Reimbursement for Obesity Consultations with Health Care Providers

Tiffany R. Beckman, M.D., M.P.H

Minnesota Medical Association Obesity Task Force Member

Assistant Professor of Medicine, University of Minnesota

Endocrinologist, Weight Management Clinic, University of Minnesota Physicians

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Presentation Overview

- Obesity consultations/counseling
  - Purpose
  - Definition
  - Review of the evidence
  - Conclusions
- Trends in counseling – opportunity for prevention
- Payment policy
- Minnesota’s experience
- Conclusions

Obesity Consultations/Counseling: Purpose

- Purpose: To modify patients' diet and/or physical activity patterns in an effort to lose weight and to improve health
  - *Behavioral interventions* – strategies to help patients acquire the skills, motivations, and support to change their diet and exercise routine.

Source: McTigue K, Harris R, Hemphil B, Lux L, Sutton S, Bunton AJ, Lohr KN. *Screening and Interventions for Obesity in Adults*. Summary of the Evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2003;139(11):933-49.

Obesity Consultations/Counseling: Definition

- Counseling approaches/components – variable
  - Recommendations from physicians on diet and/or exercise changes
  - Behavioral therapy
    - Group or individual
    - Focused on education about diet & exercise, and/or behavioral interventions
    - Varied levels of contact

Source: McTigue K, Harris R, Hemphil B, Lux L, Sutton S, Bunton AJ, Lohr KN. *Screening and Interventions for Obesity in Adults*. Summary of the Evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2003;139(11):933-49.

Obesity Consultations/Counseling: Conclusions

- Counseling has been shown to promote moderate weight loss.
- Multi-component, intensive interventions including behavioral therapy most often leads to weight loss.
- Maintenance strategies help to sustain loss.

Source: McTigue K, Harris R, Hemphil B, Lux L, Sutton S, Bunton AJ, Lohr KN. *Screening and Interventions for Obesity in Adults*. Summary of the Evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2003;139(11):933-49.

NIH Guidelines

- National Institutes of Health (1998): *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: Evidence Report*

  - The guidelines recommend weight loss to lower high blood pressure, to lower high total cholesterol and to raise low levels of HDL or good cholesterol, and to lower elevated blood glucose in overweight persons with two or more risk factors and in obese persons.

  - Conclusion: A combination of diet modification, increased physical activity, and behavior therapy can be effective.

