Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership
Introduction

The Intensive Behavioral Treatment (IBT) for Obesity benefit for Medicare Part B beneficiaries is an important first step in treating obesity medically. There are positive and negative aspects of this benefit, yet it clearly offers an opportunity for the registered dietitian (RD) to become part of the primary care provider’s (PCP’s) team. The schedule of visits is intense enough to support weight loss and behavior change and, because adequate follow-up is sanctioned, it gives the RD an opportunity to follow the treatment’s effectiveness over time.

The purpose of this toolkit is to provide you, the RD, with the information and tools you need to successfully align with PCPs to provide the new IBT for Obesity benefit under Medicare Part B. You may also find this resource useful beyond the Medicare population as more private payers are expanding obesity counseling benefits under the Affordable Care Act provisions. Almost all of the pieces within this toolkit have been written and published previously within the Academy of Nutrition and Dietetics by RDs. This toolkit brings all of these valuable resources that pertain to the RD/PCP partnership together in one place to make it easier for you to establish and foster a healthy relationship with the PCP.

There are five primary sections of this toolkit (see below). Like a real toolkit, use only the tool, section, or article that you need to get the job done. You do not need to read every section or every page of each section, or even read the sections in order. In other words, use what you need when you need it. Throughout the toolkit you will see textboxes. These highlighted areas provide background information on important concepts—new and old—for the RD to understand in order to be a contributing member of the health care team.

Section I: Nailing Down the Basics of the IBT Benefit. This section provides the nitty-gritty of coding and coverage regarding the Medicare Part B benefit for IBT for Obesity.

Section II: Aligning Yourself with the PCP. This section provides marketing basics to help you establish business with the PCP.

Section III: Creating the Blueprint to Build Your Practice. This section provides information and tools that will help you with the business and contractual aspects of working within a PCP practice.

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Section IV: Measuring Your Effectiveness. This section provides tools and resources to help you begin to collect outcomes relevant to your practice so that you can measure and share your effectiveness.

Section V: Wrench, Hammers, and Screws: Further Resources and Tools. This section provides further resources that will support your weight management practice, understanding of the IBT benefit, reimbursement know-how, and business skills.

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SECTION I. Nailing Down the Basics of the IBT Benefit

The purpose of this section is to provide the nitty-gritty details of coding and coverage for the Intensive Behavioral Therapy (IBT) for Obesity benefit for Medicare Part B beneficiaries. Although registered dietitians (RDs) cannot directly bill for this service outside a primary care physician’s (PCP’s) practice, having a solid understanding of this benefit—the codes to use for billing, the allowed frequency of visits, etc.—is important and establishes the RD as a knowledgeable and contributing member of the health care team. Knowledge of these essentials is even more important when the RD is establishing a new PCP partnership so that he or she can effectively pitch a weight management program that is reimbursable under Medicare Part B.

This benefit became effective on November 29, 2011, and covers screening and intensive behavioral counseling for obesity by PCPs in primary care settings for Medicare beneficiaries with a body mass index (BMI) ≥ 30 kg/m². The decision means RDs can provide services as auxiliary personnel in primary care settings and bill the services as “incident to” in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines (42 CFR § 410.26(b) or 410.27). CMS notes that the new benefit does not preclude PCPs from referring eligible beneficiaries to other practitioners and/or settings for counseling; however, coverage remains only in the primary care setting. RDs should work collaboratively with PCPs to provide this service.

The Benefit

Billing and Coding

- Procedure Code: HCPCS code G0447: Face-to-Face Behavioral Counseling for Obesity, 15 Minutes
- RDs must bill as “incident to” physician services
- Medicare coinsurance and Part B deductible are waived for this service
- Code in medical chart before service
- Diagnosis Code: ICD-9 Codes: V85.30-V85.39, V85.41-V85.45
- Note: ICD-10 codes will be Z68.30-Z68.39, Z68.41-Z68.45
**ICD-9 Code | BMI Range (kg/m²)**
---|---
V85.30 | 30.0-30.9
V85.31 | 31.0-31.9
V85.32 | 32.0-32.9
V85.33 | 33.0-33.9
V85.34 | 34.0-34.9
V85.35 | 35.0-35.9
V85.36 | 36.0-36.9
V85.37 | 37.0-37.9
V85.38 | 38.0-38.9
V85.39 | 39.0-39.9
V85.41 | 40.0-44.9
V85.42 | 45.0-49.9
V85.43 | 50.0-59.9
V85.44 | 60.0-69.9
V85.45 | ≥70.0

**Q&A**

**Q:** HCPCS G0447 is a time-based code. What is the difference between time-based and service-based CPT® codes?

**A:** Time-based CPT® codes are codes that have a set value assigned to the service and are intended to be used once per event. When selecting the appropriate code to use for billing purposes, time spent face-to-face with the patient is the criterion used for code selection. Examples of time-based codes that an RD may use, based on payer policies, are the Non-Face-to-Face, Nonphysician Services, Telephone Services CPT® codes 98966 to 99968. Selection of 98966, 98967, or 99968 is based on the number of minutes of discussion with the patient. A unit of time is attained when the midpoint is passed. Multiple units cannot be billed for time-based codes. For example:

- 98966: 5-10 minutes
- 98967: 11-20 minutes
- 99968: 21-30 minutes

A service-based CPT® code is a code that has been assigned a unit of time per service and can be billed as multiple units, up to a limit per payer policies, based on the amount of face-to-face time spent with a patient. The medical nutrition therapy (MNT) billing codes 97802 to 97804 are examples of service-based codes used by RDs. Multiple units of these codes can be billed per visit, per payer policies.

While G0447 for IBT for Obesity is a time-based code (15 minutes), the Academy is seeking clarification from local MACs whether multiple units can be billed for this service (this is more like a service-based CPT® code).

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**Frequency**

For claims with dates of service on or after November 29, 2011, Medicare will pay for G0447 (with an ICD-9 code of V85.30-V85.39, V85.41-V85.45) no more than 22 times in a 12-month period, counted from the date of the first claim, in accordance to the following schedule:

- One face-to-face visit every week for the first month.
- One face-to-face visit every other week for months 2 to 6.
- One face-to-face visit every month for months 7 to 12, provided the beneficiary meets the 3-kg (6.6-lb) weight loss requirement during the first 6 months. The required weight loss must be documented in the physician office record for reimbursement of the visits for months 7 to 12.
• For beneficiaries who do not achieve a weight loss of at least 3 kg (6.6 lb) during the first 6 months of intensive therapy, the practitioner must wait for a 6-month period (no IBT for Obesity) and then reassess the patient’s readiness to change and BMI. If the patient meets the criteria for treatment, the practitioner can re-administer the first 6 months of the program. (Be aware that a patient can only receive 22 visits in a 12-month period, so the restart date should be at least 12 months from the original start date.)

Units and Group Visits

• While the CMS Claims Processing Manual provides no specific guidance as to whether or not the benefit can be offered as a group service, during the June 4, 2013 CMS Physicians, Nurses & Allied Health Professionals Open Door Forum, CMS announced that the Intensive Behavioral Therapy for Obesity benefit currently cannot be provided in a group setting. The billing code established for the benefit (G0447) was valued as an individual service and so its use is limited to individual counseling sessions. CMS has received feedback from the provider community expressing concerns about this policy and is actively considering an option for group settings.

• CMS has deferred decisions about billing multiple units on the same day of service to the Medicare Administrative Contractors (MACs). [Click here](#) for a list of MACs with contact information. [Click here](#) for a compilation of the Academy’s efforts to obtain this information from the MACs.

Patient Eligibility Requirements

• Patients must be Medicare Part B beneficiaries with a BMI ≥ 30 kg/m² and competent and alert at the time counseling is provided.

• Counseling must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting (RDs may provide the service “incident to” physician services).

• At the 6-month visit, a reassessment of obesity and a determination of the amount of weight lost must be performed. If the beneficiary has lost at least 3 kg (6.6 lb) over the first 6 months of intensive therapy and this fact is

Q&A

Q: What is the difference between a CPT® code and a diagnostic code?

A: A diagnostic code identifies the patient’s diagnosis. Payers in the United States use the ICD-9 (International Classification of Disease) codes. In the past, obesity was typically identified using the ICD-9 diagnosis code of 278.00. However, for the IBT for Obesity Medicare Part B benefit, the diagnosis (ICD-9) codes to use are V85.30-V85.39, V85.41-V85.45 (see chart to find specific code to use based on patient’s BMI).

A procedure code is a code used to identify the service or procedure that the provider is billing for. CPT® (Current Procedural Terminology) codes are owned by the American Medical Association and used among private payers and the Centers for Medicare & Medicaid Services (CMS). HCPCS is a series of codes developed by the federal government and specifically CMS to describe procedures or items not listed in the CPT® manual.

The common CPT® codes for MNT are 97802 (MNT initial assessment and intervention, individual, face-to-face, each 15 minutes for 1 unit) and 97803 (MNT follow-up, individual, face-to-face, each 15 minutes for 1 unit). For IBT for Obesity, the code is an HCPCS code: G0447 (face-to-face, 15 minutes).
documented in the physician office records, additional services may be provided.

**Place of Service**

Medicare will pay for obesity counseling claims only when services are provided with the following place of service (POS) codes for PCPs:

- 11—Physician’s Office
- 22—Outpatient Hospital
- 49—Independent Clinic
- 71—State or Local Public Health Clinic

*Note: Effective January 1, 2013, IBT can be provided via telehealth as long as the service meets all other CMS requirements.*

**Type of Service**

The type of service (TOS) code for G0447 is 1.

**Eligible Primary Care Providers**

Registered dietitians may provide the new benefit “incident to” a PCP (including NPs, PAs, and Certified Clinical Nurse Specialists, as well as MDs); they may not bill directly for this service. RDs can work with the following provider specialty types to provide the service:

- 01—General Practice
- 08—Family Practice
- 11—Internal Medicine
- 16—Obstetrics/Gynecology
- 37—Pediatric Medicine
- 38—Geriatric Medicine
- 50—Nurse Practitioner
- 89—Certified Clinical Nurse Specialist
- 97—Physician Assistant

**Medicare Payment Rate**

For services provided in a primary care office practice, payment rates for the benefit are based on the current Medicare Physician Fee Schedule (PFS) and are adjusted geographically and by place of service to reflect relative differences among costs. Find the payment rate for your region and place of service via [the current Medicare PFS](http://www.medicare.gov). For institutional claims submitted by hospital outpatient departments, payment is made under the Outpatient Prospective Payment System (OPPS).

For Rural Health Clinics and Federally Qualified Health Centers, claims will be paid based on the all-inclusive payment rate. Obesity counseling is *not* separately payable with another encounter/visit on the same day. This does not apply for Initial Preventive Physical Examination (IPPE) claims, claims containing modifier 59, and 77X claims containing Diabetes Self-Management Training and Medical Self-Management Training services.

