



Referrals to a Registered Dietitian Nutritionist

A Primary Care Provider (PCP) Toolkit promoting the use of Registered Dietitian Nutritionists (RDNs) in team based care for patients with obesity or diabetes

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Academy of Nutrition and Dietetics

Amy Allen, MPH, RD

Wellness Manager
Multomah County
Portland, Oregon

Amy Davis, RDN, LRD

Director of Nutritional Services
Sanford Health

Gina Bayless, MS, RDN, LD

Dietetic Internship Director/
Clinical Nutrition Manager
University Hospitals Cleveland Medical Center

Krista Yoder Latortue, MPH, RD, LDN, PMP, PBA, FAND

Executive Director at Family Food Corporate
Wellness Nutrition
Philadelphia, PA

Marcia Kyle, RDN, LDN, CDCES, FAND

Nutrition Specialist at Penobscot Bay YMCA
Rockport, Maine

Lise Sanchez, RDN, LDN, FAND

Former Manager, Education and Advocacy
Nutrition Services Coverage
Academy of Nutrition and Dietetics

Marsha Schofield, MS, RD, LD, FAND

Senior Director, Governance and Nutrition
Services Coverage
Academy of Nutrition and Dietetics

American Academy of Pediatrics

Debra Burrowes

Manager, Director of Technical and Medical Services
Academy of Nutrition and Pediatrics.

George J. Fuchs, III, MD, FAAP

Chief, Division of Pediatric Gastroenterology
Vice-Chair, Clinical Affairs, Department of Pediatrics
UK Healthcare
University of Kentucky

Tamara S. Hannon, MD

Professor of Pediatrics
Department of Pediatrics

**Division of Pediatric Endocrinology
and Diabetology**

Director, Clinical Pediatric Diabetes Program, Riley
Hospital for Children
Director, Youth Diabetes Prevention Clinic, Riley
Hospital for Children

American Academy of Nurse Practitioners

Beth Haney, DNP, FNP-C, FAANP

CEO
Luxe Aesthetic Center
Yorba Linda, CA

American College of Physicians

Viju John, MD, FACP

Associate Professor
General Internal Medicine
Rush University Medical Center

**American College of Obstetricians
and Gynecologists**

Raul Artal, MD, FACOG, FACS

Professor and Chairman Emeritus
Department of Obstetrics, Gynecology and Women's
Health
Saint Louis University

American College of Preventive Medicine

Danielle Pere, MPM

Former Vice President, Programs & Education
American College of Preventive Medicine

This toolkit is a project of the Primary Care Provider Association Advisory Board, created in 2015 under the leadership of the Academy of Nutrition and Dietetics with a vision that primary care providers (PCPs) and registered dietitian nutritionists (RDNs) will collaborate at the practice level to improve population health through nutrition (prevention as well as treatment). The mission of the Advisory Board is to develop and implement strategies at the national level that promote successful collaboration between RDNs and PCPs at the local level. The Advisory Board consists of staff and/or member leader representatives from the following professional societies:

- Academy of Nutrition and Dietetics
- American Academy of Pediatrics
- American Academy of Family Physicians
- American Academy of Nurse Practitioners
- American College of Physicians
- American College of Obstetricians and Gynecologists
- American College of Preventive Medicine
- American Geriatrics Society

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Introduction

As a primary care provider (PCP), you recognize the rising rates of obesity and diabetes within both the adult and pediatric populations.

You recognize the important role nutrition plays in the prevention and management of these chronic diseases. And you recognize the value of the expertise of registered dietitian nutritionists (RDNs) as part of your team in working with these patients. Sometimes, though, you face challenges in successfully bringing together the team (patient, PCP, RDN) to set and achieve individual health care goals.

The purpose of this toolkit is to bring together in one easy-to-use place the information, examples, and tools you need to successfully partner with RDNs to provide care to your patients with obesity and diabetes. You may also find this resource useful beyond these specific chronic conditions. Whether you are working with adult or pediatric patients, the toolkit contains valuable tips for supporting team-based care.

There are ten primary sections of this toolkit. Like a real toolkit, use only the tool or section 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.

Section I: The Value of RDN Services to PCPs

Section II: Clinical and Practice Guidelines

Section III: Reasons for Underutilization of RDNs and Lack of RDN Referrals

Section IV: Current Coverage for Nutrition Services

Section V: Effective Referral Messaging

Section VI: Referral Tools

Section VII: Filling the Gap: Nutrition Education Between PCP Referral and First RDN Appointment

Section VIII: Coding for Nutrition Services

Section IX: Where to Find an RDN

Section X: Business Models for RDN/PCP Partnerships

Section I:

The Value of RDN Services to PCPs

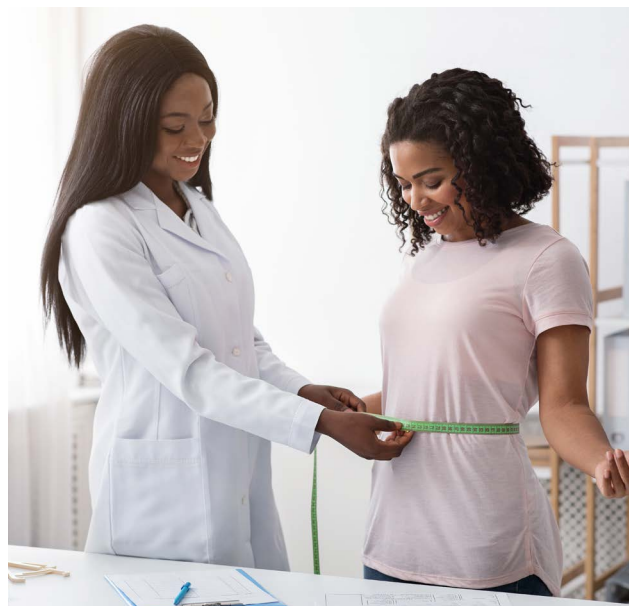
Building effective team-based patient care has been shown to improve patient outcomes, improve office efficiency, and decrease health care costs.¹ Though health care is moving in the direction of more comprehensive care, fewer than 45% of primary care visits with nutrition-related conditions like hyperlipidemia, hypertension, obesity, and diabetes include diet counseling.² As acute concerns often outweigh chronic care management in already short appointments, the majority of PCPs lack the time or focused expertise to offer adequate lifestyle counseling.²

This is where RDNs step in. As the experts in nutrition and behavior counseling, RDNs integrated into the primary care team provide cost-effective, quality care that fosters patient and provider satisfaction while improving outcomes for patients with a wide variety of medical conditions.³ Research has shown that for every \$1 invested in an RDN-led lifestyle modification program, there has been a nearly \$15 return.⁴ Several studies have shown that medical nutrition therapy (MNT) provided by RDNs improves clinical outcomes, reduces costs related to PCP time, decreases medication usage, and reduces hospital admissions for individuals with obesity, diabetes, and other chronic diseases.⁵ The Lewin Group documented a 9.5% reduction in hospital utilization and a 23.5% reduction in PCP visits when MNT was provided by an RDN to individuals suffering from diabetes mellitus.⁶

Although this toolkit focuses on obesity and diabetes, RDNs can assist primary care teams to address several conditions impacting adult and pediatric populations, including:

- hypertension,
- disorders of lipid metabolism,
- heart failure,
- gastrointestinal disorders,
- gastroesophageal reflux disease,
- chronic kidney disease,
- gestational conditions,
- pediatric growth problems, and
- type 1 and type 2 diabetes (not obesity-related).

Whether a practice is looking to provide MNT, self-management support, care management services, prevention services, or population outreach, RDNs bring a multidimensional skill set with demonstrated value to the primary care team.



1 Wasson JH. Who is in charge? Even affluent patients suffer consequences of fragmented care. *J Ambul Care Manage*. 2008;31:35-36.

2 Coaching and counseling patients: a clinical reference. American College of Preventive Medicine website. <https://c.ymcdn.com/sites/acpm.site-ym.com/resource/resmgr/timetools-files/coachingclinicalreference.pdf>. Accessed February 6, 2019.

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Section II:

Clinical and Practice Guidelines

Lifestyle modification is identified as a highly effective, evidence-based intervention to prevent and treat obesity and chronic diseases.

Nutrition is one of the major modifiable lifestyle risk factors along with smoking, alcohol consumption, and physical activity. Chronic disease management and lifestyle guidelines contain recommendations for the inclusion of medical nutrition therapy (MNT) provided by RDNs. Referring to RDNs will help to meet these guidelines and recommendations.

Lifestyle Management Medical Care Guidelines: Diabetes

According to the American Diabetes Association, “lifestyle management is a fundamental aspect of diabetes care and includes diabetes self-management education and support (DSMES), MNT, physical activity, smoking cessation counseling, and psychosocial care. Patients and care providers should focus together on how to optimize lifestyle from the time of the initial comprehensive medical evaluation, throughout all subsequent evaluations and follow-up, and during the assessment of complications and management of comorbid conditions in order to enhance diabetes care.”¹

In adults with type 1 and type 2 diabetes, three to six MNT encounters with an RDN during the first 6 months are recommended, and then it is determined if additional MNT encounters are needed. In studies reporting on the implementation of an initial series of RDN encounters (three to 11 encounters; total of two to 16 hours), MNT significantly lowered HbA1c by 0.3% to 2.0% in adults with type 2 diabetes and by 1.0% to 1.9% in adults with type 1 diabetes during the first six months, as well as optimization of medication therapy and improved quality of life. A minimum of one MNT follow-up encounter is suggested. Studies longer than six months report that continued MNT encounters resulted in maintenance and continued reductions of HbA1c for up to two years in adults with type 2 diabetes and for up to 6.5 years in adults with type 1 diabetes. In adults with prediabetes, MNT encounters with an RDN are recommended for individuals who are at high risk for type 2 diabetes. Studies reported that increased frequency of visits resulted in greater improvements in certain metabolic and anthropometric outcomes.²

For pediatric patients with diabetes, education and training are provided for caregivers and must be updated as the child grows and eventually assumes self-care responsibilities. MNT is also essential in facilitating accurate dosing of insulin for many patients with type 1 and type 2 diabetes. Children utilizing insulin must also learn to balance food, insulin, and activity to prevent hypoglycemia.