NIH - NHLBI

ICSI

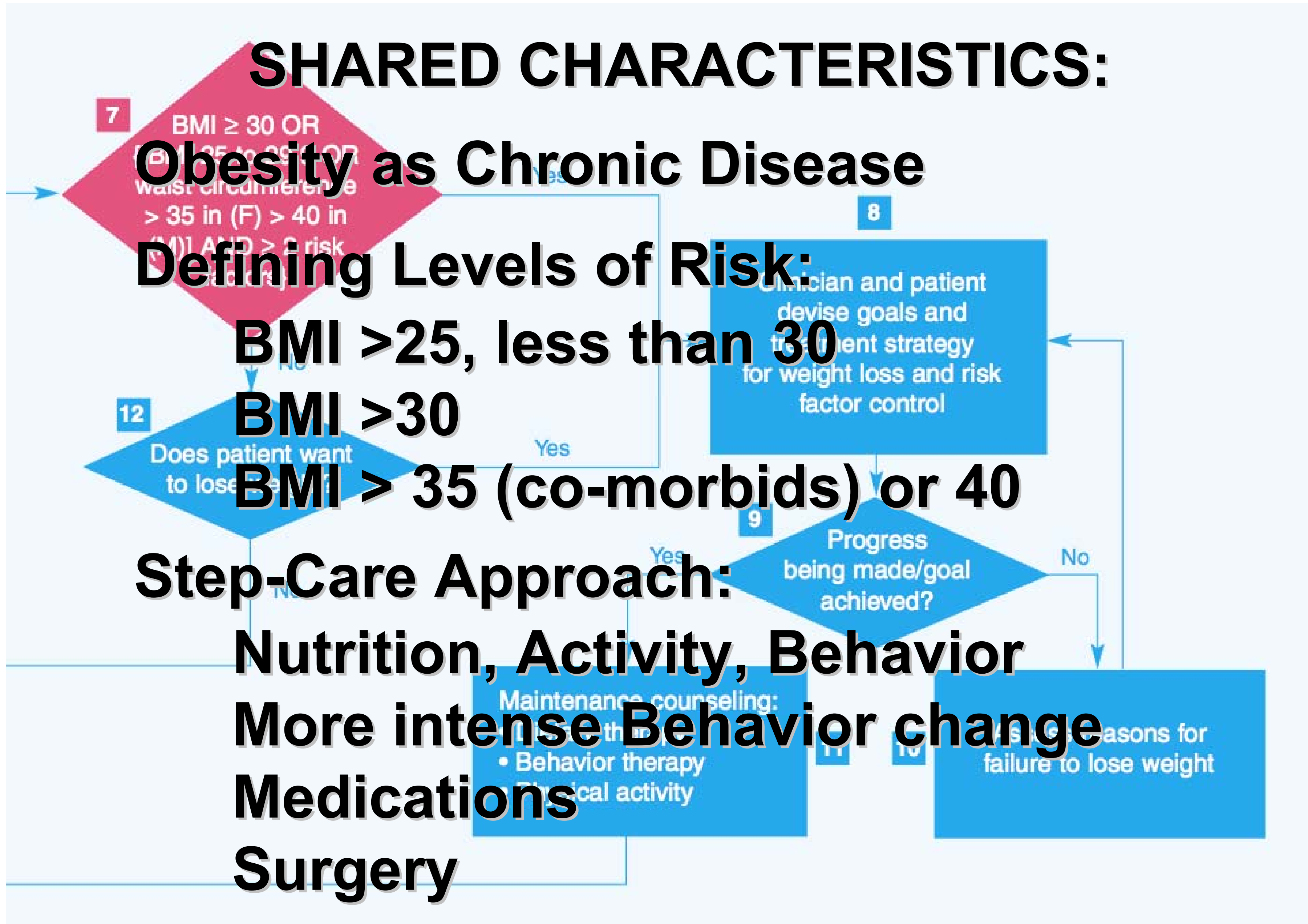
US Preventive Services Task Force

British Public Health Service

Australian Public Health Service

US VA/DOD

Many Health Plans



SHARED CHARACTERISTICS:

Obesity as Chronic Disease

Defining Levels of Risk:

- BMI >25, less than 30
- BMI >30
- BMI > 35 (co-morbids) or 40

Step-Care Approach:

- Nutrition, Activity, Behavior
- More intense Behavior change
- Medications
- Surgery

Guidelines for Intervention

BMI	18.5-24.9	25-29.9	30-34.9	35-39.9	≥40
Risk of complications	Very low	Mild	Moderate	High	Extreme
Nutrition	X	X	X	X	X
Physical Activity	X	X	X	X	X
Behavioral Management	X	X	X+ More Intense	X+ More Intense	X+ More Intense
Medication		X? Orlistat?	X	X	X
Surgery				X	X

