Slide 1

Reimbursement:
New Game, New Rules

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Slide 2

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 assit in developing integration plans with these new delivery systems

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Slide 3

Changing Times in Health Care

PPACA ACO PCMH TripleAim HigherEducation ChronicDiseaseManagement PrimaryCare ValueBasedPurchasing ProviderShortages CareCoordination Prevention P4P TopofLicense Teams

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Slide 4

▸Institute for Healthcare Improvement Triple Aim Initiative

IHI Triple Aim Initiative
Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

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

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Slide 5

Hospital Payments are Changing

·Hospital Readmissions Reduction Program

·Hospital-Acquired Conditions (HAC)

·Hospital Value-Based Purchasing (VBP) Program

·Malnutrition Coding

HOSPITAL H →

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Slide 6

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

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Slide 7

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)

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Slide 8

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" *Bard and Nugent. Accountable Care Organizations. 2011.*
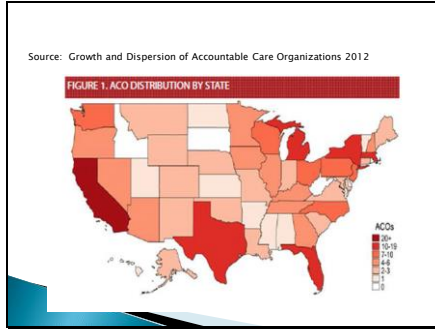
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Slide 9

Goals of the ACO

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

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Slide 10

Source: Growth and Dispersion of Accountable Care Organizations 2012

FIGURE 1. ACO DISTRIBUTION BY STATE

Slide 11

Accountable Care Organization in Hawaii

◦ Meridian Holdings, Inc.
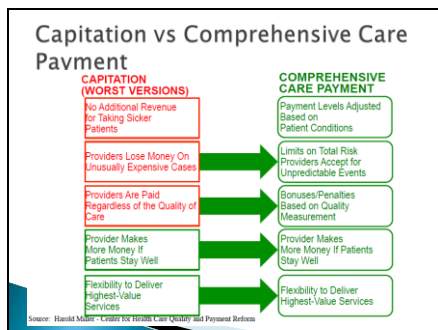
Slide 12

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
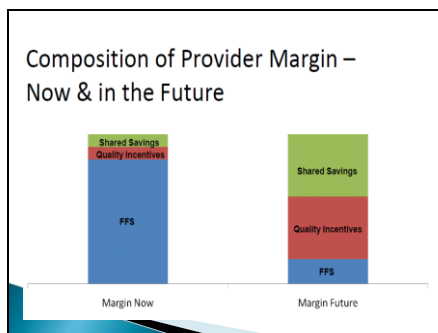- Thousands of small and large clinical practices

Benefits of Implementing the Primary Care Patient-Centered Medical Home:

Slide 13

Slide 14

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

Slide 15

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

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Slide 16

Slide 17

Slide 18

Opportunities Ahead: Bundled Payments

- Who is establishing ACOs in your community?
- Identify key leaders and decision makers (Director of Managed Care, Case Manager, MDs, CNPs, etc.)
- Arrange a meeting to discuss opportunities
- Provide evidence for the benefits that an RD can bring to ACO target population
- Build relationships across the RD community

Slide 19

What does it mean to providers?

- Good & bad
- Constant change & uncertainty
- Redefines "success"
- Potential for radical shifts in underlying financial incentives
- Not just public payers, but private/commercial payers as well

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Slide 20

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!

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Slide 21

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

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Slide 22

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
- ???

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Slide 23

Winning the Game

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

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Slide 24

Opportunities to expand nutrition practice and reimbursement

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Slide 25

Creating a Business

▸ Evaluate your AND your team's Business Plan Mindset, readiness and abilities

▸ Are you comfortable asking clients for money if you do not have a receptionist?

▸ Educate yourself on how to run a business or outpatient department

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Slide 26

Who pays for MNT?

