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- Certificates will be emailed out to you within two weeks

Medicare's Intensive Behavioral Counseling for Obesity Benefit: Coding, Coverage and Conditions for Payment



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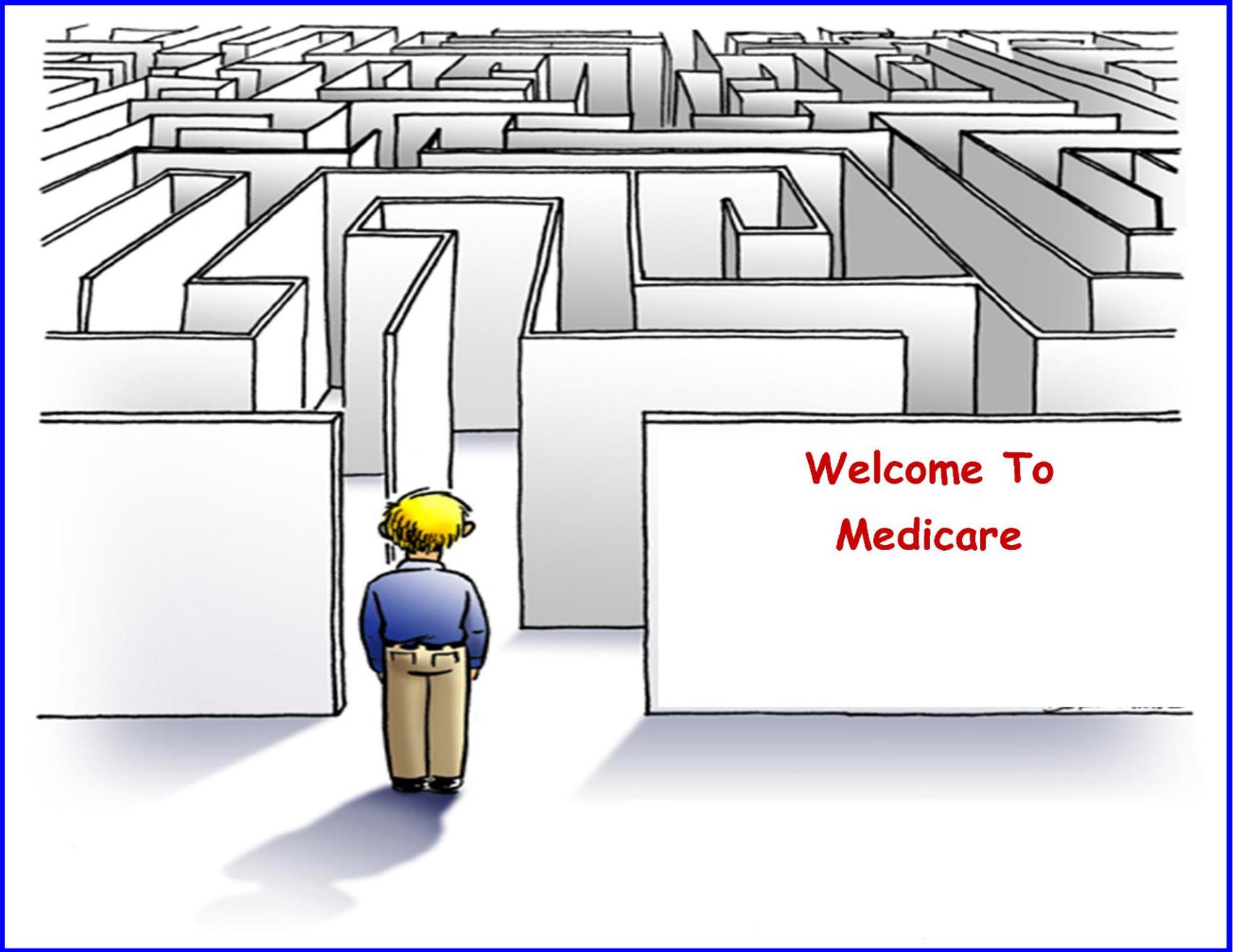
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Learning Objectives

1. For the Medicare Intensive Behavior Therapy (IBT) for Obesity benefit, name:
 - A. Minimum BMI for beneficiary eligibility
 - B. Procedure code to input on claims
 - C. Maximum amount of time allowed per visit
 - D. Total number of visits allowed per 12 months
 - E. How much weight must be lost in months 2 – 6 for beneficiary to receive IBT in months 7 – 12
 - F. Type of billing that must be used in which provider's NPI number is inputted on claim



**Welcome To
Medicare**

I Promise I Won't Put You to Sleep!



Obesity Defined

“Obesity is a complex, multi-factorial, chronic disease that develops from the interaction of the genotype and the environment and consists in excessive accumulation of fat tissue.”¹



1. **Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, the NIH, National Heart, Lung and Blood Institute , 98-4083, Sept. 1998**