Modified from ICSI, 2004

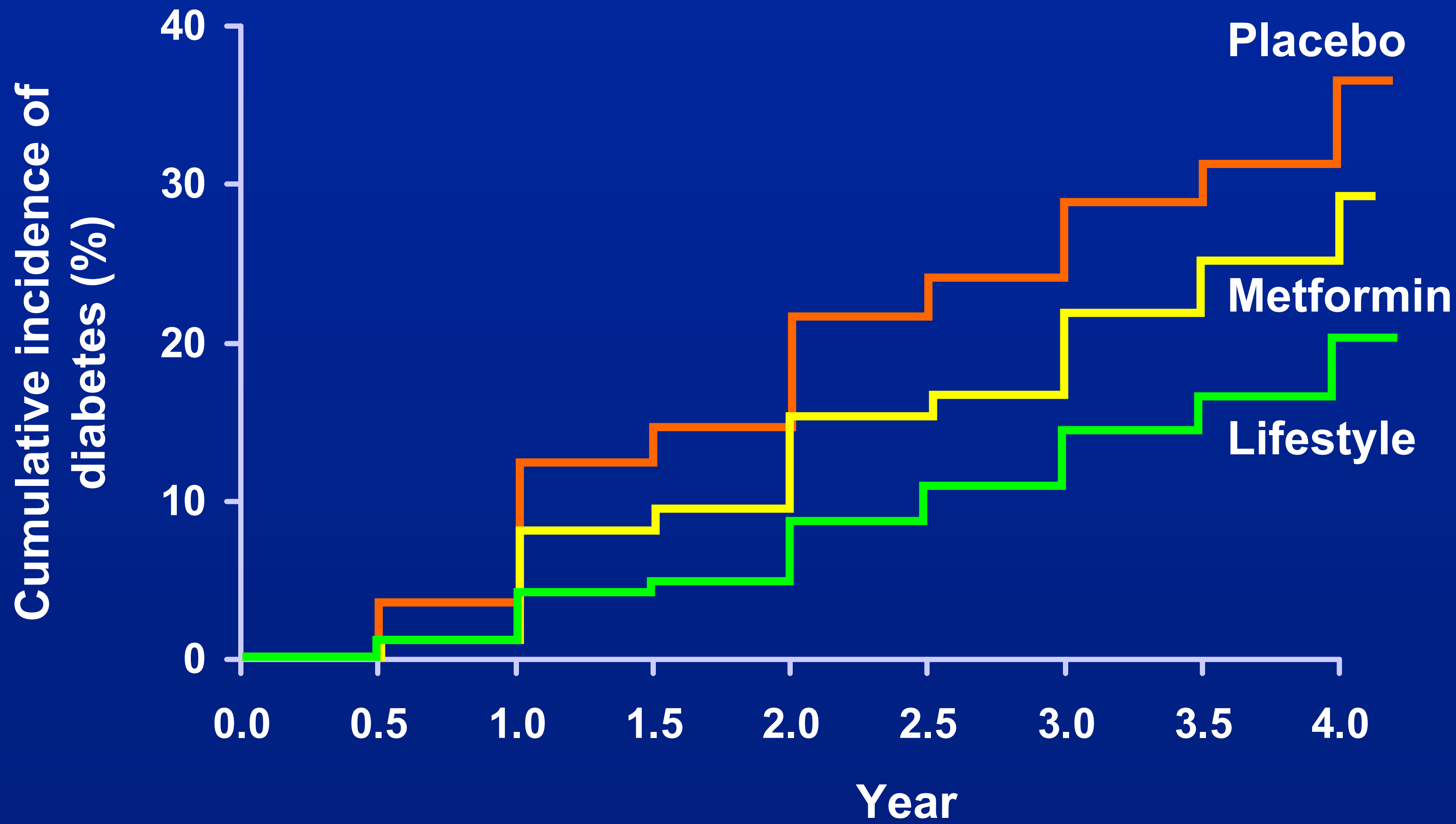
NHLBI Expert Panel: Goals of Therapy

- Reduce body weight and maintain a lower body weight for the long term.
- An initial weight loss target of 10% of body weight, lost over six months is recommended and will be medically significant. The rate of weight loss should be 1 -2 pounds each week.
- Evidence indicates that greater rates of weight loss do not achieve better long-term results.
- After the first six months of weight loss therapy, the priority should be weight maintenance through combined changes in diet, physical activity, and behavior.

Diabetes Prevention Program (DPP)

- Hypothesis: Can diabetes be delayed or prevented by addressing risk factors: impaired glucose tolerance, overweight and sedentary life - using lifestyle changes or metformin?
- 3234 pts of mean age 51, BMI 34, 68% women, 45% minorities and impaired glucose tolerance were randomized to 3 groups at 27 US centers:
  - Usual care (control)
  - Metformin 850 mg BID
  - Lifestyle intervention –
    - Goal of 7% weight loss by Food Pyramid, NCEP 1 diet
    - Goal of 150 min/wk moderate activity (brisk walking)

Diabetes Development in Diabetes Prevention Program



Practical Behavior Change

- Physicians make a difference
- Repetition and follow-up are most useful
- Likely better to do with 2-5 minutes repeatedly than with an hour at once
- Education can be done in pieces
- Let them know that you know it's hard and that the environment is against them
- Encourage patients to find their own goals (motivational interviewing techniques) but encourage specificity - go beyond "watch what I eat"

Prevention Opportunity: Estimated Adult Obesity-Attributable Medical Expenditures (2003 dollars)

