

## Reimbursement: New Game, New Rules

Jessie M. Pavlinac, MS, RD, CSR, LD  
 Director, Clinical Nutrition  
 Oregon Health & Science University  
 Portland, Oregon  
[pavlinac@ohsu.edu](mailto:pavlinac@ohsu.edu)

### Changing Times in Health Care



### Objectives

- Effectively market nutrition services and dietitians to organizations
- Describe the new health care delivery systems and what it means for nutrition services
- Utilize Academy resources to assist in developing integration plans with these new delivery systems

► Institute for Healthcare Improvement Triple Aim Initiative



- Improve the health of the population served
- Improve the experience of the individual
- Affordability as measured by the total cost of care

## Hospital Payments are Changing

- Hospital Readmissions Reduction Program
- Hospital–Acquired Conditions (HAC)
- Hospital Value–Based Purchasing (VBP) Program
- Malnutrition Coding



## Shifting Payment Models

- ▶ Patient-centered medical home (PCMH)
- ▶ Accountable Care Organization (ACO)
- ▶ Value-based Purchasing (VBP)
- ▶ Pay for Performance (P4P)
- ▶ Fee-for-Service (FFS)
- ▶ Bundled Payments
  - Episode bundles
  - Patient bundles (Global Payments)

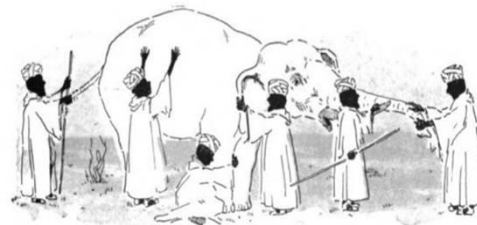


## Why New Payment Models?

- **Current fee-for-service model of care:**
  - Is not financially sustainable
  - Does not encourage disease prevention
  - Does not translate into better quality of care
- **Studies have shown that a robust primary care system leads to lower costs and better quality of care**

## Accountable Care Organization (ACO)

“An ACO is a high–performing, organized system of care and financing that can provide the full continuum of care to a specific population over an event, episode, or a lifetime while assuming accountability for clinical and financial outcomes” Bartl and Nugent, *Accountable Care Organizations*, 2011.



## Goals of the ACO

- ▶ Efficiency
- ▶ Quality
- ▶ Effectiveness
- ▶ Access
- ▶ Patient-centeredness
- ▶ Equitability

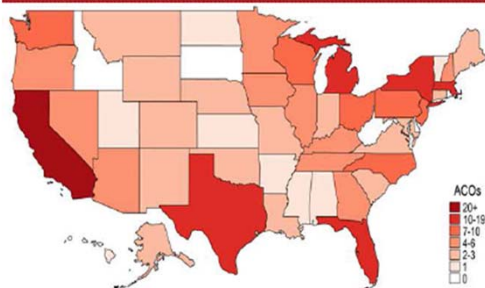


## Accountable Care Organization in Hawaii

- Meridian Holdings, Inc.

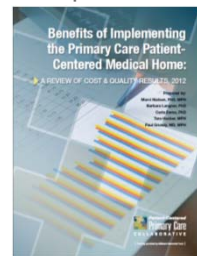
Source: Growth and Dispersion of Accountable Care Organizations 2012

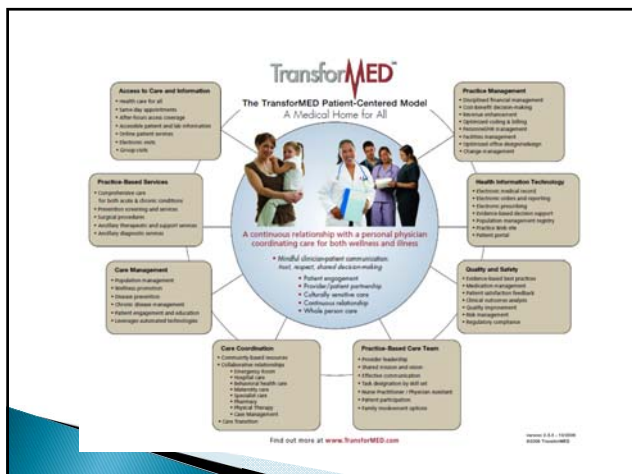
FIGURE 1. ACO DISTRIBUTION BY STATE



## Patient-Centered Medical Home/Community

- ▶ Widespread adoption in both the public and private sectors:
  - More than 90 commercial insurance plans
  - Employers
  - 42 state Medicaid programs
  - Federal agencies
  - Department of Defense
  - Hundreds of safety net clinics
  - Thousands of small and large clinical practices





