Academy of Nutrition and Dietetics

MNT Provider

Your source for practice management news

Physicians identify registered dietitians as most qualified

According to a new study led by researchers at the Johns Hopkins Bloomberg School of Public Health, primary care physicians (PCPs) acknowledge that they may not be the best choice among health care professionals to provide weight-related counseling. Using a national cross-sectional survey of 500 general practitioners, family practitioners and general internists, researchers evaluated PCPs' perspectives on the causes of obesity, competence in treating obese patients, solutions for improving obesity care and perceptions of which health professionals are most qualified to help obese patients lose or maintain weight. According to the study featured in the Dec. 20, 2012, issue of *BMJ Open*, physicians identified registered dietitians (RDs) and nutritionists as the most qualified providers to care for obese patients.

RDs are positioned to take the lead in weight management

In fact, research indicates that an RD-delivered lifestyle approach to obesity management can improve diverse indicators of health, including quality of life, productivity and total health care costs. Because RDs possess

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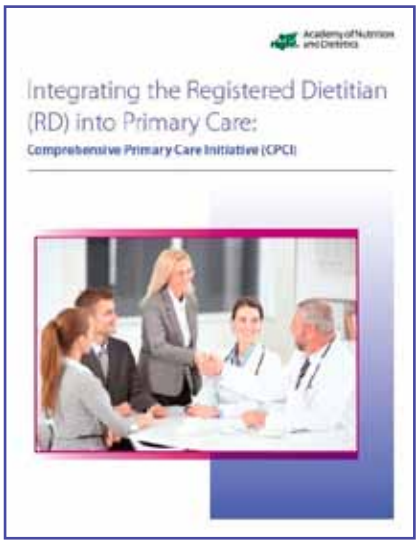
Inside:

New toolkit available: Integrating the Registered Dietitian into Primary Care: Comprehensive Primary Care Initiative

Registered dietitians (RDs) thinking about working within a patient-centered medical home (PCMH) or interested in improving outcomes and providing services to enhance care coordination have a new resource available. The new practice management toolkit *Integrating the Registered Dietitian into Primary Care: Comprehensive Primary Care Initiative* (CPCI) is now available for free to members of the Academy of Nutrition and Dietetics ($40 for non-Academy members.) Whether you are practicing in one of the states where the CPCI pilot program is taking place (Arkansas, Colorado, New York, New Jersey, Ohio, Kentucky, Oklahoma or Oregon) or just interested in integrating your services into a PCMH setting, you will want to own a copy of this toolkit. Filled with practical information, advice and tools to help get you started, this toolkit reviews team-based care, including the CPCI and quality measures for CPCI; provides an overview of other models of care; and explains how RDs can align with these emerging opportunities. The kit also offers RDs effective marketing and contractual strategies and identifies additional resources and tools. For a copy of the toolkit, visit: www.eatright.org/coverage.



experience and training in behavior counseling and comprehensive weight management, it is not surprising that they are able to achieve long-term compliance and sustained success with obese patients. Data show that medical nutrition therapy (MNT) yields positive results when it involves individualized nutrition assessment and duration and frequency of care using the Nutrition Care Process to manage disease. In a study designed to evaluate the incremental cost and health benefits of MNT for managed-care members participating in an obesity-related health management program, researchers found that "individuals who received MNT were more successful than their matched controls at maintaining or losing weight and had twice the odds of achieving a clinically significant weight loss." The study, published in the Jan. 2013 issue of *Managed Care*, concluded that "MNT is a valuable adjunct to health management programs that can be implemented at a relatively low cost."

Opportunities abound for RDs to leverage this information to establish new partnerships with PCPs—or strengthen existing ones—to deliver weight management services. With expanded obesity counseling benefits under the Affordable Care Act provision, the Medicare Part B Intensive Behavioral Therapy (IBT) for Obesity benefit, and the Healthier Generation Benefit, opportunities exist to not only enhance patient outcomes but also bring new revenue into RD and PCP practices. The Academy toolkit *Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership* offers RDs information and tools needed to successfully align with PCPs to provide the IBT for Obesity benefit under Medicare Part B and beyond.