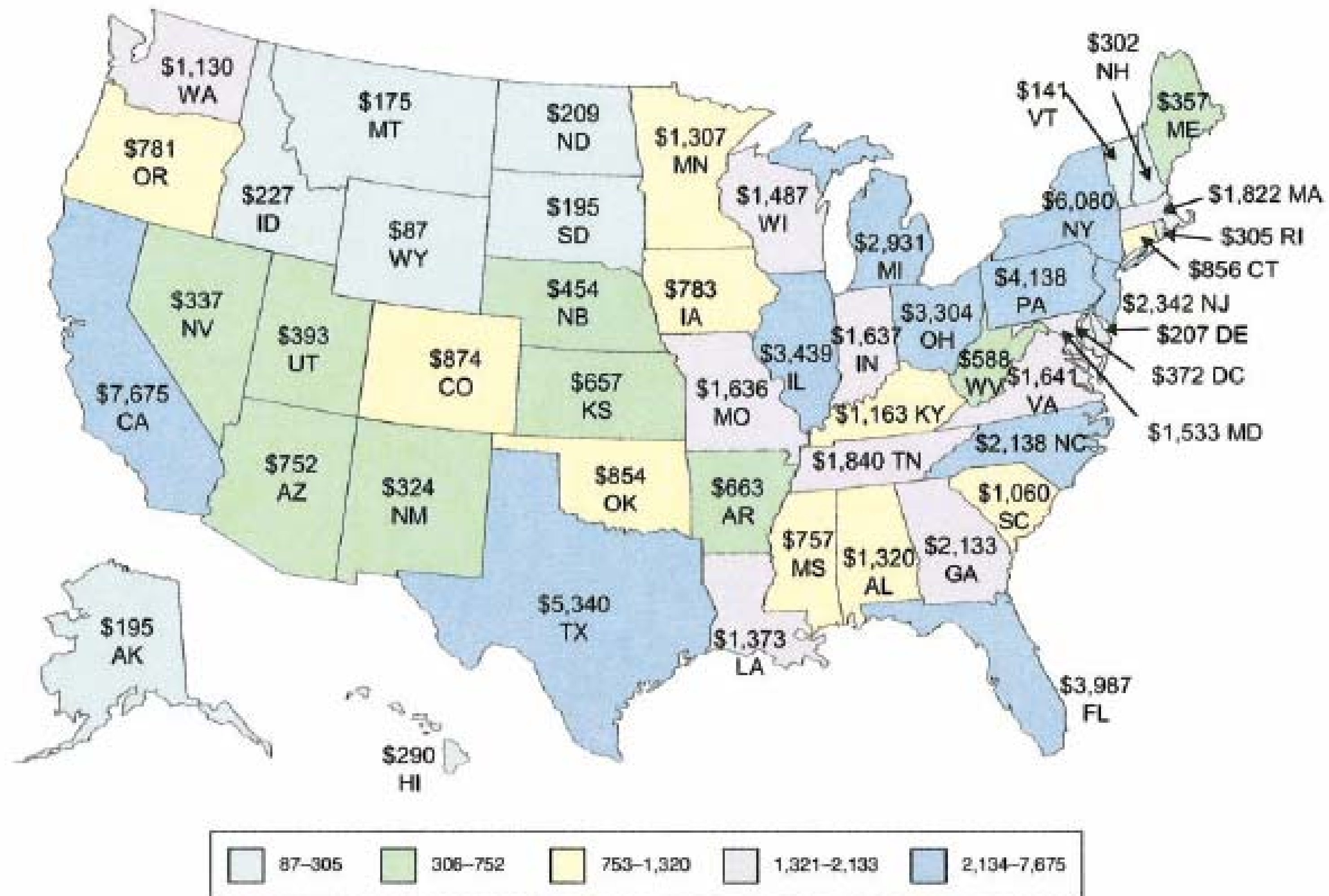