The Economist

DECEMBER 13TH-19TH 2003

www.economist.com

Gore anoints Dean

PAGES 12 AND 33

America's Taiwan test

PAGES 12 AND 29

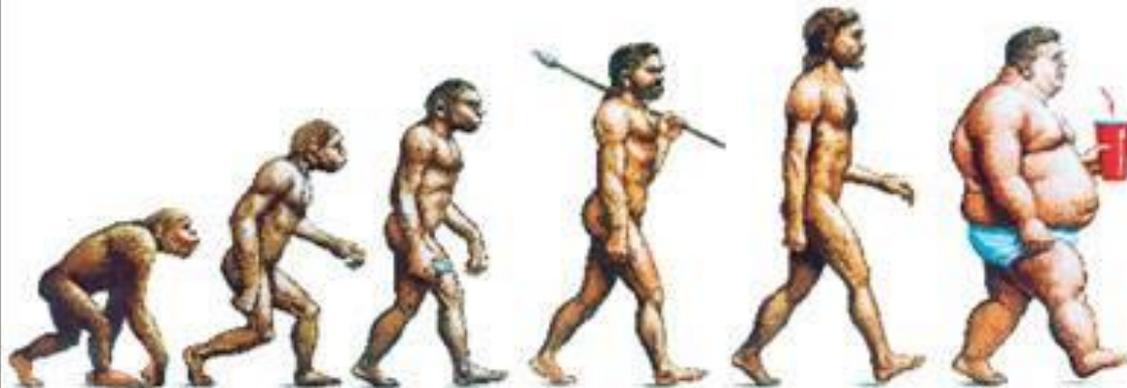
The future of flight

PAGES 79-81

A SURVEY OF FOOD

AFTER PAGE 52

The shape of things to come



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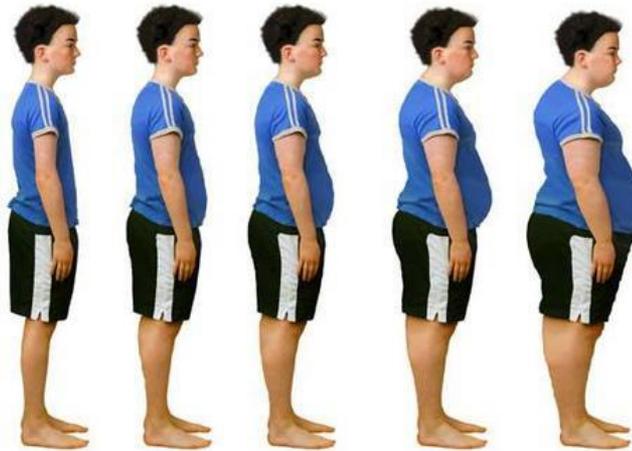
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Prevalence of Overweight and Obese Adults in U.S.

Most recent NHANES data¹ show that:

- 34.2% of Americans are overweight
- 33.8% are obese



1. J Am Med Assoc 2010;303:235-241

Medical Complications of Obesity¹

Pulmonary disease:

Abnormal function
Obstructive sleep apnea
Hypoventilation syndrome

Idiopathic intracranial hypertension

Stroke

Cataracts

Nonalcoholic fatty liver disease, Cirrhosis

Coronary heart disease

Diabetes

Dyslipidemia

Hypertension

GERD

Pancreatitis

Gall bladder disease

Cancer:

Breast, Uterus, Cervix
Colon, Esophagus, Pancreas
Kidney, Prostate

Gynecologic abnormalities:

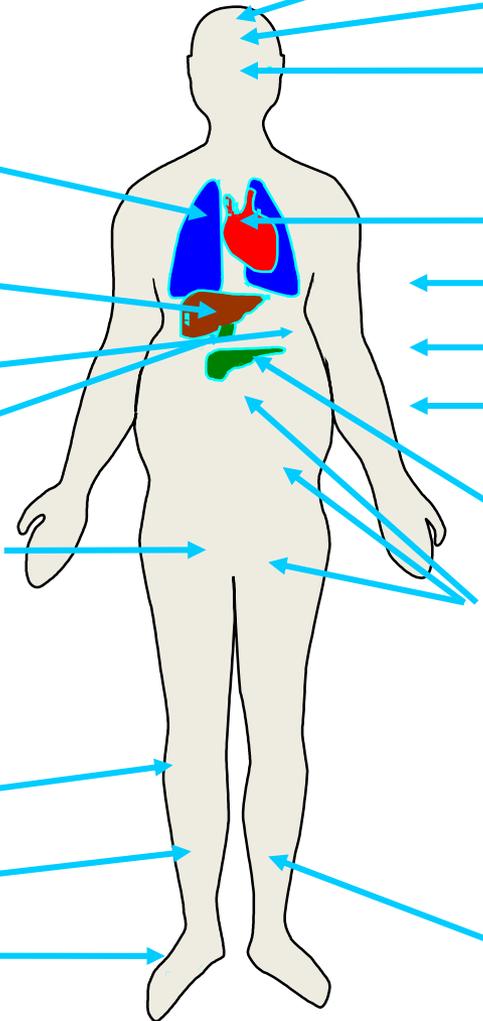
Abnormal menses
Infertility
Polycystic ovarian syndrome

Osteoarthritis

Phlebitis
venous stasis

Skin

Gout



Fertilizer for IBT for Obesity Benefit (IBT for OB)

- PCPs do not consistently address obesity
- Barriers cited by PCPs to treating obesity:^{1,2,3,4}
 - Inadequate or no reimbursement (long cited)
 - Inadequate time
 - Perception that pt lacks motivation for behavior change
 - Provider lacks confidence...and training...in obesity management

- ***Dozens*** to ***hundreds*** of studies show that **intensive weight loss counseling** **is** effective, including these 2 large trials:
 - Diabetes Prevention Program (DPP)¹
 - Look AHEAD Study²
- Medicare has thus determined that obesity treatment and management should be delivered and reimbursed in primary care setting

1. DPP Research Group, NEJM, 2002

2. Look AHEAD Research Group, Arch Intern Med, 2010

U.S. Preventive Services Task Force Recommendation (2003, Grade B)

- USPSTF recommends that clinicians:
 - Screen all adult pts for obesity
 - If obese (**BMI \geq 30 kg**):
 - Offer or refer pt for intensive weight loss counseling and behavioral interventions to promote sustained weight loss

U.S. Preventive Services Task Force Recommendation (2003, Grade B)

- Found fair to good evidence that high-intensity counseling on **diet + exercise** can produce sustained weight loss (3-5 kg for ≥ 1 year) in obese adults
- High-intensity = key behavioral interventions:
 - Skill development
 - Motivation
 - Support strategies

3 Basic Services of Medicare IBT for OB

- Benefits for prevention and early detection of obesity consisting of **3 basic services**:
 1. Screening for obesity in adults using measurement of BMI
 2. Dietary (nutritional) assessment
 3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on:
 - Diet
 - Exercise

