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Your source for practice management news

An emerging hospital trend may lead to RDN revenue opportunities

The observation stay, a hospital service that was previously seldom-used, is gaining in popularity and represents an emerging practice opportunity for registered dietitian nutritionists (RDNs). Hospitals may designate patients with "observation status" for those with unstable or uncertain conditions that necessitate close monitoring but lack insufficient reasons to call for hospital admission. Though not admitted as inpatients, observation status patients—typically those with conditions treatable within 2 days, such as nausea, vomiting, dehydration, infirmity, and abdominal pain, among others—occupy a hospital bed during treatment and assessment. Within a few days—or, for Medicare patients, within 48-hours as required—these patients are officially admitted or discharged. For billing purposes, observation stays are considered an outpatient service.

Though the concept of observation stay has existed for many years, such services only recently became more integral to hospital protocol. According to Sunitha Zechariah, MS, RD, LD, CNSC, Clinical Nutrition Manager at the University Hospital in Augusta, Georgia, the recent surge in observation status cases can be largely attributed to the Affordable Care Act (ACA). In May 2015, Kaiser Health Care News reported a 25% increase in patients admitted under observation status from 2007 to 2009 while inpatient admissions declined. Among the effects of the ACA's implementation has been an amplification by the Centers for Medicare & Medicaid Services (CMS) to more carefully scrutinize the medical necessity of the claims being submitted, an effort that includes auditing hospitals to hold them accountable for inpatient admissions.

What hospitals and RDNs may not yet recognize is the practice opportunity for RDNs that exists in observation services. While for the hospitals observation status represents

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Inside:

CMS offers 1-year of leniency for certain ICD-10 errors

The Centers for Medicare & Medicaid Services (CMS) announced that providers will have 1 more year after ICD-10 implementation to get their diagnosis coding exactly right. ICD-10 codes will still be required on claims submitted for services provided on October 1, 2015 or later and coding to the correct level of specificity is still the goal, however, a lack of code specificity will not cause claims denials. CMS has instructed Medicare Administrative Contractors (MACs) not to deny claims "through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the practitioner used a valid code from the right family." Registered dietitian nutritionists (RDNs) will continue to have time to work with their physician referral sources to obtain ICD-10 diagnosis codes with the correct level of specificity for their patients.

The leniency also applies to reporting under the Physician Quality Reporting System (PQRS). According to CMS, MACs will not assess payment penalties based on ICD-10 code use in PQRS reporting, nor will they deny eligible providers (such as RDNS) informal review requests, so long as "a valid code from the right family" is used, the right number

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Now available: FAQ companion to Pediatric Malnutrition Consensus Statement

The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) have released a set of frequently asked questions (FAQ) for pediatric malnutrition (undernutrition), generated in response to direct queries regarding translating to practice the 2014 Pediatric Malnutrition Consensus Statement. The FAQ companion document is designed to assist registered dietitian nutritionists (RDNs) and other health care professionals in implementing the recommendations into varied practice settings. The 2014 Pediatric Malnutrition (Undernutrition) Consensus Statement is not a definitive statement of the diagnostic indicators of pediatric malnutrition (undernutrition), but is a recommendation based on an evidence-informed, consensus-derived process that represents a summary of expert opinion to date. To access the pediatric malnutrition consensus statement and companion FAQ document, visit: http://bit.ly/1IyZ6NW.

Academy convenes second meeting of primary care providers associations

As part of continued efforts to promote the value of registered dietitian nutritionists (RDNs) in new primary care-centered models of health care delivery and payment, the Academy of Nutrition and Dietetics convened, for a second time, representatives from national primary care provider (PCP) associations for a 1-day meeting in Chicago. Representatives from 7 associations joined in discussions around specific opportunities to partner on initiatives to promote successful collaboration between RDNs and PCPs. Participants translated goals and strategies developed during the first meeting into actionable items. The group left the meeting committed to ongoing relationships under the leadership of the Academy. To find out more about what the Academy is doing to integrate RDNs into emerging health care delivery and payment models, and for a copy of the handout, *Why Adding an RD to Your Practice Team Is Good Medicine*, visit: www.eatrightpro.org/resource/practice/getting-paid-in-the-future/expanding-payment-and-coverage/integrating-rdns-into-emerging-health-care-delivery-and-payment-models.

