When benefits outweigh costs: Integrating dietitian services improves patient outcomes

As practice professionals seek new ways to address the needs of specific patient populations, such as those who require management of obesity-related chronic diseases, there is renewed interest in using registered dietitians (RDs) in practices. One barrier to offering these services has been little or no reimbursement, say some professionals, but one MGMA member acknowledges that the value outweighs the added cost. As a bonus, the Patient Protection and Affordable Care Act (ACA) has begun to offer incentives to practices to incorporate dietitian services in their care plans.

**Worth the price**

Jane Gorman, CMPE, MGMA member, practice administrator, Rock Hill (S.C.) Gynecology & Obstetrical Associates, PA, has offered patients dietitian services for 15 years as a way to help patients who are chronically ill or have gestational diabetes.

Lauren Henderson, RD, is a full-time member of Gorman’s staff and offers medical nutrition therapy to patients diagnosed with diabetes, high cholesterol, high triglycerides, celiac disease, osteoporosis and fatty liver to improve their diets and identify food sensitivities. She monitors patients’ blood pressure and blood sugar logs, offers nutrition education and teaches them to use blood sugar monitors.

Some patients see the RD as much as they see physicians, who no longer have to spend as much time per patient on nutrition counseling and chronic disease management, Gorman says.

The RD spends a lot of time discussing a patient’s diet and lifestyle — how food is prepared, how a family eats, fast-food habits — and provides tips on healthy meal plans, which are things physicians do not usually cover in a standard appointment, Gorman says. “It’s not that physicians don’t recognize the extreme importance of nutrition,” she adds, “but in terms of offering an hour of dietary advice, there just isn’t time.”

A doctor might watch a patient’s blood sugar and mention that he or she needs to change specific eating habits, Gorman says, but the RD devotes an hour to nutrition counseling, including providing menus and tips for changing unhealthy habits. And counseling OB patients has the added bonus of addressing or influencing potential weight-related health problems in a patient’s child(ren), she adds.

About one-third of Henderson’s services are not directly reimbursed, but the patient benefits justify the cost, Gorman says. “It improves patient care so much,” she says. “I don’t think the physicians could provide our diabetic patients that kind of constant care and attention.”

The practice also provides nutrition counseling to a local children’s home and an HIV/AIDS clinic, for which the organizations pay $65 an hour. This helps offset the overhead costs associated with Henderson’s employment at the practice.

Although Gorman doesn’t have cost-savings data, she cites the amount of time she saves physicians as another business justification.

Most importantly, the service is good for patients. They get the coaching and help they need from Henderson to make these lifestyle changes and stay motivated. “I’m sure we would have less successful outcomes [without nutrition counseling],” Gorman says.

**Care coordination**

“Dietitians are well-prepared from their training for care coordination in certain high-risk...”
populations,” says Marsha Schofield, MS, RD, manager, advocacy of nutrition services coverage, Academy of Nutrition and Dietetics, Chicago. “They have data management training, and practices use them to manage panels of patients and patient registries, which they can use to track and report quality metrics, such as body mass index (BMI), blood sugar control, blood pressure, hemoglobin A1C, lipid panels, quality of life measures and depression screenings.”

Since so many chronic diseases can be improved through better nutrition, RDs take an active role in improving a patient’s health overall.

“Dietitians know how to connect [patients] to the right people with regard to the patient’s individual situation,” Schofield says. If patients have trouble accessing the right foods, RDs can connect them with community resources, such as food banks or the Supplemental Nutrition Assistance Program.

“The perception is that we’re going to be very prescriptive,” says Kerry Regnier, MPH, RD, LDN, MGMA member, practice administrator, Genesis Pediatric Medicine, Sycamore, Ill. “Patients will say, ‘I thought you were going to be the food police.'”

Once their concerns are allayed, patients will sometimes share more information with an RD than a physician, says Regnier, who is also the manager of advocacy and communications at the Academy of Nutrition and Dietetics. Since RDs have more time with patients, they might be able to get more information about home life, stressors and anything else aside from diet that can affect a patient’s success.

“We want to work with patients to do the best they can within their lifestyle,” she says. “It’s not going to do anyone any good [to just say], ‘You need to eat more carrots.’”

Registered dietitians and primary care
Several areas of the ACA have identified primary care as the central focus of improved care delivery, disease prevention and care access. Since RDs have the ability to perform care management services, such as assisting with chronic disease management and exercise counseling, dietitian services provide added value to primary care practices, and programs such as the Comprehensive Primary Care Initiative (CPCI) make it easier for these services to be financially viable.

The CPCI, a pilot program conducted by the Centers for Medicare & Medicaid Services (CMS) and made possible by the ACA, aims to foster collaboration between public and private payers to strengthen primary care. Medicare and some commercial and state health insurance plans will offer bonus payments to primary care practices that participate in this initiative — currently available in seven states — to help offset the nonbillable provider time necessary to better coordinate primary care for patients.

“In the past, the fee-for-service system has had its limitations in helping a practice justify the cost of an RD,” Schofield says. “But the CPCI has a per-member, per-month payment system, which allows for expansion of dietitian roles in practices.”

In response to the CPCI, the Academy of Nutrition and Dietetics created a toolkit titled “Integrating the Registered Dietitian into Primary Care” as a resource for medical practices that offer dietician services as a part of the CPCI. Download from eatright.org/shop.

“Primary care physicians value nutrition, but they don’t always have the time or the knowledge that their patients need,” Schofield says. “Payments and reimbursement have always been seen as a

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Barrier, and this is an opportunity for that barrier to be removed."

**Billing and payment**

Adequate reimbursement for dietitian services is still a challenge for many practices, but there are options for collecting reimbursement for certain nutrition counseling services.

Medicare Part B covers medical nutrition therapy services for Medicare beneficiaries who meet at least one of these conditions, according to CMS:
- Diabetes
- Kidney disease
- Kidney transplant in the last 36 months

Additionally, Medicare will cover obesity screening and counseling performed by an RD with a physician present in a primary care setting for Medicare beneficiaries who have a BMI of 30 or more.

And while RDs cannot bill Medicare directly, they can help administer parts of the Medicare annual wellness visit, including the cognitive functioning tests and health risk appraisal, which saves provider time, Schofield says.

Medicare, Medicaid and some commercial payers reimburse for a limited number of Henderson's nutrition counseling services, but the majority of her services are written off or paid out-of-pocket by patients, Gorman says. All existing diabetic OB patients are required to see the RD during pregnancy; if any of the patients are on Medicaid, two visits are paid for and the rest are written off, Gorman adds.

“There are times when our doctors say our dietitian is too expensive and we can’t afford her,” Gorman says. “So I ask them, ‘Do you want to take on all diabetes management?’ And they understand that she’s worth it.”

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