Medicare IBT for OB

- Effective November 29, 2011
- For screening and intensive behavioral counseling for obesity
- Key elements of coverage:
 - Furnished by PCPs, or by auxiliary personnel
 - Furnished in **primary care** settings for Medicare beneficiaries with BMI ≥ 30 kg/m²

2012 USPSTF Update for Medicare IBT for Obesity Benefit

- PCPs to offer or refer pts with **BMI \geq 30 kg** to intensive, multi-component behavioral interventions (Grade B recommendation):
 - Behavioral therapy activities (e.g. goal setting)
 - Nutrition counseling
 - Increasing physical activity
 - Addressing barriers to change
 - Self-monitoring
 - Motivation
 - Strategizing how to maintain lifestyle changes

Frequency of IBT for Obesity (OB)*

- Limit of 22 **individual** and/or **group** visits (any combination) in initial 12-month period, counted from date of 1st claim; can be repeated **annually**
- 1x/week, face-to-face, during 1st month
- 2x/month...every other week...months 2-6 (intensive)
- 1x/month for months 7 – 12... but only **IF**
 - Patient loses ≥ 3 kg (≥ 6.6 lbs) in months 2 – 6
 - Wt loss in months 2 – 6 to be documented in MR for reimbursement of visits in months 7 – 12

*Meets USPTF criteria for “**intensive**” intervention

New: Individual **AND** Group Codes for Intensive Behavioral Therapy for Obesity

- Claims coding:
 - **G0447**: Face-to-face behavioral counseling for obesity, **individual**, each 15 minutes
 - **G0473**: Face-to-face behavioral counseling for obesity, **group** (2–10), 30 minutes

New: Individual **AND Group** Codes for Intensive Behavioral Therapy for Obesity

- Group services must still be furnished in compliance with existing criteria for IBT for obesity benefit.
- Can find Medicare local payment rates for codes on CMS Physician Fee Schedule look-up portal at:
www.cms.gov/apps/physician-fee-schedule/overview.aspx

IBT for Obesity to be Consistent with 5-A Framework

- 1. Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods
- 2. Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits
- 3. Agree:** Collaboratively select appropriate treatment goals and methods based on patient's interest in and willingness to change the behavior

IBT for Obesity to be Consistent with 5-A Framework

- 4. Assist:** Using behavior change techniques (self-help and/or counseling), aid patient in achieving agreed-upon goals by acquiring skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate
- 5. Arrange:** Schedule follow-up contacts (in-person or by telephone) to provide ongoing assistance or support and to adjust treatment plan as needed, including referral to more intensive or specialized treatment

What To Do When Beneficiary Does **NOT** Lose 3.3 kg (6.6 lbs) in Months 2 - 6

- Must **wait** for 6-month period
 - Cannot furnish IBT for OB during this time
- At 6 months, reassess readiness to change and BMI
- If pt criteria met for IBT for OB, can **re-administer** first 6 months of benefit
- As can only receive 22 visits in 12-months, restart date to be at least 12 months from **original** start date

Beneficiary Eligibility Requirements

- BMI ≥ 30 kg/m²
- Has Part B insurance
- Must be present at time of counseling
- Competent and alert at time counseling provided

Medicare Billing Requirements

- Benefit must be furnished in **primary care setting** by:
 - Qualified primary care physician (PCP), or
 - Qualified non-physician practitioner (mid-level), or
- BUT, per CMS, benefit may be covered if also furnished by PCP's **auxiliary personnel**
 - **RDs** consider auxiliary personnel to furnish benefit **“incident to”** PCP's services

DOG: “Are We Done Yet?”

CAT: “NO!”



Definition of **Primary Care** Setting

- Place where integrated, accessible health care services provided
- Services provided by clinicians who:
 - Address large majority of personal health care needs
 - Develop sustained partnership with patients
 - Practice in context of family and community

Excluded Places of Services, as are NOT **Primary Care** Settings, Per CMS

- Emergency departments
- Inpatient hospital settings
- Ambulatory surgical centers
- Independent diagnostic testing facilities
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Hospices
- Beneficiaries' homes

Approved Places of Service/Locations

- Places of service (POS) and POS codes:
 - 11 = Physician's Office
 - 22 = Outpatient Hospital
 - 49 = Independent Clinic
 - 50 = Federally Qualified Health Center
 - 71 = State or Local Public Health Clinic
 - 72 = Rural Health Center
- **Telehealth** IBT for OB
 - As of **Jan. 1, 2013**, can be furnished via telehealth; must meet all CMS requirements

Eligible PCPs Who Can Bill Medicare Directly

Licensed **physicians** who are Medicare providers:

- 01 = General Practice
- 08 = Family Practice
- 11 = Internal Medicine (endocrinologists can designate Internal Medicine as specialty type)
- 16 = Obstetrics/Gynecology
- 37 = Pediatric Medicine
- 38 = Geriatric Medicine

Licensed **qualified non-physician practitioners** who are Medicare providers:

- 50 = Nurse Practitioner
- 89 = Certified Clinical Nurse Specialist
- 97 = Physician Assistant

CMS' Rationale for **Not Including RDs as Providers**

CMS believes:

1. It lacks statutory authority to include RDs as providers outside of diabetes and ESRD
2. Important that preventive services be furnished in a coordinated approach as part of comprehensive prevention plan within context of patient's total health care
 - Thus, primary care practitioners best qualified to offer care in this context

Billing and Coding for IBT for OB

- Procedure codes:
 - **G0447**: Face-to-Face Behavioral Counseling for Obesity, **Individual**, each **15** Minutes
 - **G0473**: Face-to-Face Behavioral Counseling for Obesity, **Group** (2–10), each **30** Minutes
- Type of service (TOS) code = 1
 - G0447 must be billed along with 1 of:
 - ICD-9 codes for BMI ≥ 30.0 :
 - V85.30-V85.39, V85.41-V85.45, or
 - ICD-10 codes for BMI ≥ 30.0 :
 - Z68.30-Z68.39, Z68.41- Z68.45 (Oct, 2014)

