Introduction - Sarah Gleason RD LD CEDS-C

I am the co-owner of a business that employs 12 registered dietitians all who specialize in eating disorders Medical Nutrition Therapy (MNT). I am a Certified Eating Disorders Specialist-Consultant (CEDS-C) with 25 years experience and my business partner is also a CEDS-C with 20 years experience. Collectively we have been founding members of St Louis ED networking groups, Chair for Behavioral Health Nutrition (national group of RDs), Chair for Disordered Eating/Eating Disorders (national group of RDs), active as volunteers within local and nationwide Eating Disorder groups.

The primary diagnosis each client has when working with us is an eating disorder. In 2019 we started working with insurance to increase access to care for people who have an eating disorders diagnosis, the second deadliest mental health diagnosis. We have since become in network with UHC, Cigna, Anthem and Aetna. By taking insurance, versus being a self-pay business, we are following our mission of helping people who need it **and** by doing so we are immediately losing money (more info on this later). By dealing with improper denials from insurance we are losing even more money.

We had a thriving private practice with only self pay clients before we stared taking insurance. We were highly sought after in St Louis, we had full schedules and a wait list. At the same time, we also saw a need that many people who struggled financially were not getting care they needed so we decided to become in network with four insurance plans to help those in need of ED nutrition recovery.

Thank you for taking the time to listen to me. My issues with insurance are many but here are my main concerns.

1. Clients are dropping dietitian services due to benefit limitations and they get bad intel when calling about their own benefits.

As we receive denials and need to create appeals, many clients tell us they can not afford life saving weekly appointments and will have to drop off our schedule if they have to pay out of pocket. MANY clients have stopped appointments due to denials (see other attachement).

Clients want assurance they can see us weekly, and at times twice weekly when eating behaviors become more challenging. When clients can't trust they are going to have appointments or if they fear their benefits will stop paying, they have a difficult time sharing their eating behaviors with the dietitian. Trust is the cornerstone of our work. This is a mental health disease and we are using medical nutrition therapy to help them. We need to know the whole person, warts and all to help the client navigate ED nutrition recovery.

Before beginning appointments with us we ask clients to contact their plan to learn about benefits. Members/clients are given wildly inaccurate information when they call Customer Service for benefit info, often being told they have benefits when they don't. Or conversely, being told they don't have benefits when they actually do. When our office receives the denial, we attempt to appeal. When it doesn't get overturned WE are the ones who get yelled at by the client as they now have to pay the self pay rate which they were unable to pay. It takes 4-6 weeks to get denials back and in that time clients have seen the RD 4-6 times, which equals $640 - $960 in fees they have to pay. This can be a significant expense for someone who was expecting insurance to pay.

1. Clients are dropping dietitian services due to benefit limitations and they get bad intel when calling about their own benefits.

There are times when our office will call insurance to verify benefit information the client received. This is an unduly waste of time as we have to be on the phone for 15-30 min while the customer service rep attempts to locate what I am looking for. If this information was in the clients portal it will significantly decrease the amount of time to be on the phone with customer service. (UHC offers this in the portal, Anthem and Aetna do not)

In the attached document there are a number of clients and notes regarding the amount of time it took to receive an EOB and follow it through the appeal process, if it even got appealed. You can see that for the handful of clients in that document it took anywhere from 3 -9 months to get claims overturned, if at all. You can see the amount of work involved on our end to create appeals, follow up with them, communicate with the clients etc. All of these clients dropped services with us as they were unconvinced their plan was going to pay. This added to their financial stress and mental health issues.

Fix 1. Dedicated phone line at each insurance plan to someone who knows MHPEA, so we can fix denials in a timely manner. Thus easing the mind of the person who is struggling with their mental health.

Fix 2. Access to full benefits on the portal so that our business can help answer benefit questions quickly and easily.

2. Medical Nutrition Therapy vs Nutrition Counseling/Nutrition Based Therapy

RDs provide MNT to people who have eating disorders. The language in many benefits plans is that ‘nutrition counseling’ or ‘nutrition-based therapy’ is covered/not covered. In 2023 I worked ad nauseam attempting to appeal 100s of claims from UHC. They would deny claims for this reason: **:** YOUR PLAN DOES NOT COVER SERVICES AND ASSOCIATED EXPENSES FOR NUTRITIONAL-BASED THERAPY. “Nutritional-based therapy” sounds eerily close to Medical Nutrition Therapy and causes undue confusion about what we are providing.

I created verbiage stating we were not offering Nutrition Based Therapy but we were providing MNT. Using Nutrition Counseling or Nutrition Based Therapy in the benefits plan misidentifies what RDs are practicing with the client. I have to explain this to Customer Service, thus spending more time educating and less time working with clients.

