Registered dietitian nutritionists (RDNs) often think the terms offered in a contract with private insurers are absolute. You may be told initially, “This is what we pay in your market;” and the plan representatives may say that they do not negotiate with RDNs. However, everything is negotiable. If you want to start negotiations in a winning position, then you need to be prepared.

Begin by identifying what it is you want. Specific demands increase negotiating power. Is your goal increased payment or expanded coverage, or are there other benefits you want to negotiate? Determine what you’re willing to accept. Successful negotiation is based on preparation, so do your homework. Know when your rates were established and the last time your rates were increased. Organize data from your practice and be prepared to discuss patient outcomes and the cost savings your services have achieved for the payer. Support your case with relevant nutrition research from the Evidence Analysis Library (EAL) and peer-reviewed studies, such as “The Incremental Value of Medical Nutrition Therapy in Weight Management” (Managed Care Magazine, January 2013).

Next, set a date for a face-to-face meeting with the payer’s representative. If an in-person meeting isn’t possible, schedule time to speak with decision makers. Private practice dietitian Jaime Lynn Lewis, RD, LDN, believes the key to successful negotiations is to make sure you’re talking to the right person. Lewis has found in her experience that decisions about rates and inclusion are more commonly made by plan representatives at the network manager level.

Enter negotiation meetings with confidence, and present well-organized, clear data to support your requests. Use Academy of Nutrition and Dietetics resources, such as the Medical Nutrition Therapy MNTWorks® Kit, the third-party payer brochure and EAL to help make your case that RDN services provide a valuable return on the payer’s investment. Use data from your practice to highlight positive outcomes and potential cost savings you can offer the payer.

Don’t be afraid to ask for what you want. The conversation at the negotiation table may be new and uncomfortable at times, but you have to be your own best advocate because, as Lewis reminds us, “No one is going to do it for you!” Sometimes, just acting like you expect a positive response will sway the other party in your favor. The insurer could grant you everything or nothing, or say, “Let’s talk about this again in six months.” Ask for your optimum objective.

Inside:

Negotiating a contract with a private payer........................................ 1
New Medicare Appeals Process podcast available ......................... 1
Question Corner ............................................. 3
ICD-10 resources for small provider practices on Medscape............... 4

New Medicare Appeals Process podcast available

The Medicare Learning Network recently announced the availability of a new podcast titled “Medicare Appeals Process.” This 15-minute educational tool, available in MP3 downloadable format, is designed to inform providers and suppliers of the five levels of claim appeals for Medicare Part A and Part B claims. Included is a detailed explanation on how the Medicare appeals process applies to providers, as well as information on available appeals-related resources. For more information or to download the podcast, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/icn909016-Medicare-Appeals-Process.

See Negotiating, page 2
and then listen carefully to what the payer’s representatives have to say. Keep in mind that you are negotiating a long-term relationship, not a single transaction. Leave room for negotiation beyond payment. If it’s clear the company isn’t willing to budge on the payment terms outlined in your contract, that doesn’t have to be the end of your discussion.

**Fees are not the only items to negotiate**

Although the reimbursement level is the most significant element in a contract, additional room for negotiation exists beyond payment rates. Nonmonetary concessions can also expand and improve business. RDNs should consider the following contractual components when negotiating a contract:

- **Expanding coverage:** Request coverage for additional diagnosis codes and Current Procedure Terminology (CPT) Codes, such as telehealth services, preventive health care or multidisciplinary team codes. Be sure the correct ICD-10 codes are also included in your contract so you will continue to be paid when that transition occurs.

- **Expanding the submission period and appeal time for claims:** Try requesting an extension to the period of time by which a claim must be submitted after the service was rendered. Consider requesting a lengthened period to appeal a denied claim. Such extensions will offer you more flexibility in accommodating unusual situations. Some of these time frames may not be negotiable, but you won’t know unless you ask.

- **Requesting notification of changes:** Ask that your contract include a clause requiring advanced written notification of changes to policies and procedures. A reasonable advance notice, such as 30 days, should be provided, and changes should be clearly defined.

- **Managing your renewal:** Look at the language pertaining to contract renewal. Many payer contracts have “evergreen” clauses that delineate deadlines for sending notices to discuss the contract’s renewal. An evergreen clause automatically renews the contract for another term (typically one year) if the contract is not terminated or renegotiated within a specified notice period prior to the end of the current term.

Negotiating is a complex process that takes a lot of research, effort, communication and practice. Once you start the process, you may find there is far more that you can negotiate than you originally thought and many different ways to improve your outcome. For fact sheets addressing the value of RDN, the return on investment provided by medical nutrition therapy provided by an RD and other information supporting the RDN value proposition, download the Medical Nutrition Therapy MNTWorks® Kit at: www.eatright.org/members/mntworks. To download a copy of the third-party payer brochure, visit: www.eatright.org/Members/content.aspx?id=7775. To read the article “The Incremental Value of Medical Nutrition Therapy in Weight Management,” visit: www.eatright.org/coverage. For more information about the EAL, visit: www.andead.org/about.
**Q:** Can I offer self-pay patients a reduction in payment for prepaid services bundled together as a package?

