Medicare represents a huge potential market of clients for registered dietitian nutritionists (RDNs). According to the Medicare Enrollment Dashboard, published by the Centers for Medicare & Medicaid Services (CMS), Office of Enterprise Data and Analytics, 44 million beneficiaries—some 15 percent of the U.S. population—are enrolled in the Medicare program, with over 38 million enrolled in original Medicare alone. Twenty-eight percent of these beneficiaries have diabetes and 17 percent have chronic kidney disease.

The business opportunity for MNT provided to Medicare beneficiaries is great. Medicare covers medical nutrition therapy (MNT) for diagnoses of diabetes, non-dialysis kidney disease, and 36 months post kidney transplant when a Medicare beneficiary has been referred by a physician, and when provided by an RDN enrolled as a Medicare Provider. Three hours of MNT are covered the initial calendar year of referral and up to 2 hours of MNT for subsequent years. Additional coverage is available in the same calendar year with a second referral when more MNT is medically necessary. Making an informed choice about whether or not to participate in Medicare and choosing the right option for participation can make a big difference in revenue and practice. So, what options are available for RDNs considering Medicare participation?

**What Are My Options?**

Participating in Medicare is more nuanced than just enroll or not enroll. Are you aware that providers can't just ask Medicare beneficiaries to pay out of pocket if they simply choose not to enroll in Medicare? Did you know that if you do not enroll or opt-out of Medicare, you need to send the business to...

See Options, page 2

**Now Available:**

The 2020 Medicare Physician Fee Schedule

The Academy has taken the worry out of calculating the 85 percent of physician payment rate for registered dietitian nutritionist (RDN) Medicare providers. Each year, the Centers for Medicare & Medicaid Services publishes a complete list of fees used by Medicare to pay providers and suppliers, known as the Medicare Physician Fee Schedule (MPFS). As a service to its members, the Academy calculates the 85% rate adjustment, required by law, for RDN-covered services paid under the MPFS and develops a table of rates for reference. Rates do not reflect the mandatory 2% reduction required under the Budget Control Act of 2011, known as “sequestration.” Newly included in the 2020 table are the RDN payment rates for the Online Assessment and Management Services. All rates are effective for dates of service between January 1 and December 31. To download Medicare payment rates for MNT CPT codes by geographic area specific to RDNs, visit: www.eatrightpro.org/payment/medicare Providing-service-and-billing/medicare-physician-fee-schedule. Nonmembers can also order a copy of the table for a nominal fee at: www.eatrightstore.org/product-subject/nt-references/medicare-physician-fee-schedule.
someone else? Understanding your options and the potential impact on practice and payment are vital to making an informed business decision.

**Participating Providers**

A participating provider is one who voluntarily and in advance enters into an agreement in writing to provide all covered services for all Medicare Part B beneficiaries on an assigned basis. Some practitioner types who enroll in Medicare program are required to accept assignment for all Medicare Part B claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for services. All RDNs who enroll in Medicare are considered participating providers and must agree to accept assignment.

Participating providers are required to file a claim for Medicare-covered services provided to the beneficiary. They are paid by Medicare directly and may not request payment from the beneficiary beyond any coinsurance or deductible which may apply (e.g. Medicare pays 80% of the fee schedule for diabetes self-management training services and the beneficiary is responsible for the remaining 20%). Participating providers may, however, collect payment for services that are statutorily excluded from Medicare (e.g. medical nutrition therapy [MNT] for diagnoses besides diabetes and non-dialysis kidney disease). Prior to providing services which are not covered by Medicare, RDNs should inform beneficiaries they will be responsible for the payment in full.

Participating in Medicare could allow you to establish a predictable cash flow while developing other services or reaching out to new markets. Medicare rules and regulations are more “black and white” than those of private payers. Understanding what CPT codes to use for billing, what diagnoses are covered, how many hours of coverage are available per year, are consistent no matter the state in which you practice. Medicare is also completely transparent with payment rates. How much you will get paid is straightforward and clean claims take approximately 30 days to process. As a service to its members, the Academy develops a table of rates for reference. RDNs can visit the Academy website for a chart listing the calculated rate adjustment for RDN covered services by state/locality for services provided in a non-facility and facility settings.

**Non-Participating Providers:**

Non-Participating Providers enroll in Medicare but do not agree to accept assignment in all cases, meaning that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services as full payment. RDNs do NOT have the option to become non-participating providers.