**Inside Scoop on Payment Rate**

To be economically viable at current reimbursement levels, the counseling will probably have to be offered through a non-physician provider.

General reimbursement at the 2012 conversion rate translates to $25 payment for each 15-minute counseling session. (Actual payments to individual clinicians will vary according to geographic adjustments factors.)

Given the reality of packed physician appointment calendars and the fact that reimbursement levels for obesity counseling are not as high as for a regular primary care office visit, some physicians may conclude that they cannot afford to provide the service. This burden for physicians, however, creates a golden opportunity for RDs who are able to work “incident to” a physician to provide the service.

The Academy is recommending that its members align themselves with primary care practitioners in new ways to take advantage of the available reimbursement opportunities.
Private Insurance

The IBT for Obesity is a benefit for people who have Medicare Part B. This benefit does not apply to private insurance companies unless the insurance company agrees and creates an internal benefit to cover IBT for Obesity. Medicare, however, exerts a major influence on the rest of the health care system, and its reimbursement and coverage policies in the past have been widely adopted by private insurers and other public programs. It is important for RDs to check the coverage policies of the private health insurance companies in their area. Click here for information on insurance coverage or talk with your Academy regional Reimbursement Representative to get information on local insurance coverage.

“Incident to” Guidelines for Medicare Part B

In order to bill a service as “incident to,” the service must be:

- An integral, although incidental, part of the physician’s professional service.
- Commonly rendered without charge or included in the physician’s bill.
- Of a type that is commonly furnished in physicians’ offices or clinics.
- Furnished by the physician or by auxiliary personnel under the physician’s supervision.
- Established patient visits.

The Centers for Medicare & Medicaid Services defines auxiliary personnel as “any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee or contractor of the physician, or of the legal entity that employs or contracts with the physician” (Medicare Benefit Policy Manual, Chapter 15). Registered dietitians may be considered auxiliary personnel for the purposes of providing several Medicare Preventive Services:

- Intensive Behavioral Therapy for Obesity
- Intensive Behavioral Therapy for Cardiovascular Disease
- Annual Wellness Visit

Specific guidelines for billing “incident to” services vary based on the practice setting. The best way to determine which rules apply is to identify how the office/facility bills and gets paid under Medicare. If it is through the Medicare PFS, then follow guidelines for the primary care office setting. If payment is made through the Medicare OPPS, then follow the outpatient hospital setting rules. Click here for more details on the following information.

Primary Care Office Setting

- “Direct supervision” means the physician must be present in the office suite and immediately available to provide assistance and direction at the time the auxiliary personnel is performing the service.
- The physician does not need to be present in the room when the service is performed.
- The supervising physician does not need to be the same physician upon whose professional service the “incident to” service is based. One physician in a group practice can supervise all services performed in the office on any given day where patients are under the care of any of the group’s physicians.
- Billing is done under the physician’s NPI with payment going to the physician or facility to which the physician has reassigned his or her benefits. The RD would be paid under a previously established agreement with the physician or the practice.

[Source: 42 CFR §410.26(b); 42 CFR §410.32(b)(3)(iii); 42 CFR §410.26(b)(5).]
Outpatient Hospital Setting

- Under the 2011 Outpatient Prospective Payment System rule, all hospital outpatient therapeutic services provided “incident to” a physician service require direct supervision by the physician.
- Direct supervision for therapeutic outpatient services is defined as “immediately available to furnish assistance and direction throughout the performance of the procedure.”
- There is no defined special requirement for the supervision.
- Most hospitals establish their own policies regarding supervision of therapeutic outpatient services. So before providing the “incident to” service, RDs should become familiar with their hospital’s policies and ensure that the supervision requirements are met.
- The physician must be involved in the management of that course of treatment and see the patient periodically and sufficiently often to assess progress.
- Billing is done under the physician’s NPI with payment going to the facility to which the physician has reassigned his or her benefits.

Additional Information

- CMS Intensive Behavioral Counseling for Obesity Billing Guidelines
- Medicare Claims Processing Manual—Chapter 18: Preventive and Screening Services
- National Coverage Determination Memorandum

Medicare’s Federally Qualified Health Centers

To increase access to primary and preventive care services for individuals living in medically underserved communities, Congress authorized Federally Qualified Health Centers (FQHC) as a health care facility type and established requirements for Medicare coverage and payment as FQHCs under the Omnibus Budget Reconciliation Act (OBRA) of 1990. FQHCs are typically rural and urban safety net providers that provide primary and preventive care services to individuals regardless of their ability to pay.

A basic understanding of FQHCs is important for three reasons. First, FQHCs are demonstrative of a team-based approach to primary care, relying on advanced practice nurses, physician assistants, and other nonphysician practitioners, as well as physicians. Second, FQHCs are required to provide care in medically underserved areas or to treat medically underserved populations and play a role in meeting primary care capacity challenges in low-density rural areas. Third, the change in Medicare’s payment system from a per visit cost-based reimbursement to a prospective payment system will likely result in higher payments to FQHCs, thus encouraging these providers to serve more Medicare beneficiaries.

Rural Health Clinics, using TOB 71X, and FQHCs, using TOB 77X, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not applied to this service. Such claims will be paid based on the all-inclusive payment rate.
SECTION II. Aligning Yourself with the PCP

The Intensive Behavioral Treatment (IBT) for Obesity benefit, as well as other important health care initiatives such as the Annual Wellness Visit, the Patient-Centered Medical Home, and Accountable Care Organizations, offers the registered dietitian (RD) new business opportunities and practice models. As health care reform unfolds with the intention of improving the quality of health care and reducing costs, the model of health care is changing to one that is more team based, providing more coordinated care to support the patient’s health. The RD is an important member of the health care team. While this is widely recognized in the inpatient setting, it is not fully actualized in the outpatient setting. This is an important time for the RD to create new alliances and establish new partnerships with the primary care practitioner (PCP).

Looking at the Benefits and Challenges of IBT to Create Your Marketing Message

The positive aspects of the IBT benefit are that it reimburses behavioral counseling for weight loss within the PCP setting, and the schedule of visits is intense enough to support weight loss and behavior change with the opportunity to provide the service over multiple years. In addition, because adequate follow-up is sanctioned, it gives the provider an opportunity to follow the treatment’s effectiveness over time. Another potential benefit is that other private health insurance companies may follow suit and cover or create a benefit for intensive behavioral counseling for obesity in the future.

The challenge of this benefit is how to deliver it in a cost-efficient manner. Each visit is 15 minutes, and the payment rate averages $25 per visit (click here to see the reimbursement rate in your area). Relative to reimbursement for other medical services, the rate is low and limits who can realistically provide that service. The Centers for Medicare & Medicaid Services (CMS) is referring providers to local Medicare Administrative Contractors (MACs) to provide clarification about whether the benefit can be delivered in groups or if multiple units can be administered on the same date of service (for example, Can two units be used on one visit for a 30-minute visit?).

Given this situation, RDs can align their services with PCPs and market themselves as highly qualified, effective, and less expensive providers for the IBT benefit, which would be billed “incident to” the physician/PCP. The following section provides information and tools to help the RD position him/herself to partner with the PCP. The first two pages provide a handout that can be reproduced for use in marketing efforts.
RDs and PCPs: A Healthy Partnership

Why Adding an RD to the Medical Staff is a Good Idea

RDs Are Effective

- Studies show medical nutrition therapy (MNT) provided by a registered dietitian (RD) to overweight and obese adults for less than 6 months yields significant weight losses of approximately 1 to 2 pounds per week.
- MNT provided from 6 to 12 months yields significant mean weight losses of up to 10% of body weight with maintenance of this weight loss beyond 1 year.
- Overweight/obese individuals who received MNT provided by RDs in addition to an obesity-related health management program that included physician visits, nursing support, and education materials and tools were more likely to achieve clinically significant weight loss than individuals who did not receive MNT.¹

Improved health outcomes using MNT by RDs has also been published in the area of diabetes, hypertension, and disorders of lipid metabolism, as well as HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults.

RDs Are Cost-Efficient Providers

- RDs provide MNT and have experience and training in behavior counseling and weight management.
- RDs fees are lower than physicians, nurse practitioners, and physician assistants.
- Having a strong clinical and counseling background, RDs can effectively provide Intensive Behavioral Treatment for Obesity and help with the Annual Wellness Visit incident to the PCP.
- MNT by the RD for diabetes and chronic kidney disease is a covered, billable benefit by Medicare Part B and many private health insurance companies.

- Many RDs are certified diabetes educators and can provide and bill for Diabetes Self Management Treatment.

RDs Provide a Positive Return on Investment

- MNT is linked to improved clinical outcomes and reduced costs related to physician time, medication use, and hospital admissions for people with obesity, diabetes, and disorders of limpid metabolism, as well as other chronic diseases.¹
- An RD-delivered lifestyle approach to diabetes and obesity improved diverse indicators of health, including weight, HbA1c, health-related quality of life, use of prescription medications, productivity, and total health care costs²,³,⁴ For every dollar invested in the RD-led lifestyle modification program there was a return of $14.58.⁵
- The Lewin Group documented an 8.6% reduction in hospital utilization and a 16.9% reduction in physician visits associated with MNT for patients with cardiovascular disease. The group additionally documented a 9.5% reduction in hospital utilization and a 23.5% reduction in physician visits when MNT was provided to persons with diabetes mellitus.⁶

RD Services Are Integral to the Patient-Centered Medical Home

RDs work hand-in-hand with referring providers and multidisciplinary health care team members to deliver care that is coordinated and cost-effective. In addition to providing MNT, RDs address areas such as glucose monitoring and chronic disease self-management.

Please see reverse side for footnotes

¹Please see reverse side for footnotes

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How to Connect with Physicians
By Ann Silver, RD, MS, CDE, CDN
Long Island, NY

Adapted with permission from “Making Nutrition Your Business.” MNT Provider. Chicago, IL: Academy of Nutrition and Dietetics; July 2010, p. 4.

Ann Silver, RD, MS, CDE, CDN, discussed how she was successfully able to integrate her services into multiple physician offices in New York.

Silver owns a private practice with three office locations on Long Island, New York. She has her own office, and she rents space in two different physician’s practices. One office is in an endocrinology practice and the other, approximately 30 miles away, is in a primary care office. She credits much of her referral stream to the positive working relationships she has developed with physicians and their office staff throughout the years.

Step 1: Identify doctors with whom you have a connection or offices in your community that you think might be a fit for your specialty.

Consider reaching out to:
• Doctors you worked with in a hospital, clinic, or nursing home
• Your own personal doctor
• A doctor you know through networking at a church or synagogue
• A doctor who is opening a new office in the area
• A doctor who is highly recommended by your patients
• A specialist in the area who would benefit from an RD on site (e.g., for weight management, diabetes, renal disease, sports nutrition, ENT for sleep apnea)

Step 2: Decide how best to communicate with the doctor. Consider these questions before reaching out:
• Why would the physician want an RD in the office?