Billing and Coding for IBT for OB

- Re: billing **multiple** units on same day:
 - Per ***Medicare Claims Processing Manual¹, 200.1: Policy (Rev. 3160, Issued: 01-07-15, Effective: 01-01-15, Implementation: 01-05-15)***, Medicare benes eligible for:
 - 1 face-to-face visit every wk for first month
 - 1 face-to-face visit every other wk for months 2-6
 - 1 face-to-face visit every month for months 7-12, BUT only if beneficiary lost 6.6 lbs (3 kg) by end of 6th month: think “6..6..6”

Billing and Coding for IBT for OB

- Furnishing and billing **multiple** 15 min. and 30 min. units on same day:

– Per *Medicare Claims Processing Manual*¹, Chapter 18 - Preventive and Screening Services (Rev. 3159, **12-31-14**):

- Can only bill 1 unit of code/beneficiary/visit
- Effective for claims with dates of service on or after January 1, 2015, codes G0473 and G0447 can be billed for a total of no more than **22 sessions in a 12-month period.**

1. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>

Billing and Coding for IBT for OB

- When applying frequency limitations, MACs count 22 counseling sessions for any combination of **G0473** and/or **G0447** (for total of no more than **22 sessions** in **same 12-month period**) along with 1 ICD-9 code from V85.30-V85.39 or V85.41-V85.45 in consecutive 12-month period.¹
- For G0473 or G0447: MACs allow both a claim for the **professional service** and a claim for a **facility fee**

1. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>

Billing and Coding for IBT for OB

- For further interpretation of these frequency limitation guidelines, can contact your regional **Medicare Administrative Contractor (MAC)**
- **MACs** are allowed to make “*local coverage decisions*” with regard to benefit’s coverage guidelines....and this may include allowing more than 1 unit of these codes to be billed on same day.

Billing and Coding for IBT for OB

- About **MACs**:
 - CMS contractor that performs all Part A and Part B fee-for-service claims administration services
 - Will eventually replace Part A fiscal intermediary and Part B carrier in geographical jurisdiction area
 - Not all states have transitioned to MACs yet
 - Websites for list of MACs:
 - <http://www.entnet.org/Practice/MAC-websites.cfm>
 - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html#il>

ICD-9 and ICD-10 Codes and BMI Range

V85.30	=	30.0 - 30.9
V85.31	=	31.0 - 31.9
V85.32	=	32.0 - 32.9
V85.33	=	33.0 - 33.9
V85.34	=	34.0 - 34.9
V85.35	=	35.0 - 35.9
V85.36	=	36.0 - 36.9
V85.37	=	37.0 - 37.9
V85.38	=	38.0 - 38.9
V85.39	=	39.0 - 39.9
V85.41	=	40.0 - 44.9
V85.42	=	45.0 - 49.9
V85.43	=	50.0 - 59.9
V85.44	=	60.0 - 69.9
V85.45	=	≥70.0

ICD-10 Codes:

Z68.30 to Z68.39

Z68.41 to Z68.45



QUESTIONS
?



Medicare Payment for IBT for OB

- **PCPs:**
 - Paid via Medicare Physician Fee Schedule (MPFS)
- Rates adjusted based on:
 - Geographical location in U.S., and
 - Place of service
 - Reflects relative differences among costs
- Can find your MPFS payment rate on CMS website:
www.cms.gov

Coinsurance and Part B deductible waived!

Medicare Payment for IBT for OB

- **Institutional** claims submitted by **hospital OP depts:**
 - Paid under **Outpatient Prospective Payment System** (OPPS)....but:
 - Only on Type of Bill (TOB) 13x (= hospital OP)
 - Likely will result in higher payment amount
 - For G0447 code:
 - Ambulatory Payment Classification (APC) code = 0432
 - Status indicator = 0432

Medicare Payment for IBT for OB

- **Rural Health Clinics** (TOB 71x)

and

- **Federally Qualified Health Centers** (TOB 77x)

claims:

- Paid under **Part A** “all-inclusive payment rate”
- Code G0447 and G0473 reported on separate service line to ensure coinsurance and deductible **not** applied to service

Medicare Payment for IBT for OB

- Following **institutional claims** identified as **facility fee claims** for this service:
 - TOB 13x (hospital OP)
 - TOB 85x (critical access hospital)
 - BUT only when **revenue code** is **NOT**:
 - 096x = professional fees
 - 097x = professional fees
 - 098x = professional fees

Medicare Payment for IBT for OB

- All other claims are identified as **professional service claims**
 - **No facility fee billing** is allowed or paid by Medicare on these types of claims

Medicare Payment for IBT for OB

- **Critical Access Hospitals** (CAHs) - TOB 85x – based on **reasonable cost**:
 - TOB 85x....CAH Method II...based on 115% of lesser of Medicare Physician Fee Schedule amount or actual charge, applicable with revenue codes:
 - 096X
 - 097X
 - 098X

