

Medicare's Intensive Behavioral Therapy for Obesity

Linda Bartholomay, RD, LRD
Manager Diabetes Education and Nutrition – Sanford Health,
Fargo, ND

What is this benefit?

- November, 2011: CMS allows a benefit called “Intensive Behavioral Therapy” for obesity if a Medicare recipient has a BMI of 30 or greater.
- IBT providers include: primary care physicians, nurse practitioners, CNS, physician assistants

USPSTF

- The United States Preventive Services Task Force (USPSTF) found good evidence that body mass index (BMI) is a reliable and valid indicator for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. It also good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥ 30 kg/m²) produces modest, sustained weight loss.

Comment period to CMS

- Studies providing evidence for IBT included multidisciplinary approaches – these providers (dietitians, psychologists, exercise physiologists, etc., are not included in the list of providers of this service - -despite their expertise in obesity treatment)
- Despite comments made from multiple disciplines, the decision stood to reimburse primary care MDs, PAs and NPs

- *Response*

While CMS is providing coverage for additional preventive services, we believe it is important that these preventive services should be furnished in a coordinated approach as part of a comprehensive prevention plan within the context of the patient's total health care. Primary care practitioners are characterized by their coordination of a patient's comprehensive healthcare needs. Primary care practitioners are generalists who are specifically trained to provide primary care services. Other provider specialties may provide patient care in other settings but do not offer care in the context of being the coordinator of the patient's healthcare needs, not limited by problem origin or diagnosis. Coordination of health services is especially important in the presence of the coexisting health issues of our Medicare beneficiaries.

Primary care providers

- Access issues for patients to get appointments
- Feel that it is not their area of expertise to counsel patients on healthy eating, activity and behaviors
- Reimbursement for IBT is very low
- Would rather have other disciplines see their patients for weight loss

Survey of US Primary Care Physicians – published in BMJ Open 2012

Table 3 Physician perspectives on health professional most qualified to help obese patients lose or maintain weight, by years since completing medical school N (%)

Percentage of citing most qualified	Overall N=500	Years since completing medical school		p Value
		<20 N=277	20+N=223	
Nutritionist/dietitian	223 (45)	166 (48)	67 (41)	0.21
Primary care Physician	199 (39)	135 (41)	64 (37)	0.40
Behavioural Psychologist	57 (14)	30 (9)	27 (20)	0.01
Endocrinologist	6 (1.0)	3 (0.7)	3 (1.5)	0.45
Nurse	3 (0.5)	2 (0.7)	1 (0.5)	0.81

Source: Survey of General Practitioners, Family Practitioners and General Internists between 9 February and 1 March 2011.

Notes: p Values are for t tests for differences in proportions. The mean year medical school was completed is 1993.

What is the IBT benefit?

- Screening for obesity using BMI
- Dietary assessment
- “Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise”

Qualifications to receive IBT

- BMI \geq 30
- Patients must be competent and alert at the time of counseling
- Service is provided by a qualified primary care provider in a primary care setting

Primary Care

- Family Medicine, Geriatrics, General Practice
- Internal Medicine
- OB
- Pediatrics
- Mid-level practitioners (NP, PA, CNS)
- Cannot be provided by any other specialty or referred for this service by another specialty
- Locations – must be an outpatient setting (clinic, hospital outpatient, physician office, state or local public health clinics)

Specifics

- 22 visits in 12 month period
- 1 visit per week in first month
- 2 visits per month through month 6
- At month 6 – must document weight loss in physician office record.
 - If has lost 3 kg (6.6 lbs) at that point, the patient can continue to be seen for this service through month 12
 - If has not – needs to wait 6 months and be reassessed by physician & if deemed appropriate, can start again
- Months 7 through 12 – seen once a month

Specifics continued

- Is an annual benefit – so can begin again if BMI is still ≥ 30
- BMI must be documented by using a ICD-9 V-Code that corresponds to the BMI (or ICD-10 Z-code)
- Patient has no copay or deductible

Providing the service

- Can be provided by auxiliary staff under the supervision of a primary care provider
- “Incident to” billing requirements
- Requires a PC provider be on-site at the time the service is being delivered by auxiliary staff
- Service can be provided via telehealth, but if done this way by auxiliary staff, a PC provider must still be on-site where the auxiliary staff is providing the service to the recipient.

USPSTF's 5A's approach for each encounter

- **Assess** – factors affecting choice of behavior change goals or methods
- **Advise** – provide clear, specific and personalized behavior-change advice
- **Agree** – collaboratively select treatment goals

Assist and Arrange

- **Assist** – using behavior change techniques, help the patient achieve their agreed-upon goals by acquiring the skills, confidence, social and environmental supports for change
- **Arrange** – schedule follow-up contacts. Provide ongoing support – changing treatment plan as needed. May include referral to more intensive or specialized treatment

G0447 (HCPCS code)

- Face-to-face behavioral counseling for obesity, 15 minutes



Unknowns...