Annual Wellness Visit: An Opportunity for RDs to Work with PCPs
As a result of the Affordable Care Act, Medicare beneficiaries may now receive an Annual Wellness Visit (AWV), opening up new opportunities for registered dietitians (RDs) to partner with physicians and market their services. New Medicare beneficiaries, within 12 months of enrollment in Part B, are eligible for a one-time “Welcome to Medicare Visit” as a means for developing a personalized plan for preventive services. If patients have had Medicare Part B for longer than 12 months, they are eligible for a yearly wellness visit to develop or update their personalized plan to prevent disease based on their current health and risk factors. Even if the beneficiary never received a Welcome to Medicare Visit, he or she is still eligible to receive an AWV. This benefit is provided at no cost to the beneficiary and provides an ongoing focus on prevention.

Why Is This New Benefit Important to RDs?
Because it provides two opportunities to provide services to Medicare beneficiaries and demonstrate the value of these services to the health care team. First, under certain circumstances, RDs can actually provide the AWV fully or as part of a team. RDs would deliver this service under direct supervision of the physician and the office would bill the services “incident to.” Second, the AWV can spur referrals to RDs for Medicare Part B medical nutrition therapy (MNT) services for beneficiaries diagnosed with diabetes or renal disease and for those who have received a kidney transplant within the previous 3 years. These MNT services can be provided on the same day as the AWV or on another day.

To learn more specifics about this benefit:
1. MNT Provider Oct 2011 “New Opportunities under Medicare” article.
2. “Annual Wellness Visit” downloadable format from the Medicare Learning Network.
3. The Preventive Services Quick Reference Chart.
• What benefit will an RD be to the doctor and staff?
• How can I make a difference?

Step 3: Perfect your messages and on-site deliverables. Consider these points:

• RDs can improve the overall health of patients in the practice.
• RDs can save the doctor time by offering more comprehensive care.
• RDs are the nutrition experts.
• You can use Academy resources such as the Medical Nutrition Therapy MNTWorks Kit and others provided in this toolkit.
• Face-to-face visits work the best for establishing relationships with physicians. E-mails often get lost in the mix.
• Be confident. Physicians are human too!

In addition, Silver suggested getting tips from other RDs. “Network with colleagues who are already in physician’s offices or join dietetic practice groups.” Getting the wheels in motion is sometimes the hardest part. However, by strategically thinking about which physicians to contact and making sure all messages are on point, Silver believes that RDs can position themselves for some interesting business opportunities. Plus, she said, the key to raising the visibility of the RD lies in easy access to nutrition services. “The more RDs in MD offices, the more our services are going to be sought.” Silver shares more details about starting a private practice with her coauthor Faye Berger Mitchell in the Academy of Nutrition and Dietetics publication *Making Nutrition Your Business: Private Practice and Beyond.*
There are seven key components that comprise a complete service marketing plan for individuals and businesses that offer services rather than products.

1. **Product**: Primary nutrition services offered.

2. **Place**: Location where nutrition services are delivered.
   Depending on the business model selected for delivering nutrition services, you may not be able to select the location (e.g., as traditional employee in a clinic). But if you can, seek to offer your services:
   - In multiple sites, especially where there is a heavier concentration of patients.
   - In areas with high traffic and pedestrian volume (e.g., strip mall).
   - In close proximity to referring providers.
   - In locations that are safe, convenient for your clients, handicap accessible, spacious, and sporting a professional décor.

3. **Promotion** (including advertising)
   The promotion section of your marketing plan describes how you’re going to deliver your “selling proposition” to your target markets. To select your promotions from the dozens that are available, the RD must focus on the message that she/he wants to convey to the patients and providers. Promotions may include:
   - Logo and tagline to create a brand
   - Website (own or link on other related sites)
   - Feature and seasonal articles in newspapers, hospital newsletters, and website
   - Own newsletter (hard copies, direct mail, e-mail)

4. **Price** of Nutrition Services
   Pricing starts with setting your *pricing objective* in order to develop a metric; possible objectives are profit maximization, revenue maximization, loss minimization, or breaking even. The second step is to identify and flesh out the key factors that are routinely used to determine the price of any and all services delivered in a medical practice:
   - Insurance reimbursement rates (Medicare, Medicaid, and private payers) for in-network and out-of-network providers.
   - What the market will bear; this requires you to research competitors’ fees.
   - Target markets’ perceived value of nutrition services.
   - Fixed and variable expenses.
   - The time, complexity, and format of the various types of nutrition services offered.

   Setting your prices requires decisive and deliberate action steps. If these steps are not taken, your fee schedule can be too low or too high, which can cause detrimental side effects, and ultimately loss of market share.

5. **Packaging** of Nutrition Services
   RDs must be aware of not only how *they* are “packaged” but also how their nutrition services are packaged. Why is “self-packaging” important? It speaks, albeit silently. People are judged by their cover, whether we like it or not, and first impressions are everything! Make sure this nonverbal data says to your target markets that you are organized, disciplined, and confident; have self-respect and respect for others; and that you are a high-level professional with exceptional expertise. Why is packaging of your services important? It will convey the same positive or negative message.
to your patients and providers as self-packaging. Your marketing brochures, education handouts, folders, stationery, etc. should be the highest quality you can afford. And do not undervalue the importance of your telephone voice message and even the promptness of return phone calls. How you package your office space is also critical. Clutter, dust, torn carpeting, chipped furniture, and broken clocks all convey a “no care attitude” that will eventually translate to a loss of patients and referrals. Remember, everything gives off a message of professionalism and competence…or lack thereof.

6. **Person/People** Providing Nutrition Services

In my experience as an RD of over 30 years, I believe that the RD must have basic skills in at least three key areas to attain and maintain a position in a medical practice: interpersonal skills, clinical skills (competency and proficiency in the services furnished), and teamwork skills. Patients will communicate their perceptions not only of the RD but also of the services they received to the referring provider, and these three areas are typically what patients focus on. In addition, advanced clinical skills and/or advanced credentials may be required for reimbursement, or as a condition for hiring. Often, we hesitate to step out of our comfort zone to obtain these higher-level skills, but it is well worth the time, effort, and money, as career doors open in places you don’t even expect! Take the plunge…you’ll be glad you did in this highly competitive market.

7. **Process** Related to Delivery of Nutrition Services

The processes used to deliver the nutrition services must be efficient and be of the highest quality. Why is this important? Because the final activity of a marketing plan is furnishing your services in a way that meets or exceeds the target markets’ identified needs and expectations. Processes should be developed with these goals in mind:

- Increase efficiency, timeliness, effectiveness, and quality of your operations, claims processing and payment, and quality management systems.
- Increase patient and provider loyalty, confidence, and satisfaction.
- Decrease patient “no show” rates.
- Increase patient referrals from providers.
- Increase patient self-referrals.
- Maximize utilization of products/services by patients and providers.

In the end, the seven “Ps” of the RD’s service marketing plan must work together in synergistic harmony to maximize impact on and profit for the medical practice…keys to attaining and maintaining a position within the practice.

**Sources:** See primary article for a list of resources and references.
The relationship between the registered dietitian (RD) and physician (MD) is crucial in the field of dietetics and is one of many excellent avenues to utilize in branding ourselves as “the nutrition experts.” The physician is the head of the health care team and drives referrals. New payment models such as Accountable Care Organizations are opening doors for RDs and make good relationships with physicians essential. In addition, new coverage decisions by the Centers for Medicare & Medicaid Services are reinforcing the need for RDs to develop strong relationships with physicians and other primary care providers.

A successful relationship with a physician is no different than a successful relationship in any other area of your life. Key ingredients to a successful relationship should include, but are not limited to, open communication, trust, dependability, and respect. RDs need to enter relationships with MDs with confidence, certainty of their own expertise, and a strong desire to share the common goal of improving patient outcomes. If you are passionate about what you do, that passion will always shine through. A successful RD-MD relationship is evidenced by the trust physicians bestow on us by referring patients to our practices for medical nutrition therapy and diabetes self-management training.

How do we begin to establish the relationship with physicians? How do we approach MDs? Approaches can be made in a number of ways, including person-to-person introductions, e-mail, mailings, websites, and media. Regardless of the approach, always display the utmost confidence and have a customer value proposition (CVP) prepared.

A CVP is a business or marketing statement that summarizes why a consumer should buy a product or use a service. A strong CVP is expressed from the customer’s perspective and highlights the experiences and benefits you provide. Find tangible ways to convey your worth. For example, present quantified data and patient testimonials to demonstrate your value to your customer. Include a testimonial from a physician or patient.

Keep in mind, you may only have a few minutes to present your proposition. Be sure your statement is clear, concise, and compelling. Once you have your plan in place, it is time to hit the road running. But, don’t let the face-to-face meeting with a physician be your first attempt at your presentation—practice, practice, practice! Be prepared to convince the physician that your product or service will add more value or better solve a problem than other similar offerings.

Most importantly, remember to ask for the business! One thing is a certainty: if you don’t ask for the business, you will never get the business. “No” is a small but powerful word, and you may be scared of rejection. However, you are guaranteed to miss every shot you don’t take. Therefore, don’t think of rejection as a negative experience. Those who have not been rejected have not succeeded. We can learn best from those that have traveled this road before us. Persistence is the key.

Once you have established a relationship with an MD, it is very important to nurture the relationship through continued communication and by seeking feedback for improvement. Supply the physician with documentation of improved subjective and objective patient outcomes. Also, ask the physician and the office staff what you can do to strengthen your relationship. Set an appointment with the physician once or twice a year to present an outcomes report. Even if the meeting lasts only a few minutes, it reinforces that your services are an asset to the practice. The best advice I can give is to develop your plan, take action on your plan, monitor outcomes and feedback, and improve your plan based on the information you collect.
The Patient-Centered Medical Home (PCMH) model for health care delivery is designed to improve the quality of the U.S. health care system and reduce health care delivery cost. This model departs from the current fee for service system, which bases physician payment on the number of patients they see and the individual services or resources they use. The PCMH model adds a care coordination payment to the physicians. This provides an incentive for physicians to maximize quality care, reduce costs for repetitive services, and decrease hospital admissions and emergency room visits.

Introduction to the Patient-Centered Medical Home

The RD’s Role in the PCMH

Since medical home tenets include disease prevention and management of co-morbidities, RD participation is essential to improve patient health outcomes and reduce costs.

– Academy of Nutrition and Dietetics Medical Home Workgroup’s “Patient-Centered Medical Home Strategic Plan”

Many PCMH models are in place across the country. A variety of groups, including payer groups, state medical boards, state and federal government agencies, and national medical associations, have collaborated to develop local PCMH models. Most models are initiated as demonstration projects to assess the program’s impact and cost savings on a particular patient group, and in some cases the model targets specific disease conditions. Registered dietitians can be an integral part of the team that provides patient-centered care to individuals through the medical home.