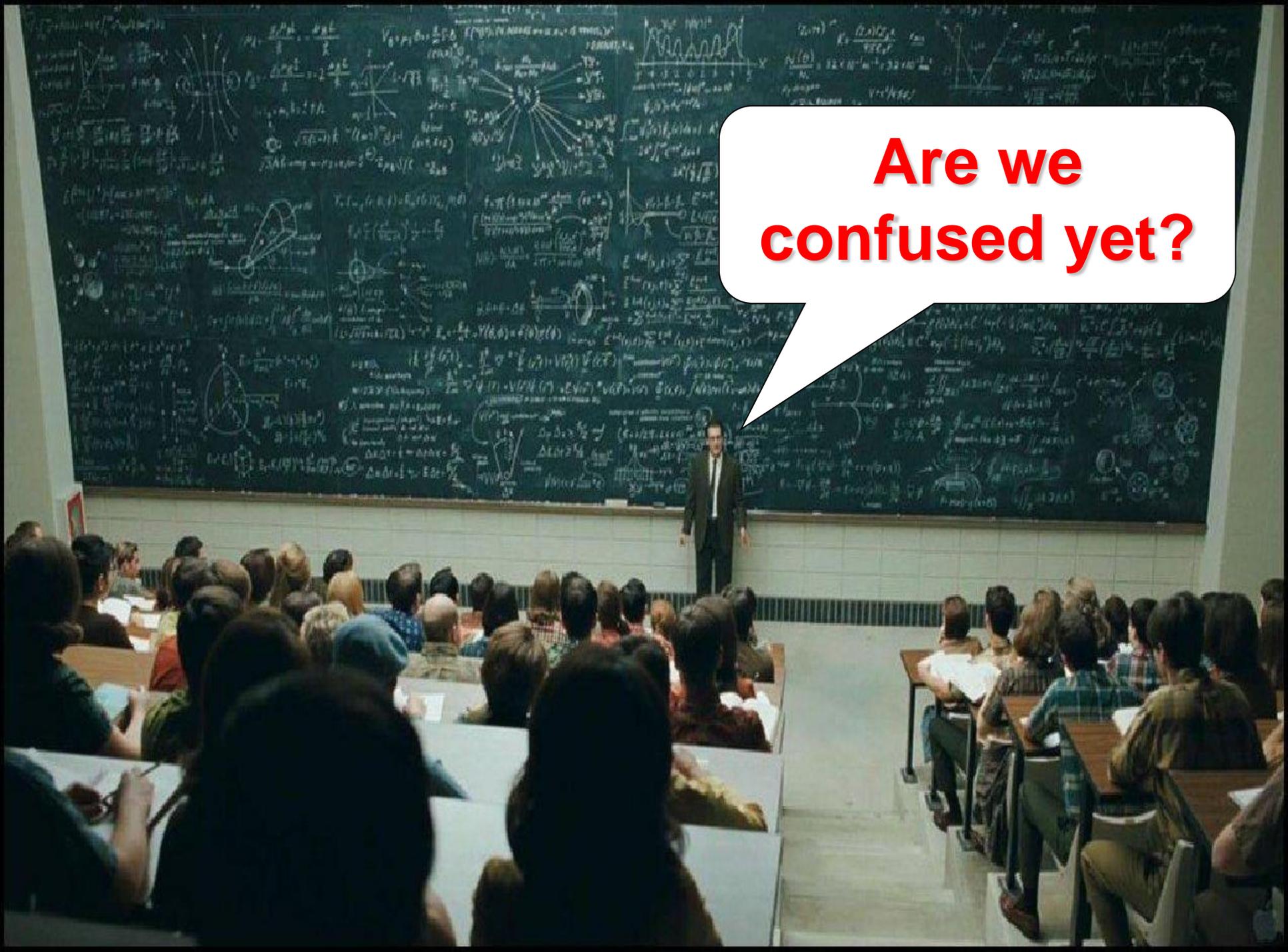
Medicare Payment for IBT for OB

- Benefit **NOT** separately payable with another PCP encounter/visit on **same** day

BUT

- **CAN** be furnished on **same** day with 1 of these benefits....and **is** separately payable:
 - **Initial Preventive Physical Exam**
 - **Modifier 59**
 - **DSMT**
 - On **77x claim (Federally Qualified Health Center)**
 - **MNT**
 - On **77x claim (Federally Qualified Health Center)**

**Are we
confused yet?**



Medicare Reimbursement Rates

- **2015 national unadjusted* payment rates:**

- **G0447**, one 15 minute unit, individual visit

- **Non-facility:** \$26.10.....**Facility:** \$23.96

- **G0473**, one 30 minute unit, group visit

- **Non-facility:** \$12.51.....**Facility:** 11.80

- *Actual payments to individual clinicians vary according to geographic adjustments factors

- Example: **22 individual visits x \$25 = \$574.20**

Can Physicians/PCPs Afford to Furnish IBT for OB Themselves?

- Most likely not.....why?
- Packed physician/PCP appointment calendars
- Reimbursement rates not as high as for regular primary care office visit
- Creates **golden opportunity** for **RDs*** able to work **“incident to”** a physician/PCP to provide benefit

*** and RNs**

Benefit Can Be Furnished by **Auxiliary** Personnel

- Can be furnished by **auxiliary personnel** (e.g., RDs)
- To be billed as **incident to physician services** (ITPS)
 - Medicare's ITPS rules apply¹
- Auxiliary personnel = individual who is:
 - Acting under PCP's direct supervision
 - Employee, leased employee or independent paid contractor of PCP, or of legal primary care entity that employs/contracts with PCP

More About Medicare “Incident To” Services

- RDs can be considered auxiliary personnel for providing these Medicare Preventive Services:
 - Intensive Behavioral Therapy for Obesity
 - Intensive Behavioral Therapy for CVD
 - Annual Wellness Visit



More About Medicare “Incident To” Services

- PCP bills for RD (auxiliary personnel) services as **“incident to”** physician services under physician’s or mid-level’s NPI #
 - RD cannot bill Medicare directly for benefit
- All **“incident to”** rules to be followed by PCP + RD
 - Rules vary per practice setting

More About Medicare “Incident To” Services

Service must be:

- Integral, although incidental, part of PCP’s professional service
- Commonly rendered without charge or included in PCP’s bill
- Of type commonly furnished in PCP offices, clinics
- Furnished by PCP or by auxiliary personnel under PCP’s supervision
- **Established** patient visit

More About Medicare “Incident To” Services

- Specific guidelines for billing “incident to” (IT) services vary based on *practice setting*
- If paid through Medicare **Physician Fee Schedule**:
 - IT guidelines for **primary care office** setting apply
- If paid through Medicare **Outpatient Prospective Payment System (OPPS)**
 - IT guidelines for **OP hospital rules** apply

“Incident To” Rules in Primary Care Setting

- “Direct supervision” rule:
 - PCP must be present in office suite and immediately available to provide assistance and direction at time auxiliary personnel performs service
 - PCP need **not** be present in room where service is performed