Lifestyle Management Medical Care Guidelines: Overweight or Obese Adults with Chronic Disease

Lifestyle Management Medical Care Guidelines: Overweight or Obese Adults with Chronic Disease Experts, including the US Preventive Services Task Force (USPSTF), American Heart Association, American College of Cardiology, and The Obesity Society, agree that intensive nutrition counseling provided by clinicians, including RDNs, should be recommended for adults with overweight or obesity with chronic disease.³



For weight loss in adults with overweight or obesity, at least 14 MNT encounters (either individual or group) over a period of at least 6 months are recommended. High-frequency comprehensive weight loss interventions result in weight loss. For weight maintenance, at minimum monthly MNT encounters over a period of at least 1 year are recommended. High-frequency comprehensive weight maintenance interventions result in maintenance of weight loss.⁴

Lifestyle Management Medical Care Guidelines: Pediatrics

RDNs play a key role in preventing and treating pediatric overweight and obesity. “The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. (B recommendation).”⁵

Additionally, the American Academy of Pediatrics provides recommendations for assessment and management of childhood obesity in patients age 2 years and older. “Providers’ offices need to prepare by implementing a system for evaluation; by identifying resources, such as pediatric dietitians or behaviorists, or training staff members for diet and activity assessments; and by identifying community resources and referral centers, if available. Referral centers may emerge in response to the needs of area practices. For each stage of obesity treatment, the expert committee has recommended a process for implementation, suggesting how the primary care provider can provide this care or identify support beyond the office.”⁵ For more information, refer to the Obesity Prevention, Assessment and Treatment Algorithm on the American Academy of Pediatrics Institute for Healthy Childhood Weight website https://ihcw.aap.org/Pages/Resources_ClinicalSupports.aspx.

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Section III:

Reasons for Underutilization of RDNs and Lack of RDN Referrals

Nutrition plays a significant role in both the prevention and management of the leading US causes of death and chronic disease, such as cardiovascular disease, diabetes, and obesity.

Unfortunately, it is not sufficiently emphasized in the clinical setting nor do PCPs commonly refer their patients to the services of an RDN. There are several potential reasons for this, including

1. lack of physician training and full understanding of nutrition and the role it plays in health,
2. limited understanding of the role and expertise of the RDN,
3. lack of referral networks,
4. continued use of the fee-for-service (FFS) model,
5. misunderstanding of reimbursement and patient coverage, and
6. underutilization of team-based care and care coordination models.



The field has cited lack of confidence and knowledge as major barriers to counseling patients about lifestyle interventions, including nutrition and weight loss.¹ On average, physicians receive only 21 hours of nutrition training during their medical education, which is widely accepted as inadequate to respond to most patient questions and concerns about diet and lifestyle change to prevent and treat chronic disease.² Additionally, physicians are not trained in competencies related to lifestyle or behavior modification as a frontline therapy to treat or prevent chronic disease. Medical training more often emphasizes pharmaceutical intervention management, which becomes a primary mode for treatment in nutrition-related medical conditions.³

Physicians' limited training and familiarity with evidence base relating to nutrition and health provides an additional barrier when considering the importance of referral to RDNs. The traditional clinical team does not always understand the specialized skills, knowledge, and training of RDNs.⁴ Physicians may be unaware to whom they can refer their patients for therapeutic lifestyle change counseling as RDNs are generally not integrated, formally or informally, into the primary care setting. Despite both adequate reimbursement rates for services and preventive coverage benefits for patients, current levels of understanding and the absence of networks and relationships between RDNs and PCPs serve as a barrier to RDN referrals, which can impact patient health.

Until recently, the US health care system has spent vast resources on episodic care focused on treating and managing disease at its diagnosis going forward. The passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) begins to move our system incrementally away from FFS models and towards value-based payments that emphasize quality and coordinated patient care, which realign incentives towards paying physicians more when their patient population maintains good health. Even with this incremental movement, a majority of physicians still utilize FFS, which can limit the incentive for referral to an RDN.⁵



Under FFS, PCPs' understanding of reimbursement for RDN services is a significant challenge. Although Medicare has standard coverage, not all RDNs are Medicare providers. Medicaid coverage differs by state, while private/commercial payers differ by plan and/or region, leading to a complicated matrix of covered nutrition services. New payment models in both public and private sectors, such as bundles, can add incentives for providers, but they are still not widely used or understood beyond large, integrated health care systems.

Although Medicare covers medical nutrition therapy (MNT) per physician referral for diabetes and chronic renal disease, physicians must decide whether they want to administer intensive behavior therapy for obesity or have a team member, such as an RDN, play that role. Team-based care or coordination is still not emphasized as an optimal practice design outside of the inpatient setting. More evidence is needed to show that an RDN integrated into the primary care setting will result in significant return on investment. The lack of well-known business models and practice examples of how to successfully incorporate RDNs into health care services presents an added challenge. Specific models are needed to drive integration that focus on how to contract with and/or employ RDNs, along with practice flow and case management protocols.⁶

Some specialties, including preventive medicine, recognize and support a team-based care model for primary care practice, which integrates a variety of clinicians into a practice team to share responsibilities for better coordinated patient care.⁷ In a team-based care approach, there is usually an emphasis at the end of the visit on follow-up activities, such as arranging referrals, follow-up visits, and so on. Even with the advent of the Patient Centered Medical Home (PCMH), this type of practice infrastructure or utilization of RDNs is still not standard.

Care coordination among providers is challenging no matter what specialties are involved. Even in the best situations, after a referral to an RDN is made, the patient must understand the value of their expertise and carry through scheduling an initial visit or following recommendations. On the backend, there might be challenges with the RDN circling back to the PCP to share critical health care information about the patient.

Many of these reasons for underutilization of RDNs do not need to stand in the way of changing practice. This toolkit is designed to offer practical tools and tips to help PCPs overcome some of the obstacles faced in their efforts to offer team-based care that addresses the nutrition needs of their patients with diabetes or obesity.

1 Lianov L, Johnson M. Physician competencies for prescribing lifestyle medicine. *JAMA*. 2010;304(2):202-203. doi:10.1001/jama.2010.903.

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7 Edshteyn I, Uduhiri KA, Morgan TO, Rhodes KL, Sherin KM; American College of Preventive Medicine Prevention Practice Committee. Integrating effective weight management into practice. *Am J Prev Med*. 2016;51(4):542-548. https://cdn.ymaws.com/www.acpm.org/resource/resmgr/statements/ajpm_weight-management.pdf. Accessed March 4, 2019.

Section IV:

Current Coverage for Nutrition Services

Many medical providers are operating under an old and incorrect assumption that payment for nutrition services does not exist. Benefits for nutrition counseling have evolved, and medical providers need to remain current to support appropriate referrals to RDNs.

Health care payments are shifting from a traditional fee-for-service (FFS) model to value based payments. Emerging models of health care delivery emphasize value-based payments, increasing access to nutritional services. Potential payment streams may include FFS, per-member-per-month (PMPM), quality incentive payments, shared savings, and bundled payments.

In addition to face-to-face visits with an RDN, coverage may also include telehealth visits. Patients can verify their individual insurance coverage by calling the insurance member benefit phone number on the back of their card.



Medicare

Medical Nutrition Therapy

Medical nutrition therapy (MNT) covered by Medicare includes diabetes, non-dialysis kidney disease, and 36 months post kidney transplant. Medicare covers 3 hours of MNT the initial year of referral and up to 2 hours of MNT for subsequent years. Additional coverage is available with a second referral in the same year for a change in diagnosis, medical condition, or treatment regimen. This is often a missed piece of coverage. Some Medicare Advantage plans may also offer additional benefits, including coverage beyond these diagnoses covered by traditional Medicare.

Intensive Behavioral Therapy for Obesity

RDNs can partner with PCPs to address weight management. Patients must be Medicare Part B beneficiaries with a body mass index (BMI) greater than or equal to 30. RDNs may provide this benefit "incident to" physician services as auxiliary personnel.

Medicare Diabetes Prevention Program

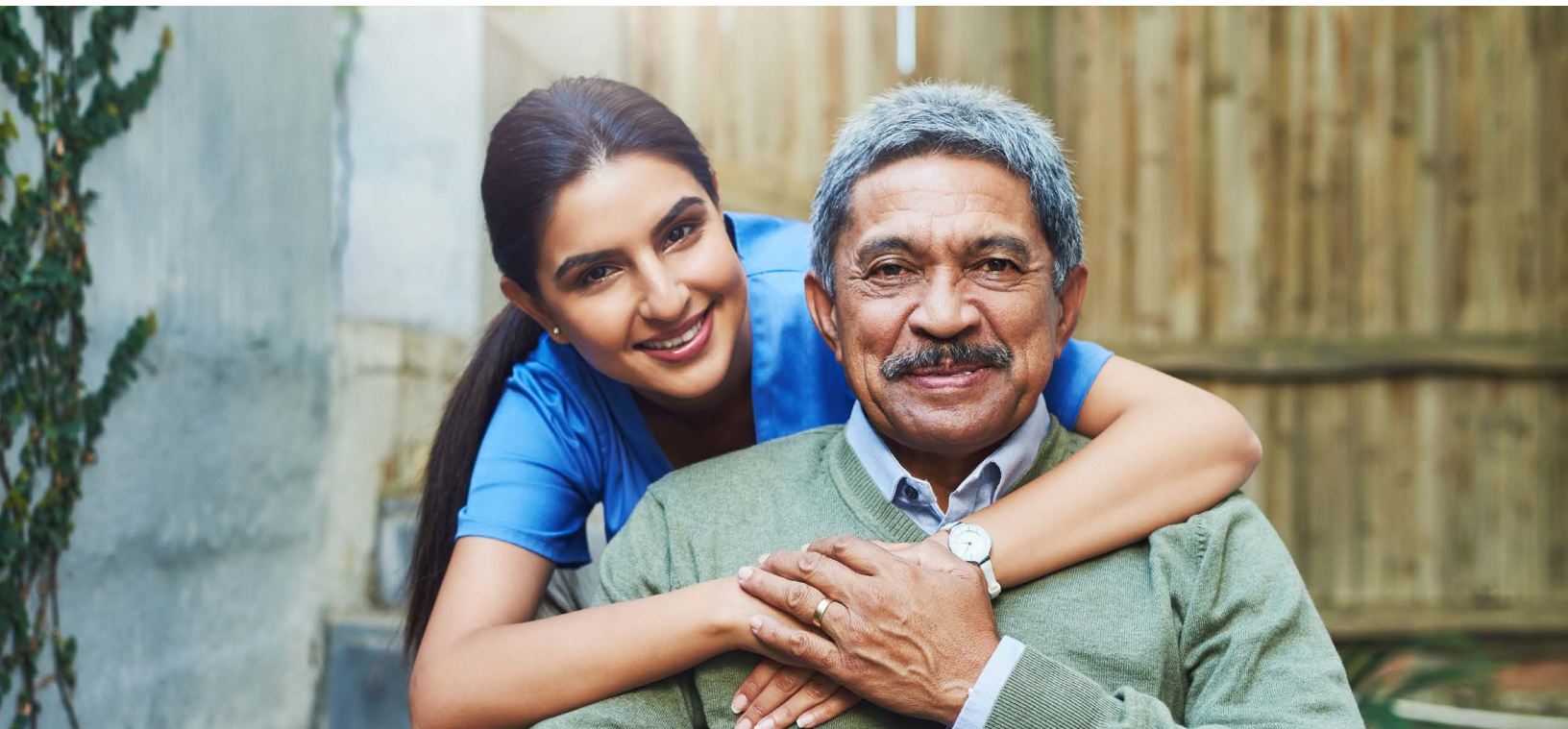
Medicare beneficiaries with pre-diabetes who have an elevated BMI of at least 25 (at least 23 if self-identified as Asian) are eligible to receive a diabetes prevention service, the Medicare Diabetes Prevention Program.