Further Reading

1. Academy of Nutrition and Dietetics Website.
2. Patient-Centered Primary Care Collaborative.
3. TransforMed.
6. American College of Physicians.
Accountable Care Organizations (ACOs) are teams of doctors, hospitals, and other health care providers and suppliers working collaboratively to coordinate a patient’s care for Medicare participants. The creation of ACOs was among the many reforms born with passage of the Patient Protection and Affordable Care Act (HR 3590) in March 2010. And with those ACOs, officials see clearly a system trending toward bundled payment models for reimbursement, away from the traditional fee-for-service approach. “Bundled payment” refers to a single payment for all care related to a treatment or condition—a payment that is then apportioned to multiple providers across many settings.

In the hypothetical case of a bypass surgery for a patient suffering uncontrolled diabetes, the fee-for-service payment would entail $47,500 to the hospital and $15,000 to the surgeon; $12,000 for the hospital and $2,000 to the physician for uncontrolled diabetes management. This case assumes an additional 3 days in the hospital and another $25,000 for readmission 1 week after discharge to treat an infection from the vein. The grand total for that under the fee-for-service model would be $101,500. In contrast, under the model of bundling, the overall budget for the case would be set at $89,300. This would allow for $61,000 for the hospital, $13,000 for the physician, and an allowance of $15,300 for potentially avoidable costs. In comparison, the cost to the insurer is $12,200 less under the bundling model, and if readmission is prevented, the hospital and physician would be paid $12,800 more. Providers are thus financially rewarded for good outcomes rather than number of visits. However, the provider bears the risk of negative outcomes, as complications arising afterward will not be reimbursed, nor will follow-up visits.

The triple-aim goals to be met by the ACO are improving the health of the targeted population, improving the patient experience, and improving the affordability of health care. The Medicare Shared Savings Program launched January 1, 2012.

Why Is This Important for the RD?

While RDs are not listed by profession in these models, institutions and providers have a financial incentive to prevent issues such as readmission. Including RDs and nutritional services could be seen as an investment to improve the health and well-being of the patient. Those professionals, such as RDs, who can demonstrate outcome improvement, will become invaluable players on health care teams at every level.

The Academy’s Marsha Schofield advises RDs to embrace the changes and move with them as they present an opportunity to shine. RDs have strong documentation skills and a proven track record of improving outcomes, she points out, adding these assets can help them rise above competitors from other fields. Speaking the language of quality outcomes, data management, demonstrated results, and evidence-based protocols will make RDs welcomed members of those teams.

Further Reading

SECTION III. Creating the Blueprint to Build Your Practice

Whether the registered dietitian (RD) has an established office and practice or is beginning his or her private practice, with the advent of the IBT for Obesity benefit as well as other team-based approaches to health care (Patient-Centered Medical Home, Accountable Care Organizations), it is more and more likely that the RD will be seeing patients in medical clinics, physician’s offices, or within an ambulatory care clinic. Because the IBT for Obesity benefit is to be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, RDs can provide the service, but “incident to” physician services. The provision of “incident to” services also requires that the RD must see the patient in the same office suite as the PCP or within close proximity to the PCP’s office (see “Incident to” Guidelines for Medicare Part B in Section I). This type of practice may be new to the RD. The purpose of this section is to provide information that will help the RD with the business and contractual process of working within the PCP’s office.

Potential Business Models for Physician and RD Partnership Related to Medicare Medical Nutrition Therapy and Intensive Behavior Therapy for Obesity Benefit

By Mary Ann Hodorowicz, MBA, RD, CDE, CEC
Palos Heights, IL

Registered dietitians (RDs) who wish to obtain and maintain positions in multidisciplinary medical practice (MDMP) must first select a business model for working within the MDMP. The basic business models for RDs working in MDMP are as a traditional employee; an independent paid contractor; an independent private practitioner; or a combined independent paid contractor and independent private practitioner. Below are some potential scenarios of how RDs and MDs can work together to furnish office patients with medical nutrition therapy (MNT) and also Medicare’s Intensive Behavior Therapy (IBT) for Obesity benefit, and what the RD must consider in each model.

As traditional employees, RDs are paid an hourly rate and typically receive benefits for furnishing nutrition services in the MDMP. The practice bills for the services and retains the reimbursement. As independent paid contractors (aka freelancers), RDs are not employees and do not receive benefits; they are hired under a business contract to deliver nutrition services for a certain number of patients in a time period for a negotiated rate per patient seen, which is usually higher than an hourly rate paid to a traditional employee to compensate mainly for no benefits received, such as vacation time and sick pay. The MDMP bills for the services and retains the reimbursement. This model gives RDs more autonomy and flexibility in setting their own schedule and often in delivering the services at locations other than the brick-and-mortar MDMP.

In the independent private practitioner model, RDs have already established private practices and are thus considered self-employed. They sign provider contracts with health insurers and directly receive the reimbursement. Nutrition services are typically delivered in the RD’s own office. But a new and growing trend is for the independent private practitioner to also deliver services within the MDMP itself.
and pay fair market value rent to the physician for the space occupied during patient visits. The RD can also opt for a combination business model: being an independent paid contractor to furnish Medicare’s IBT benefit and an independent private practitioner to furnish MNT. This combined model is a bit more complex and does, therefore, require more careful planning and processing of the unique components of this dual model.

**Scenario 1: Traditional Employee in Physician’s Office**

Al Fresco, PhD, RD, CD, FADA, is a traditional employee of a local physician group doing MNT and IBT benefit, both as incident to physician services. He sees patients in the physician’s office or at patients’ homes. Fresco does not own a private practice but is willing to become a credentialed provider with Medicare Part B and reassign his reimbursement back to his physician-employer.

1. **Billing Methods**
   a. For IBT benefit, physician bills Medicare under **physician’s provider number** as “incident to” physician’s services.
      i. This benefit cannot be furnished in the patient’s home.
   b. For MNT to private payer patients, physician bills private insurers under **physician’s provider number** as “incident to” services.
      i. With regard to private insurers, the insurers must be contacted by physician/physician’s office to determine if “incident to” billing is allowed for MNT.
      ii. When billing as “incident to” services, the MNT cannot be furnished in the patient’s home.
   c. For MNT to Medicare patients, physician bills Medicare Part B on RD’s behalf under RD’s Medicare provider number. The RD has re-assigned his reimbursement back to his employer-physician (note: this situation is not considered “incident to” billing).

2. **Physician’s Compensation**
   a. Reimbursement from insurers at 100% (insurer payment plus patient co-payment; note that Medicare and some payer plans have waived patient co-payments for MNT).
   b. Patient out of pocket at 100%.

3. **RD’s Compensation**
   a. Physician pays RD an **hourly rate** as an employee for the hours worked in the physician’s office providing nutrition services.

4. **Benefits**
   a. RD receives benefits.

5. **Taxes**
   a. Physician withholds taxes.
Scenario 2: Independent Paid Contractor (Does Not Own a Private Practice)
Sue Flay, MS, RD, LDN, does not want to be an hourly employee, as it is too restrictive to her family schedule, nor does she want to be involved in implementing a multicomponent business plan for developing a private practice. Sue wants to set her own work schedule in physician practices a few days a week. She is willing to become a credentialed provider with Medicare Part B to do MNT. Sue has negotiated working in two local medical practices where she will see the physicians’ respective patients; the physicians will give her office space and bill for her services.

1. Billing Methods
   a. For IBT benefit, physician bills Medicare under **physician’s** provider number as “incident to” billing.
   b. For MNT for private payer patients, physician bills private insurers under **physician’s** provider number as “incident to” as authorized by each insurer.
      i. Private insurers must be contacted by physician/physician’s office to determine if “incident to” billing is allowed for RD’s services.
   c. For MNT to Medicare patients, physician bills Medicare Part B on RD’s behalf under RD’s Medicare provider number, as RD has re-assigned his reimbursement back to employer-physician (note: this situation is not considered “incident to” billing).

2. Physician’s Compensation
   a. Reimbursement from insurers at 100% (insurer payment plus patient co-payment; note that Medicare and some payer plans have waived patient co-payments for MNT).
   b. Patient out-of-pocket fees at 100%.

3. RD’s Compensation
   a. For IBT benefit and for all MNT patients (Medicare and private payer patients), physician pays RD a **negotiated rate** per each patient seen in the physician’s office (not an hourly rate).
      i. Example: RD is paid a rate of $____ per each patient who receives nutrition services in the physicians’ practices.

4. Claims Processing
   a. Physician’s biller processes nutrition services claims.

5. Benefits
   a. RD does not receive benefits.

6. Taxes
   a. Physician does not withhold taxes, as RD pays own taxes via private practice.
Scenario 3: Independent Private Practitioner Who Owns a Private Practice but Does Not Want to Work in a Physician’s Office
Mya Ownboss, PhD, RD, LDN, FADA, owns her own private practice and has her own office. She has established great relationships with area physicians who refer patients to her practice. She sees the patients in her own office or at patients’ homes and does her own marketing and billing. Mya is an independent private practitioner. She does not want to work in a physician’s office. Thus, Mya cannot furnish the Medicare IBT benefit in her own private practice office.

1. Billing Method
   a. RD services billed to private insurers under RD’s credentialed provider number.

2. Physician’s Compensation
   a. None. Physician refers to RD as member of health care team for holistic care of office patients.

3. RD’s Compensation
   a. Reimbursement from insurers (RD is provider with various insurers) and from patient out-of-pocket fees.

4. Claims Processing
   a. RD processes own claims, or
   b. RD contracts with private biller to process RD’s claims, or
   c. RD uses superbill with patients who paid out of pocket and are submitting MNT visits to own insurance company for reimbursement.

5. Benefits
   a. RD does not receive benefits from physician.

6. Taxes
   a. RD pays own taxes via private practice.
Scenario 4: Combination of Two Business Models for RD Who Wants to Work in a Physician’s Office: Independent Private Practitioner as Owner of a Private Practice and Independent Paid Contractor to Furnish Medicare’s IBT Benefit

Eileen Mann, MS, RD, CSR, LD, owns her own private practice and operates it 3 days a week in an office suite of a local internal medicine physicians’ practice. She is a credentialed provider with Medicare Part B and several major private payers. Eileen rents space in the internal medicine practice and bills payers for MNT using her own provider number and keeps the reimbursement. She now wants to furnish Medicare’s IBT benefit to Medicare patients in the office suite as an independent paid contractor.

1. Billing Methods
   a. For IBT benefit, physician bills Medicare under physician’s provider number as “incident to” billing.
   b. For MNT, RD services billed to Medicare and private insurers under RD’s credentialed provider number.