## Bundled Payments

*“The bundled payment may cover services furnished by a single entity. In this context, bundled payment refers to a single negotiated episode of a predetermined amount for all services (physician, hospital, and other provider services) furnished during an episode of care.”*

CMS, August 23, 2011



**CONFRONTING COSTS**  
Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System

The Commonwealth Fund Commission on a High Performance Health System  
January 2013

Report identifies primary care and PCMH as keys to improving quality of care and reducing costs

## Capitation vs Comprehensive Care Payment

### CAPITATION (WORST VERSIONS)

No Additional Revenue for Taking Sicker Patients

Providers Lose Money On Unusually Expensive Cases

Providers Are Paid Regardless of the Quality of Care

Provider Makes More Money If Patients Stay Well

Flexibility to Deliver Highest-Value Services

### COMPREHENSIVE CARE PAYMENT

Payment Levels Adjusted Based on Patient Conditions

Limits on Total Risk Providers Accept for Unpredictable Events

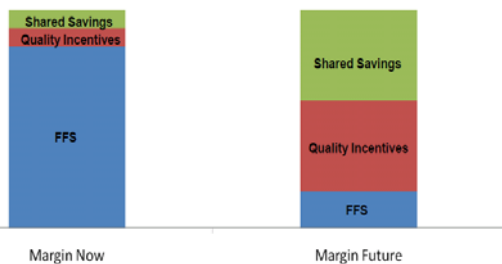
Bonuses/Penalties Based on Quality Measurement

Provider Makes More Money If Patients Stay Well

Flexibility to Deliver Highest-Value Services

Source: Harold Miller - Centers for Health Care Quality and Payment Reform

## Composition of Provider Margin – Now & in the Future



## Reimbursement Models are Changing !

- ▶ RDNs need to rethink the value proposition/message
- ▶ Document outcomes
- ▶ Build your skill set
- ▶ Be a risk-taker; be comfortable with uncertainty
- ▶ Don't wait for them to call you...make the first move
- ▶ RDNs need to learn to speak a new language



## Reimbursement models are changing!

- ▶ Emphasis on services provided within the PCP office environment
- ▶ Moving away from fee-for-service:
- ▶ Moving to bundled payments and PMPM payments
- ▶ Opportunities (and challenges) for RDNs to become integrated part of primary care!



## Winning the Game

- Build the RDN Skill Set**
- ▶ Collaboration vs. referrals
  - ▶ Contract/employment business models
  - ▶ Care coordinator/case manager
  - ▶ Transitions of care
  - ▶ Population management
  - ▶ Quality improvement teams (leader)
  - ▶ Self-management training
  - ▶ Group medical appointments
  - ▶ Employee wellness programs
  - ▶ Health coach
  - ▶ Enhanced access
  - ▶ ???



## Winning the Game

- ▶ Learn today's language of healthcare
- ▶ New assessment skills (BP, BS, AWW)
- ▶ Informatics
- ▶ Outcomes data collection
- ▶ Motivational interviewing
- ▶ Team work
- ▶ Business
- ▶ Marketing/communications
- ▶ Leadership
- ▶ Persistence



## Who pays for MNT?

Medicare

Medicaid



Commercial Insurance

Fee for Service or Self Pay

## Opportunities to expand nutrition practice and reimbursement



## Terms and Acronyms

▶ **NPI** = National Provider Identifier- standard unique identifier that replaces other provider numbers used on healthcare claims.