Diabetes Self-Management Training

Diabetes Self-Management Training (DSMT) is also a covered benefit up to 10 hours of training the first year and up to 2 hours of follow-up training each subsequent year.

Alternative Payment Models and Advanced Alternative Payment Models

Patients who are participating in a Centers for Medicare & Medicaid Services (CMS) Innovation Model, including Comprehensive Primary Care Plus (CPC+), Comprehensive ESRD Care Model (CEC), and Oncology Care Model (OCM), may have access to RDN services. For a list of Alternate Payment Models (APMs) and Advanced APMs, visit the CMS Innovation Center website (<https://innovation.cms.gov/initiatives/#views=models>).



Medicaid

Medicaid programs vary state to state. Individual state Medicaid plans are offered in a variety of delivery models, which could include a traditional FFS plan or managed Medicaid plan. Contact your state's Medicaid program for information about coverage for nutrition services provided by an RDN.

Medical Nutrition Therapy

Medicaid coverage for MNT for adults and children varies state to state and varies by diagnosis within the states.

Children's Health Insurance Program

Children's Health Insurance Program (CHIP) serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid. Coverage for nutritional services also varies state to state.

National Diabetes Prevention Program

Individual state Medicaid benefits may include coverage for the National Diabetes Prevention Program (National DPP).

Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is the child health component of Medicaid. The federal government does not require states to provide nutrition counseling services, but states are allowed to determine what other services are "medically necessary" as part of the program.

Under the screening component of EPSDT, state Medicaid programs are responsible for assuring that children under the age of 21 receive periodic physical examinations, complete health and developmental histories, and health education.

Any medical service or treatment determined to be medically necessary for the child that can be covered under Medicaid, such as additional nutritional assessments, counseling, or surgery, would be available through the EPSDT benefit.

Private Insurance Plans

Opportunities for coverage by third-party payers for nutrition services provided by RDNs continue to expand as a result of the Affordable Care Act (ACA) and the efforts of RDNs demonstrating their value as an integral member of the health care team.

Nutrition/MNT coverage varies across the country. Not all insurance companies offer the same policies, and two policies within the same company can be very different. Nutrition services may be covered under preventive benefits, "incident to" physician services, PMPM, or bundled payment.

Additional Coverage Options

Additional coverage options include:

- My Healthy Weight: <https://bipartisanpolicy.org/events/my-healthy-weight/>
- Applying for medical necessity
- Out of pocket

Section V:

Effective Referral Messaging

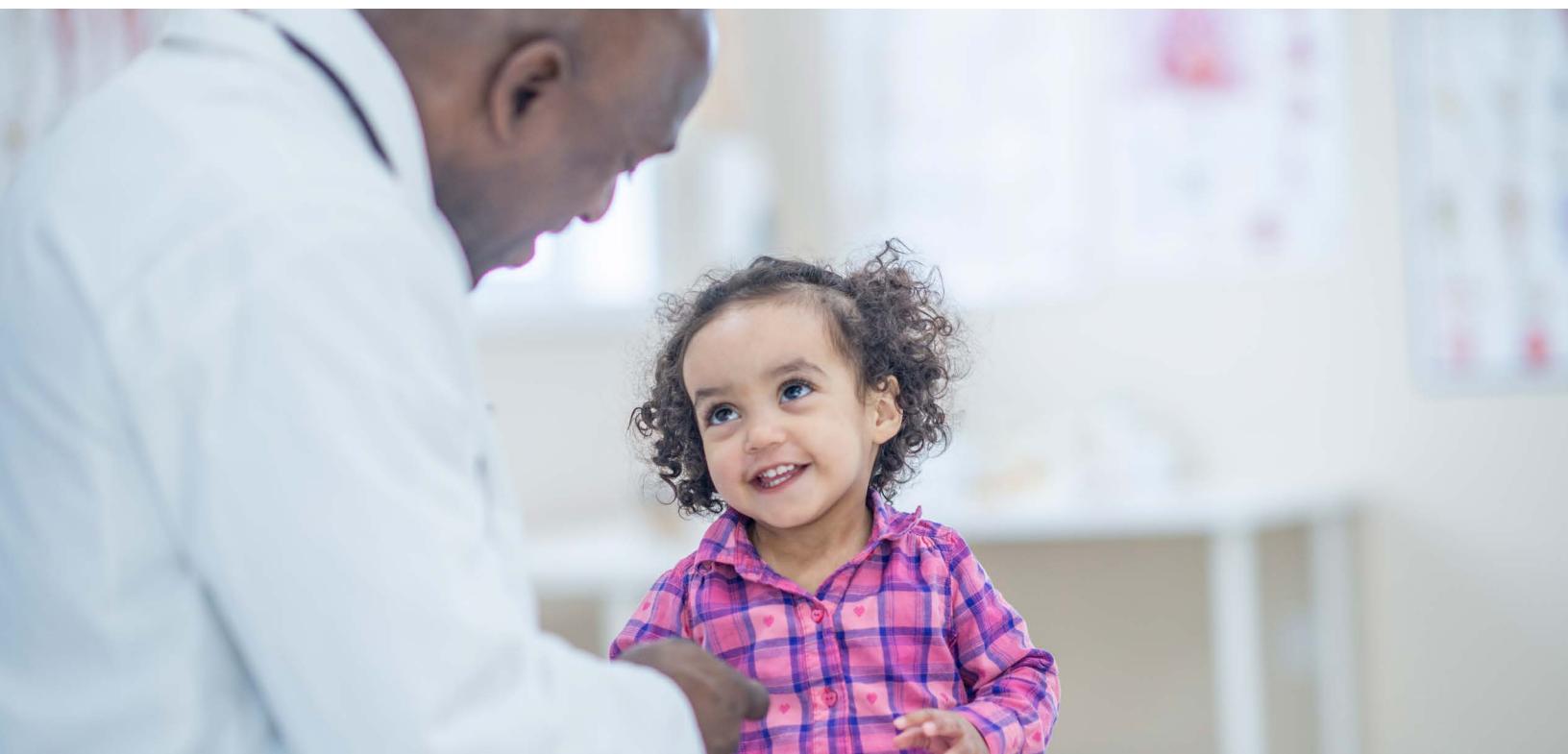
Physicians are the trusted source of information by the public.¹

As a result, PCPs are in a unique position to be a critical factor in the success of a patient receiving medical nutrition therapy (MNT) from an RDN. The following communication tips and recommendations are shown to improve the likelihood of a patient successfully meeting with an RDN to receive MNT.

Become familiar with what happens during an RDN visit.

Learn more about a typical visit with an RDN so you can effectively explain the RDN's role to your patients. You may find the video "What a Registered Dietitian Nutritionist Can Do for You" on the Academy of Nutrition and Dietetics website (www.eatright.org/videos) to be a good starting point. Additionally, the following handouts offer patient friendly language you can refer to as well:

- Top 10 Reasons to Consult with an RDN
https://www.eatrightpro.org/-/media/eatrightpro-files/career/career-development/flyers-and-handouts/rdn_top_10_reasons.pdf?la=en&hash=6F3293BBADF46930EECEB4C4DB537629ACC46331
- Registered Dietitian Nutritionists Bring Food and Nutrition Expertise to the Table
www.eatrightpro.org/-/media/eatrightpro-files/career/career-development/flyers-and-handouts/rdn_expertise_to_the_table.pdf?la=en&hash=5CF4DDE238311F42DCD619D6C393C7D684BFEBF2
- Registered Dietitian Nutritionists – Your Recipe for Success!
https://www.eatrightpro.org/-/media/eatrightpro-files/career/career-development/flyers-and-handouts/rdn_recipe_for_success.pdf?la=en&hash=A5AECC5D98C63EAE78962ACAECFBC12B4F29D63



Use people-first language.

To align with the preferred standard of people-first language, the following is recommended²:

- Use neutral words like “weight” and “body mass index” rather than terms like “obese,” “extremely obese,” “fat,” or “weight problem.”
- Use language that places the individual first before the medical condition or disability. For example, “a child with an unhealthy weight” instead of “an obese child” or “an adult with diabetes” instead of “a diabetic adult.”
- Use more neutral terms in clinical documentation, such as “unhealthy weight” and “very unhealthy weight.”

Using people-first language is especially significant when working with children and adolescents. According to the American Academy of Pediatrics (AAP), “it is important for pediatricians and pediatric health care professionals to use appropriate, sensitive, and nonstigmatizing language in communication about weight with youth, families, and other members of the pediatric health care team. Words can heal or harm, intentionally and unintentionally.”²

To further prevent your own potential attitudes and beliefs related to body weight to impact your messaging to patients, visit the University of Connecticut's Rudd Center for Food Policy & Obesity website (www.uconnruddcenter.org/weight-bias-stigma-health-care-providers) to explore their resources to increase self-awareness around weight bias.



Beginning the conversation.

Conversations about weight and other chronic diseases linked with eating and nutrition are sensitive and can be challenging. Despite the challenge, the conversations are crucial since “having the conversation and formally diagnosing and documenting overweight or obesity is the strongest predictor of having a treatment plan in place and subsequent successful weight loss.”³ Consider these tips to make your conversations effective:

- Start with an empathetic statement.
- Ask permission.

Examples:

- You mentioned a number of symptoms, such as fatigue and aching knees, which may be related to excess weight. Would you like to talk about this to see if we can help you feel better?
- Would it be okay if we discussed your weight?
- Are you concerned about the effect of your weight on your health? Do you feel that affects your quality of life? For example, do you find it difficult to do everyday things like walking up a flight of stairs?
- Our measurements indicate that you are carrying excess weight. Excess weight can be unhealthy for you and strain your body, making it work harder than it needs to work. Excess weight also increases your risk for diabetes, heart disease, high blood pressure, stroke, and cancer. The good news is that moderate weight loss has been shown to greatly reduce the risk of these disease. If you're interested, we can talk a bit more about weight and related topics....
- You mentioned you're concerned about your child's weight. Would you like some ideas to support a healthy weight for your child?