2. Physician’s Compensation
   a. Medicare reimbursement for IBT benefit.
   b. RD pays fair market value rent to physician for hours spent in physician’s office furnishing MNT.
      i. To determine fair market value for medical office space, RD may contact commercial real estate companies in local area. Rental usually quoted as $_____ per square foot per ____ days of occupancy.
      ii. Rental payment also includes services from physician’s support staff/billers (list is not all-inclusive).
         • Processing of insurance claims for RD services.
         • Collection of patient’s out-of-pocket expenses prior to RD’s services.
         • Scheduling RD’s patient appointments.
         • Greeting patients as they arrive and giving them pre-visit paperwork.
         • Use of office equipment, such as copy and fax machine, telephone, computers, etc.

3. RD’s Compensation
   a. For IBT benefit, physician pays RD a negotiated rate per each patient seen in the physician’s office (not an hourly rate).
      i. Example: RD is paid a rate of $_____ per each patient who receives nutrition services in the physicians’ practices.
   b. For MNT, reimbursement from private insurers, Medicare and Medicaid, and patient out-of-pocket fees.

4. Claims Processing
   --For MNT
   a. RD processes own claims, or
   b. RD contracts with physician’s biller to process RD’s claims.
   --For IBT
   a. Physician’s billers process RD claims.

5. Taxes
   a. Physician does not withhold taxes, as RD pays via RD’s private practice.

6. Considerations
   a. RD may/may not be able to receive referrals from other area physicians while working in the internal medicine practice.
b. Reimbursement from private insurers at 100% (insurer payment plus patient co-payment; note that Medicare and some payer plans have waived patient co-payments for MNT).
c. Patient out-of-pocket fees at 100%.

7. **Suggested Policies**
   a. Pre-payment required for patients who pay out of pocket (cash, check, credit card).
   b. Full payment due for patient no-shows without 24-hour cancellation notice.
   c. RD collects out-of-pocket payments at end of day and does own bookkeeping and deposits.

*This information is intended for educational and reference purposes only. It does not constitute legal, financial, medical, or other professional advice.*
<table>
<thead>
<tr>
<th>Office Space</th>
<th>Traditional Employee</th>
<th>Independent Paid Contractor (RD does not have private practice)</th>
<th>Independent Private Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Bills</td>
<td>PCP's office.</td>
<td>PCP’s office.</td>
<td>RD bills for patients seen (or hires billing service).</td>
</tr>
</tbody>
</table>

**Billing Methods**

<table>
<thead>
<tr>
<th>1. IBT</th>
<th>&quot;Incident to&quot; PCP.</th>
<th>&quot;Incident to&quot; PCP.</th>
<th>Cannot provide IBT benefit in RD office.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. MNT private payers</td>
<td>&quot;Incident to&quot; as authorized by each insurer: --PCP's office needs to check with each private insurer to determine if &quot;incident to&quot; billing is allowed for RD's services.</td>
<td>&quot;Incident to&quot; as authorized by each insurer: --PCP's office needs to check with each private insurer to determine if &quot;incident to&quot; billing is allowed for RD's services.</td>
<td>Provides MNT as authorized and contracted with private payers. RD uses own credentialing number and tax ID.</td>
</tr>
<tr>
<td>3. MNT Medicare</td>
<td>Service billed under RD's Medicare provider number. The RD has re-assigned his reimbursement back to his employer-physician (note: this situation is not considered &quot;incident to&quot; billing).</td>
<td>Service billed under RD's Medicare provider number. The RD has re-assigned his reimbursement back to his employer-physician (note: this situation is not considered &quot;incident to&quot; billing).</td>
<td>Provides MNT for patients with DM or CKD if RD is Medicare provider. RD uses own NPI.</td>
</tr>
</tbody>
</table>

**Compensation**

<table>
<thead>
<tr>
<th>Traditional Employee</th>
<th>Independent Paid Contractor (RD does not have private practice)</th>
<th>Independent Private Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing revenue goes to PCP's office. RD paid hourly rate.</td>
<td>Billing revenue goes to PCP's office. RD paid negotiated rate per patient seen.</td>
<td>Billing and patient out of pocket revenue goes to RD.</td>
</tr>
<tr>
<td>MD withholds taxes from RD's paycheck.</td>
<td>No withholding from PCP office. RD pays all taxes as self-employed.</td>
<td>RD pays all taxes as self-employed.</td>
</tr>
</tbody>
</table>

**Pros**

<table>
<thead>
<tr>
<th>Traditional Employee</th>
<th>Independent Paid Contractor (RD does not have private practice)</th>
<th>Independent Private Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours and salary are regular. RD potentially receives benefits (vacation, sick time). No office expense. No need for business plan and marketing. Do not have to bill.</td>
<td>Flexible working schedule. No need for business plan and marketing. Higher rate of compensation. Do not have to bill.</td>
<td>Flexible schedule. Highest revenue potential.</td>
</tr>
</tbody>
</table>

**Cons**

<table>
<thead>
<tr>
<th>Traditional Employee</th>
<th>Independent Paid Contractor (RD does not have private practice)</th>
<th>Independent Private Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set schedule may be too restrictive for some RDs. Hourly rate lower than other models due to benefits and salary stability.</td>
<td>No benefits (vacation, sick time). Need to negotiate office space costs. Reimbursement not as high as private practice.</td>
<td>No benefits (vacation, sick time). Responsible for all business expenses (office space, billing, marketing).</td>
</tr>
</tbody>
</table>
Making Nutrition Your Business: What to Think About When You Want to Work in a Physician’s Office


Registered dietitians (RDs) are often approached by physicians who want to make nutrition services more accessible to their patients. This is a business proposition that RDs find attractive—it involves a steady stream of referrals and often a flexible schedule. And for physicians who want to offer cost-effective, preventive care to patients on site, hiring an RD is a logical move. However, this win-win situation can sometimes get complicated when physicians ask RDs financial and legal-related questions that aren’t so cut and dry.

Ellen Layton, JD, a partner in Healthcare Department and Associations and Foundations Practice Group at Barnes & Thornburg LLP, helped prepare RDs for what to expect when integrating their services into a physician’s office during a recent webinar called “Making Nutrition Your Business: Legal and Financial Advice for Integrating Your Private Practice into a Physician’s Office.”

As a first step, Layton suggested helping the physician understand the benefits of having an RD on site and the landscape for coverage of nutrition services.

As you begin to engage in conversations, Layton said there are three key things to think about:

1. Is the physician’s practice financially stable? (Ask about the types of challenges the practice encounters, its issues with payers, and its referral sources and competitors.) Discuss how you can help them realize growth through a nutrition-related component.

2. Where is your business going to come from? What are the patients’ needs? Can you use your own network as referral sources?

3. What will your life be like if you work in that office? What is the leadership style? From the start, establish who is in charge of the office. Inquire about what resources exist to assist you: office waiting room, phone, Internet, journals, materials, billers? Clarify expectations on both sides.

In addition, Layton said the physician will want to have a frank discussion on reimbursement for nutrition services. “Most doctors who don’t have experience with nutrition services will not be familiar with how billing works for medical nutrition therapy (MNT). Lack of coverage might be an unusual concept for doctors,” Layton said. “They will want to know how much the RD can charge. The RD should be able to explain this at the onset.”

To prepare for a coverage discussion, Layton advised RDs to consider the following:

1. Medicare coverage is limited to MNT for diabetes and non-dialysis kidney disease. Be familiar with coverage guidelines and enrollment rules. Learn more at the Academy’s Medicare MNT page.

Continued on next page
2. Private insurance coverage for nutrition services is limited. Let the physician know that some payers offer coverage and more flexibility depending on the patient's diagnosis. Know your local market for payers. Go to the Academy's Coding, Coverage & Compliance page for information on insurance coverage. Or talk with your Academy regional reimbursement representative to get information on local insurance coverage.

3. Be prepared to discuss what happens if nutrition services are not covered by insurance. By obtaining an upfront agreement from patients that they will pay you out of pocket, your services can be paid for. "At the outset, everyone should be clear about patient payment in case there is little or no coverage," Layton said. The more informed the RD is prior to meeting with a physician, the greater the chance that an employment opportunity will arise from the discussion.
Mastering the Art of Negotiation
By Nancy Collins, PhD, RD, LD/N, FAPWCA, and Colleen Sloan, RD.


We can bargain at garage sales and settle arguments, but when it comes to negotiating for a better employment package, we freeze. Negotiating for the best deal not only involves salary or hourly wages, but also work hours, weekend coverage, duties, or benefits package. For the consultant registered dietitian, additional issues arise such as the number of hours allotted for a particular facility, the process of handling recommendations, and dealing with facility-wide problems. The process of negotiation takes a lot of creativity, practice, effort, and research. However, if you equip yourself with the right skills and information you will be able to successfully negotiate your way into the ideal career or contract.

Why Negotiate?
Whether you are entering the workforce or a seasoned professional looking to change careers, negotiating skills are essential to getting what you want out of the job. Negotiating provides an opportunity for you to demonstrate your problem-solving skills, business etiquette, and ability to sell your worth. Although both the company and the candidate are looking to get the best deal for themselves, ultimately, negotiation is about compromising. You need to convince the company that your request for increased compensation, hours, or benefits is justified. The company needs to believe that your work experience and knowledge will add to their growth and bottom-line.

Knowing Your Make-Up
Mastering the art of negotiation must begin with understanding the importance of self-awareness. Being certain of who you are and what you are capable of is vital to successfully selling yourself. Although it takes time and experience to develop this confidence, there are several things you can do to harness an understanding of yourself. Take time to reflect on past responsibilities and determine what skills or attributes you obtained. Consider a situation in which you had to make a decision or resolve a conflict and relate that to your interpersonal or problem-solving skills. Think about how your career has progressed thus far and where you would like it to be in the future. Often times to discover traits within yourself you must seek advice from third-party individuals. Discuss your work ethic, demeanor, abilities, or areas to improve with a superior or mentor. An honest, unbiased opinion may bring to light character traits or situations you never considered. Determining your worth not only depends on your education and background, but also the geographic location, size, and financial state of the company.

In addition to knowing who you are, it is helpful to keep a record of your achievements. One of the best ways to showcase your accomplishments is to create a professional portfolio. If maintained over a period of time, this can be a great way to prepare for your meeting and review key moments in your career that you would like to discuss. Save awards and recognitions, publications, thank you notes from clients, and letters of recommendations from superiors. Be sure to keep this up-to-date so it will be ready when needed. When kept organized and presented professionally this portfolio can be a very impressive, visible sample of who you are and what you have done in the past.

Understanding the Company and Job Profile
Once you have a good grip on your character and ability, you should become familiar with the company with which you are seeking to further your involvement. Regardless of what you are negotiating, it is essential that you are keenly aware of the company philosophy and mission. Your recommendations and suggestions for improvement or change should support the company goals. If a larger salary or wage is what you are after, be sure to do your research to determine the average pay for comparable positions. You do not want to overstep your boundaries or appear uninformed. Search online sites or ask
individuals who are currently in a similar position for a general idea of a plausible salary. Be sure the job and pay-grade is an appropriate level for you. Your goal should be to maximize your salary and benefits package from the start. Have a specific package deal you would like and know what you will and will not accept. For example, if you cannot reach an agreement on the salary perhaps you can negotiate an additional week of vacation time. Sometimes, it takes creativity to reach an agreement where all parties feel they have won. At some point, you must be willing to walk away if you simply cannot be happy with the deal.