**A:** Some states allow some forms of prepay plans, but the legalities vary widely from state to state. Registered dietitian nutritionists (RDNs) should first determine whether prepaid plans or services are allowable by laws in the state in which they practice. Some states’ Insurance Departments have released advisory opinions stating that offering prepay plans or services could constitute conducting insurance business within the meaning of the state’s insurance law, unless certain circumstances are met. Examples of such conditions could be disclosing clearly to the patient that “this is not insurance” or ensuring the services received are not dependent on a chance or unplanned event.

If allowed, a plan should be set forth in writing, clearly describing the specific number of visits or services that are to be included for a specified price. In some states, additional provisions may also apply. For example, in some states, it is legal to offer prepay plans as long as you fully refund the patient’s money upon request, should she decide not to participate fully in outlined programs or services. Other states allow a prorated refund, as long as the patient has been informed of such. Still others demand that you keep prepay funds in an escrow account until they are all used up and that you offer a refund plus interest if the patient cuts his care short. Be sure that your policy also states the period of time with which any requested refunds must take place and always maintain detailed records of the amounts paid by each patient. RDNs are encouraged to seek professional counsel for legal and business advice when establishing policies and procedures.

**Q:** When is it appropriate to use a CMS 1500 form versus the UB04 form?

**A:** The CMS-1500 form is the standard paper claim form used by a noninstitutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. This form has been adopted by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services. The CMS 1500 form is also used for billing of some Medicaid state agencies as well as some private payers.

The UB-04 form is the paper uniform bill (UB) used for institutional health care providers, such as hospitals, nursing homes, hospices and home health agencies, for claims processing. This form is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the ASCA. To read about the ASCA, visit: www.cms.gov/Medicare/Billing/Electronic-BillingEDITrans/Administrative-Simplification-Compliance-Act-Enforcement-Reviews.html. For more information about the CMS 1500 form, see the sidebar to this article. For more information about billing for medical nutrition therapy services under Medicare, visit: www.eatright.org/mnt. A billing resource for RDNs

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**“Medicare Billing: 837P and Form CMS-1500” Fact Sheet—revised**

The revised “Medicare Billing: 837P and Form CMS-1500” Fact Sheet (ICN 006976) is now available in downloadable format. This fact sheet, designed to provide education on electronic and paper claims for health care professionals and suppliers, includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, timely filing, and where to submit fee-for-service (FFS) claims. To download a copy of the fact sheet, visit: www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf.

See Question Corner, page 4
ICD-10 resources for small provider practices on Medscape

Three new educational resources are now available from Medscape to help small physician and other provider practices prepare for ICD-10.

- ICD-10: Getting From Here to There—Navigating the Road Ahead: This video lecture gives providers an overview of ICD-10 and its benefits, the differences between ICD-9 and ICD-10, and the CMS “Road to 10” tool.

- ICD-10 and Clinical Documentation: This video discusses the role of documentation and coding in health care and examines why documentation is important for ICD-10.

- Preparing for ICD-10: Now Is the Time: This expert column explores the effect ICD-10 will have on systems, the coding process, documentation and quality reporting. It also provides steps to prepare for ICD-10 implementation.

Accessible online, these resources are offered at no charge; however, first-time visitors to Medscape must create a free account to access these resources. For more information about ICD-10 or to access these resources, visit: www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10. For a list of resources to help guide registered dietitian nutritionists through the upcoming ICD-10 transition, visit: www.eatright.org/Members/content.aspx?id=6442465636.

Question Corner, from page 3

How do I determine which payer pays first when providing medical nutrition therapy (MNT) services to Medicare Part B beneficiaries who also have other health insurance coverage?

Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for the items or services supplied to the beneficiary. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage, but Medicare may also pay first in certain circumstances when the beneficiary has other insurance coverage. The Medicare Secondary Payer (MSP) fact sheet, which is available on the Academy of Nutrition and Dietetics website, outlines some common situations where a beneficiary has both Medicare and other health insurance coverage and analyzes which entity is the primary payer. The fact sheet also explains how to gather accurate MSP data from the beneficiary and who to contact for questions. It is important to note that with regard to MSP regulation, federal law takes precedence over state laws and private contracts. Even if a payer believes that state law or the insurance policy indicates that it is the secondary payer to Medicare, the MSP provisions apply when billing for services. For more information or to access the MSP fact sheet, visit: www.eatright.org/Members/content.aspx?id=7306.

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.