Pediatric Examples:

- What physical activities/sports do you like to do? Does your health prevent you from enjoying these?
- How do you feel about the meals and foods you are eating?
- Do you think making some changes with your food choices might help you feel better?
- How do you feel your blood sugars are related to the foods you are choosing?
- Can we talk about how your family makes food choices?
- How do you feel about the meals and snacks that your family consume?

Keep it positive.⁴

- Share confidence in the process, person, and experience.
- Explain what the patient might expect from the nutrition counseling process and experience.
- Support patient efforts to reach out for more help.
- Emphasize that a referral is not to address “failure” but to increase the likelihood of success.

Consider a “warm handoff.”

- The US Department of Health and Human Services states, “a warm handoff is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.”⁵ For more information, visit the Agency for Healthcare Research and Quality website <https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html>.

See Figure 5.1 for sample conversations.

1 Food insight. 2018 food and health survey. International Food Information Council Foundation website. <https://foodinsight.org/2018-food-and-health-survey/>. Published May 13, 2018. Accessed February 15, 2019.

2 Pont SJ, Puhl R, Cook SR, Slusser W; AAP Section on Obesity, The Obesity Society. Stigma experienced by children and adolescents with obesity. *Pediatrics*. 2017;140(6):e20173034. <http://pediatrics.aappublications.org/content/pediatrics/140/6/e20173034.full.pdf>. Accessed October 8, 2018.

3 Dietz WH, Kahan S, Gallagher C, et al. Why weight? A guide to discussing obesity & health with your patients. *Stop Obesity Alliance website*. <http://stopobesityalliance.org/wp-content/themes/stopobesityalliance/pdfs/STOP-Provider-Discussion-Tool.pdf>. Accessed October 8, 2018.

4 Hartung A, Sulik B. Primary care plus: how a registered dietitian nutritionist adds value to your practice. 2018. Available at: <https://www.eatrightstore.org/product-type/webinars-and-presentations/primary-care-plus-how-a-registered-dietitian-nutritionist-adds-value-to-your-practice>. Accessed October 8, 2018.

5 Warm handoff: intervention. Agency for Healthcare Research and Quality website. <http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html>. Published April 2017. Updated December 2017. Accessed February 15, 2019.

6 Hassink SG; Pediatric Weight Management Clinic; Al DuPont Hospital for Children, Thomas Jefferson University Medical School, eds. Pediatric obesity clinical decision support chart. American Academy of Pediatrics; 2008. <https://ebooks.aappublications.org/content/5210-pediatric-obesity-clinical-decision-support-chart-3rd-ed>. Accessed November 1, 2019.

Figure 5.1. Fifteen-Minute Obesity Prevention Protocol

Steps	Sample Language
STEP 1. ASSESSMENT	
Weight and height, convert to BMI. Provide BMI information.	We checked your child's body mass index (BMI), which is a way of looking at weight and taking into consideration how tall someone is. Your child's BMI is in the range where we start to be concerned about extra weight causing health problems.
Elicit parent's concern.	—What concerns, if any, do you have about your child's weight? — <i>He did jump two sizes this year. Do you think he might get diabetes someday?</i>
Reflect/probe.	So you've noticed a big change in his size and you are concerned about diabetes down the road. What makes you concerned about diabetes in particular? <i>Etc.</i>
Sweetened beverages, fruits and vegetables, TV viewing and other sedentary behavior, frequency of fast-food or restaurant eating, consumption of breakfast, and others	(Use verbal questions or brief questionnaires to assess key behaviors.) Example: About how many times a day does your child drink soda, sports drinks, or powdered drinks like Kool-Aid?
Provide positive feedback for behavior(s) in optimal range. Elicit response.	You are doing well with sugared drinks. <i>I know it's not healthy. He used to drink a lot of soda, but now I try to give him water whenever possible. I think we are down to just a few sodas a week.</i> So you have been able to make a change without too much stress.
Reflect/probe.	
Provide neutral feedback for behavior(s) NOT in optimal range. Elicit response.	Your child watches 4 hours of TV on school days. What do you think about that? <i>I know it's a lot, but he gets bored otherwise and starts picking an argument with his little sister.</i> So watching TV keeps the household calm.
Reflect/probe	
STEP 2. AGENDA SETTING	
Query which, if any, of the target behaviors parent/child/adolescent may be interested in changing or might be easiest to change.	We've talked about eating too often at fast-food restaurants, and how TV viewing is more hours than you'd like. Which of these, if either of them, do you think you and your child could change? <i>Well, I think fast food is somewhere we could do better. I don't know what he would do if he couldn't watch TV. Maybe we could cut back on fast food to once a week.</i>
Agree on possible target behavior.	That sounds like a good plan.
STEP 3. ASSESS MOTIVATION AND CONFIDENCE	
3a: Willingness/Importance On a scale of 0 to 10, with 10 being very important, how important is it for you to reduce the amount of fast food he eats? 0 1 2 3 4 5 6 7 8 9 10 Not at all Somewhat Very	
3b: Confidence On a scale of 0 to 10, with 10 being very confident, assuming you decided to change the amount of fast food he eats, how confident are you that you could succeed? 0 1 2 3 4 5 6 7 8 9 10 Not at all Somewhat Very	
3c: Explore IMPORTANCE and CONFIDENCE ratings with the following probes: Benefits Barriers Solutions	You chose 6. Why did you not choose a lower number? <i>I know all that grease is bad for him.</i> You chose 6. Why did you not choose a higher number? <i>It's quick, cheap, and he loves it...especially the toys and fries.</i> REFLECTION: So there are benefits for both you and him. What would it take you to move to an 8? <i>Well, I really want him to avoid diabetes. My mother died of diabetes, and it wasn't pretty...maybe if he started showing signs of it...maybe if I could get into cooking a bit.</i>
STEP 4. SUMMARIZE AND PROBE POSSIBLE CHANGES	
Query possible next steps.	So where does that leave you? OR From what you mentioned it sounds like eating less fast food may be a good first step. OR How are you feeling about making a change?
Probe plan of attack.	What might be a good first step for you and your child? Or What might you do in the next week or even day to help move things along? Or What ideas do you have for making this happen? <i>If patient does not have any ideas...</i> If it's OK with you, I'd like to suggest a few things that have worked for some of my patients.
Summarize change plan, provide positive feedback.	Involving child in cooking or meal preparation Ordering healthier at fast-food restaurants Trying some new recipes at home
STEP 5. SCHEDULE FOLLOW-UP	
Agree to follow up within X weeks/months.	Let's schedule a visit in the next few weeks/months to see how things went.
If no plan is made	Sounds like you aren't quite ready to commit to making any changes now. How about we follow up with this at your child's next visit? OR Although you don't sound ready to make any changes, between now and our next visit you might want to think about your child's weight gain and lowering his diabetes risk.

Source: Reproduced with permission from American Academy of Pediatrics. Pediatric obesity clinical decision support chart.⁶

Section VI: Referral Tools

There are a variety of ways that PCPs can refer patients to RDNs.

The medical nutrition therapy (MNT) referral is most often the key element that initiates the services of a RDN. Most RDNs in private practice or outpatient hospital settings already have a standard referral form they can share with PCPs. Many health care providers are now using an electronic MNT referral, which can be communicated from the PCP to the RDN through a shared electronic system. An electronic MNT referral is maintained in the patient's electronic health record for a determined amount of time.

When referring patients to an RDN, the following minimum information is suggested:

- PCP referral with PCP name, signature, contact information, and national provider identifier (NPI) number
- Patient name, address, and phone number(s)
- Name of parent/responsible adult if patient is a minor
- Reason for referral, including related ICD-10 codes
- PCP goals for RDN treatment

The following additional information is helpful, especially when referring to a private-practice RDN or an RDN outside of a hospital where patient chart access may be limited:

- Special needs, including language, emotional, learning, mobility
- Recent lab data and current medication list
- Height and weight history, including growth charts for pediatric patients
- Current feeding/nutrition support regimen if applicable
- Recent history and physical with office visit notes, including all medical diagnoses
- Copy of patient insurance cards (front and back)

When making an RDN referral, the PCP should include a copy of the RDN referral in the patient medical record and document the need for MNT in the office visit note as well.

For your convenience, sample referral forms can be found at the end of this section (Figures 6.1 through 6.3). Ideally the provider's office should schedule the first appointment with the RDN while the patient is onsite as it communicates to the patient the provider's support of the referral and increases the likelihood of patient follow-through. The RDN will then send follow-up information to the provider's office and request any additional patient information as needed.

Sometimes state laws and/or payer policies will restrict the types of PCPs who can write orders for referrals. For example, for Medicare patients, only a physician can refer a patient to an RDN for MNT services; physicians, nurse practitioners, and physician assistants can all make referrals for Diabetes Self-Management Training (DSMT).

Figure 6.1. Adult Referral Form

(Place Logo Here)
PRACTICE/HOSPITAL NAME

Medical Nutrition Therapy (MNT) Referral Form

PLEASE CALL TO SCHEDULE: () - - ; FAX: () - -

Adult Nutrition Services Locations: _____, _____, _____

Patient's Name: _____ **Date:** _____

DOB: _____

Patient's Phone: _____

Medical Record Number: _____

DIAGNOSIS CODE/S (required)

O	Gestational Diabetes Mellitus		
E	Other Specified Diabetes Mellitus		
R73.9	Hyperglycemia, UNS	K58.0	Irritable bowel syndrome with diarrhea
N18.9	Chronic Kidney Disease, unspecified	K58.9	Irritable bowel syndrome without diarrhea
N18.3	Chronic Kidney Disease Stage III	K59.00	Constipation, unspecified
N18.4	Chronic Kidney Disease Stage IV	K31.84	Gastroparesis
I10	Essential (primary) hypertension	K21.0	Gastroesophageal reflux disease with esophagitis
E78.00	Pure hypercholesterolemia, unspecified	K21.9	Gastroesophageal reflux disease without esophagitis
E78.1	Pure Hyperglyceridemia	E66.01	Morbid (severe) obesity due to excess calories
E78.2	Mixed Hyperlipidemia	E66.09	Other obesity due to excess calories
R63.4	Abnormal weight loss	E66.1	Drug-induced obesity
R63.6	Underweight	E66.3	Overweight
R62.7	Failure to thrive (adult)	E66.8	Other obesity
E46	Unspecified Protein Caloric Malnutrition	E66.9	Obesity, unspecified
E55.9	Vitamin D Deficiency, unspecified	E88.81	Metabolic Syndrome
K90.0	Celiac Disease	R63.5	Abnormal weight gain
K52.29	Allergic and dietetic gastroenteritis and colitis, other	Z68.0	Body Mass Index (BMI) _____

****Other DX and ICD-10 Code/s (specify):** _____

LABORATORY DATA

Wt: _____ Ht: _____ BMI: _____

Glomerular Filtration Rate (13-50 ml/min/1.73m): _____ OR Serum Creatinine: _____

Fasting Blood Glucose (≥ 126 mg/dl): _____ HgbA1c: _____

Total Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ BP: _____ *Please attach any other labs if necessary

Reason for Referral:

_____ Weight Reduction Needed _____ Food Allergy: _____

_____ Weight Gain Needed _____ Low Cholesterol/Low Saturated Fat Diet

_____ Diabetes Medical Nutrition Therapy _____ Low Sodium Diet

_____ Other: _____

If patient requires nutrition support, provide current feeding regimen

****For Weight Loss Referrals--Clearance for Exercise Yes No (Circle One)**

Relevant Medications: _____

Print Physician's Name: _____

Physician's Phone/Fax: _____

Physician's Signature: _____ Date: _____

*Physician- retain original and fax a copy to the dietitian.