Not only is it important to have an understanding of the company profile, but you should have a solid understanding of what the job entails. If you are a consultant, you must be clear on the duties and how your recommendations will be instituted and the steps that will be taken if they are not. Be familiar with past inspection reports, pending litigation and any other information that will both necessitate and justify additional hours in your contract.

Renegotiating
Consultant registered dietitians are often in the position of negotiating contracts because many are written as one-year agreements. After one year, you may find that the contract was not appropriate for some reason and now you want to change certain aspects of the agreement. Be prepared with data and solid reasons for requesting changes. Often the issue is insufficient time to provide adequate care for the residents. In this case, you must know basic information such as number of monthly admissions, number of high risk and complex residents, abilities of other nutrition staff members, and any recent deficiencies or complaints. It is important to remember that as a consultant you are not an employee and typically are not covered under the umbrella insurance policies of the facility. This means should a legal problem arise, you will be treated as a separate entity. For your own peace of mind, it is imperative that you feel your contract is adequate to meet the needs of each and every resident. Let your conscience be your guide and explain this while negotiating. It is reasonable to explain that your professional credentials and/or license come with a professional and ethical duty to provide a certain level of care. If in your heart you believe you cannot do this, you must renegotiate or walk away. Walking away is difficult especially in some rural areas where other jobs may be hard to find. However, it is only through fierce negotiating and standing up for what we believe that we will ever change the tide.

Closing the Deal
Keep in mind that business is about business, not friendship. You should have the mindset that you are a valuable employee or consultant and the company is fortunate to have you. Don’t shy away from asking for what you deserve because you don’t want to upset your relationship with your superior. Knowing your capabilities should empower you to be confident to ask for what you deserve. Once you are fully versed on how much you are worth and how you benefit the company, you need to be able to sell yourself. This not only encompasses your education, training, and prior experience, but also your personality, demeanor, and verbal and non-verbal communication skills. No matter what you are negotiating, your goal should be to make the employer believe without a shadow of a doubt that they need you and your services. To be an effective negotiator it is important to know what key messages you want to discuss, have supporting examples or scenarios, and present the information with meaning and relevance. Developing this confidence takes time, so be
patient and remain positive. The key to becoming a successful, confident negotiator is practice, practice, practice. Role play in front of the mirror, practice with your friends, and recite responses in the car. Find a method that works for you and stick to it.

References
Items to Consider When Establishing an RD/MD Partnership

Fee Splitting
Fee splitting is a state law issue that prohibits some professionals from sharing their professional fees with others who were not involved in the care of the patient. For example, if a surgeon offered to share a portion of his or her professional fee with the primary care physician who referred the patient, that would be considered fee splitting in many states. It is a type of prohibition on kickbacks. The exact nature and extent of fee splitting prohibitions varies from state to state. In general, if a professional is paid for the services he or she performs, fee splitting can be avoided. For example, if a physician employs or has an independent contractor relationship with the RD (where the physician bills for the RD’s services) it would not be considered fee splitting in most states. Arrangements in which an MD or RD pay money to each other in exchange for referrals could be considered prohibited fee splitting and may also violate other kickback prohibitions.

Charges for Services and Fee Setting
While the Academy does not collect fee information from RD members due to antitrust laws, there are a few resources where fee data is available to the public regarding payment levels for RDs, such as the fee schedule for RD Medicare MNT providers. The Medicare fee schedule lists payment rates for MDs, and RDs by law are paid 85% of the rate physicians receive under Medicare. The MNT codes (97802-97804) are time-based codes, so the rates are for one unit of the code (individual MNT code is 15 minutes and group MNT code is 30 minutes).

The Academy also published a compensation survey, which describes salaries for dozens of core dietitian and dietetic technician jobs, broken down by region, education, experience, supervisory experience, supervisory responsibility, and much more. While the publication does not show hourly rate, there is information on private practitioners’ compensation that might be of interest to you.

Private Insurance and “Incident to” Physician’s Services
If RDs do not have contracts with private insurance plans (e.g., with Anthem VA), but they are employed by physicians who would like to bill private insurance companies for nutrition services, the MDs should review their contracts with the insurance plan(s). According to the American Medical Association, physicians should, with respect to commercial insurer regulations, keep in mind that each commercial insurer has its own policy for billing for non-physician practitioners’ services. Some require the non-physician practitioner’s services to be billed using the non-physician provider’s number, while other commercial insurers require the non-physician practitioner’s services to be billed under the physician’s provider number. If a physician is unsure how to bill, he or she should call the insurer’s provider relations director. Physicians should also make sure they are aware of state laws regarding billing for other non-physician practitioners. Some of these payment mechanisms hinge on current state regulations.
Sample RD-MD Business Agreement
Available to download at www.eatright.org/shop.

Basic Contract Terms
This Contract is made on __Date____, 200x, between __your official company name___________
(shortened name or abbreviation, YOU) residing or located at _________________________________ City of
_____________, State of __________; and __name or abbreviation of the physician group residing or located at
____________________, City of __________________, State of _________________.

Guiding principles or Whereas or Shared rationale such as: Because we both share a goal
of__________________, for valuable consideration, the parties agree as follows:

1. Description of services. You will provide RD services to patients.
2. Qualifications. RD will maintain all required credentials at all times (RD, LD, specialty certifications, etc.). Group
   will maintain corporate registration and qualifications.
3. Insurance. Describe who will provide professional liability insurance with a limit of __________ (e.g., at least
   $1,000,000 per occurrence and $3,000,000 in the aggregate). Group will maintain insurance covering the
   group.
4. Billing. Describe who bills for your services and who has the right to keep collections.
5. Compensation and benefits. Describe the compensation methodology and benefits package if applicable.
6. Scheduling and time off. Describe full or part time, how hours will be scheduled, how time off will be
   coordinated.
7. Restrictive covenant. Non-competition or non-solicitation provisions are common in employment
   agreements. Must be reasonable as to duration and length. Often subject to negotiation.
8. Recordkeeping. You will maintain appropriate records. Clarify who owns the records, who will maintain them.
   Provide right of access for non-owning party after termination.
9. Term and termination. Initial term of at least 1 year. Describe length of notice period for without cause
   termination (30, 60, 90 days or longer?). Describe events of “for cause” termination: loss of license,
   credentialing, bankruptcy of group, etc. Describe any payments upon termination (especially if
   compensation is dependent on collections).
10. Indemnification. Seek legal counsel before agreeing to an indemnification or limitation of liability.
11. Legal compliance. Both parties should agree to comply with all applicable laws.
12. Relationship of the parties. Employee/employer or independent contractor?
13. Governing law. Should be the law in your state. Agreement must be signed and dated by both parties.
SECTION IV. Measuring Effectiveness

How effective is a registered dietitian (RD)? This is an important question and one that a primary care practitioner (PCP) may ask the RD before they work together. While the Evidence Analysis Library (EAL) quantifies the RD’s effectiveness using the literature, nothing speaks as loud and clear about the RD’s effectiveness as data from one’s own practice. Services provided under the Intensive Behavioral Treatment (IBT) for Obesity benefit provide a perfect opportunity for the RD to use an outcomes management system for collecting and evaluating outcomes because the benefit’s length of follow-up and intensity is great enough to measure change. The purpose of this section is to provide information, practice examples, and resources to encourage the RD to collect outcomes relevant to his or her practice to be able to measure and share effectiveness in providing obesity services.

Outcomes management involves use of a system that evaluates the effectiveness and efficiency of the Nutrition Care Process (NCP) (assessment, diagnosis, interventions, cost, and others).¹ This system is outside yet connected to the fourth step of the NCP, “Nutrition Monitoring and Evaluation.” The purpose of step 4 is to evaluate the amount of progress being made and whether goals are being met over the course of care.² By contrast, an outcomes management system takes a step back and evaluates the intervention or health professional’s effectiveness overall, and it may include a variety of aggregate data from different health professionals. It is used to improve performance and provide insight on the effectiveness of the intervention.

Why Use an Outcomes Management System?

1. To document and demonstrate the effectiveness and efficiency of the NCP and medical nutrition therapy services. Clinicians use the outcomes of medical nutrition therapy (MNT) to:
   - Guide the treatment process by comparing outcomes achieved with those anticipated.
   - Track performance.
   - Manage resources and ultimately improve the quality of care.
   - Summarize results.
   - Demonstrate value and effectiveness to the patient and the payer.

2. To meet requirements of health care providers, third-party payers, administrators, and regulatory organizations. Accrediting agencies such as the Joint Commission and the National Committee for Quality Assurance (NCQA) are now including performance measurement and outcomes monitoring as a requirement for accreditation. For example, in order to meet Joint Commission standards, leaders must

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evaluate the outcomes related to the use of clinical practice guidelines and make any necessary changes to improve pertinent processes. The intent of these standards is to ensure the organization monitors the guidelines it implements in order to evaluate their effectiveness.

3. **To earn “bonus” payments and avoid penalties.** In 2006, Medicare established the Physician Quality Reporting System (PQRS). The PQRS is a voluntary program that allows physicians and other health care professionals to report information to Medicare about the quality of care they provide to people with Medicare Part B who have certain medical conditions. This reporting system includes incentive payment for eligible health professionals who satisfactorily report data on the identified quality measures. In the future, eligible practitioners (including RDs) will be penalized for not meeting the PQRS reporting requirements. Pay for performance, a payment system that rewards physicians, hospitals, medical groups, and other health care providers for meeting certain performance measures for quality and efficiency, is also a growing trend. NCQA, PQRS, and organizations that “pay for performance” define which outcomes or process measures they want health professionals to collect and evaluate. RDs are eligible to participate in the PQRS program. Currently there are 13 measures on which an RD can report outcomes. For more information on how to report national performance measures, [click here](#).

4. **To establish the RD’s role in new health care delivery systems.** In the advent of Accountable Care Organizations with bundled payments as well as working within a team setting, it is important for RDs to track and evaluate outcomes that are relevant to their practice. By evaluating effectiveness, RDs can:
   - Document and share their effectiveness with the PCP.
   - Document their contribution and value.

Additionally, clinicians have an obligation to their clients to collect and evaluate outcome data. It is natural to have confirmation bias when informally recalling outcomes: one remembers successful clients vividly, but other cases often fade from memory. Only through thorough collection and evaluation of outcome data can the clinician accurately assess the efficacy of various counseling methods and diet therapy options, and only through this accurate assessment can the clinician be certain of providing the best possible care and enabling the best outcomes and quality of life for clients.