Medicare   Medicaid

HEALTH INSURANCE
MEDICAL RECORD

Commercial Insurance   Fee for Service or Self Pay

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Slide 27

Addition Factors

▸ Medicare Part B (very specific regulations in place for MNT for diabetes and renal/post transplants)

▸ Medicaid (Ambulatory MNT coverage driven by state specifications)

▸ Private payers (specific coverage and provider policies determined by the plan)

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Slide 28

Decisions on Becoming a Provider

▸ Market Analysis with Networking

▸ Identify major providers in your community

▸ Ask your:
    Academy Affiliate
    State Reimbursement Representative
    Other private practitioners
    Hospital departments and staff

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Slide 29

Network

▸ **How can I identify major providers in my community?**
    State Academy
    State Reimbursement Representative
    Other private practitioners
    Hospital departments and staff

▸ **How can I find contacts?**
    Colleagues
    Internet
    Phone book (local medical directory)
    State insurance commission
    Local biller

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Slide 30

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)

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Slide 31

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

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Slide 32

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

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Slide 33

Insurance 101

▶ **Commercial:**
- PPOs/Open Access /POS/EPO

- HMOs

- Health Savings Plan (HAS)

- Indemnity plan: Cadillac plans few and far between

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Slide 34

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)

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Slide 35

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

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Slide 36

Insurance 101

Variation in Insurance Carriers Product Lines

One product plan:
- May cover nutrition services whereas others will not
- May be based on Medicaid as the insured are Medicaid eligible
- May be based on Medicare
- May be a commercial product ***
  ***commercial product lines will usually reimburse at the highest level

Verifying Coverage is vital to ensuring reimbursement
- Determines if a patient's coverage is current
- Determines eligibility for nutrition services based on the diagnosis

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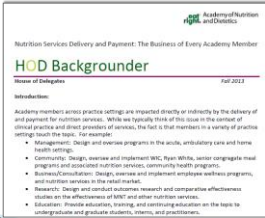_____

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Slide 37

Insurance 101

▸ Verifying coverage for nutrition services is tricky; not clear cut at times!
▸ Cannot assume that if two clients have the same commercial carrier that their benefits are the same
▸ Mistakes will result in non payment of claims
▸ Affects bottom line
▸ Requires collection procedures

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Slide 38

The *Business* of Dietetics

All nutrition professionals need to know the business of dietetics.

Academy of Nutrition and Dietetics

Nutrition Services Delivery and Payment: The Business of Every Academy Member

HOD Backgrounder

House of Delegates   Fall 2013

Introduction:

Academy members across practice settings are impacted directly or indirectly by the delivery of and payment for nutrition services. While we typically think of this issue in the context of clinical practice and direct providers of services, the fact is that members in a variety of practice settings touch the topic. For example:
• Management: Design and oversee programs in the acute, ambulatory care and home health settings.
• Community: Design, oversee and implement WIC, Ryan White, senior congregate meal programs and associated nutrition services, community health programs.
• Business/Consultation: Design, oversee and implement employee wellness programs, and nutrition services in the retail market.
• Research: Design and conduct outcomes research and comparative effectiveness studies on the effectiveness of MNT and other nutrition services.
• Education: Provide education, training, and continuing education on the topic to undergraduate and graduate students, interns, and practitioners.

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Slide 39

CREDENTIALING…Where to begin?

▸ NPI
▸ Liability
▸ CAQH

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Slide 40

National Provider Identifier (NPI)

‣ 10-digit, *intelligence free* numeric identifier used to recognize the provider on claims transactions.

‣ The standard unique identifiers for ALL health care providers and health plans (HIPAA requirement).

Contact the National Plan & Provider Enumeration System
◦ Apply over the Web: https://nppes.cms.hhs.gov
◦ Apply by phone: 1-800-465-3203 (NPI Toll-Free)

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Slide 41

Professional Liability Insurance

Protection against claims arising from real or alleged errors or omissions in the course of your professional duties is available at recently reduced rates through the Academy.

Administered by Marsh, a service of Seabury & Smith, and available for private practice or traditional employment.

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Slide 42

The Credentialing Process – How?

