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

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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.”

The shape of things to come
Prevalence of Overweight and Obese Adults in U.S.

Most recent NHANES data\(^1\) show that:

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

Medical Complications of Obesity

Pulmonary disease:
- Abnormal function
- Obstructive sleep apnea
- Hypoventilation syndrome

Nonalcoholic fatty liver disease, Cirrhosis

Gall bladder disease

Gynecologic abnormalities:
- Abnormal menses
- Infertility
- Polycystic ovarian syndrome

Osteoarthritis

Skin

Gout

Idiopathic intracranial hypertension

Stroke

Cataracts

Coronary heart disease

Diabetes

Dyslipidemia

Hypertension

Pancreatitis

Cancer:
- Breast, Uterus, Cervix
- Colon, Esophagus, Pancreas
- Kidney, Prostate

Nonalcoholic fatty liver disease, Cirrhosis

Hypertension

Dyslipidemia

Cataracts

Skin

Gout

Phlebitis

venous stasis

1. www.obesityonline.com
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 Study\(^2\)

• 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 \[\text{BMI} \geq 30 \text{ kg}\] 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 GROUP Service and Group Code for Intensive Behavioral Therapy for Obesity

- As of 1-1-15, Medicare covers IBT for Obesity as a GROUP service, using new G-code:
  - **G0473**: Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

- Individual visit code still valid
New GROUP Service and Group Code for Intensive Behavioral Therapy for Obesity

- Group code rates similar to MNT group code 97804

- Services must still be furnished in compliance with existing criteria for IBT for obesity benefit.

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
- 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 Manual*¹, 200.1
  – *Policy (Rev. 3160, Issued: 01-07-15, Effective: 01-01-15, Implementation: 01-05-15)*, Medicare benees 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, if beneficiary meets 3 kg (6.6 lbs) weight loss requirement during first 6 months
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**):

  - NOTE: 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**.

Billing and Coding for IBT for OB

– When applying frequency limitations, MACs count 22 counseling sessions of any 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 12-month period.¹

• For G0473 or G0447: MACs allow both a claim for the professional service and a claim for a facility fee

Billing and Coding for IBT for OB

– For further interpretation of these frequency limitation guidelines, you 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
<table>
<thead>
<tr>
<th>Code</th>
<th>BMI Range</th>
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<tbody>
<tr>
<td>V85.30</td>
<td>30.0 - 30.9</td>
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<tr>
<td>V85.31</td>
<td>31.0 - 31.9</td>
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<tr>
<td>V85.32</td>
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<tr>
<td>V85.43</td>
<td>60.0 - 69.9</td>
</tr>
<tr>
<td>V85.44</td>
<td>≥70.0</td>
</tr>
</tbody>
</table>

**ICD-10 Codes:**

- Z68.30 to Z68.39
- Z68.41 to Z68.45
Medicare Payment for IBT for OB

- **PCPs:**
  - Paid via Medicare Physician Fee Schedule (PFS)
- Rates adjusted based on:
  - Geographical location in U.S., and by
  - Place of service
    - Reflects relative differences among costs
- Can find your PFS 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) only on Type of bill (TOB) 13X
  - Likely will result in higher payment amount

- **Rural Health Clinics** (TOB 71X) and **Federally Qualified Health Centers** (TOB 77X) claims:
  - Paid under Part A all-inclusive payment rate
  - **HCPCS code G0447** and **G0473** reported on separate service line to ensure coinsurance and deductible **not** applied to service
Medicare Payment for IBT for OB

• MACs identify following institutional claims as facility fee claims for this service:
  – TOB 13X, TOB 85X when revenue code is NOT 096X, 097X, or 098X

• MACs shall identify all other claims as professional service claims (i.e., no facility fee billing paid)

• Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost
  – CAH Method II – TOB 85X - based on 115% of lesser of Medicare Physician Fee Schedule’s amount or actual charge as applicable with revenue codes 096X, 097X, or 098X
Medicare Payment for IBT for OB

• IBT for OB benefit **NOT** separately payable with another encounter/visit on **same** day

  **BUT**

• Benefit **CAN** be furnished on **same** day with 1 of benefits below and **is** separately payable:
  