**Which Specific Outcomes Should the RD Measure?**

That depends on the RD’s practice, experience, time, and interest. The NCP standardized terminology offers categories and examples of outcomes measures that an RD may want to incorporate into an outcomes management system. When it comes to obesity services, here are a few ideas:

- **If the RD is new to outcome measurement and tracking,** she or he may want to collect only weight, body mass index (BMI), and waist circumference to start. BMI is an NCQA and PQRS measure and therefore an important one to collect, monitor, and document.
- **If the RD has access to clinical laboratory measures,** then monitoring change in clinical labs such as A1C (for people with diabetes and prediabetes) and fasting lipid measures is useful. Collecting blood pressure is another useful outcome to collect since weight loss and dietary changes are known to improve blood pressure.
- **The goal of IBT for Obesity is weight loss through improving diet quality, reducing caloric intake, and increasing physical activity.** Hence, measuring any type of behavior change related to
diet and physical activity would be useful and give a more well-rounded sense of the program’s or RD’s effectiveness beyond anthropometrics and laboratory measures. The RD should consider measuring the change in dietary intake and physical activity in a manner that is clinically relevant, short, and easy to administer (so that the burden is not great on the patient or on inputting the data). Potential outcomes to track include caloric intake or daily servings of each individual food group, stage of change represented as a number (e.g., 1 for precontemplation through 5 for maintenance). The Diabetes Mellitus Toolkit (available at Shop EatRight) has some useful examples of potential questions, such as “Chooses foods/portions per meal plan (% of time)” or “Verbalizes understanding of meal plan (Y/N).” In addition, the research toolkit, Understanding the Basics of Research (also available at Shop EatRight), is a great resource geared to those who know little about research but want to try to incorporate some research or outcome tracking into their practice.

Let your practice, experience, and time guide you as to what outcomes to collect. The bottom line: The RD should choose the outcomes and measures that fit his or her practice knowing that “anything is better than nothing.”

Tools to Build Your Outcomes Management System

1. The Obesity Society
In 2000, the Obesity Society gathered a group of obesity specialists with the goal of recommending a set of clinically useful outcome measures that physicians who treat obesity could use in their practice.³ While the recommendations are now dated, the summary (Table 1) does provide some useful recommendations as to which measures and tools to use to measure various outcomes. The papers within the supplemental journal provide the evidence behind using each of the measures. The intention was to support clinicians like RDs to integrate outcomes management into their practice knowing that clinicians could not and should not measure all of these outcomes.

2. Adult Weight Management Toolkit
The Adult Weight Management Toolkit (available at Shop EatRight) is a useful resource that contains not only relevant forms and information to establish a weight management practice but also information and a system to support RDs in the collection and evaluation of their effectiveness. It includes an Excel workbook that collects, aggregates, and evaluates outcome data easily. More specifically, the workbook has five useful worksheets for practice:

1. Individual Outcomes Monitoring Form: Monitor data for an individual patient/client over six encounters, the percent change will be calculated.
2. Aggregate Input Form: Input and monitor aggregate data, averages will be calculated.
3. Aggregate Outcomes Monitoring Form: Pulls data from the “Aggregate Input Form” and calculates percentage change from the first to last encounter.
4. Weight, BMI, Waist Circumference Tracking: Monitor aggregate data over several encounters for weight, BMI, and waist circumference, calculates averages.
5. Weight, BMI, Waist Circumference Charts: Pulls data from “Weight, BMI, Waist Circumference Tracking” sheet to show bar graphs of weight, BMI, and waist circumference averages for aggregate data, also shows a sample chart.

# Recommended Outcome Measures for the Overweight and Obese Patient

<table>
<thead>
<tr>
<th>Health Concept to Measure</th>
<th>Outcome/Surrogate Outcome Measure</th>
<th>Measure/Instrument</th>
<th>How to Obtain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL ENDPOINTS: OBESITY</strong></td>
<td></td>
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<tr>
<td>Obesity</td>
<td>BMI</td>
<td>Measured height and weight</td>
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<tr>
<td></td>
<td>Weight</td>
<td>Measured weight</td>
<td></td>
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<tr>
<td></td>
<td>Waist</td>
<td>Measured waist circumference</td>
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| **CLINICAL ENDPOINTS: MORBIDITY** | | | |
| Hyperlipidemia | Cardiovascular risk factors | Fasting Triglyceride | | |
| | | LDL-cholesterol | | |
| | | HDL-cholesterol | | |
| Hypertension | Blood pressure | Blood pressure | | |
| At risk for Diabetes | Blood glucose | Fasting blood glucose | | |
| Diabetes | | | | |
| Osteoarthritis | SF-36 (pain and physical function subgroups) | www.sf36.com | | |
| Sleep apnea | Epworth Scale; if +, then Sleep study | Johns MW. Sleep. 1991;14:540-545 | | |

| **HEALTH-RELATED QUALITY OF LIFE (QOL) ENDPOINTS** | | | |
| QOL | Overall | SF-36 or SF-12 | www.sf36.com |
| | Nutrition-related QOL | Barr J. J Am Diet Assoc. 2003;103:844-851 |
| | Binge eating disorder | Eating and Weight Patterns (QEWP-R) | Yanovski SZ. Obesity Research. 1993;1:306-324 |
| | Depression | Beck Depression Inventory | www.psychcorp.com |
| Functional status | SF-36 Subscales: | | |
| | Physical activities | | |
| | Social functioning role activities | | |
| | Physical and emotional factors | | |
| | General mental health | | |

| **ECONOMIC ENDPOINTS** | | | |
| Economic | Medical care "cost" | Medication changes, Diabetes, antihypertensive and GERD meds | | |
| Dietary intake | Diet quality meal patterns | Triple pass 24-hour recall | | |
| | Specific nutrient intake | Average of 3-day Food Records being entered into Nutrition database | | |
| | Fiber and fat intake | Block Dietary Screeners | www.nutritionquest.com |
| Physical activity | Physical activity | PACE Questionnaire | www.paceproject.org |

Collecting Outcomes in Practice: Three Case Reports by RDs Who Measure and Evaluate Their Outcomes
By Michele Kuppich, RD; Nikki Anderson, RD, LD, CDE; and Anne Wolf, MS, RD

The Power of Data
By Michelle Kuppich, RD
San Francisco, CA

I recently began working with a multispecialty otolaryngology practice where nutrition is considered an important component of treatment for many patients with obstructive sleep apnea (OSA), esophageal reflux, sinusitis, and allergies. There are several opportunities to measure outcomes in this environment, yet my initial focus is sleep apnea, because it is estimated that two-thirds of persons with sleep apnea are obese, adherence and/or effectiveness of current treatment (e.g., continuous positive airway pressure [CPAP]) is variable, and reductions in weight may improve comorbid conditions that obesity and OSA share. Measurement of changes in anthropometric, clinical, and subjective data will be necessary to determine whether MNT in this setting can achieve reductions in the Apnea-Hypopnea Index (AHI) and/or daytime sleepiness reported in other studies using structured programs and meal replacements.

Before venturing into private practice in the summer of 2011, I managed a quality improvement department at an independent physician association (IPA). In that capacity I collaborated with analysts to produce patient-level data and quality performance reports for physicians and aggregate data for California’s pay for performance program. My previous work experience included several years of providing nutrition counseling and MNT in various settings. But it was during my hiatus from patient care and experience in quality improvement when I realized that data collection is imperative. Systematic data collection in health care is imperfect, yet it still tells us something about what is (or is not) happening and informs policy makers and decision makers in health care. Data helps to tell the story, identify strengths as well as areas for improvement, and expand opportunities. It does not have to be “perfect,” but good enough to get the attention of your audience.

At my first meeting with members of the otolaryngology practice, I learned that they shared the same value and approach to data collection. Patient clinical information is maintained in a database, and post-treatment evaluations are performed via follow-up sleep studies and the Epworth Sleepiness Scale & Snoring Questionnaire. Access to laboratory results and other diagnostic tests are available through a shared electronic medical record, decreasing duplication of services and the administrative burden associated with obtaining results ordered by other providers. And the practice will eventually place computers in the waiting room for patients to complete standard assessments at each visit, allowing for the collection of patient data at each encounter. Even when working in a setting without this level of interest, infrastructure, or sophistication, dietitians can use software such as Microsoft Excel or Access to record and analyze data.

There are several endpoints for potential evaluation in persons with sleep apnea, and here are some of the questions I would like to answer as well as endpoints I would like to evaluate.

- Does a $\geq 10\%$ weight loss from baseline within 6 months confer improvement in sleep apnea as measured via sleep study? Patients using CPAP will be analyzed separately.
- What is the average change in the AHI score(s)?
- What is the average change in the daytime sleepiness score?
- In what percent of referred patients is weight loss alone an effective treatment for OSA?
- What are the associated changes with $\geq 10\%$ weight loss in 6 months (anthropometric, diagnostic, subjective, biochemical)?
• What are the associated changes with 5% to 9.9% weight loss in 6 months (anthropometric, diagnostic, subjective, biochemical)?
• What conclusions can be drawn from changes in biochemical markers, anthropometric data, and subjective assessment?
• What is the cost of treatment for patients where MNT was the only treatment for OSA?
• How does the cost of MNT compare with traditional treatment (CPAP)?

I look forward to getting started with data collection, receiving input from my colleagues, and watching this project evolve over the next 12 months. My initial goal is to share the results with the practice and use the data to help determine what type of patients are most likely to benefit from MNT in the management of sleep apnea. Ultimately, I would like to share what I learn with dietitians and the larger health care community. Stay tuned.

<table>
<thead>
<tr>
<th>Anthropometric Data, Diagnostic Tests, Subjective Assessment</th>
<th>Biochemical</th>
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<tr>
<td>Height, weight, BMI</td>
<td>Serum glucose</td>
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<tr>
<td>Weight classification based on body mass index (BMI)</td>
<td>Fasting glucose</td>
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<tr>
<td>Percent body fat (bioelectrical impedance)</td>
<td>A1c</td>
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<tr>
<td>Waist circumference (cm)</td>
<td>Triglycerides</td>
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<tr>
<td>Neck circumference (cm)</td>
<td>Total cholesterol</td>
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<tr>
<td>Systolic blood pressure</td>
<td>LDL cholesterol</td>
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<tr>
<td>Diastolic blood pressure</td>
<td>HDL cholesterol</td>
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<tr>
<td>Apnea Hypopnea Index (AHI)</td>
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<tr>
<td>Sleep apnea classification based on AHI</td>
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<tr>
<td>Epworth Sleepiness Scale &amp; Snoring Questionnaire score</td>
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<tr>
<td>Lifestyle Questionnaire (Eating &amp; Physical Activity)</td>
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How Do You Measure Success?
By Nikki Anderson, RD, LD, CDE
Bowling Green, KY

I have owned a private practice for 9 years and have learned firsthand the importance of outcomes over the years. Measuring outcomes for an RD’s services is crucial. We have to know that the service we provide to our clients or patients produces the outcomes we have targeted. The definition of insanity applies... If you keep on doing what you are doing, you will keep getting what you got. Outcomes are vital to our profession from both a clinical and a business standpoint. The most important reason to measure outcomes is to improve the client’s health. I have had clients that I have seen for years, and I am not sure if I get more excited or if they do as they make progress. If the patient does not see a value to the service or desired outcomes we run the risk of them not scheduling a return appointment to continue education and address obstacles in reaching their goals. Referrals for our clients are generated from the physician. Outcomes are the best-selling tools dietitians have to market our services for referrals.