▪ Each company is different
▪ Each state is different
▪ Contact the credentialing department
▪ Complete a Uniform Application or enroll with Council for Affordable Quality Healthcare (CAQH)
http://www.caqh.org/ucd.php

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Slide 43

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 limite... as Diabetes or Hyperlipidemia.*

‣*There is growing coverage for Preventative Care, but every policy varies.*

Slide 44

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, <u>with</u> patient/family present, ≥ 30 minutes

   99368 ….participation by non-physician provider, <u>without</u> patient/family present, ≥ 30 minutes

Slide 45

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.*

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Slide 46

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.

Slide 47

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/m² 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

Slide 48

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

Slide 49

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

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Slide 50

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
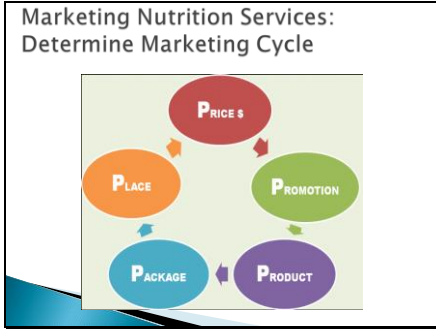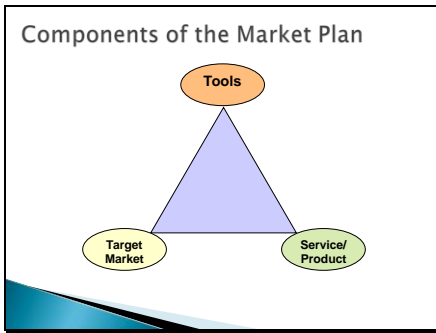- The Academy = your "go to" resource

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Slide 51

**Marketing Nutrition Services:
Determine Marketing Mix**

price · place · the marketing mix · promotion · product

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Slide 52

Marketing Nutrition Services: Determine Marketing Cycle

- **Price $**
- **Place**
- **Promotion**
- **Package**
- **Product**

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Slide 53

Components of the Market Plan

- **Tools**
- **Target Market**
- **Service/ Product**

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Slide 54

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   Flicker
  - Facebook   Tumbir   Meetup

- Seek listing with organizations in which you specialize

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Slide 55

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

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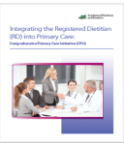
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Slide 56

Academy Resources

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Slide 57

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/

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Academy Resources
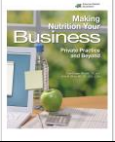
- www.eatright.org/coverage
- www.eatright.org/mnt
- www.eatright.org/shop
- reimburse@eatright.org
- Fall 2013 HOD Meeting Backgrounder
- http://www.eatright.org/meinc/

Registered Dietitians
Your Nutrition Experts
For Prevention, Disease Management And Cost-effective Care

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Slide 59

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
  ○ Idaho
    • Wendy J. Haws Rice, MS, RD, LD
    • wrice@ahcfacilities.com

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Slide 60

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
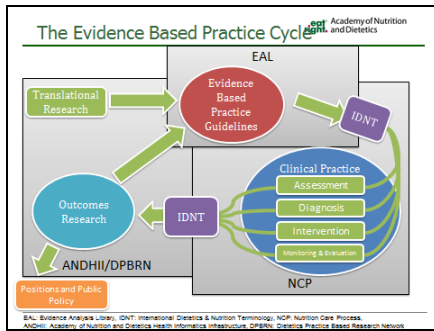
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Slide 61

"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

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Slide 62

The Evidence Based Practice Cycle

Academy of Nutrition and Dietetics

EAL

Translational Research

Evidence Based Practice Guidelines

IDNT

Clinical Practice
- Assessment
- Diagnosis
- Intervention
- Monitoring & Evaluation

Outcomes Research

IDNT

ANDHII/DPBRN

NCP

Positions and Public Policy

EAL: Evidence Analysis Library, IDNT: International Dietetics & Nutrition Terminology, NCP: Nutrition Care Process, ANDHII: Academy of Nutrition and Dietetics Health Informatics Infrastructure, DPBRN: Dietetics Practice Based Research Network

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Slide 63

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=nI_48GJ4MmU

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Slide 64

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Slide 67

http://www.eatright.org/coverage/
reimburse@eatright.org

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Slide 69