▶ **Diagnosis codes (ICD-9)** = Describe an individual's disease or medical condition; physicians and trained billers determine these codes

▶ **CPT codes** = Current Procedural Terminology codes (procedure codes) that describe the service performed by the healthcare professional

▶ **HCPCS codes** = Healthcare Common Procedure Coding System developed by payers to describe services where no CPT code exists (G codes, V codes)

## Commercial (Private) Insurance

Medicare	Private Payers
Black and white	50 (or more) shades of gray
NPI + PECOS	NPI + Credentialing (CAQH)
Referral required	Referral may or may not be required
Diabetes and renal disease	Potential for many diagnoses
MNT codes	MNT codes plus potentially others
CMS1500 form, UB04 form	CMS1500 form, UB04 form, Superbill
Medicare Physician Fee Schedule	Individual contracts and fee schedules

## Insurance 101

- ▶ **Commercial:**
  - PPOs/Open Access /POS/EPO
  - HMOs
  - Health Savings Plan (HAS)
  - Indemnity plan: Cadillac plans few and far between

## Insurance 101

- ▶ **Insurance Plans:**
  - Medicaid (remember varies from state to state):
    - HMO-Medicaid
    - Medicaid Managed Care Plans: reform differs from state to state
    - Straight Medicaid
  - Medicare:
    - Traditional Medicare
    - Medicare Advantage Plan-Can be HMO or PPO
    - PFFS (private fee for service)
    - Medicare supplement
    - Medicare as a secondary payer

## Insurance 101

- ▶ Self Insured Health Plans
  - Employer assumes financial risk
  - Employer customizes benefit package
  - Employer contracts with providers
  - Regulated under federal, not state laws
- ▶ Self Administered Plans vs Third Party Administrator (TPA)



## Insurance 101

- ▶ Insurance companies are not selling only “one policy”
- ▶ Coverage for nutrition services varies widely
  - Diagnoses covered
  - Number of visits
  - Referral requirements
  - Co-pays/deductibles
- ▶ Can access general information via websites



## Trends in Private Insurance

- ▶ Credentialing of Dietitians varies state to state.
  - ▶ *If you are credentialed with your ‘home’ or state plan, then you can accept insurances from any Blue Cross Blue Shield Policy.*
- ▶ Coverage varies state to state.
  - ▶ *Many states cover Medical Nutrition Therapy with limitations such as Diabetes or Hyperlipidemia.*
  - ▶ *There is growing coverage for Preventative Care, but every policy varies.*



## The *Business* of Dietetics

All nutrition professionals need to know the business of dietetics.



## Procedure Codes (CPT) for RDNs

- ▶ **Medical Nutrition Therapy ( 97802–97804)**  
Assessment and intervention, face-to-face with the patient (could include caregiver/family) each 15 minutes (individual) or 30 minutes (group)
- ▶ **Education and Training (98620–98962)**  
Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual and group
- ▶ **Medical Team Conference**  
  - 99366** .... participation by non-physician provider, with patient/family present, ≥ 30 minutes
  - 99368** .... participation by non-physician provider, without patient/family present, ≥ 30 minutes





## Procedure Codes for RDNs

### Telephone Services\*\*

98966-98968

Non-physician, non-face-to-face assessment and management services by phone, more than 7 days after a face-to-face visit; 5-30 minutes.

### On-line Medical Evaluation \*\*

98969

Online assessment and management service provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network



\*\*Not billable to Medicare; check payer policies to determine use of codes.

## Codes Applicable to RDNs:

### Intensive Behavioral Therapy (IBT) for Obesity

**G0447** Face-to-Face Behavioral Counseling for Obesity, 15 Minutes

ICD-9 diagnosis codes for BMI 30.0 kg/m<sup>2</sup> or over (**V85.30-V85.39, V85.41-85.45**)

Service can be provided up to 22 times in a 12-month period per CMS schedule

RDNs can provide IBT as auxiliary personnel in primary care settings

RDNs must bill as "incident to physician services" (guidelines differ for office-based vs. hospital outpatient clinics)

Learn more at:

<http://www.eatright.org/Members/content.aspx?id=6442468513>



## Procedure Codes for RDNs

### Preventive Medicine \*\*

99401-99404

Preventive medicine counseling and/or risk factor reduction intervention; individual; 15, 30, 45 or 60 minutes

99411-99412

Preventive medicine counseling and/or risk factor reduction intervention; group; 30 minutes or 60 minutes

**S9470 Nutrition counseling, dietitian visit \*\***



\*\*Not billable to Medicare; check payer policies to determine use of codes.