- Description of the service did not specify if could be done in a group or individually
- Could you bill for more than one “unit” of service since the description says “15 minutes” if saw the recipient for 30 , 45 or 60 minutes

Dietitians Providing this service “incident to”

- Does the patient need to be seen by the referring provider at the 6 month visit to document the weight loss to allow us to continue seeing the patient from months 7 to 12?
- As the BMI changes, should the V-code be changed?
- Patients were referred from Primary Care providers or mid-levels. Electronic referral was developed.

Lessons learned

- Our MAC advised that we should bill for 2 units of this service if saw the patient for 30 minutes. However...
 - Any claim submitted with more than one unit of G0447 was denied. Reason was that more than one of this service could not be provided per day.
- This service cannot be provided on the same day where another office visit or E/M service is provided – but can be provided on the same day as Preventative Exam, DSMT, MNT

Lessons Learned continued

- Created a template for documentation designed around the 5 A's recommended by the USPSTF
- Tried to get physicians to include V-Code in referral, but this was rarely done
- Numbers of patients referred increased rapidly as word spread - - even without any promotion of the service
- Route all notes back to referring provider
- Include in documentation the on-site provider for each day for each clinic where dietitians are providing this service

Sought clarification from CMS

- Was hearing from others across the country that if they updated the V-Code for BMI as weight changed, services were denied once BMI went below 30
- CMS did respond (after a couple of months) that the V-Code submitted with the claim should be the initial V-Code when the service started.

Realities...

- How *INTENSIVE* can this service be if limit a visit with the patient to 15 minutes??
- Need at minimum a 30 minute time allowed
- Documentation of the 5 A's takes time, so each visit also took additional time to complete documentation
- Dietitians had to monitor visits and when the 6 month time was approaching – assure that the patient lost 3 kg or more

Realities continued

- As the number of these patients increased, access to dietitians for other MNT & DSMT became difficult
- Revenue from this service is poor – so financially, displaces potential MNT revenue, which is much better
- As with all weight loss, some patients quit after a few months
- “Snow birds” presented some challenges with timing of visits
- Not all patients are able to lose 3 kg by 6 months

Positives

- Some patients have done very well - - especially if they were seen for the maximum visits allowed in a year
- Improved BG, Lipids and blood pressure in these patients have increased referrals even more
- No show rate is less with this group

BG Control and Hypertension or Lipid Disorders

- Patients with poor BG control – dietitians could also work on food choices to enhance BG control
- Hypertension or Lipid disorders – Medicare does not cover MNT for these diagnoses. RDs could also work in food and exercise strategies to benefit these health conditions



As of January 1, 2015

- Medicare will cover IBT provided in a group setting
- Unsure of \$\$ covered
- Assumes a 30 minute group class
- Should improve access if fewer visits are individual
- Can provide some structure with topics



HCPSC code G0473

Adult Weight Loss Program

S9470 – “Nutrition Counseling”

- Structured visits similar to the Medicare IBT
- Visits with the dietitian every other week then monthly over time
- Family Practice physician medically manages patients
- Psychology led behavioral groups

G0447 - IBT

- Individual visits with RD every other week until month 6, then monthly after that
- Can participate in group classes if desire (self pay)
- Can attend Psychology led classes – Medicare covers
- Sees same FP physician and is medically managed

Billing compliance advice:

- If we provide the same service and bill the same fee, we can use the G0447 code for Medicare recipients and the S9470 code for private insurers or self pay
- **G0447= S9470 (Nutrition Counseling)**
- With the new G0473 groups covered, these patients can go into the existing group classes for the same fee as the privately insured patients. Now there will be no copay or fee for the Medicare patients.
- **G0473 = S9449 (Nutrition Class)**

Results

- Since starting to track these patients in our electronic patient record – we have seen 380 patients since 7/2013. This does not include patients in seen in our AWLP.
- On average, we see 115-120 unique patients per month for IBT
- Most patients reach the 3 kg weight loss by 6 month, but some do not
- For those in the program for a year or more –wt loss has been between 10-30 lbs or more

Challenges

- Tracking results electronically. One incorrect weight entered in ER or other clinic area can skew results
- Need to separate results of those patients who have completed the year versus those who have just started or only attended a few sessions before quitting
- Scheduling enough classes to handle volume (ie: need at least 10-12 classes for 110-120 patients per month)
- Increasing staff as demand increases

Challenges continued

- Curriculum is defined for Adult Weight Loss Program, but not a set curriculum for the IBT only recipients
- Will likely use class curriculum from AWLP for the IBT only patients as well
- Ideally, incorporate exercise specialists
- Outcome data – share with Medicare and other payors to demonstrate effectiveness of ancillary staff when working with these patients - - MDs still need to refer and, ultimately, are still the care coordinators for their patients

Questions??

Thank you for your time today

References

- **DHHS – CMS: Intensive Behavioral Therapy (IBT) for Obesity - ICN 907800
January 2014**
- **Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N)**
<http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253&>
- Bleich SN, Bennett WL, Gudzone KA, et al. National survey of US primary care physicians' perspectives about causes of obesity and solutions to improve care. *BMJ Open* 2012;2:e001871. doi:10.1136/bmjopen-2012-001871