A sample adult referral form is shown.

Figure 6.2. Pediatric Referral Form

(Place Logo Here)
PRACTICE/HOSPITAL NAME

Medical Nutrition Therapy (MNT) Referral Form

PLEASE CALL TO SCHEDULE: () ___-___; FAX: () ___-___

Pediatric Nutrition Services Locations: _____, _____, _____

Patient's Name: _____ **Date:** _____ **DOB:** _____

Patient's Phone: _____

Medical Record Number: _____

DIAGNOSIS (required)-select diagnosis

<input type="checkbox"/> R63.4 Abnormal Loss of Weight and Underweight <input type="checkbox"/> R62.51 Failure to Thrive <input type="checkbox"/> R63.3 Feeding Difficulties <input type="checkbox"/> Z91.010 Peanut Allergy <input type="checkbox"/> Z91.011 Milk Allergy <input type="checkbox"/> Z91.012 Egg allergy <input type="checkbox"/> Z91.018 Multiple Food Allergies <input type="checkbox"/> K90.0 Celiac Disease <input type="checkbox"/> E55.9 Vitamin D Deficiency, unspecified <input type="checkbox"/> Z93.1 Gastronomy status, G tube	<input type="checkbox"/> E66.3 Overweight <input type="checkbox"/> E66.9 Obesity, unspecified <input type="checkbox"/> Z68. BMI <input type="checkbox"/> R63.5 Abnormal Weight Gain <input type="checkbox"/> E78.00 Pure Hypercholesterolemia, unspecified <input type="checkbox"/> E78.2 Hyperlipidemia, mixed <input type="checkbox"/> I10 Hypertension <input type="checkbox"/> R73.03 Pre-diabetes <input type="checkbox"/> Z78.9 Ketogenic Diet <input type="checkbox"/> G40.909 Epilepsy, unspecified
---	--

****Other DX and ICD-10 Code/s (specify):** _____

GROWTH AND LABORATORY DATA

Current: Wt: _____ Ht: _____

Include pertinent growth history: _____

Current feeding regimen: _____

Glomerular Filtration Rate: _____ OR Serum Creatinine: _____

Fasting Blood Glucose (> 126 mg/dl): _____ HgbA1C: _____

Total Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ BP: _____

*Please attach any other labs if necessary

REASON FOR REFERRAL

<input type="checkbox"/> Weight Reduction <input type="checkbox"/> Weight Gain <input type="checkbox"/> High Fiber Diet <input type="checkbox"/> Modified Consistency Diet: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Food Allergy: _____ <input type="checkbox"/> Carbohydrate Counting <input type="checkbox"/> Low Cholesterol / Low Fat Diet <input type="checkbox"/> 2 Gram Sodium Diet
---	--

****Weight Loss Referrals -Clearance for Exercise Yes No (Circle One)**

Comments: _____

Physician Name (print): _____

Physician Signature: _____

Physician Phone/Fax: _____

*Physician- retain original and fax a copy to the dietitian.

A sample pediatric referral form is shown.

Figure 6.3. DSMT Referral Form

Diabetes Services Order Form (DSMT and MNT Services)

**Indicates required information for Medicare order*

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle _____
 Date of Birth ____/____/____ Medicare HICN # _____ Gender ____ Male ____ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Contact Phone _____

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually

**Check type of training services and number of hours requested:*

Initial group DSMT: 10 hours or ____ no. hrs. requested
 Follow-up DSMT: 2 hours or ____ no. hrs. requested
 Additional insulin training: ____ no. hrs. requested

*** Patients with special needs requiring individual DSMT**
Check all special needs that apply:

Vision Hearing Physical Cognitive Impairment
 Language Limitations Other _____

*** DSMT Content**

All ten content areas, as appropriate

<input type="checkbox"/> Monitoring diabetes	<input type="checkbox"/> Diabetes as disease process
<input type="checkbox"/> Psychological adjustment	<input type="checkbox"/> Physical activity
<input type="checkbox"/> Nutritional management	<input type="checkbox"/> Goal setting, problem solving
<input type="checkbox"/> Medications	<input type="checkbox"/> Prevent, detect and treat acute complications
<input type="checkbox"/> Preconception/pregnancy management or gestational diabetes management	<input type="checkbox"/> Prevent, detect and treat chronic complications

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

** Check the type of MNT and/or number of additional hours requested:*

Initial MNT Annual follow-up MNT
 Additional MNT services in the same calendar year, per RD recommendations ____ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

Specify type, dose and frequency

Oral: _____

Insulin: _____

Patient now uses: Pen Needle Pump

* DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

Type 1 uncontrolled Type 1 controlled
 Type 2 uncontrolled Type 2 controlled
 Gestational diabetes Other _____

Complications/Comorbidities
Check all that apply:

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Nephropathy	<input type="checkbox"/> PVD
<input type="checkbox"/> Renal disease	<input type="checkbox"/> Retinopathy	<input type="checkbox"/> CHD
<input type="checkbox"/> Non-healing wound	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Obesity
<input type="checkbox"/> Mental/affective disorder	<input type="checkbox"/> Other _____	

*Signature and NPI # _____ *Date ____/____/____

Group/practice name, address and phone: _____

Revised 8/31/05 by the Academy of Nutrition and Dietetics and the American Association of Diabetes Educators after substantial review and consultation. Authors do not recommend or endorse any revisions or modifications.

A sample DSMT referral form is shown.

Section VII:

Filling the Gap:

Nutrition Education
Between PCP Referral and
First RDN Appointment

With ever-growing demands on the PCP schedule and patient health outcomes increasingly tied to value-based care and population health, PCPs can utilize the expertise of the health care team nutrition expert and refer their patients to an RDN for a comprehensive nutritional assessment, education, and monitoring to improve patient health, satisfaction, and outcomes.

Diets do not work, and traditional diet sheets historically given in a PCP office are generally not enough to get patients to make significant changes to their nutrition habits, so referrals to an RDN are key in controlling weight and diabetes.

From the time a PCP refers a patient to an RDN to the patient's first RDN appointment, exists the perfect opportunity for patients to begin addressing lifestyle behaviors, which can impact both weight and diabetes control. Finding the right approach for each PCP will vary. However, knowing how to easily communicate desired healthy lifestyle changes and identifying key nutrition-support educational pieces will go a long way toward bridging the gap between the PCP referral to an RDN and the actual appointment date.

This section includes tools and resources for providing a patient/PCP contract that identifies specific basic nutritional "survival" information. The PCP can use the reference tables included in this toolkit to easily write in the recommendations based on patient age. Patient goals can be identified for sleep, screen time, physical activity, fruit and vegetable consumption, and limiting added sugar in beverages. The provided contract can easily be customized with your practice logo.

Also provided is a list of free helpful basic healthy eating nutrition education tools for the PCP to consider as a supplement to help their patients bridge the education gap between the PCP referral to the RDN and the actual appointment date. Several key examples of actual handouts are included for your consideration (Figures 7.1 and 7.2). Additional resources are listed by patient age for ease of reference and are from a variety of reputable professional organizations, including the Academy of Nutrition and Dietetics. Also included is a detailed list of professionally made nutrition brochures available for purchase from the Academy of Nutrition and Dietetics website (www.eatrightstore.org).

Finally, you will find suggestions for evidence-based best practices related to discussing lifestyle changes and education with patients. While ultimately the goal is to reach the recommended nutrition parameters, long-term success results from slow changes over time. Specific tips are provided to equip you with key phrases and communication tools to educate patients effectively.

7.1. Nutrition Goals Contract

Insert Your Practice Logo

You Deserve the Best of Health – Let’s Start Now!

Making healthy changes in our daily routine can seem overwhelming to both adults and children. Did you know that even small daily lifestyle choices can add up to big changes in health?

Where can you start? Here are some healthy lifestyle choices based on your age that can improve how you feel and perform each day. When can you start? Why not start now?

To get nutrition advice specifically for you and your needs, it is recommended you follow up with an appointment with a Registered Dietitian Nutritionist (RDN). Together you will design individualized nutritional meal and snack recommendations based on your favorite foods, culture, grocery budget, family needs, school or work schedule, and lifestyle. Several important nutrition goals to help you get started are in your nutrition goals below.

Let’s Get Started on My Nutrition Goals

Fruit goal: _____ cups daily (no added sugar; fresh, frozen, or canned all count)

How I plan to meet this goal:

Vegetable goal: _____ cups daily (fresh, frozen, or canned all count)

How I plan to meet this goal:

Beverages goal: _____ cups daily (Unsweetened drinks only; milk, water, juice
[limit juice to ½ cup each day])

How I plan to meet this goal:

This Nutrition Plan is designed especially for VIP: _____

By: _____ Date: _____

7.1. (continued)

Resources for Filling Out Nutrition Goals Contract

The following tables are provided to assist with filling out the provided nutrition goals contract.

Children Fruit and Vegetable Recommendation

Age	Fruit	Vegetable
2–3	1 cup	1 cup
4–8	1–1½ cups	1½ cups
9–13	1½ cups	2 cups
14–18	1½ cups	2½ cups
9–13	1½ cups	2½ cups
14–18	2 cups	3 cups

Adult Fruit and Vegetable Recommendation

Age	Fruit	Vegetable
19–30	2 cups	2½–3 cups
31–50	1½ cups	2½–3 cups
51+	1½ cups	2–2½ cups

Based on a 2,000 calorie diet.

A sample nutrition goals contract is shown.

7.2. Wellness Tips Handout

Tips for Before Your First RDN Appointment

The following are some helpful resources to help you prepare for your RDN visit.