Changes to the Medicare Opt-Out Law, effective June 16, 2016

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015 will automatically renew every 2 years. Registered dietitian nutritionists (RDNs) who file affidavits effective on or after June 16, 2015 but who do not want their opt-out to automatically renew at the end of a 2-year opt-out period must cancel the renewal by written notification to all Medicare Administrative Contractors (MACs) with which they filed an affidavit, no less than 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015 will expire 2 years after the effective date of the opt-out period. RDNs who filed affidavits effective before June 16, 2015 and who want to extend their opt-out must submit a renewal affidavit to all MACs with which they would have filed claims within 30 days after the current opt-out period expires.

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and type of measures in appropriate domains have been submitted for the specified number/percentage of patients, and the errors are related only to the specificity of the ICD-10 diagnosis code.

CMS promises further guidance on these issues and plans to set up "a communication and collaboration center" with an "ICD-10 ombudsman to help triage provider billing and payment issues" closer to the transition deadline. For a list of ICD-10 codes for RDNs and a sample medical nutrition therapy (MNT) referral form, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/preparing-for-icd-10-cm. For information about PQRS reporting, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/getting-started-with-pqrs.

QUESTION CORNER

Q: If I provide medical nutrition therapy (MNT) services to a patient in September but prepare the bill in October, after the ICD-10 transition deadline, do I need to use an ICD-9 or ICD-10 code on the claim?

A: The date of service determines which ICD code version is needed for the claim. If service is provided before the ICD-10 transition deadline of October 1, 2015, then the claim should contain an ICD-9 code, even if the claim is completed and submitted after the transition deadline. Services provided after the transition deadline should contain ICD-10 codes. For more information on preparing for the ICD-10 transition, visit: http://bit.ly/1KPCjCj.

Q: How long do I have to submit a claim to Medicare?

A: Claims must be submitted to Medicare within one calendar year of the date of the service. Claims filed later than one year after the date of service will be denied with no appeal rights. In rare cases, Medicare can waive the time limit for filing a claim if the delay in filing was due to an error by Medicare, retroactive Medicare entitlement, or delayed disenrollment from a Medicare Advantage Plan. For more information on billing Medicare, visit: http://bit.ly/1JMS0vk.

Q: Can a registered dietitian nutritionist (RDN) provide and bill Medicare for medical nutrition therapy (MNT) and the Intensive Behavioral Counseling (IBT) for Obesity benefit on the same day?

A: Yes, with one exception. The Centers for Medicare & Medicaid Services (CMS) states that primary care practitioners can refer eligible beneficiaries to other practitioners and/or settings for auxiliary services on the same day that the IBT for Obesity benefit is provided as long as the other service is a distinct service, the criteria for that service are met, and the service is coded appropriately. Registered dietitian nutritionists (RDNs) can provide the IBT for Obesity benefit as auxiliary personnel in primary care settings and bill "incident to" the physician on the same day MNT services are provided. RDNs should work collaboratively with primary care providers when providing the IBT for Obesity benefit and securing referrals for MNT.

The exception to this rule is when services are provided at Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). In the RHC and FQHC settings, obesity counseling is not separately payable with another face-to-face encounter on the same day. MNT and IBT for Obesity can be provided on the same day of service, but only one encounter can be billed. For more information on the IBT for Obesity benefit and the claims processing guidelines, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/medicare-preventive-services-obesity. To access the toolkit, Meeting the Need for Obesity Treatment, visit: http://bit.ly/1GqqOwb.

Q: What are Medicare Administrative Contractors (MACs), and how are they related to reimbursement for nutrition services?

