transplant in the last 36 months, a referral from a treating physician (MD/DO), 3 hours the first calendar year and 2 after, more with G0270/G0271 and a new referral. Z71.3 alone does not qualify.
- **Aetna Better Health** is Medicaid: the state's rules apply. **Aetna Signature Administrators** and **Meritain Health** plans: file where the member ID card says.
- **Timely filing** comes from your Aetna agreement and state law. Check your contract, not a blog.

6 Before the first visit: the benefits check

- ☐ **Which plan?** Commercial (fully insured or self-funded), Medicare Advantage, Medicaid, or a plan administered for an employer?
- ☐ **In network?** Are you credentialed for this product, under your individual NPI?
- ☐ **Covered codes:** 97802 / 97803 (and 97804) when a registered dietitian provides them?
- ☐ **Which benefit:** preventive or medical? Which diagnoses process as preventive *today*? Is Z71.3 accepted, and in which position?
- ☐ **Exclusions:** does the plan exclude diet and weight-control services?
- Availability or the Provider Contact Center. Write the answers in the chart.
- ☐ **Limits:** visits or units per year, calendar or plan year, and how many are used? Shared with other providers?
- ☐ **Member cost:** deductible, copay, coinsurance for each route.
- ☐ **Gatekeeping:** referral or prior authorization?
- ☐ **Telehealth:** covered to the home, with which POS and modifier?
- ☐ **Proof:** rep's name, date and call reference number, saved in the chart.

7 Common denials and how to fix them

X12 claim adjustment reason codes (CARC) on your ERA · full guides at farela.ai/denials

DENIAL	USUAL CAUSE	FIX
CO-16 · Missing info or billing error	Empty diagnosis slot or pointer, missing NPI, a referral the plan requires but isn't on the claim	Read the remark code, fix the field, send a corrected claim. Every line points to a filled diagnosis.
CO-50 · Not medically necessary	Diagnosis outside CPB 0049 (Z71.3 alone, overweight with no risk factor, asthma or ADHD)	Lead with the condition the note supports. Appeal with the note, the referral and CPB 0049.
CO-96 · Non-covered charge	The plan excludes nutrition or weight-control services, or the benefit isn't in the plan	Check the exclusion on the benefits call. A true exclusion is not appealable on coding.
CO-97 · Bundled into another service	97802 and 97803 on one visit, group and individual MNT on the same date, a same-day visit billed under the group	One code per encounter. Two real sessions need two start and stop times.
CO-45 · Charge exceeds the fee schedule	Not a denial: your charge minus the contracted allowed amount	Post it as a contractual write-off. Don't bill the member for it. Check the <i>allowed</i> amount against your contract.
CO-119 · Benefit maximum reached	Yearly visits used up, sometimes by another provider	Ask how many visits remain. Track them per patient.
CO-197 · Authorization absent	HMO referral or prior authorization not on file	Get it before the visit.
CO-4 / B7	Video visit without 95/GT or a POS that doesn't match; rendering NPI not credentialed	Match §4. The rendering NPI is the RD who signed the note.

8 Checklist: before you submit an Aetna claim

- ☐ Benefits check done this year, answers and call reference in the chart (§6).
- ☐ Referral on file when the plan requires one; its diagnosis matches the claim.
- ☐ First diagnosis is the condition CPB 0049 covers; Z68 and Z71.3 sit behind it.
- ☐ Overweight (E66.3)? The CVD risk factor is documented and coded.
- ☐ Preventive route relies on Z71.3, Z68 or Z82.49 alone? Confirm it still processes (§3).
- ☐ Units match this visit's documented minutes (§2); 97802 only on the first visit.
- ☐ Telehealth: live video, POS and modifier agree, patient location in the note.
- ☐ Rendering NPI is the RD who saw the patient; the note is signed before the claim goes out.
- ☐ Date of service is the visit's local date, the same as on the note.
- ☐ Visits remaining under any limit, and the member ID copied from the current card.

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Sources: Aetna Clinical Policy Bulletin 0049, Nutritional Counseling (last reviewed 3/10/2026). Aetna CPB 0039, Weight Reduction Medications and Programs. Aetna Telemedicine and Direct Patient Contact Payment Policy (public copy, last reviewed June 2021). Aetna provider manual (9/22): Provider Contact Center and claims routing. AMA CPT® 97802–97804 descriptors, CPT time rule and Appendix P (modifier 95). ICD-10-CM Official Guidelines, §I.B.14 and §I.C.21.c.3 (BMI). USPSTF: adult obesity (2018) and healthy diet & physical activity with CVD risk factors (2020). ACA §2713. CMS: NCD 180.1 and 42 CFR 410.130–410.134 (Medicare MNT); Telehealth FAQ (Feb 26, 2026). X12 Claim Adjustment Reason Codes.