The CPT codes dietitians can use to create CMS 1500 claims are 97802, 97803, 97804.

2. Medical Nutrition Therapy vs Nutrition Counseling/Nutrition Based Therapy

Official language for the CPT codes per CMS.gov

97802: **Medical nutrition therapy**; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803: **Medical nutrition therapy;** re-assessment and intervention, individual, face to face with the patient each 15 minutes

97804: **Medical Nutrition Therapy;** group (2 or more individual(s)), each 30 minutes

Fix: 'Medical Nutrition Therapy' should be the language in insurance nutrition benefits and in MPHEA

3. Time and money lost being an in-network provider dealing with denials and appeals.

I spend approximately 25 hours a week working on denials and appeals and my business partner spends 15 hours a week creating claims and figuring out the labyrinth of rules necessary to get the right CPT code and diagnostic code for a patient. Using our hourly rate this is $332,800 in UNPAID work.

Over the course of 2023 this time could be spent seeing clients (generating income) or creating webinars to sell to help less experienced dietitians learn how to work in the ED world (generating income) or meeting with other clinicians telling them about our practice so they will refer to us (generating income).

Unfortunately, these are not able to happen as we have to spend time with insurance customer service learning about the denial or creating appeals. These are tedious calls as I know exactly what I am looking for but Customer Service does not. The phone calls last 15-30 min EACH for me to learn about benefits or to figure out why an appeal is not going through their system. Many times the customer service rep wants to pass my call from the medical benefit department to behavioral health. I have to educate Customer Service that we are providing MNT to a behavioral health dx and that I need to keep talking with them.

3. Time and money lost being an in network provider dealing with denials and appeals.

In 2023 our office had 4332 client encounters. If we were to charge our self pay rate we would have brought in $693,120. However due to insurance contracts, we are averaging $90/appointment = $389,800 (approx. income for 2023) . This is a **difference of $303,320 of actual income.** We are not able to negotiate fees with insurance AND even though we have a contract with insurance they have CUT OUR FEES this year. How is this even legal!?! We have a contract.

My business partner and I have regular discussions about dropping insurance, specifically Anthem as they are by far the lowest payer in Missouri. But, if we do this, we will lose a significant number of clients thus losing more money in the process. And, if we drop insurance these clients will not have access to qualified clinicians to help with their ED nutrition recovery. A second piece of this is that since we are not able negotiate contracts with insurance to increase our rate, we are not able to offer raises to our RDs. This could have an impact on our employee retention in the near future.

Fix: Dedicated phone line to someone who knows about MHPEA so that our office does not have to spend a significant amount of time educating customer service about the reason for the appeals.

Fix - Insurance should pay out RDs at the state medicare rate (at a minimum) so we can offer cost of living raises for our employees and independent contractors.

Timeline of denial process:

Client sees an RD
CMS 1500 gets created and submitted to insurance within a week of the appointment
Wait 4-6 weeks to receive a denial or payment

The week we receive a denial:

15-30 min spent reviewing current denial reason and reviewing chart to assess past denials for the same client
15-30 min to create, send and document the appeal in the clients chart. This is IF I am able to send an appeal via the plan's portal. It is quite common that the portal is down and I have to fax the appeal in. However, for EACH smaller cut out plan within the 'parent plan' there is a different fax number. Thus, if I do not have the fax number I have to call insurance plan to gather this information. The call is not as straightforward as calling customer service and gathering the fax. I need to input all of the client's details, sit on hold and wait for a rep to answer the phone.

Wait up to 30 business days to learn the outcome of the appeal. During this time I monitor the clients specific page in the portal weekly to see if there is any decision made or if the plan needs more information from the provider. If the plan needs more information from the provider I reach out to the dietitian asking for chart notes, diagnosis and send that to the plan.

After 30 days we can contact insurance to learn about the outcome of the appeal. Often I am told the appeal was not received (even though I have confirmation the fax was sent or the e-appeal went through the system). The rep will either resubmit the appeal on my behalf or they ask me to resubmit. There have been times when I have been told that I have appealed the claim too many times and that I need to appeal it in a different manner. Thus ANOTHER phone call to another department to explain the fact that I know the client has MNT benefits and the denial is still improper.

This pattern can go on for MONTHS (see attachment with client timelines for appeals). Sometimes the denial is overturned, sometimes it is not. Depending on the financial status of the client we may or may not ask for the self pay rate. If they are not able to pay and if insurance does not overturn the appeal the client is informed of this. More often than not, the client terminates appointments with the dietitian and they get sicker.

Thank you for your time!