  • Initial Preventive Physical Exam
  • Modifier 59
  • Diabetes Self Management Training (DSMT)  
  – On 77X claim
  • Medical Nutrition Therapy (MNT)  
  – On 77X claim
Medicare Reimbursement Rates

• 2015 national unadjusted* payment rate:
  – 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

• Medicare may cover benefit when furnished by **auxiliary personnel** (e.g., RDs) and billed as “incident to” services in:
  – Primary care office setting & hospital OP setting

• “Auxiliary personnel” = individual who is:
  – Acting under PCP’s supervision
  – Employee, leased employee, or independent contractor of:
    • PCP, or
    • Legal entity that employs/contracts with PCP

1. Medicare Benefit Policy Manual, Chapter 15
More About Medicare “Incident To” Services

• RDs = auxiliary personnel for providing these Medicare Preventive Services:
  – Intensive Behavioral Therapy for Obesity
  – Intensive Behavioral Therapy for CVD
  – Annual Wellness Visit
“Incident To” Physician Services Billing

- 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
“Incident to” Guidelines for Medicare Part B

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?
Treating Obesity in Primary Care

Weight Loss

• Appel\(^1\)
  – Usual care: 0.8 kg
  – Telephone intervention: 4.6 kg
  – Telephone intervention + in-person support: 5.1 kg

• Wadden\(^2\)
  – Usual care: 1.7 kg
  – Monthly counseling: 2.9 kg
  – Enhanced counseling (meal replacement or meds): 4.6 kg

Treating Obesity in Primary Care

- Bennett\(^3\)
  - Usual care: 0.5 kg
  - IVR*/web intervention with optional in-person sessions: 1.5 kg

*Interactive Voice Response

# Treating Obesity in Primary Care

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP treatment alone (4 studies)</td>
<td>0.6 to 2.3 kg</td>
</tr>
<tr>
<td>PCP treatment + pharmacotherapy (3 studies)</td>
<td>3.4 to 7.5 kg</td>
</tr>
<tr>
<td>Collaborative treatment (3 studies)</td>
<td>0.2 to 7.7 kg</td>
</tr>
</tbody>
</table>

1. Tsai and Wadden, J Gen Intern Med, 2009
Study: RD + Meal Replacements (MRs) More Effective than PCPs and MRs

1. Ashley, 2001, Arch Intern Med
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!

<table>
<thead>
<tr>
<th>P</th>
<th>Pursue Medicare provider status</th>
</tr>
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<tbody>
<tr>
<td>R</td>
<td>Retain your own legal business entity in state (LLC, corporation, partnership, etc.)</td>
</tr>
<tr>
<td>R</td>
<td>Read &quot;Meeting the Need for Obesity Treatment: A Toolkit for the RD/PCP Partnership (A.N.D. Toolkit)&quot;</td>
</tr>
<tr>
<td>O</td>
<td>Obtain own website.</td>
</tr>
<tr>
<td>O</td>
<td>Optimize fact that you are wt management expert.</td>
</tr>
<tr>
<td>O</td>
<td>Obtain own contract with provider; 1st research info on art of negotiation and elements of contract.</td>
</tr>
</tbody>
</table>
| M | Make sure to ask your Medicare Administrative Contractor (MAC) if:  
   • Multiple units of G0447 or G0473 code can be billed on same day |
| O | Obtain subscription to Academy’s online Nutrition Care Manual.  
   Obtain Certificate of Weight Management. |
| T | Transact detailed Marketing Plan (7 “P”s). Focus on Promotion which includes face-to-face marketing with providers. |
| E | Emphasize 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.  
|       | Outcomes from current and previous weight management patients in summary format.  
| **U** | You are able to meet needs of provider and nutrition needs of providers’ patients.  
|       | Understanding 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 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!

Only one procedure code is accepted,
But many diagnosis codes not to be neglected.
Documentation is a must....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 MNT in disease control is **KEY.**
To our Academy and Weight Management **DPG,**
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
References

1. Medicare Claims Processing Manual, Chapter 18 - Preventive and Screening Services, Rev. 3159, 12-31-14


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


• **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