## Diagnosis Codes – Hot Off The Press

*Coming in 2015: ICD-10-CM and ICD-10-PCS*

- Claims for services provided on or after this date must use ICD-10 codes (all HIPAA covered entities)
- Transition to ICD-10 will impact all billing software, forms, and billing procedures
- Why change?
  - Improve ability to measure health care services
  - Enhance ability to conduct public health surveillance
  - Improve ability to add new codes
  - Align with current medical practices

### Differences between ICD-9 and ICD-10

There are structural differences between ICD-9 and ICD-10 that will make converting to the updated code set complex. Table 1 provides a comparison of the features of the ICD-9 and ICD-10 diagnosis code sets.

**Table 1 – Comparisons of the Diagnosis Code Sets**

ICD-9	ICD-10
3 to 5 characters in length	3 to 7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First character may be alpha (E or V) or numeric; characters 2–5 are numeric	Character 1 is alpha; characters 2 and 3 are numeric; characters 4–7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality (i.e., codes identifying right vs. left)

The expanded number of characters of the ICD-10 diagnosis codes provides greater

### Marketing Nutrition Services: Determine Marketing Cycle

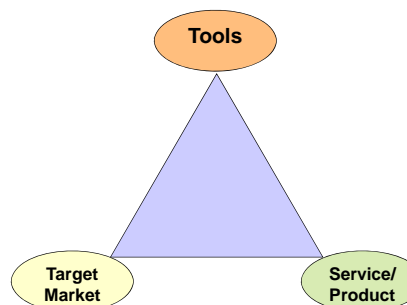


### Key Take-Aways

- The bottom line is always the bottom line.
- Think clinical outcomes and financial outcomes.
- Follow the money → jobs/job security.
- Be the expert in the business of MNT.
- Be an advocate for expanded coverage and the role of the RDN
- The Academy = your “go to” resource



### Components of the Market Plan



## Maximize Marketing Tools

- ▶ Explore resources:
  - ▶ Utilize Academy toolkits for patient education, and the online Nutrition Care Manual
- ▶ Create a presence on social networking online sites:
 

LinkedIn®	Pinterest	Instagram
Twitter	Google Plus	Flickr
Facebook	Tumblr	Meetup
- ▶ Seek listing with organizations in which you specialize



## Academy Resources



## Face to Face Contact & Community Outreach

- ▶ Visit physicians offices and use Referral Forms
- ▶ Offer a presentation to parent teacher organizations at schools
- ▶ Write an article; distribute flyers; send announcements in community or facility newspapers



## Academy Resources

- ▶ Comprehensive Primary Care Initiative: Partnering RDs with Primary Care Practices
  - Webinar – Bonnie Jortberg, PhD, RD, CDE
  - Free to Academy Members
  - Recorded and available at the Coding and Coverage Webpage

<http://www.eatright.org/coverage/>



### Academy Resources



- ▶ [www.eatright.org/coverage](http://www.eatright.org/coverage)
- ▶ [www.eatright.org/mnt](http://www.eatright.org/mnt)
- ▶ [www.eatright.org/shop](http://www.eatright.org/shop)
- ▶ [reimburse@eatright.org](mailto:reimburse@eatright.org)
- ▶ Fall 2013 HOD Meeting Backgrounder
- ▶ <http://www.eatright.org/meinc/>