- **Practice weight management.**
 - Limit sugar sweetened beverages (SSBs). Consuming calorie-free liquids is a great way to cut out calories. Drinking water (regular, flavored, or carbonated), unsweetened tea, black coffee, and diet soda are great alternatives. The body can confuse hunger with thirst, so it is important to stay hydrated and drink water or calorie-free beverages before eating a meal.
 - www.heart.org/idc/groups/heart-public/@wcm/@fc/documents/downloadable/ucm_469558.pdf
 - www.heart.org/idc/groups/heart-public/@wcm/@fc/documents/downloadable/ucm_469557.pdf
 - www.choosemyplate.gov/fruit
 - www.choosemyplate.gov/vegetables
 - <https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipSheet24MyPlateSnackTipsforParents.pdf>
 - www.nhlbi.nih.gov/health/educational/wecan/downloads/go-slow-whoa.pdf
 - www.fda.gov/downloads/Food/LabelingNutrition/UCM537178.pdf
- **Monitor screen time.**
 - www.nhlbi.nih.gov/health/educational/wecan/downloads/screen-time-log.pdf
- **Monitor sleep.**
 - https://sleepfoundation.org/sites/default/files/sample_sleep_log_by_national_sleep_foundation.pdf
- **Keep a food log**, including brand, preparation, servings, frequency, and common foods.
 - www.heart.org/idc/groups/heart-public/@wcm/@fc/documents/downloadable/ucm_467642.pdf
- **Think about goals.**

A sample wellness tips handout is shown.

Free Downloadable Resources

Children

- www.kidseatright.org
- <https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipsheet11KidFriendlyVeggiesAndFruits.pdf>
- www.heart.org/idc/groups/heart-public/@wcm/@fc/documents/downloadable/ucm_469558.pdf
- www.5210letsgo.info/download/2012-2013-HEALTHCARE-TOOLKIT-Running-File.pdf

Teens

- www.kidseatright.org
- www.cdc.gov/nutrition/downloads/rethink_your_drink.pdf
- <https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipsheet34ChooseTheFoodsYouNeedToGrow.pdf>

Pregnancy

- www.eatright.org
- [https://professional.diabetes.org/sites/professional.diabetes.org/files/media/Gestational Diabetes - Treatment.pdf](https://professional.diabetes.org/sites/professional.diabetes.org/files/media/Gestational_Diabetes_-_Treatment.pdf)

Adults

- www.eatright.org
- https://choosemyplate-prod.azureedge.net/sites/default/files/printablematerials/mini_poster.pdf?utm_source=MailingList&utm_medium=email&utm_campaign=Healthy+Kids+Challenge+WOWS+011514
- https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipsheet2AddMoreVegetables_0.pdf
- https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/MPMW_Tipsheet_4_activelifestyle.pdf
- http://www.heart.org/HEARTORG/HealthyLiving/PhysicalActivity/FitnessBasics/American-Heart-Association-Recommendations-for-Physical-Activity-Infographic_UCM_450754_SubHomePage.jsp

Older Americans

- www.eatright.org
- <https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipsheet42ChoosingHealthyMealsAsYouGetOlder.pdf>
- https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/MPMW_tipsheet_12_Mealplanningforone_0.pdf
- <https://choosemyplate-prod.azureedge.net/sites/default/files/tentips/DGTipsheet30BeActiveAdults.pdf>

Patient Education Nutrition Brochures and Handouts

A variety of professionally designed patient education nutrition brochures and handouts are available for purchase from the Academy of Nutrition and Dietetics website (www.eatrightstore.org).

- **Added Sugars (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/added-sugars-brochure-25-pack
- **Eating Out, Eating Healthy (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/eating-out-eating-healthy-25-pack
- **Healthy Weight for Life (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/healthy-weight-for-life-brochure-25-pack
- **Mediterranean-Style Eating (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/mediterranean-style-eating-25-pack
- **Pregnancy Nutrition (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/pregnancy-nutrition-25-pack
- **Smart Snacking (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/smart-snacking-25-pack
- **Understanding Food Labels (Brochure)**
www.eatrightstore.org/product-type/brochures-handouts/understanding-food-labels-25-pack

Free Resources Available from PCP Associations

- **Academy of Nutrition and Dietetics**
www.kidseatright.org
www.eatright.org
- **American Academy of Pediatrics**
<https://www.healthychildren.org/English/ages-stages/gradeschool/nutrition/Pages/Making-Healthy-Food-Choices.aspx>
- **American College of Preventive Medicine**
www.acpm.org/page/dppresources
- **American Academy of Family Physicians**
www.aafp.org/patient-care/public-health/fitness-obesity.html
- **American College of Physicians**
www.acponline.org/system/files/documents/practice-resources/patient-resources/obesity-facts.pdf
- **American Geriatrics Society**
www.healthinaging.org/aging-and-health-a-to-z/topic:nutrition/
- **American Association of Nurse Practitioners**
www.aanp.org/education/education-toolkits/obesity#treatment-tools

Lifestyle Change Communication

Making lifestyle changes is challenging. One tool you can use in your practice to effectively support patients in implementing and progressing in their lifestyle changes is the Readiness-to-Change Ruler activity (see Figures 7.3 and 7.4).

7.3. Readiness-to-Change Ruler Instructions

READINESS-TO-CHANGE RULER

The Readiness-to-Change Ruler is used to assess a person's willingness or readiness to change, determine where they are on the continuum between "not prepared to change" and "already changing", and promote identification and discussion of perceived barriers to change. The ruler represents a continuum from "not prepared to change" on the left, to "already changing" on the right.

The Readiness-to-Change Ruler can be used as a quick assessment of a person's present motivational state relative to changing a specific behavior, and can serve as the basis for motivation-based interventions to elicit behavior change. Readiness to change should be assessed regarding a very specific activity such as taking medications, following a diet, or exercising, since persons may differ in their stages of readiness to change for different behaviors.

ADMINISTRATION

1. Indicate the specific behavior to be assessed on the Readiness-to-Change Ruler form. Ask the person to mark on a linear scale from 0 to 10 their current position in the change process. A 0 on the left side of the scale indicates "not prepared for change" and a 10 on the right side of the scale indicates "already changing".
2. Question the person about why he or she did not place the mark further to the left, which elicits motivational statements.
3. Question the person about why he or she did not place mark further to the right, which elicits perceived barriers.
4. Ask the person for suggestions about ways to overcome identified barriers and actions that might be taken.

SCORING

A score above 5 shows that the person is willing to consider change and should be supported and encouraged.

Source: adultmeducation.com

7.3. (continued)

FOLLOW-UP QUESTION SUGGESTIONS

If the person's mark is on the left of center:

- How will you know when it is time to think about changing?
- What signals will tell you to think about making a change?
- What qualities in yourself are important to you?
- What connection is there between those qualities and not considering a change?

If the person's mark is near the center:

- Why did you put your mark there and not closer to the left?
- What might make you put your mark a little further to the right?
- What are the good things about the way you are currently trying to change?
- What are the things that are not so good?
- What would be a good result of changing?
- What are the barriers to changing?

If the person's mark is on the right of center:

- What is one barrier to change?
- What are some things that could help you overcome this barrier?
- Pick one of those things that could help and decide to do it by _____ (specific date).

If the person has taken a serious step in making a change:

- What made you decide on that particular step?
- What has worked in taking this step?
- What helped it work?
- What could help it work even better?
- What else would help?
- Can you break that helpful step down into smaller parts?
- Pick one of those parts and decide to do it by _____ (specific date).

If the person is changing and trying to maintain that change:

- Congratulations! What's helping you?
- What else would help?
- What makes it hard to maintain the change?

If the person has "relapsed":

- Don't be hard on yourself. Change is hard and may take time.
- What worked for a while?
- What did you learn that will help when you give it another try?

Source: Zimmerman et al., 2000.

Source: adultmedication.com

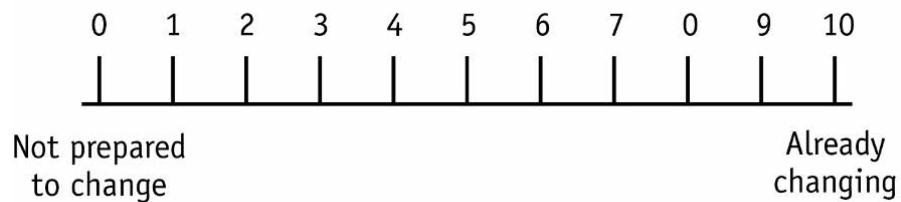
Source: Reproduced with permission from Adult Medication: Improving Medication Adherence in Older Adults.¹

Table 7.4. Readiness-to-Change Ruler Form

READINESS RULER

Below, mark where you are now on this line that measures your change in _____.

Are you not prepared to change, already changing or somewhere in the middle?



Source: Reproduced with permission from Adult Medication: Improving Medication Adherence in Older Adults.¹

¹ Readiness-to-change ruler. Adult Medication website. http://adultmedication.com/AssessmentTools_3.html. Accessed March 4, 2019.

Section VIII:

Coding for Nutrition Services

Coding for nutrition services is a key component to receiving reimbursement from third party payers.

If PCPs decide to incorporate RDNs into their practice rather than referring patients to them, an awareness of these codes is useful. Medical nutrition therapy (MNT) current procedural terminology (CPT) codes are used by many third-party payers, including Medicare. These codes best describe the MNT services that RDNs provide to patients. Healthcare Common Practice Coding System (HCPCS) G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered when the PCP determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Occasionally S codes are encountered; S codes were developed by payers before MNT CPT codes were created.



Codes

CPT Codes for Nutrition Services

MNT CPT codes are unique codes to submit claims for MNT provided by RDNs. Compared with other CPT codes, the MNT CPT codes best describe the services that RDNs provide to patients receiving MNT services for a particular disease or condition. The codes can be used among private insurance companies, depending on the coding and billing details listed in the RDN's contract with the insurance plan. Additionally, the Centers for Medicare & Medicaid Services (CMS) requires the use of these codes for the Medicare MNT benefit by RDN providers who perform MNT services for diabetes and non-dialysis kidney disease. Depending on the coding and billing details listed in the RDN's contract with the insurance plan, CPT codes may also be used among private insurance companies. The best way to determine patient coverage is to contact the insurance company directly.

Private insurance companies and state Medicaid programs may provide coverage and payment for CPT codes beyond the MNT code, depending on the RDN's individual scope of practice. See Table 8.1. Refer to individual payer policies for specific coverage parameters and the CPT Manual for full code descriptors. Consider adding additional CPT codes to your contract during negotiations with payers.

Table 8.1. Codes Within an RDN's Scope of Practice

Code	Description
97802- 97804	Medical nutrition therapy; initial; follow-up; group.
98960- 98962	Education and training for patient self-management by a qualified, non-physician health care professional
98966- 98968	Telephone assessment and management service provided by a qualified non physician health care professional
98970- 98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days
99071	Educational supplies (books, tapes, and pamphlets)
99366, 99368	Medical team conference, with and without the patient and/or family
99401- 99404	Preventive medicine counseling and/or risk factor reduction intervention(s), individual
99411- 99412	Preventive medicine counseling and/or risk factor reduction intervention(s), group
99487, 99489, 99490	Complex chronic care management services
99250- 99251	Ambulatory continuous glucose monitoring

CPT codes, descriptions and material only are copyright © 2020 American Medical Association. All Rights Reserved.