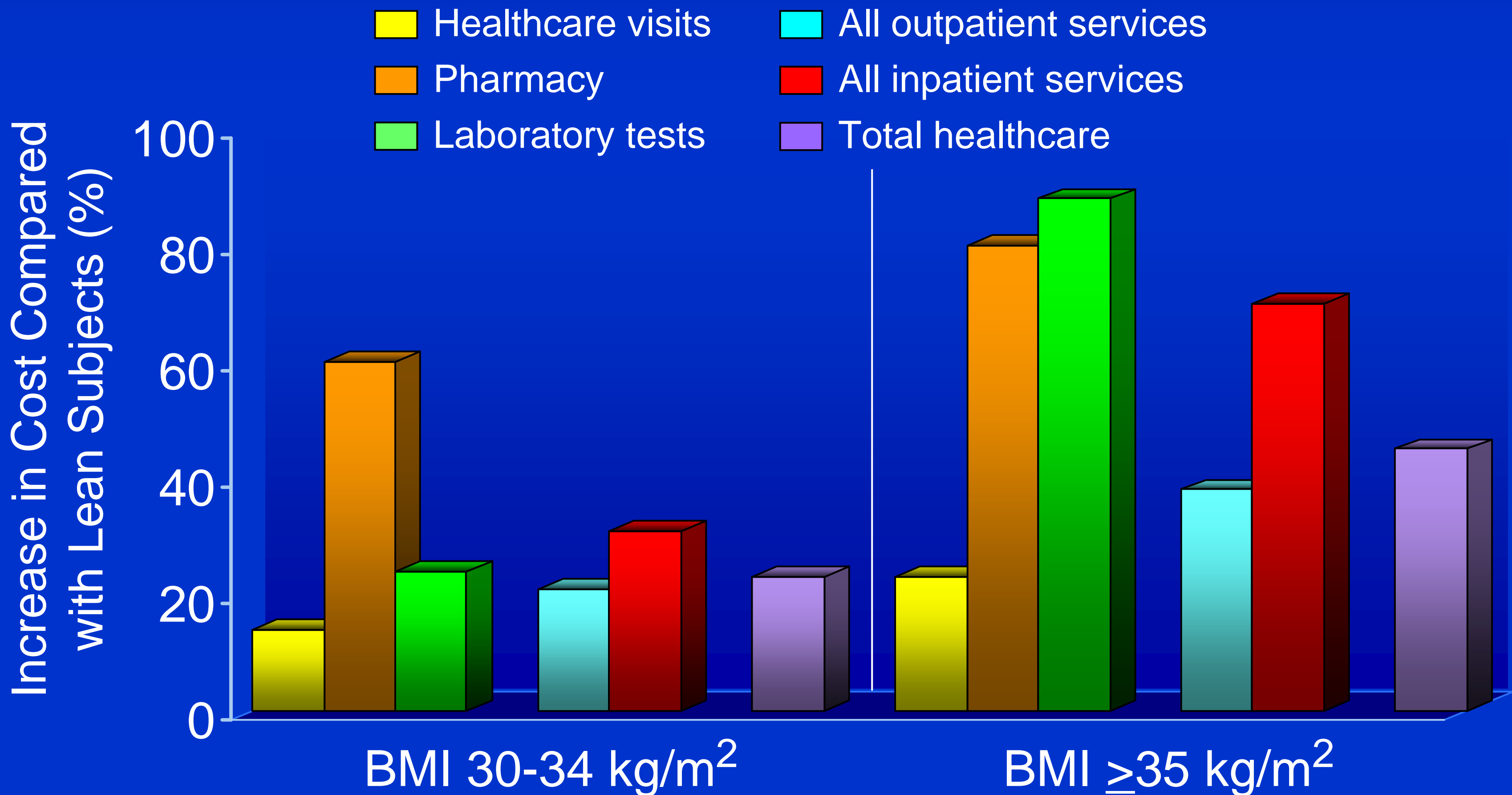