A: MACs are private organizations that carry out the administrative responsibilities of Medicare (Parts A and B). Each MAC signs a contract with the federal government to administer the Medicare program in a certain region of the United States. MACs are responsible for many tasks, including:

- Enrolling, educating, and training Medicare providers on billing procedures
- Claims processing, or cutting checks to Medicare providers, including registered dietitian nutritionists (RDNs), for their services;
- Making sure services are correctly coded and billed, both before and after payment;
- Deciding which health care services are medically necessary. MACS follow the national coverage determination set by the Centers for Medicare & Medicaid Services (CMS), but in cases where there is no such determination or the rules are too vague regarding a specific procedure, a MAC may develop a local coverage determination;
- Collecting overpayments; and
- Serving as the primary contact for questions about the Medicare Fee-For-Service (FFS) program, whether it be questions about enrollment or billing.

For a Medicare Administrative Contractor Directory Interactive Map, visit: www.eatrightpro.org/resource/practice/getting-paid/nuts-and-bolts-of-getting-paid/providing-the-service-and-billing-under-medicare.

Do you have a question for the Question Corner?

E-mail your question to **reimburse@eatright.org** to have it answered in an upcoming issue of the *MNT Provider*.

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a means to assess patients without clear diagnoses while avoiding the time and costs related to inpatient admission, for RDNs it presents a potential additional source of revenue and an opportunity to showcase RDN value. Patients in observation status may require or benefit from nutrition services, such as medical nutrition therapy (MNT) for diabetes and chronic renal disease for Medicare patients, as well as additional covered nutrition and diet counseling services for those who are insured by private payers. Counseling observation status outpatients involves the same level of care as would be required for inpatients—the only difference is in the coding.

"There is an opportunity for MNT to be applied for a dietitian consult," says Zechariah. "Dietitians can actively look for these opportunities, as most hospitals do not know it's available." In conditions where there are prospects for increasing revenue via observation status patients, there is a recommended strategy to moving this concept to implementation.

First, it is paramount to identify a RDN on the staff—the lead dietitian, a clinical dietitian, or the clinical nutrition manager—who will champion the effort. Components of this effort include collecting and evaluating statistics about nutrition care consults at the institution, including the rationale for nutrition consults that have been performed, and presenting these data to interested parties who would have approval power or be affected by implementation of dietetics services for observation status patients. These stakeholders might include the hospital administration; financial and billing and coding principals; and physician and nurse leaders, including the chief medical officer and the chief nursing officer.

According to Zechariah, there are some circumstances where the opportunity may not be feasible. In county- or state-run hospitals with large indigent or Medicaid populations, for example, obtaining reimbursement for observation stays may be more difficult, as care for indigent patients is written off and not all state Medicaid programs reimburse for observation stays (and those that do often offer limited coverage). Furthermore, opportunities to offer reimbursable services to patients in observation status are affected by what the hospital has negotiated with private payers.

However, once approval has been obtained from hospital committees, where such opportunities are indeed feasible, it is essential to educate key staff—namely, physicians, nurses, case managers, and RDNs—on their roles, as well as protocols and procedures in the provision of dietetics services to this outpatient population. For example, RDNs need to make sure that the referring physicians know how to specify related diagnoses in nutrition referrals to ensure that submitted claims are not denied by the payer. Similarly, RDNs should involve the billing department in establishing the appropriate charges to provide greater assurance of accurate billing.

Once dietetics services for observation status patients have been implemented, data monitoring and evaluation should continue so that outcome measures—statistics including number of consults received for this outpatient population, billing associated with these consults, and number of subsequent readmissions—can be collected. These data are critical not only to demonstrate to administration and other hospital leadership the effectiveness and value of incorporating nutrition and diet consults into the care of patients designated for observation stay, but also to further illustrate the value of the RDN in providing cost-effective quality care for patients. To learn more about expanding the scope of billable services provided by RDNs, visit: www.eatrightpro.org/resources/practice/getting-paid-in-the-future/expanding-payment-and-coverage. To find out more about the Medicare MNT benefit, visit: www.eatrightpro.org/resource/practice/getting-paid/getting-started-with-payment/medicare-mnt. For details about preventive services under the Affordable Care Act, visit: www.eatrightpro.org/resource/advocacy/disease-prevention-and-treatment/access-to-health-care/healthcare-reform-and-preventive-services.

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