HCPCS S Codes for Nutrition Services

The S codes are considered temporary national codes designed to be used by non-Medicare payers, such as Blue Cross Blue Shield, to report drugs, services, and supplies where no other codes are available. If the contract with an insurer allows for the use of CPT codes, it is best to use those more specific CPT codes in place of HCPCS codes.

See Table 8.2.

Table 8.2. Nutrition-Related HCPCS S Codes

Code	Description
S9465	Diabetic management program, per dietitian visit
S9470	Nutritional counseling, per dietitian visit

Source: Reproduced with permission from Centers for Medicare & Medicaid Services.²



HCPCS G Codes for Nutrition Services

The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes. If a CPT code is available, it should be used. If no appropriate CPT code is found, then a G code should be considered.

CMS established additional codes for use with Medicare-covered MNT services. Depending on the coding and billing details listed in the RDN's contract with the insurance plan, G codes may also be used among private insurance companies. With a second referral from the treating physician, these G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered (3 hours in the initial calendar year and 2 follow up hours in subsequent years with a physician referral) or when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary.

See Table. 8.3.

Table 8.3. Nutrition-Related HCPCS G Codes

Code	Description
G0270	MNT; reassessment and subsequent interventions following second referral in same year for change in diagnosis, medical condition, or treatment regimen, individual, face-to-face with the patient, each 15 minutes
G0271	Group (two or more individuals), each 30 minutes
G0108	Diabetes outpatient self-management training services, individual
G0109	Diabetes outpatient self-management training services, group session (two persons or more)
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit
G0447	Face-to-face behavioral counseling for obesity, 15 minutes, individual
G0473	Face-to-face behavioral counseling for obesity, 30 minutes, group (two to ten individuals)
G2061	Qualified nonphysician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
G2062	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes)
G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

Source: Reproduced with permission from Centers for Medicare & Medicaid Services.²

Determining If PCP or RDN Can Bill for RDN Services

“Incident to” physician services must meet certain criteria. In order to bill “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,
- commonly furnished in physicians’ offices or clinics, and
- furnished by the physician or by auxiliary personnel under the physician’s supervision.

Medicare

Medicare MNT for Chronic Kidney Disease and Diabetes Must Be Billed by an RDN

Medicare MNT services are not billable as “incident to” physician services. CMS regulations explicitly prohibit MNT services from being billed as “incident to” physician services. This prohibition applies to all diagnoses, including diabetes and non-dialysis renal disease. The Medicare MNT regulations state that all MNT services provided after January 1, 2002 must be billed to Medicare Part B, utilizing the RDN’s Medicare Part B provider identification number (PIN) or national provider identifier (NPI), and not be billed as “incident to” physician services.

Medicare Part B cannot be billed for MNT that is provided for other diseases besides diabetes and non-dialysis kidney diseases (benefit effective January 1, 2002). RDNs who provide nutrition services to Medicare beneficiaries with diagnoses other than diabetes and non-dialysis kidney disease can bill the patient for the service. Alternatively, if the patient has secondary insurance, the RDN can determine if the secondary payer covers MNT services and then bill that payer for the visit.

RDNs Can Provide Medicare Preventive Services if PCP Bills “Incident to” Physician Services

CMS 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 independent contractor of the physician, or of the legal entity that employs or contracts with the physician.”³ RDNs may be considered auxiliary personnel for the purposes of providing several Medicare preventive services, including:

- intensive behavioral therapy for obesity,
- intensive behavioral therapy for cardiovascular disease, and
- annual wellness visits.

Private Insurance

If RDNs are employed by PCPs that would like to bill private insurance companies for nutrition services, the PCPs should review their contracts with the insurance plan(s). 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 commercial insurers require the non-physician practitioner's services to be billed using the non-physician provider's number, while others require the non-physician practitioner's services to be billed under the physician's provider number. If a physician is unsure how to bill, the physician should call the insurer's provider relations director. Physicians should also be aware of state laws regarding billing for other non-physician practitioners. Some of these payment mechanisms hinge on current state regulations.⁴



Quality Payment Program and Healthcare Effectiveness Data and Information Set and Performance Measurement

RDNs can play a key role in assisting practices in completing quality measures. RDNs are eligible to participate in Medicare's Quality Payment Program (QPP) and can support PCPs in meeting quality measures. In addition to QPP, RDNs can support PCP efforts to collect Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of more than 90 measures across 6 domains of care.⁵ Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. One area RDNs can be of particular assistance with HEDIS measures is childhood obesity measures. The metric is the percentage of members ages 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year with documentation of:

Body mass index (BMI) percentile

- Must show evidence of the BMI percentile value or BMI plotted on an age growth chart. A BMI value alone is not acceptable for this age range. Members with a diagnosis of pregnancy are excluded.

Counseling for nutrition

- Must indicate discussion occurred (eg, nutrition education, eating habits, dieting behaviors).

Counseling for physical activity

- Must indicate discussion occurred (eg, exercise routine, sports).⁵

1 Diagnosis and procedure codes. Academy of Nutrition and Dietetics website.

<https://www.eatrightpro.org/payment/coding-and-billing/diagnosis-and-procedure-codes>. Accessed February 15, 2019.

2 HCPCS general information. Centers for Medicare & Medicaid Services website. <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html>. Accessed February 15, 2019.

3 Centers for Medicare & Medicaid Services website. <https://www.cms.gov>. Accessed February 15, 2019.

4 Items to consider when establishing an RDN/MD partnership. Academy of Nutrition and Dietetics website. <https://www.eatrightpro.org/payment/nutrition-services/private-payers/items-to-consider-when-establishing-an-rdnmd-partnership>. Accessed March 12, 2019.

5 HEDIS and performance measurement. National Committee for Quality Assurance website. <http://www.ncqa.org/HEDISQualityMeasurement.aspx>. Accessed March 5, 2019.

Section IX:

Where to Find an RDN

For the best health outcomes and to help your patients succeed, it is key to connect them with RDNs.

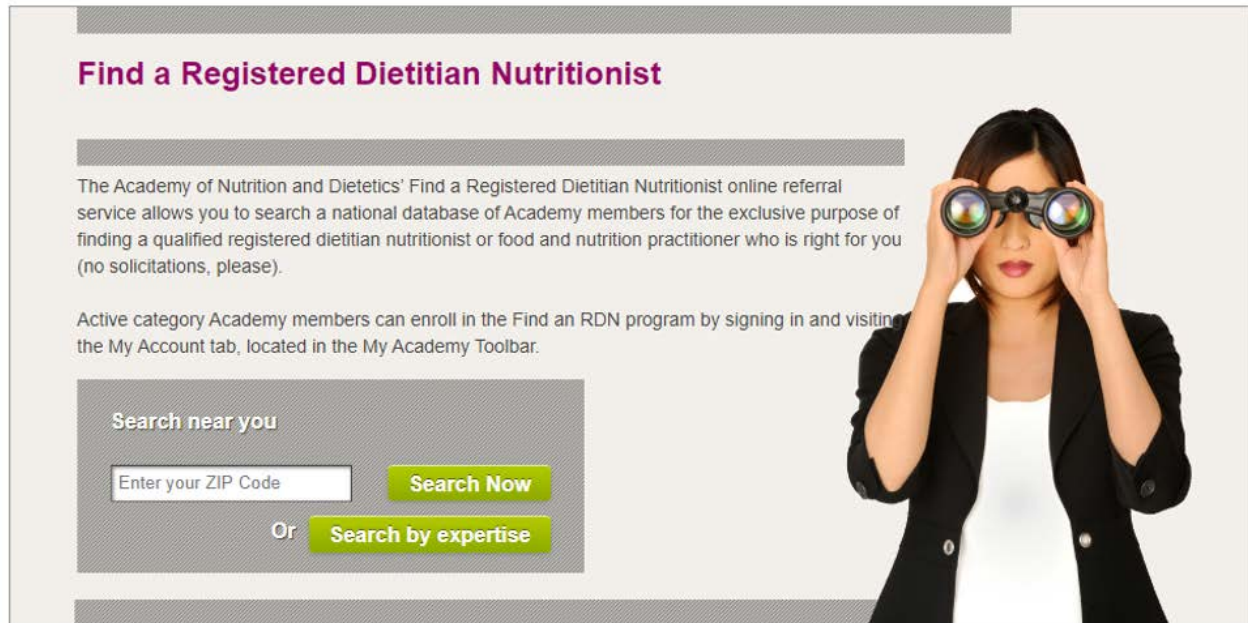
The National Academy of Medicine, formerly the Institute of Medicine, found that “the Registered Dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”¹ In order to protect the public and ensure evidence-based nutrition services, rely on RDNs for nutrition services. In addition to the RDN credential, 47 states, Puerto Rico, and the District of Columbia currently have statutory provisions regulating the dietetics profession or associated titles, such as “dietitian” and “nutritionist.”² RDNs can be located using a variety of methods:

- Most providers are aware that RDNs are a part of the interdisciplinary health care team within hospitals working to educate patients about nutrition, administering MNT, providing nutrition support and evaluation in critical care, as well as managing the foodservice operations.
- RDNs may be part of recognized diabetes self-management programs (eg, American Diabetes Association, Association of Diabetes Educators).
- Look in your hospital system electronic medical record (EMR) to place an order for nutrition services.
- Many RDNs are working in the community in private practice and in ambulatory hospital nutrition centers.
- You may have RDNs working in your office building, via the area hospital outpatient nutrition office, or by word of mouth from their colleagues.
- Contact the health insurance plans the majority of your patients are covered by to identify RDNs contracted with those plans in your geographic area. Many health insurance plans cover MNT without copays.
- Searching online is also a possibility. Instead of doing a general search, look to the Academy of Nutrition and Dietetics for their quick and easy Find an Expert tool (Figure 9.1) that makes finding an RDN in your area easy (www.eatright.org/find-an-expert).

Find an Expert

Figure 9.1. Find an Expert Tool

Find an Expert



The Find an Expert tool is available from the Academy of Nutrition and Dietetics.³

You can use this tool to search by zip code or areas of expertise for RDNs in your area. Your search will yield RDN names, addresses, and direct contact information. The Find an Expert tool is updated regularly by the Academy of Nutrition and Dietetics. This is a great user friendly resource that is free and available to everyone!

1 Work with an RDN or NDTR. Academy of Nutrition and Dietetics website.

<https://www.eatrightpro.org/about-us/what-is-an-rdn-and-dtr/work-with-an-rdn-or-dtr>. Accessed February 15, 2019.