Figure 1: Estimated adult obesity-attributable medical expenditures (2003 dollars in millions).

Source: NAASO Web site; Obesity Research, Vol 12, No 1, January 2004, Finkelstein et al

Increase in Healthcare Costs Among Obese Compared with Lean (BMI <25 kg/m2) Patients*



*HMO Setting: Northern California Kaiser Permanente.

Quesenberry CP Jr et al. *Arch Intern Med*. 1998;158:466-472.

Slide Source:
www.obesityonline.org

The Reality of Practice

- Despite increases in adult obesity rates (and medical costs associated with obesity), *fewer* obese patients are receiving health care advice to lose weight
  - 42% of obese U.S. adults reported receiving such advice in 1994*
  - 40% of obese U.S. adults reported receiving such advice in 2000**
- **WHY?**
  - **Role of payment policies?**

Sources:

*Galuska DA, Will JC, Serdula MK, Ford ES. Are health care professionals advising obese patients to lose weight? *JAMA* 1999;282:1576-8.
**Abod A, Galuska D, Khan LK, Gillespie C, Ford ES, Serdula MK. Are healthcare professionals advising obese patients to lose weight? A trend analysis. *MedGenMed* 2005 Oct 12;7(4):10.

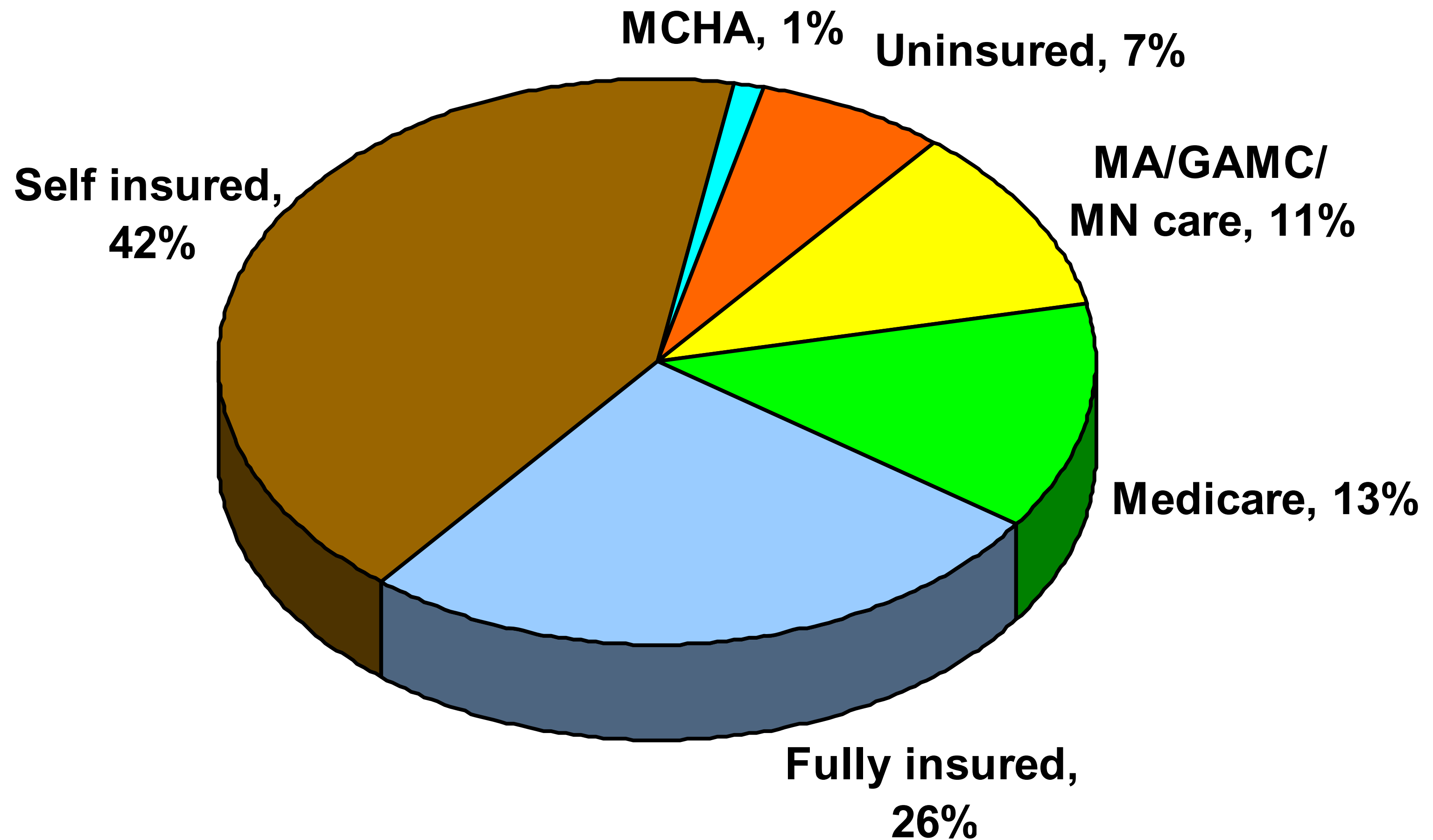
The Role of Payment Policy

- Payment policy is defined individually – by Medicare, Medicaid, and private health insurers
- "*Medically necessary*" is often the key to whether services are covered
  - Lingering debate about role of "personal responsibility"
- Billing and coding requirements drive specific payment policy and payment rates