Source: 42 CFR §410.26(b); 42 CFR §410.32(b)(3)(iii); 42 CFR §410.26(b)(5)

“Incident To” Rules in Primary Care Setting

- Supervising physician does **not** need to be same PCP upon whose professional service “incident to” service based
 - One PCP in group practice can supervise all services performed in office on any given day where patients are under care of any of group’s PCPs



“Incident To” Rules in Primary Care Setting

- Billing done under **physician’s or mid-level’s NPI**
- Payment sent to referring PCP:
 - Physician
 - Mid-level: CNS, PA, NP
 - Facility to which physician or mid-level (PCP) reassigned his/her Medicare reimbursement
- RD paid under previously established agreement with PCP or practice

Source: 42 CFR §410.26(b); 42 CFR §410.32(b)(3)(iii); 42 CFR §410.26(b)(5)

“Incident To” Rules in OP Hospital Setting

- Under the 2011 **Outpatient Prospective Payment System** rule, all hospital outpatient therapeutic services provided “incident to” a PCP service require direct supervision by PCP
- Direct supervision for therapeutic outpatient services is defined as ***“immediately available to furnish assistance and direction throughout the performance of procedure.”***

“Incident To” Rules in OP Hospital Setting

- No defined special requirement for supervision
- Most hospitals establish own policies regarding supervision of therapeutic OP services
- So before providing “incident to” service, RDs to be familiar with hospital’s policies and ensure that supervision requirements met



“Incident To” Rules in OP Hospital Setting

- PCP must:
 - Be involved in management of specific treatment
 - See patient periodically and sufficiently often to assess progress
 - Reassign Medicare reimbursement for benefit back to facility
- Billing done under PCP’s NPI #
- Payment goes to facility to which PCP has reassigned his/her Medicare reimbursement



QUESTIONS?

Studies on Treating Obesity in Primary Care

Weight Loss as Outcome

- Appel¹
 - Usual care: 0.8 kg
 - Telephone intervention: 4.6 kg
 - Telephone intervention + **in-person support**: **5.1 kg**
- Wadden²
 - Usual care: 1.7 kg
 - Monthly counseling: 2.9 kg
 - Enhanced counseling (**meal replacement or meds**): **4.6 kg**

1. Appel, NEJM, 2011

2. Wadden, NEJM, 2011

Studies on Treating Obesity in Primary Care

- Bennett³
 - Usual care: 0.5 kg
 - IVR*/web intervention with optional **in-person** sessions: **1.5 kg**

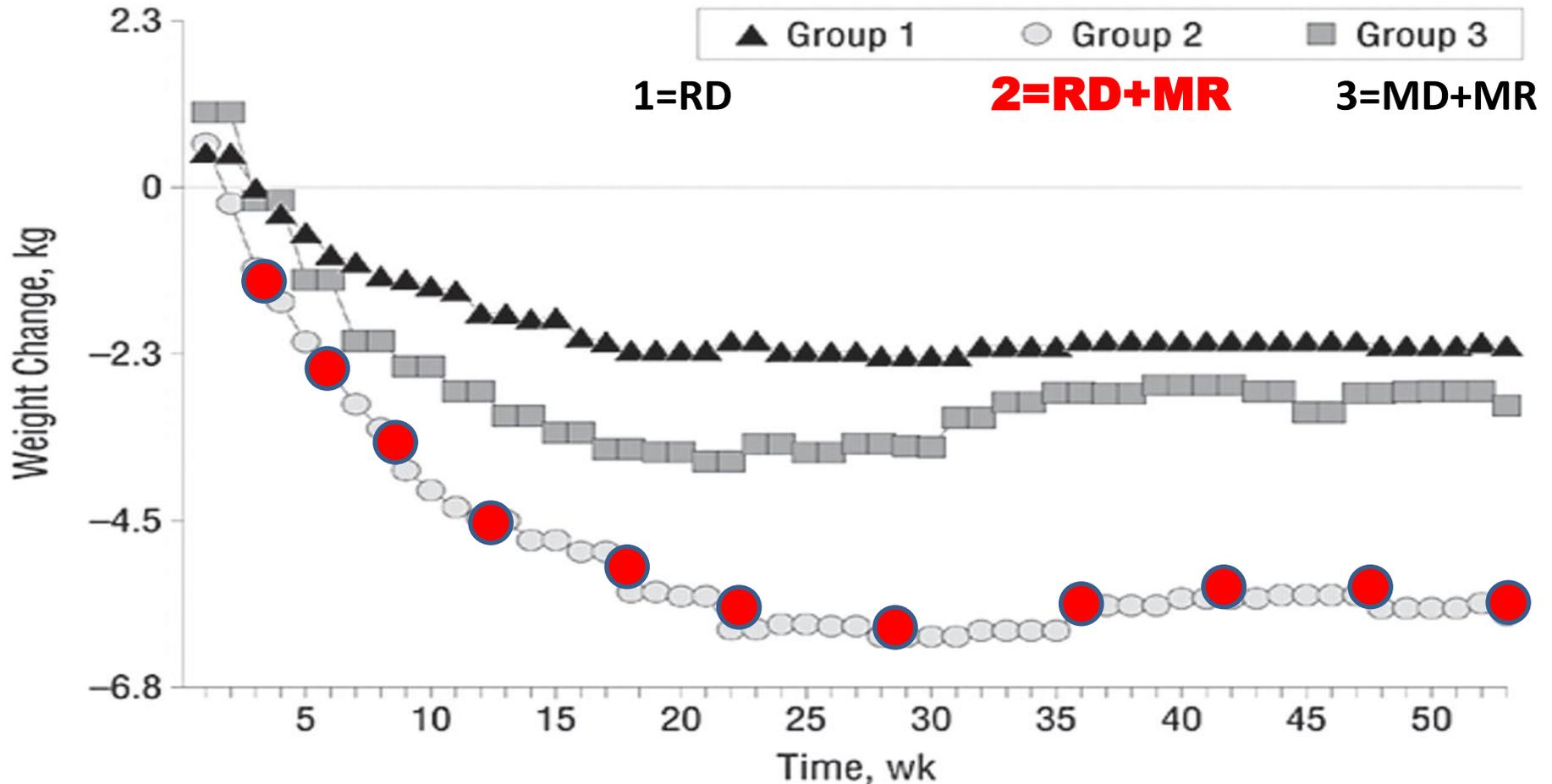
*Interactive Voice Response

Studies on Treating Obesity in Primary Care

Treatment Type ¹	Weight Loss
PCP treatment alone (4 studies)	0.6 to 2.3 kg
PCP treatment + pharmacotherapy (3 studies)	3.4 to 7.5 kg
Collaborative treatment (3 studies)	0.2 to 7.7 kg

