Establishing and Improving Cancer Nutrition Programs in the Community Cancer Setting

An Education Program from ACCC's Center for Provider Education

# Q&A

## "Oncology Nutrition: What's the Point?" Webinar

*Presenters: Kim Jordan, MHA, RD, CNSD*
*Seattle Cancer Care Alliance*
*Heidi Ganzer, RD, LD*
*Minnesota Oncology Hematology, PA*

**Q:** Where can the Standards of Practice for Registered Dieticians be found?

**A:** You can access the SOP/SOPP at http://www.oncologynutrition.org or reference:

Robien K, Bechard L, Elliott L, Fox N, Levin R, Washburn S. American Dietetic Association: *Revised Standards of Practice and Professional Performance for Registered Dietitians* (Generalist, Specialty and Advanced) in Oncology Nutrition Care. *JADA.* 2010;11(2):310-317.

**Q:** What are the Pre-cachexia Guidelines?

**A:** The reference utilized in the presentation was:

Muscaritoli M, et al. Consensus definition of sarcopenia, cachexia, and pre-cachexia: Joint document elaborated by Special Interest Groups (SIG) "cachexia-anorexia in chronic wasting diseases" and "nutrition in geriatrics." *Clin Nutr* . 2010;29:154-159.

"Pre-cachexia is defined based on the presence of all of the following criteria: (a) underlying chronic disease (b) unintentional weight loss of less than or equal to 5% of usual body weight during the last 6 months (c) chronic or recurrent systemic inflammatory response (d) anorexia or anorexia related symptoms."

**Q:** Do you charge for your services or are you reimbursed through insurances?

**A:** Heidi Ganzer does bill for nutrition consults while Kim Jordon does not bill for nutrition consults. There are some private insurance companies that pay for the service, others do not. Medicare does not cover nutrition consults unless there is a diagnosis of diabetes or renal disease.

**Q:** What equipment do you use for metabolic testing?

**A:** ReeVue™ metabolic testing--Korr Medical Technologies Inc.

**Q:** I am an RD in private practice. In terms of reaching out to MD's for referrals , I know it sounds primitive, but some still express fear that if you feed the patient you feed the tumor. Could you suggest how to respond to this?

**A:** There were some excellent studies noted in the ACCC supplement *Cancer Nutrition Services: A Practical Guide for Cancer Programs* supplement about the benefit of adequate nutrition before, during and after treatment. The classic DeWys study that was shown in the presentation also identified the impact that weight loss had on survival. Many studies show the benefit of adequate nutrition as it relates to quality of life during treatment as well. I would suggest you utilize a literature search and provide examples of the benefit of early nutrition and how it impacts outcome in oncology patients.

**Q:** Does the pre-cachexia criteria also apply to pediatric patients?

**A:** No, I believe the pre-cachexia tool is used only with adults so far (it is relatively new). Pediatric patients are judged by growth rate, etc according to the CDC charts. We only see pediatric transplant patients here and have an entire section of our Hematopoietic stem cell transplantation (HSCT) Nutrition Care Criteria Manual dedicated to assessment.

**Q:** I may have the opportunity to work in a private practice setting with a Med Onc in Eastern Pennsylvania. How should I approach pay? Should I be paid hourly (consultant vs. on staff?)? vs. request a percent of what we get reimbursed per patient (and if so, what percent should I request? 50%?).

**A:** We cannot offer specific advice in regards to your private practice. In general, the Academy of Nutrition and Dietetics has excellent information in regards to reimbursement on the http://www.eatright.org website. If you log in and click on "Practice," there you will find a wealth of information in regards to guidelines, coding, coverage, compliance, medical MNT, etc. You will also need to determine your state's regulations/guidelines on billing. Take home point, there are many regulations and guidelines in regards to reimbursement, be sure that you are aware of them and that you are in compliance with them.

**Q:** In the first case study example in the presentation, could you speak about role of decreasing obesity in this type of patient - perhaps promote weight loss (especially loss of fat mass) by some weight loss. 1) lessen co-morbidities hopefully preserve lean body mass (LBM) 2) possibly greater mobility of patient, less joint stress, etc. 3) Survivorship - less risk of secondary cancers as less fat mass.

**A:** I agree with promoting gradual, healthy weight loss if possible during treatment for breast, prostate and other types of general oncology patients. However we do not ever emphasize the weight loss itself during treatment, only the behaviors supporting a healthy weight: plant-based diet, low fat, and increased activity. We do counsel on the role of obesity in recurrence, and the need to focus on LBM maintenance and attaining a healthy weight after treatment. Things get even trickier with Bone Marrow or Stem Cell Transplant patients-LBM loss is so common that we try to avoid any caloric restriction and really watch diet and protein intake closely. Every transplant patient is referred to our PT department to try to keep LBM by minimizing deconditioning.

**Q:** In an outpatient setting, how are nutrition counseling services reimbursed?

**A:** If you are able to come to the ON DPG symposium in Dallas (April 27-28) there will be a panel discussion regarding this topic. If you work with private insurance companies it would be helpful to meet with them and discuss the benefit of oncology nutrition services and the value-added service it would provide to their patients.