The Role of Payment Policy

- All participants in the health care system respond to the financial incentives in place
  - "Every system is perfectly designed to get the results it gets." *(Paul Batalden, M.D., Director of Health Care Improvement, Dartmouth)*
- Demands placed on the office visit often conflict with the expressed "value" of that service
  - Are "encounters" the optimal means to manage obesity?
  - Physicians become subject to "the tyranny of the office visit."
    (Don Berwick, M.D., President & CEO, Institute for Healthcare Improvement)

Distribution of MN Population by Primary Source of Insurance Coverage (2004)



Source: Minnesota Department of Health, Health Economics Program, *Distribution of Health Insurance Coverage in Minnesota, 2004*. Issue Brief 2006-04, August 2006.

Medicare Payment Policy

- July 2004: Medicare removed coverage policy language that stated, "obesity is not an illness."
  - Did not affirmatively define obesity as a disease
  - Opened the door a bit
    - By law, Medicare only pays for the treatment of illnesses and accidents
    - Policy changes allow for National Coverage Determination (NCD) requests to evaluate the effectiveness of treatments/interventions and possible Medicare coverage
- Treatments for obesity alone remain non-covered

Medicare Payment Policy – cont'd.

- “Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions and it can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension.’
- ‘Services in connection with the treatment of obesity are covered services when such services are an integral and necessary part of a course of treatment for one of these medical conditions.”

Medicare Payment Policy: Bariatric Surgery

- Effective February 2006: Medicare will cover open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
- IF patients:
  - Have a BMI $\geq$ 35
  - Have at least one co-morbidity related to obesity
  - Have been previously unsuccessful with medical treatment for obesity.
- Services must be performed in facilities that are:
  - (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center; or
  - (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE)

Medicaid Payment Policy

- Minnesota is one of ~29 states that precludes coverage for weight-loss drugs
- Minnesota looking to create “Centers of Excellence” for Bariatric surgery in the same way that Medicare and some of the other insurers have – there is an ongoing review
- “Centers of Excellence” are defined by quality criteria based on positive outcomes

Private Health Plan Coverage for Obesity

- Obesity or weight management counseling may or may not be covered depending on the diagnosis submitted with the claim
  - Illness-related service vs. routine exams/benefits
    - Nearly universal coverage for illness-related services, less for “routine”
- Obesity diagnosis vs. co-morbidity diagnosis
  - 278.00 Obesity, unspecified
  - 278.01 Morbid obesity
- Claims data integrity issue

Minnesota Health Plans

- Blue Cross Blue Shield of MN
  - Services for treatment of obesity, weight management, nutrition, and physical activity counseling are covered*
- HealthPartners
  - Physician-directed dietary consultation services are covered to teach diet modification for a newly diagnosed condition (e.g. diabetes, high blood pressure, pregnancy)*
    - Excludes visits with a dietitian for weight monitoring as part of weight reduction, unless it is for weight loss surgery patients.
- Medica
  - Physician-directed dietary assessments and counseling services to individuals whose medical diagnoses require guidance to properly manage an illness or disability are covered.*

*Subject to contract allowances/exclusions

Source: *Quick Reference Guide for Coverage of Weight Management Care.* BCBSMN Web Site, March 2007.
Weight Loss Management and *Dietitian Counseling* Medical Policies. HealthPartners Web site, March 2007.
Dietitian Consultations. Medica Coverage Policy. Medica Web site, March 2007.

Conclusions

- The evidence and consensus for consultations and counseling as a means to address obesity and achieve weight loss are well established.
- The offering of advice and/or counseling by physicians and other providers is limited.
- Highly variable sources of coverage results in varied responses from insurers
- The challenge of the “personal responsibility” argument
- Variable coverage for early intervention in obesity
- Universal coverage for late-stage surgery

Challenges to Accessing Healthcare for the Obese: Reimbursement

Tiffany R. Beckman, M.D., MPH

- **Are referrals from school nurses to health professionals and allied health professionals reimbursed?**

Challenges to Accessing Healthcare for the Obese: Reimbursement

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- **What referrals are made for overweight versus Class I, II, and II obesity and to whom?**