1. Tsai and Wadden, J Gen Intern Med, 2009

Study: **RD + Meal Replacements (MRs)** More Effective than PCPs and MRs¹



1. Ashley, 2001, Arch Intern Med

Must Have Resource for Treating Obesity

- *2013 AHA/ACC/TOS* Guideline for the Management of Overweight and Obesity in Adults*
 - A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society
 - *Journal of the American College of Cardiology*, 2014, The Expert Panel Members, Elsevier, Vol. 63, No. 25, 2014, ISSN 0735-1097, <http://dx.doi.org/10.1016/j.jacc.2013.11.004>

*AHA = American Heart Association

ACC = American College of Cardiology

TOS = The Obesity Society

SEE
SEPARATE
WORD
DOCUMENT
FOR
LARGER
VIEW
OF
GRAPHIC



AMERICAN
COLLEGE of
CARDIOLOGY

2013
AHA/ACC/TOS
GUIDELINE
FOR THE
MANAGEMENT
OF OVERWEIGHT
AND OBESITY
IN ADULTS

5

POINTS TO
REMEMBER

1 Measure height and weight and calculate body mass index (BMI)

at annual visits or more frequently to identify patients who need to lose weight



▶ Continue use of current cut points to identify adults who may be at increased risk for cardiovascular disease (CVD):

Overweight
(BMI > 25.0-29.9 kg/m²)

Obesity
(BMI ≥ 30 kg/m²)

▶ The obesity cut point should be used to identify adults at increased risk for all-cause mortality.

2 Measure waist circumference

at annual visits or more frequently in overweight and obese adults



▶ Use cut points defined by National Institutes of Health or World Health Organization

3 Overweight and obese adults with CVD risk factors should be counseled that even **modest weight loss** (3 – 5% of body weight) can result in clinically meaningful benefits for triglycerides, blood glucose, glycated hemoglobin, and development of diabetes.



Greater weight loss (> 5%)

can further reduce blood pressure, improve lipids, and reduce the need of medications to control blood pressure, blood glucose, and lipids.

4 A diet prescribed for weight loss is recommended to be part of a comprehensive lifestyle intervention, a component of which includes a plan to achieve reduced caloric intake. Any one of the following methods can be used:

Prescribe

FOR WOMEN:

1,200 -1,500*
kcal/day

FOR MEN:

1,500 -1,800*
kcal/day



Prescribe a
500
kcal/day
or
750
kcal/day

ENERGY DEFICIT



Prescribe one of the **Evidence-Based Diets** that restricts certain food types (such as high-carbohydrate foods, low-fiber foods, or high-fat foods) in order to create an energy deficit by reduced food intake.

*kcal levels are usually adjusted for the individual's body

5 Prescribing a calorie-restricted diet should be based on the patient's preferences and health status, and preferably with a referral to a nutrition professional for counseling.



Patient Education Materials for Obesity Counseling

- Academy of Nutrition and Dietetics' Online Nutrition Care Manual
- Diabetes Prevention Program
- LEARN Manual
 - Lifestyle, Exercise, Attitudes, Relationships, Nutrition by Kelly Brownell, PhD
- National Institutes of Health
- USDA

Business Models for PCP and RD Partnership to Furnish Medicare's IBT for OB

- Traditional Employee (TE)
- Independent Paid Contractor (IPC)...aka, freelancer
- Independent Private Practitioner (IPP)
- Combined IPC and IPP
 - Independent Paid Contractor, and
 - Independent Private Practitioner

Traditional Employee (TE)

- RD paid hourly rate
- Typically does receive benefits
- Practice bills for RD services, retains reimbursement



Independent Paid Contractor (IPC)... aka, Freelancer

- RD not employee, typically does not receive benefits
- Practice bills for RD services, retains reimbursement
- Negotiates business contract to deliver services for:
 - Specific number of pts in specific time period, OR
 - Payment rate per patient seen
- Rate higher than TE hourly rate to compensate mainly for no benefits received
- ↑ RD autonomy and flexibility in setting own schedule and thus can more easily practice in other entities

Independent Private Practitioner (IPP) for **MNT**

- RD has own private practice, so is IPP
- Is credentialed provider with private payers to furnish **MNT**
- Bills payers for MNT and receives reimbursement
- As IPP:
 - Can also opt to furnish **MNT** in PCP office
 - Can negotiate contract with PCP to do
 - Pay **fair market value** rent to PCP for space occupied during **MNT** patient visits as PCP's compensation

Example of Dual Model: Independent Private Practitioner (IPP) and Independent Paid Contractor (IPC)

- As **IPP**:
 - Furnishes MNT in PCP office
 - Bills Medicare and private payer under own NPI #
 - Keeps reimbursement
 - Pays fair market value rent to PCP

Example of Dual Model: Independent Private Practitioner (IPP) and Independent Paid Contractor (IPC)

- As **IPC**:
 - Furnishes **IBT for OB** in PCP office
 - PCP bills Medicare under own NPI # as **incident to**
 - PCP keeps reimbursement
 - PCP pays RD negotiated hourly rate or per pt rate

STILL Not Done ???



