# Enhancing Revenue for RDNs Demonstrates Value for Expanded Scope of Practice and Increases Access to Care Webinar - Questions & Answers

**Wendy Phillips, MS,RD, FAND, FASPEN, March 13, 2024**

1. Q: We are preparing a proposal for RDNs to take over the NG/NJ tube placement in our facility. We expect an increase in orders for nasal feeding tubes. How can we address this in our proposal?
   *I recommend that you do a productivity study.*
   - *Track the number of minutes it takes to review the chart including the order, place the tube, and document the procedure. Include the follow-up time to assess tube placement if it is the RDN who does the follow-up. Don't include the time for the RDN nutrition assessment/re-assessment because you would have done that anyway on a tube fed patient.*
   - *Run a report from the medical record system (or another way that the hospital has to do so) of tube placements for the last 6 months. Divide that number by 6 to get the average monthly tube placements.*
   - *Multiply that by the number of minutes per tube placement, then convert to hours. Advocate for an increase in RDN FTEs to offset the increased number of hours to place tubes. Justify this based on nursing time saved, comparing average salary for RNs with average salary for RDNs. (Or whichever healthcare professional places the tubes at your hospital.)*
   - *After go-live, continue the productivity studies for RDN time spent placing tubes and track actual tube placements, and advocate for increased RDN FTEs if needed. As supporting documentation, track patient outcomes related to more timely nutrition support.*
     - *Recommended outcomes to track: resolution of nutrition diagnosis, time to extubate, time to discharge from ICU, time to discharge from hospital, etc.*

2. Q: How does Medicare justify not providing nutrition coverage when we have overwhelming mountains of data showing positive outcomes?
   - *I assume this is for outpatient. There are many reasons.*
   - *Medicare doesn't have the authority to expand nutrition coverage. Only Congress does.*
   - *Many Congress members know that nutrition is important, but they're worried about other things and mostly worried about the federal debt and sustainability of Medicare overall.*
   - *Many Congress people have told me they think MNT is important, just don't think RDNs are the only ones who can provide it.*
   - *Nutrition research is ridiculously hard to conduct because it is nearly impossible to control for every possible confounding factor. It leads to limitations that other professionals try to poke holes at. (Not that I support those who poke the holes,*

*just pointing out what I have heard from Congress people, and they're the ones who hold the decision making power at this point.)*

- *Medicare wants to save money, so they are very careful which services they expand.*
- *Biggest reason: Medicare doesn't "see" that there are enough RDNs to provide services to their beneficiaries for MNT for DM or CKD. So, they think that if they expand to more conditions, there won't be enough RDNs to provide those services anyway. Reasons for this:*
  - *Most RDNs do not have an NPI number. Medicare doesn't ask the Academy or CDR how many RDNs there are in the U.S., they consult the NPI database for how many providers there are in the different categories.* ***Learn more and obtain a free NPI here: https://npiregistry.cms.hhs.gov/search.***
  - *Not enough RDNs are Medicare providers, further limiting the visibility to eligible RDNs to provide services to their beneficiaries.*
  - *Relatively few beneficiaries take advantage of the current services that are covered. At one point, it was only 3% of beneficiaries (I haven't looked up recent numbers, but it's still very low). Of course, that's because their coverage is low and it is difficult to get enrolled, but that's not what Medicare thinks the reason is.*
  - *Relatively few RDNs participate in the advocacy campaigns that the Academy organizes, so Congress doesn't hear the message.* ***Learn more about Action Alerts here: https://www.eatrightpro.org/advocacy/take-action/action-alerts.***

3. Q: How do we as dietitians know what salary ranges are appropriate?
   *There seems to be a lot of conversation in the dietitian world about the accuracy of the Academy's Compensation and Benefits Survey. I do think it is pretty accurate based on my experience. RDNs in research, those with PhDs (who are often also in research) and those who are directly responsible for very large budgets and a very high number of direct and indirect reports (and therefore more stress) make the most money. Beyond this, I apologize but I don't have a good answer.*

4. Q: Malnutrition coding only impacts acute care facilities on the DRG system. For facilities paid on the CMG, it will not impact CMI, LOS, or reimbursement. What's the best way of advocating for being able to code for malnutrition for patients in the rehabilitation setting or other facilities who don't get reimbursed?
   *All healthcare facilities should code for malnutrition, whether or not they receive increased reimbursement for it. The problem is, there isn't motivation for the coders to*

*follow-up to ensure that physicians diagnose it and then they code it because it isn't reimbursed. As RDNs in these healthcare facilities, you can start a QI program to get this started. The Malnutrition Quality Improvement Initiative (MQii) offers fantastic resources to do so. Medicare doesn't realize that malnutrition is a problem for patients in these facilities because it isn't visible to them because it isn't coded. So, the more RDNs start an effective QI program for it in these facilities for coding, the more likely they are to start to cover it.*

*I wrote an article on this topic that gives a good starting point, but it was 2019 so I recommend that you use it as a starting point and then look up the more recent payment rules to see if anything has changed.*

*Phillips W. Identifying and Documenting Malnutrition in Inpatient Rehabilitation Facilities. J Acad Nutr Diet. 2019; 199(1);13-16. http://jandonline.org/article/S2212-2672(17)31403-X/fulltext*

5. Q: Are you aware of any RDNs that are billing for outpatient feeding tube placement?
   *I don't know. The Dietitians in Nutrition Support DPG would be a great resource to find out. There may be articles published on this topic on Support Line or threads on the Discussion Board. If there is not already a thread, you can create one to find out what others are doing. I have found a lot of value in my membership over the years, and I am still a member even though I no longer practice in that area. Another great resource is the Clinical Nutrition Management DPG as CNMs are often the ones who manage these areas.*

6. Q: Can you talk a little bit about the difference between order writing privileges and protocol-supported order entry?
   *They are the same thing, just different terminology. Most states and/or most facilities allow protocol-support order entry rather than fully independent order writing by RDNs.*

7. Q: How many states are currently in the proposed dietitian licensure compact? Any idea when this might be available?
   *It has been introduced in 10 states! OH, KY, TN, GA, AL, MS, MO, IA, NE, KS. It needs to be passed in at least 7 states to be enacted. It will be at least 2025 until it is available.*

8. Q: I've tried to implement a lot of these ideas and I am still not getting paid any more than I was. Any suggestions for what I can do?

*I recommend you seek mentorship from RDNs who have been successful in increasing their salaries, if possible, to find out what worked from them. Consider changing your outcomes measurement strategies, and the way that you are presenting your cost savings/potential revenue generation potential. Ask a Finance professional to review your proforma. Seek a champion from another healthcare profession, such as a pharmacist or a physician. Accept greater responsibility and/or diversify your work to generate new income streams. Be willing to take risks.*