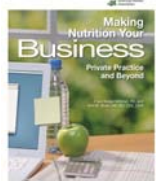


### Accountable Care 101 Webinar

- ▶ Leavitt Partners Center for Accountable Care Intelligence
  - A Short History of Integrated Care
  - Various Models of Accountable Care Organizations
  - Market Updates
- May 13, 2014 at 3 p.m. ET - [Register](#)
- June 10, 2014 at 3 p.m. ET - [Register](#)
- July 8, 2014 at 3 p.m. ET - [Register](#)
- August 12, 2014 at 3 p.m. ET - [Register](#)
- September 9, 2014 at 3 p.m. ET - [Register](#)


### Academy Resources

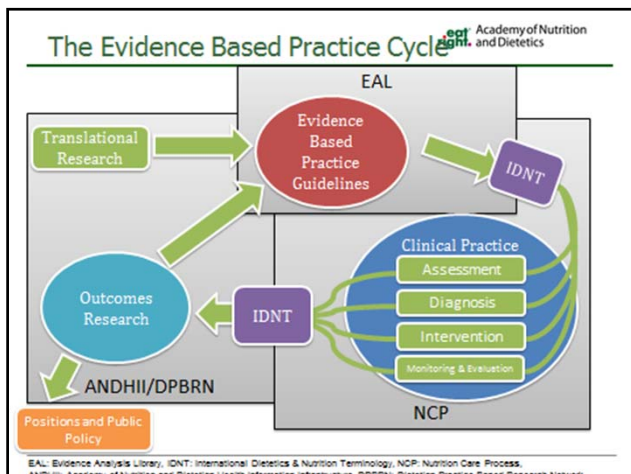
- ▶ **Making Nutrition Your Business: Private Practice and Beyond:** a resource for any RDN considering private practice.
- ▶ **Academy state dietetic association & DPG Reimbursement Representatives:** to assist RDNs with local coverage and coding issues (check Academy or affiliate/DPG web page for contact information)
  - Washington
    - Laurie Kutrich, RD
    - [laurie.kutrich@cwhs.com](mailto:laurie.kutrich@cwhs.com)
  - Idaho
    - Wendy J. Haws Rice, MS, RD, LD
    - [wrice@ahcfacilities.com](mailto:wrice@ahcfacilities.com)



### “To Do” List

- Demonstrate good outcomes
- Document ROI, cost-savings
- Build relationships with key decision-makers
- Build alliances
- Develop and implement your plan (small steps → big difference)
- Educate, educate, educate





## Innovative Encounters with ANDHII

- ▶ Instant Search
  - Find Nutrition Care Process Terms
  - Intelligent Suggestions
  - Customization

## Academy of Nutrition and Dietetics Health Informatics Infrastructure – ANDHII

- ▶ To provide an innovative platform
- ▶ To aggregate nutrition care and outcome data
- ▶ To support nutrition-focused research and quality improvement

[https://www.youtube.com/watch?v=nl\\_48GJ4MmU](https://www.youtube.com/watch?v=nl_48GJ4MmU)

IDNT Term	Value	Units/Indicators	Reference Standard
glucose		mg/dL	Individualized; currently in go
<b>Biochemical Data, Medical Tests and Procedures (BD)</b>			
Glucose/endocrine profile (1.5)			
glucose, fasting		g/day	Individualized; currently in go
glucose, casual			
preprandial capillary plasma glucose			
peak postprandial capillary plasma glucose			
glucose tolerance test			
<b>Diagnosis</b>			
Problem	Etiologies	Signs/Symptoms	
excessive carbohydrate intake	<input type="checkbox"/> disordered eating pattern <input type="checkbox"/> food- and nutrition-related knowledge deficit <input type="checkbox"/> limited access to food or water <input checked="" type="checkbox"/> decreased nutrient needs	<input type="checkbox"/> glucose, casual <input checked="" type="checkbox"/> glucose, fasting <input type="checkbox"/> glycosylated hemoglobin A1c measu <input checked="" type="checkbox"/> total carbohydrate intake <input type="checkbox"/> total carbohydrate estimated needs <input checked="" type="checkbox"/> triglycerides, serum <input type="checkbox"/> type of carbohydrate needed	

[http://www.eatright.org/coverage/  
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thank  
you!