Outcomes measured will be both subjective and objective. Our practice measures two primary objective outcomes, weight and HgbA1C. Currently we collect our objective outcomes manually from our practices’ records and lab reports from patients’ physician offices. The clinical outcomes are shared with the physicians on a semiannual basis. Subjective outcomes shared by the clients speak volumes. I had a 45-year-old male client with elevated blood glucose tell me he would come home from work and go straight to the TV remote and the recliner. He improved his blood glucose and came into the office beaming from ear to ear. He had reported that his energy level was 180 degrees different, and he had even hand-washed four cars one day after work.

The best advice I can give is to start simple and measure the most important outcome you are trying to achieve. You will share these outcomes with your clients on a regular basis. However, don’t stop there; scream it from the top of a mountain! Share the success with anyone and everyone that will listen. Share the power of nutrition!
In Practice: Using an Outcomes Management System to Enhance Marketing
By Anne Wolf, MS, RD
Charlottesville, VA

Sitting at the table with the employer, the health insurance company, and the partnering Fitness and Wellness Center, I heard myself say, “And we need to collect outcomes.” After months of planning, we had created a model weight loss program for high health-risk employees. In this role, I was wearing the hat as the RD who would be overseeing the program and delivering the nutrition components. I could have felt great about “doing my job” as the clinician. So why would I advocate collecting and evaluating outcomes when that translated into more work, no additional revenue, and “not part of my nutrition job”? I realized that I was sitting at that table in the first place because I was able to show effectiveness and a positive return on investment for MNT based on the Improving Control with Activity and Nutrition (ICAN) project, a randomized controlled trial of MNT’s effectiveness and cost-effectiveness in diabetes and obesity. Also, I understood that this was a new program and without effectiveness data to justify its effectiveness, I believed that the program could easily be scratched if budget woes hit the table (they did and we survived). Lastly, I was curious. We were using newer delivery technologies such as Web-based group classes and tele-delivery of follow-up MNT visits, and I wanted to know how effective and acceptable these modes of delivery were in practice. So, I set up my outcomes management system.

I want to be clear here. I have a lot of experience in research and outcomes. I worked for the Nurse’s Health Study (NHS) and grew up with the Willet Food Frequency Questionnaire. I validated the NHS physical activity questionnaire. I chaired the TOOLS Task Force for the Obesity Society, a task force whose goal was to find a set of clinically useful outcome measures for clinicians when they worked with obese patients. I was the principal investigator of the ICAN project. So, I had a lot of confidence that I could measure this program’s effectiveness. But I had never done it in practice.

What helped is that our program’s frequency and schedule of visits, like the IBT for Obesity, is intense and long enough to support and measure weight loss and behavior change; we could easily do a before and after analysis of employees’ changes. So, what outcomes did I choose to collect and evaluate? I wanted to measure “success” in more ways than weight alone, which meant that I needed to expand my list of outcomes. Including anthropometric outcomes was straightforward because that was part of my initial assessment. I measured body weight, height (calculate BMI), waist circumference, and neck circumference (we have a lot of sleep apnea). Body fat was collected only because a BodPod was available at the Fitness facility and they included that measurement into the package for free. Including clinical labs was also straightforward. The employer had a contract with a local lab and was able to set it up so that I had electronic access to the program employees’ labs. We decided on fasting lipid panel and HbA1C for people with diabetes and a history of pre-diabetes.

The behavioral outcomes were more complicated. I could not find a validated tool that measures behavior change that is short, clinically useful, and free. The Block Fat and Fruit/Vegetable Screeners are excellent to measure relative fat and fruit/vegetable intake, but they cost money to administer. So I developed my own Food and Physical Activity Behavior Questionnaire, which scores the following areas:

- Physical inactivity level
- Physical activity level
- Dietary Score—Overall
  - Dietary Fat Score
  - Meal Regularity Score
  - Caloric Drink Score
  - Fruit, Vegetable, and Fiber Score
  - Eating Out Frequency Score
  - Behavioral Eating Score
The questionnaire is short (four pages), quick to complete (5-10 minutes), clinically useful, and easy to score. The other outcomes that I evaluate are employee retention, participation, and satisfaction with the survey.

**Reporting Outcomes to Your Partners**
Equally if not more important than measuring outcomes in your practice is sharing them with your partners. A before and after summary of an employee’s progress is given and reviewed with each employee at the final visit. It is so rewarding to review not only weight changes (which, for many patients, is never enough) but also patients’ labs and behavioral changes. My final review with patients is always uplifting as they recognize how far they have come. Also, after each program, I send a report that summarizes the aggregated anthropometric, clinical, and behavioral impact of the program. I also include retention, participation, and program satisfaction. The report is long (about eight pages) and filled with graphs and tables (vs. words), but it tells my stakeholders (the employer and health insurance company who pay for the program) about the following outcomes (not all outcomes included due to space). On average, the employee has the following changes:

- 17-pound weight loss (7% of initial body weight)
- 2.9-inch reduction in waist circumference
- 3% body fat loss
- 30% improvement in physical activity
- 38% improvement in fruit, vegetable, and fiber intake
- 0.54% reduction in Hemoglobin A1c (for people with diabetes)
- 32% reduction in fasting triglycerides
- 85.5% program retention at 6 months (100% at 3 months)
- 78% attend all group classes
- 90% attend all one-on-one nutrition sessions
- Out of a possible rating of 5, participants rate our program a 4.4 (and the RD is a 4.8)

**The Rest of the Story**
The program and I have not only weathered the recession but continue to grow. The current employer is an advocate of the program and my services. When they were going through the bidding process for a health insurance provider, they listed my services, among others, as being a prerequisite for getting the final contract. Two other local employers are now starting the program, and I am training their RDs to deliver the program. The health insurance company, Coventry Health Care, has branded the program and is bringing it to other employers. After the first pilot program, I requested and now receive payment for the leasing, collection, analysis, and reporting of my outcomes system. I am now contracted to do the outcome analysis at other sites using my outcome system, called WM SNAP® (Systematic Evaluation and Reporting for Weight Management Programs). What started out as good practice and curiosity is now creating jobs for RDs and paying me a reasonable income. More than that, I feel satisfied and good about my practice because I know it is having a meaningful impact—I can measure it!

**Resources**

[Agency for Healthcare Research and Quality (AHRQ) Fact Sheet on Outcomes Research](#).

[CMS Website on Physician Quality Reporting System](#).
SECTION V. Wrench, Hammers, and Screws: Further Resources and Tools

Resources to Improve Your Weight Management Practice

1. **Weight Management DPG membership.** The Weight Management Dietetics Practice Group’s mission is to help you meet your career goals through our resources, continuing education activities, networking, and advocacy. Cost is $25 for members and $15 for students per year.

2. **Adult Weight Management Guideline.** The guideline is an evidence-based approach to nutritionally caring for the overweight and obese patient. You must sign in to the Evidence Analysis Library in order to get full access to the guideline.

3. **Adult Weight Management Toolkit.** This toolkit is designed to assist the registered dietitian in applying the ADA Adult Weight Management Evidence-Based Nutrition Practice Guidelines. The toolkit includes resources such as the MNT protocol, sample documentation forms, client education materials, and outcomes monitoring forms. Available for $20.

4. **Adult Weight Management Self-Study E-Module.** The new online Adult Weight Management Self-Study E-Module addresses the fundamentals of adult weight management. The module has been awarded 16 CPEUs. Available for $69.

5. **Commission on Dietetic Registration’s Certificate Courses on Weight Management.** Level I and II Adult certificate courses and Level I Pediatric Weight Management courses are available throughout the year.

6. **The Academy’s Evidence Analysis Library (EAL).** Access evidence-based nutrition information (condition-specific information), MNT effectiveness review, and MNT cost-effectiveness review. You must be logged into the EAL site to access.

7. **Nutrition Care Process.** The Nutrition Care Process and Model is the framework for the critical thinking process used by dietetics professionals as they provide nutrition services to their clients/patients. You must be logged into the EAL site to access.

Additional Information on Medicare Preventive Services for Obesity

1. Academy Member Website: MNT. Visit for up-to-date information on Medicare preventive services benefits as they relate to registered dietitians.

2. CMS Intensive Behavioral Counseling for Obesity Billing Guidelines

3. Medicare Claims Processing Manual—Chapter 18: Preventive and Screening Services

4. National Coverage Determination Memorandum

5. Academy Reimbursement Community – IBT Discussion Thread

Reimbursement Resources and Tools

1. Academy Member Website: Coverage. For many resources on billing and practice management.

2. Medicare Part B MNT Resources. When providing MNT to Medicare Part B beneficiaries, the Academy provides many resources and handouts to help you enroll, manage, and get reimbursement rates.

3. Academy Reimbursement Online Community. Join an online listserv/discussion from RDs who are interested and/or involved in reimbursement for MNT. Discussion thread on the IBT benefit and providing the benefit has started. You must be an Academy member and “join” the community to participate (free).

4. MNT Advocacy. Academy resources to aid the practitioner in advocating for expanded coverage for MNT services in the public and private markets.

5. MNT Provider Newsletter. A monthly publication from the Academy that is an essential practice management resource for registered dietitians and includes articles on business skills, technology, coding and coverage, nutrition practice guidelines, Medicare and Medicaid, and more.

Business Practice Tools

1. Nutrition Entrepreneurs DPG Membership. The mission of the NE DPG is to help members achieve their professional and financial potential by providing tools to build and maintain a successful nutrition-related business. Membership is $30 a year.

2. MNT Business Practice Tools. Academy handouts to aid the practitioner in providing MNT services.


4. Medical Nutrition Therapy MNTWorks Kit. This kit provides handouts that can be used during meetings and presentations to local third-party payers, employer groups, and hospital finance and billing departments to expand MNT coverage.

5. FastTrac: Educational Programs for Aspiring Entrepreneur. Funded by the Kauffman Foundation and offered nationally through 300 alliance organizations.
6. **Business Stages for Entrepreneurs.** By the esteemed James H. Hill Reference Library, this free online information resource for small businesses and entrepreneurs is loaded with business publications and information, including free podcasts on Business Strategies, an Entrepreneur Seminar Series, and more.