**Opt-out Providers:**

Opting out of the Medicare program means that the provider does not bill or file claims to Medicare but opting out is slightly more complicated than simply providing MNT services to a Medicare beneficiary and billing the patient directly. Section 1802 of the Social Security Act, as amended by §4507 of the Balanced Budget Act of 1997, permits certain physicians or practitioners to opt-out of Medicare and enter into private contracts with Medicare beneficiaries. RDNs are among the list of providers who are permitted to opt-out of Medicare. In order to opt-out of Medicare, providers must file an affidavit with their Medicare Administrative Contractor (MAC) prior to providing services to Medicare Part-B beneficiaries. The Centers for Medicare & Medicaid Services (CMS) does not have a standard opt-out affidavit form, but many MACs have forms on their websites. The provider must also supply the beneficiary with a private contract, describing all charges and confirming that the beneficiary understands he/she is responsible for the full cost of care and that Medicare will not reimburse either party prior to providing services and billing. RDNs and other providers can create their own private contract or download a fillable sample private contract from their MAC website, when available. A complete list of required private contract statements can be found on at: https://bit.ly/389ko92. A sample opt-out private contract is also available at: https://bit.ly/2TjavBD.

Before deciding to formally opt-out of Medicare, RDNs should be aware of the following:

- Participating providers may opt-out at the beginning of each calendar quarter (January, April, July, or October) by submitting a valid affidavit postmarked 30 days prior to the first day of the new quarter.
- RDNs not previously enrolled in Medicare do not need to enroll in Medicare in order to opt-out.
- To formally opt out of Medicare, an affidavit must be filed with all Medicare Administrative Contractors (MACs) that have jurisdiction over claims the RDN would file for Medicare provided services.
- The opt-out period lasts two years.
- The continuous two-year opt-out period begins the date

See Options, page 3

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**2019 MIPS Data Submission Deadline Reminder**

The data submission deadline for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2019 performance period of the Quality Payment Program (QPP) is next month. Data can be submitted and updated any time until **8:00 p.m. EDT on March 31, 2020.** To learn more about how to submit data, review the 2019 Data Submission FAQs and other resources available in the QPP Resource Library, available at: qpp.cms.gov/about/resource-library. For more information about the QPP and MIPS, visit www.eatrightpro.org/payment/medicare/quality-payment-program.
the affidavit is signed, provided it is filed with the MAC within ten-days after entering into a private contract with a Medicare beneficiary.

- No changes to provider status can be made within the two-year opt-out period.
- Opt-outs will auto-renew at the end of the two-year period without a need to resubmit an updated affidavit.
- If a provider wishes to cancel the automatic renewal extension, they must notify in writing all MACs with which they filed an affidavit at least 30 days prior to the start of the next two-year opt-out period.

While opt-out providers may set their own fees for services, certain rules and guidelines still apply. Medicare will not pay for care beneficiaries receive from an opt-out provider. Beneficiaries are responsible for the entire cost of care and should be billed directly by the provider. Once a provider elects to opt-out of Medicare and enter a private contract with a Medicare beneficiary, all future Medicare beneficiary relationships will be impacted. Providers cannot opt-out for some services and not others, some locations and not others, or some patients and not others. That means, opting-out terminates all active Medicare enrollments. Additionally, providers who opt-out of Medicare cannot participate in any Medicare program, including original fee-for-service Medicare (Medicare Part B), Medicare Managed Care Plans, Medicare+Choice, and Medicare Advantage Plan (Medicare Part C).

Prior to opting-out of Medicare, consider the growth in both Medicare and Medicare Advantage programs. Enrollment in Medicare programs is expected to rise to 79 million by 2030, as the baby boomers age. The collective pool of Medicare beneficiaries represents a huge business opportunity, so saying ‘no’ to Medicare could potentially mean turning away a lot of business. Opting-out of Medicare could also negatively impact referrals to your practice for patients with private insurance. Busy physician practices are more likely to establish strong working relationships with and refer patients to an RDN who accepts most payers which cover their patient population, than remember who is credentialled with what insurance.

Refer Out:
RDNs also have a third option for Medicare beyond participating or opting-out. If you have not decided to become a participating provider, but don’t want to limit your options for a two-year period, you can refer the beneficiary to another RDN who is a Medicare provider. Referring out keeps you compliant with the law and offers you time to weigh the advantages and disadvantages of participation options without the extended commitment. Referring out also allows the work of RDNs to be counted, as the claims data generated from each encounter leaves a footprint from the participating provider.

Medicare is Good for Business and the Profession
By saying ‘yes’ to Medicare, you pave the way for expansion of MNT coverage in for both public and private payers. Increasing the pool of RDN Medicare providers can assure CMS that there is an adequate number of RDN providers to support expansion of the Medicare MNT benefit beyond diabetes and renal disease. When RDNs don’t seize existing opportunities under Medicare, it becomes difficult to convince payers that more coverage is needed. Becoming a Medicare provider also impacts coverage for benefits under private payers, as they frequently following the lead set by Medicare when establishing their coverage policies. Your practice and the profession can benefit by you becoming a participating provider under Medicare. To read about the benefits of becoming an Medicare provider and how to enroll in Medicare, visit: www.eatrightpro.org/payment/ medicare/medicare-provider-enrollment. To learn more about opting-out of Medicare, visit: www.cms.gov/Outreach-and-Education/ Medicare-Learning-Network-MLN/MLN-Matters/Articles/Downloads/SE1311.pdf. To access the 2020 Medicare physician fee schedule, visit: www.eatrightpro.org/payment/ medicare/providing-service-and-billing/ medicare-physician-fee-schedule. To access a MAC directory interactive map, visit: www.eatrightpro.org/payment/ medicare/mnt/mnt-forms-and-resources.