2 Licensure and professional regulation of dietitians. Academy of Nutrition and Dietetics website. <https://www.eatrightpro.org/advocacy/licensure/professional-regulation-of-dietitians>. Accessed February 15, 2019.

3 Find an expert. Academy of Nutrition and Dietetics website. <https://www.eatright.org/find-an-expert>. Accessed October 1, 2018.

Section X:

Business Models for RDN/PCP Partnerships

As health care reform unfolds, health care is transitioning into a team-based model of care, allowing for more coordinated care to support the patient’s health. The RDN is an important member of the health care team. The RDN can be integrated into the PCP practice setting in a multitude of ways. The basic business models for RDNs working in a multidisciplinary medical practice include the following:

- Employed (part-time or full-time)
- Independent contractor
- Consultant
- Referrals (private practice RDN or within IPA, medical group, or system)
 - See Section IX for information on where to find RDNs.

RDNs can be utilized within the PCP practice and maximize workflow through developing practice-based protocols, scheduling same-day provider appointments, conducting group medical appointments, and providing case management and coordination of care for the patient.

Refer to Table 10.1 for some basic considerations when selecting a business model.

Table 10.1. RDN/PCP Business Model Matrix

		Traditional Employee	Independent Paid Contractor (RDN does not have private practice)	Independent Private Contractor
Office Space		In PCP's office complex.	In PCP's office complex. Rented at reasonable rate from PCP.	RDN pays for own office space.
Who Bills		PCP's office.	PCP's office.	RDN bills for patients seen (or hires billing service).
Billing Methods	1. IBT	"Incident to" PCP.	"Incident to" PCP.	Cannot provide IBT benefit in RDN office.
	2. MNT private payers	"Incident to" as authorized by each insurer: --PCP's office needs to check with each private insurer to determine if "incident to" billing is allowed for RDN's services.	"Incident to" as authorized by each insurer: --PCP's office needs to check with each private insurer to determine if "incident to" billing is allowed for RDN's services.	Provides MNT as authorized and contracted with private payers. RDN uses own credentialing number and tax ID.
	3. MNT Medicare	Service billed under RDN's Medicare provider number. The RDN has re-assigned his reimbursement back to his employer-physician (note: this situation is not considered "incident to" billing).	Service billed under RDN's Medicare provider number. The RDN has re-assigned his reimbursement back to his employer-physician (note: this situation is not considered "incident to" billing).	Provides MNT for patients with diabetes mellitus or chronic kidney disease if RDN is Medicare provider. RDN uses own NPI.
Compensation		Billing revenue goes to PCP's office. RDN is paid an hourly rate.	Billing revenue goes to PCP's office. RDN is paid a negotiated rate per patient seen.	Billing and patient out-of-pocket revenue goes to RDN.
Taxes		MD withholds taxes from RDN's paycheck.	No withholding from PCP office. RDN pays all taxes as self-employed.	RDN pays all taxes as self-employed.

Source: Reproduced with permission from the Academy of Nutrition and Dietetics. Intensive behavioral therapy for obesity: putting it into practice.¹

Private practice RDNs may have their own business contract to present for consideration; however, PCPs may want to negotiate the terms of the contract or develop their own. Ultimately, both parties need to agree on the business details and sign a binding contract to formally enter into business together. The following are important operational items to discuss when contracting with an RDN. Note that PCPs should consult their legal counsel prior to entering a contractual business relationship; the items below are not intended to serve as a comprehensive list.

Professional Qualifications:

- *Is the nutrition professional currently an RDN?*
Commission on Dietetic Registration (CDR) Online Credential Verification System: <https://secure.eatright.org/CGI-BIN/lansaweb?wam=CDR900&webtrn=entrywr&ml=LANSAXHTML&part=PRD&lang=ENG>
- *Does the state require RDNs to be licensed or certified in that state? If so, is the candidate currently licensed or certified?*
National State Licensure Board
- *Does the nutrition professional have additional specialty board certifications from the CDR?*
CDR Online Credential Verification System: <https://secure.eatright.org/CGI-BIN/lansaweb?wam=CDR900&webtrn=entrywr&ml=LANSAXHTML&part=PRD&lang=ENG>

Office Space:

- *Will the RDN rent space in the office or work out of a separate space?*
- *Is the RDN an independent contractor? If so, subleasing may offer:*
 - More flexibility for both the RDN and the PCP as well as added convenience for the patient.
 - Extra revenue potential from a room that may be empty a few days a week. Rate to be negotiated between PCP and RDN.
- *How will the RDN interact with the current staff and office environment?*
 - Who handles referrals and make appointments?
 - Will the RDN or the office staff pre-authorize or verify insurance?
 - Will the RDN or the office staff greet and check in the patients?
 - Will the RDN or the office staff submit visit summary letters to referring PCP?
 - Will the RDN have access to the office equipment, including phones, answering service, copy machines, fax machines, computers, scales, and so on or will the RDN need to purchase separate equipment?
 - Will the RDN's name be posted outside the office along with PCP staff?

Billing:

- *Does the RDN have a national provider identifier (NPI) number?*
- *Will the RDN submit the bill for patients seen or will the PCP's office staff?*
- *Will the RDN bill under their NPI number or under the PCP tax ID number (TIN)?*
- *Will the RDN be credentialed with private payers under the PCP office contract or be credentialed with the payer separately?*
- *Which insurance companies will the RDN bill for services?*
 - Identify which private insurance plans the RDN is a credentialed provider for.
 - Identify if the RDN is a credentialed Medicare provider.
 - Identify if the RDN is a credentialed Medicaid provider.
 - Medicare medical nutrition therapy (MNT) services are NOT billable as "incident to" physician services.
 - Medicare Part B covers MNT that is provided for diabetes and non dialysis kidney disease.
 - Medicare Intensive Behavioral Therapy for Obesity MUST be billed as "incident to" physician services.

Compensation:

- *Will the RDN be paid a salary, paid hourly, receive commission, or be compensated per patient?*
- *Will the RDN make separate revenue with no PCP involvement?*
- *Will the RDN receive benefits, paid vacation time, or holiday time off?*
- *Will the RDN be offered any incentives, such as flex time or bonuses?*
- *Will the RDN be responsible for any community service presentations or workshops, and if so, how will compensation be factored into the package?*

Work Schedule:

- *Consider how often the RDN will be in the office.*
 - Days scheduled each week
 - Number of hours per day
 - Evening or weekend hours
 - Vacation days (paid/unpaid)
 - Sick days (paid/unpaid)
 - Specialty service time (ie, community service presentations, telenutrition, workshops)

Marketing:

- Consider who will market RDN services for patients and other referring providers (eg, RDN, outside consulting firm, PCP designated office staff, social media outlets).

RDN Responsibilities:

- Determine the “menu” of services the RDN will provide to PCP patients and business operations. Below is a starting list of services available. Offerings can be customized based on patient mix and business needs. Management of patient with multiple chronic conditions
 - Specialized nutrition counseling
 - Lifestyle counseling
 - Quality measures data collection and/or reporting
 - Between visit follow-up
 - Fee-for-service (FFS) MNT
 - “Incident to” weight management services for patients covered by Medicare
 - Quality improvement initiatives
 - Group cooking classes for kids, adults, and families
 - Group weight management classes
 - Group diabetes classes
 - Group healthy eating classes for children
 - Diabetes Prevention Program
 - Diabetes Self-Management Training


Other Contract Considerations:

- Non-compete clause
- Length of contract
- Terms for termination of contract
- Indemnification clause
- Benefits (if applicable)

RDN/PCP Contract

See Figure 10.1 for a sample RDN/PCP contract.

Figure 10.1. Sample RDN/PCP Contract



CONTRACT AND TERMS CONSIDERATIONS

The following terms are considerations for developing a contract specific to your practice. Registered dietitian nutritionists (RDNs) should consult with a lawyer who is familiar with local and state law and regulations before entering into an official contract with another health care provider. These considerations are for educational purposes only.

[Note: Words or phrases contained in brackets are intended as example language for the users of these contract and terms considerations.]


Example Contract Introduction:

[This Contract (“Contract”) is made on [date] between [name of RDN practice] (“RDN”), located at [street address], [city], [state], [zip code], and [name of physician practice] (“Physician”), located at [street address], [city], [state], [zip code].]

- 1. Description of Services.** Describe RDN services provided to Physician’s patients.
- 2. Qualifications.** Describe RDN and MD qualifications.
[RDN will maintain all required credentials (RDN, LD, specialty certifications, etc.) at all times. Physician will maintain corporate registration and qualifications.]
- 3. Insurance.** Indicate who will provide professional liability insurance, including limit.
[At least \$1,000,000 per occurrence and \$3,000,000 in the aggregate; Physician will maintain insurance covering his/her group.]
- 4. Billing.** Indicate who will bill for the RDN’s services and who will receive payment.
- 5. Compensation and Benefits.** Describe the compensation structure, methodology and benefits package (if applicable).
- 6. Scheduling and Time Off.** Indicate whether services will be performed full- or part-time, schedule structure, and time off coordination.
- 7. Restrictive Covenant.** A non-compete or non-solicitation provision is common in employment agreements. Include a restriction of reasonable duration, if applicable. This section is often subject to negotiation.
- 8. Recordkeeping.** Include clarification of record ownership and maintenance responsibilities. Provide right-of-access information for non-owning party after termination of the contract.
[RDN will maintain appropriate records.]
- 9. Term & Termination.** Include an initial term (often at least one year.) If ‘termination without-cause’ clause is included, describe the length of notice period. Describe events

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Figure 10.1. (continued)



and/or conditions for “for-cause” termination. Include any payment conditions upon termination, especially if compensation is dependent on collections.
[The length of notice period for a “termination without-cause” is 60 days. Loss of license/credentials and/or bankruptcy of group are conditions for a “termination without-cause”.]

10. Indemnification. Seek legal counsel before agreeing to an indemnification clause or limitation of liability.

11. Legal Compliance. Both parties shall agree to comply with all applicable laws as identified by legal counsel.

12. Relationship of the Parties. Indicate whether the RDN will be an employee of the Physician or an independent contractor.

13. Governing Law. Indicate relevant state law(s) as identified by legal counsel.

Example Contract acknowledgement. Include space for acknowledgement of contract
[I certify and acknowledge that I have had the opportunity to read this Contract, that I have voluntarily entered into this Contract fully aware of its terms and conditions, and that I have received a copy of this Contract.]

Signed and accepted on this [__th] day of [month], [year].

[RDN practice name]

By: _____

[Physician practice name]

By: _____

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Source: Reproduced with permission from the Academy of Nutrition and Dietetics.

1 Academy of Nutrition and Dietetics. Intensive Behavioral Therapy for Obesity: Putting It into Practice. 2nd ed. Chicago, IL: Academy of Nutrition and Dietetics; 2017:44.