For a copy of the *Medical Nutrition Therapy MNTWorks®Kit*, which explains how MNT provides a return on investment, visit: www.eatright.org/members/mntworks. For additional weight management resources developed by the Academy of Nutrition and Dietetics, see the accompanying sidebars.

Adult weight management resources

- For a copy of *Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership*, visit: www.eatright.org/Members/content.aspx?id=6442468513.
- For information on the Intensive Behavioral Counseling for Obesity benefit under Medicare, visit: www.eatright.org/Members/content.aspx?id=6442468513.
- Results of the Adult Weight Management Update Evidence Analysis Project can be found at: http://andevidencelibrary.com/topic.cfm?cat=42.
- The Adult Weight Management Toolkit, which contains a list of practice tools for weight management, can be found at: www.eatright.org/shop/product.aspx?id=6442451095.
- To access the Commission on Dietetic Registration's Certificate of Training in Adult Weight Management Program and self-study module, visit: www.cdrnet.org/weight-management-adult-program.

Pediatric weight management resources

- For more information about the Healthier Generation Benefit, visit: www.eatright.org/Members/content.aspx?id=6442451325.
- Pediatric Weight Management Evidence-Based Nutrition Practice Guidelines can be found at: http://andevidencelibrary.com/topic.cfm?cat=2721.
- The Pediatric Weight Management Toolkit can be found at: www.eatright.org/Shop/Product.aspx?id=6442472059.
- The Commission on Dietetic Registration's Childhood and Adolescent Weight Management Self-Study Module can be found at: http://cdrnet.org/weight-management/childhood-module.

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*.

QUESTION CORNER

Q: The newest patient in my practice is a 67-year-old woman with diabetes who has Medicare Part B but is also insured by a Group Health Plan (GHP) associated with her husband's small business. How do I determine which coverage is the primary payer and which is the secondary payer when submitting a claim for medical nutrition therapy (MNT) services provided to this patient?

A: To determine if Medicare is the primary payer for your patient, you can ask her a few simple questions about her other coverage. In this case, you already know she is a Medicare beneficiary who is also covered by a GHP through her spouse's employment. Your next step would be to ask her how many employees work for the employer providing coverage. If her husband's business has fewer than 20 employees, then Medicare is the primary payer and the GHP is secondary. If his business has more than 20 employees, then the GHP would be the primary payer. The Centers for Medicare & Medicaid Services (CMS) has developed a Medicare Secondary Payer (MSP) questionnaire for providers to use as a guide to help identify other payers that may be primary to Medicare. For more information, refer to the MSP questionnaire in the *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1 (page 13) at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf.

For additional information on determining which entity will be the primary or secondary payer when Medicare and other health insurance or coverage is present, read "Determining Which Payer Pays First: Medicare Secondary Payer Fact Sheet" at: www.eatright.org/Members/content.aspx?id=7306.

Q: What obligations do registered dietitians (RDs) have under the Americans with Disabilities Act to provide an interpreter for clients with hearing disabilities?

A: Title III of the Americans with Disabilities Act (the "Act") requires that entities furnishing health care or other professional services provide clients with hearing disabilities with "auxiliary aids and services" as necessary for effective communication [42 USC §12182(b)(2)(A)(iii); 28 CFR §36.303(c)]. The health care provider must determine (usually in conjunction with the client) what type of auxiliary aid or service is required for the particular client situation. For example, in the context of a typical retail sales transaction or in placing a restaurant order, the exchange of short notes may be sufficient to provide effective communication. However, in the context of health care counseling, where communication not only is critical to the service being provided but also can be extensive and complex, provision of a sign language interpreter often may be necessary to communicate effectively with individuals who have certain hearing impairments. If a health care provider attempts to communicate with a patient by writing but is communicating less or providing less information in writing than he or she would provide when speaking to a patient, this is an indication that written communication is ineffective in that context and an interpreter is required.