Question Corner

Q: Will Medicare accept referrals to an RDN made by a physician who has opted out of Medicare?
A: Yes.

Q: Can I provide MNT services to a Medicare Part B beneficiary diagnosed with diabetes if I want to bill the beneficiary directly?
A: Maybe. RDNs enrolled in Medicare may provide Medicare covered services to Medicare Part B beneficiaries without billing Medicare only if they submit an opt-out affidavit to all applicable Medicare Administrative Contractors (MACs) and enter into a private contract, prior to providing the service and signed between the RDN and the individual beneficiary, stating that neither the patient nor the RDN can receive payment from Medicare for the services that were performed. When these steps have been completed, the RDN may bill the beneficiary for Medicare covered services directly. RDNs who have not formally opted-out of Medicare or entered a written agreement with the beneficiary must refer patients to another Medicare provider.

Q: Can a group practice continue to bill for services provided by an RDN who has reassigned her Medicare benefits to the organization if she has opted-out of Medicare in her private practice?
A: No. The organization may no longer bill Medicare or be paid by Medicare for the services that RDN furnishes to Medicare beneficiaries if she has opted-out of Medicare. The decision to opt-out of Medicare applies to all

See Question Corner, page 4
Academy Launches Payment Matters Program

No matter where you work, understanding the basics of healthcare payment and reimbursement for the services you provide is an asset to every registered dietitian nutritionist. That’s why the Academy is launching Payment Matters, a free program for all members. Upon registering for the program, you will receive six monthly emails that include valuable information, resources, and learning activities regarding reimbursement, payment for telehealth, alternative payment models, and more! Now is the time to put yourself in a better position to negotiate salaries and secure the future of your profession. As an RDN, you deserve to be recognized for the value you bring to your workplace. Register for the Payment Matters program and start receiving your monthly emails this April. For more information or to register, visit: https://bit.ly/2vRQYyy.

Question Corner, from page 3

Q: I provide telehealth services to Medicare beneficiaries across several state lines and am wondering if I can opt-out of Medicare for some carrier jurisdictions but not others?

A: No. The opt-out applies to all items or services furnished to Medicare beneficiaries, regardless of the location where such items or services are furnished or the Medicare Administrative Contractor managing the claim.

Q: If I opt-out of original Medicare, can I still provide services to Medicare Advantage patients and submit claims to the Medicare Advantage Plan providing patient benefits?

A: No. RDNs that chose to opt-out of Medicare cannot participate in any Medicare program, including original fee-for-service Medicare (Medicare Part B), and Medicare Advantage Plans, also known as Medicare Part C, Medicare Managed Care Plans, Medicare+Choice.

Q: Do I need to enroll in Medicare first, before I can opt-out of Medicare?

A: No. RDNs who have never enrolled in Medicare are not required to enroll in Medicare before they can opt-out of Medicare, but they must submit an opt-out affidavit to their MAC.

Q: I work in an out-patient clinic at my local hospital and have my own private practice. Can I opt-out of Medicare in my private practice, but still provide services to Medicare beneficiaries at the clinic and have the hospital bill Medicare?

A: No. Providers who opt-out of Medicare terminate their Medicare enrollment, regardless of where they provide services. If you want to continue to submit claims to Medicare for services provided to beneficiaries at the clinic but do not wish to bill Medicare for services provided in your private practice, you must refer Medicare Part B beneficiaries that come to your private practice to another provider.

Q: Can’t I just provide Medicare beneficiaries that come to my private practice with a superbill to submit to Medicare for reimbursement on their own?

A: No. RDNs who enroll in Medicare are considered participating providers and are required, by law, to file a claim for Medicare-covered services provided to the beneficiary. The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement is known as the Mandatory Claim Submission Rule and applies to all Medicare participating and non-participating providers, including RDNs, who provide covered services.

LISTEN AND LEARN:
FNCE® 2019 Session Recordings Now Available

Looking for solutions to common payment pitfalls, such as what to do if a provider network is full, how to resolve billing issues and respond to denials, and what to do when a diagnosis is not listed as a covered benefit under a patient’s health plan? Listen to the FNCE® 2019 session recording, Parlez-Vous Revenue? Winning at Third Party Payment. Recordings of this and other FNCE® 2019 educational sessions are now available on eatrightstore.org. To access this and other recordings, visit: www.eatrightstore.org/collections/fnce-2019.

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