Steps to **P.R.O.M.O.T.E. Y.O.U.** to Furnish Medicare IBT for OB !

P	P ursue Medicare provider status
R	R etain your own legal business entity in state (LLC, corporation, partnership, etc.) R ead “ <i>Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership (A.N.D. Toolkit)</i> ”
O	O btain own website. O ptimize fact that you are wt management expert. O btain own contract with provider; 1 st research info on art of negotiation and elements of contract.

- | | |
|----------|--|
| M | M ake sure to ask your Medicare Administrative Contractor (MAC) if: <ul style="list-style-type: none">• Multiple units of G0447 or G0473 code can be billed on same day |
| O | O btain subscription to Academy's online Nutrition Care Manual.
O btain Certificate of Weight Management. |
| T | T ransact detailed Marketing Plan (7 "P"s). Focus on Promotion which includes face-to-face marketing with providers. |
| E | E mphasize with providers in your face-to-face relationship-building meeting the following: |

- Y** Your use of evidence-based:
- Nutrition practice guidelines when furnishing IBT for OB and MNT.
 - Standards of medical care in disease states.

- O** Obesity benefit's coverage guidelines in provider's practice setting and Medicare reimbursement rate.
- O**utcomes from current and previous weight management patients in summary format.

- U** are able to meet needs of provider and nutrition needs of providers' patients.
- U**nderstanding of ***proven*** weight loss strategies, per study results (see previous slides).

In Summary.....For Fun!

*Everywhere people are obese,
There IS a way to make it cease!
Medicare payment now exists,
So RDs must now enlist.*

*Fifteen and thirty minute visits, a big concern.
So MAC's multiple units rule, a must to learn.
More money the "group" visits can bring in.
As Medicare now allows this "win-win"!*

*“Incident to” billing is the way to go,
Provider’s NPI number on the claim to show.
Treating provider must always be around,
When the obesity benefit is going down.*

*IBT benefit is not limited to office PCP,
In hospital outpatient departments it can also be.
FQHC’s and RHC’s.....also are approved,
But payment is different, so don’t be confused!*

*Twenty-two visits in twelve months not to exceed,
But only if weight loss is actually achieved.
Wait.....we must....if loss does not happen,
But do start again, so spirits don't dampen!*

*Two procedure codes now accepted,
But many diagnosis codes not to be neglected.
Documentation is required....you must believe,
If Medicare money you want to receive!*

If weight management is your thing,

Yourself to PCPs do bring!

Others, the IBT benefit, will surely provide,

If RDs decide to sit on the side.

Little by little Medicare does see,

That nutrition in disease control is KEY.

To Medicare ,we thank you now

And for a promising future to be!

**DO YOUR HOMEWORK, BE PREPARED AND
TAKE THE PLUNGE!**



OTHERWISE YOU'RE GONNA FIND YOURSELF UP A CREEK WITHOUT A PADDLE





**I'm
sleepy
after
all that
info!**

EFFECT of INFORMATION OVERLOAD



Disclaimer:

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The information does not necessarily reflect opinions, policies and/or official positions of the Center for Medicare and Medicaid Services, the federal government, state government, private healthcare insurance companies, other companies, corporations, professional associations or individuals. Information contained herein is subject to change by these and other organizations at any moment, and is subject to interpretation by its legal representatives, end users and recipients. Readers should seek professional counsel for legal, ethical, financial and business concerns. The information is not a replacement for the publications of the Academy of Nutrition and Dietetics (e.g., Nutrition Practice Guidelines), the American Association of Diabetes Educators, or like associations, nor for the American Diabetes Association Standards of Medical Care in Diabetes, As always, the reader's and user's clinical judgment and expertise

References

1. Medicare Claims Processing Manual, Chapter 18 - Preventive and Screening Services, Rev. 3159, 12-31-14
2. Intensive Behavioral Therapy (IBT) for Obesity, Medicare Learning Network, DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services, ICN 907800 August 2012, accessed 2-12-13 from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ICN907800.pdf>
2. Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership, publisher Academy of Nutrition and Dietetics, 2013

Obesity Management: A 911 Call to American Healthcare: New CE Course for Registered Dietitians

- AND has collaborated with Nutrition Dimension, division of Gannett Healthcare Group, to contribute content and resources from AND for new CE course aimed at tackling obesity crisis
- 12-hour online CE program, "Obesity Management: A 911 Call to American Healthcare," is now available for RDs
- Goal: educate healthcare providers about causes and consequences of obesity and provide them with tools necessary to implement Medicare-compliant program for Intensive Behavioral Therapy for Obesity, including data collection forms, readiness-to-change questionnaire, food diaries and education handouts.

- **Turn Key Materials for AADE DSME Program Accreditation**
 - *DSME Program Policy & Procedure Manual Consistent with NSDSME (69 pages)*
 - *Medicare, Medicaid and Private Payer Reimbursement*
 - *Electronic and Copy-Ready/Modifiable Forms & Handouts*
 - *Fun 3D Teaching Aids for AADE7 Self-Care Topics*
 - *Complete Business Plan*
- **3-D DSME/T and Diabetes MNT Teaching Aids ‘How-To-Make’ Kit**
 - *Kit of 24 monographs describing how to make Mary Ann’s separate 3-D teaching aids plus fun teaching points, evidence-based guidelines and references*
- **Money Matters in MNT and DSMT: Increasing Reimbursement Success in All Practice Settings, The Complete Guide ©”, 5th. Edition, 2014**
- **Establishing a Successful MNT Clinic in Any Practice Setting ©”**
- **EZ Forms for the Busy RD” ©: 107 total, on CD-r; Modifiable; MS Word**
 - *Package A: Diabetes and Hyperlipidemia MNT Intervention Forms, 18 Forms*
 - *Package B: Diabetes and Hyperlipidemia MNT Chart Audit Worksheets: 5 Forms*
 - *Package C: MNT Surveys, Referrals, Flyer, Screening, Intake, Analysis and Other Business/Office and Record Keeping Forms: 84 Forms*