If it is determined that an interpreter is necessary, the health care provider must provide the interpreter unless doing so would create an "undue burden" or result in a fundamental alteration of the service being provided. It is very difficult for a health care provider to demonstrate that providing an interpreter is an undue burden.

Recognizing the complex and sensitive nature of patient instructions and counseling, the U.S. Department of Justice (DOJ), which enforces Title III of the Act, has initiated enforcement actions against and/or entered into settlement agreements with various health care providers, including hospitals, clinics and community health centers, requiring the providers to furnish sign language interpreters when necessary.

Q: What if the cost of providing an interpreter for a patient with a hearing disability exceeds the fee I charge for an office visit?

A: The DOJ rejects the argument that an interpreter need not be provided if the cost of providing the interpreter exceeds the fee received for the service being

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sought. Establishing an undue burden defense requires that the health care provider be able to prove that furnishing an interpreter would result in "significant difficulty or expense," taking into account factors such as the entity's overall financial resources and the effect of providing the interpreter on the entity's expenses and resources [28 CFR §36.104]. For example, if a service provider receives only the occasional request for an interpreter, an undue burden defense based on the cost of the interpreter is likely not available. It is very difficult to establish a cost defense to providing an interpreter in the context of health care services because the DOJ essentially considers such accommodations as a cost of doing business.

Commercial video interpreting services, where the interpreter is remotely provided via a webcam and an Internet connection, are available. Depending on the particular vendor, such an alternative may be a more affordable alternative to an in-person interpreter. In addition, a federal tax credit is available to certain small businesses to help cover expenses incurred in providing access for individuals with disabilities, including the provision of sign language interpreters [Omnibus Budget Reconciliation Act of 1990, PL 101-508, §44]. To find out if your business is eligible for this tax credit, consult with your financial or tax adviser. To view a presentation addressing other business management considerations, visit: www.eatright.org/Members/content.aspx?id=11339.

Q: Do co-pays still apply to preventive services if an insurance plan is grandfathered under the Affordable Care Act?

A: Yes, co-pays may still apply. Under the Affordable Care Act, most health plans are required to provide certain recommended preventive services without charging the consumer a co-payment for that service. However, grandfathered plans are excluded from this requirement. Grandfathered *individual health insurance policies* are also exempt from a few additional provisions of the Affordable Care Act that apply to all other plans. A group health plan that enrolled members on or before March 23, 2010, may be grandfathered even if an individual member did not enroll until after that date. Health plans must disclose their grandfathered status in any plan materials in each new plan year. Patients can check their plan materials and registered dietitians can contact provider relations to determine whether a co-pay is required for a service. To learn more about grandfathered health insurance plans under the Affordable Care Act, visit: www.eatright.org/Members/content.aspx?id=6442471132.

Q: Can health care providers charge clients interest on overdue accounts?

A: According to Laura D. Seng, partner, Barnes & Thornburg LLP, interest can be charged on overdue accounts if policies are clear and applied consistently to all patients. Good business practice recommends that practitioners develop written billing and collection policies and have patients sign a statement that they have received and understand those policies. Health care providers should check regulations regarding the charging of interest on patient accounts in their individual state law and/or licensure code of conduct. State laws and specific insurance contract provisions may require different terms. For example, some states specify a particular interest rate (or range) that can be charged on patient accounts. In addition, if the services are billed to a third-party payer, the health care provider should review his or her agreement with that payer to ensure that interest can be charged on overdue patient balances. Registered dietitians should consult a competent lawyer for specific advice to create a tailored policy for their practice. For sample financial and patient policies, visit: www.eatright.org/Members/content.aspx?id=7501.

Opinions expressed here do not necessarily reflect the views of the Academy. Advice is general, and readers should seek professional counsel for legal, ethical and business concerns.

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