Clinical Economics
Obesity

OVERVIEW

More than one-third of American adults are obese, according to the United States Centers for Disease Control and Prevention. This high prevalence rate has drawn increasing levels of national attention, and the spotlight is often focused on the health-related and economic costs of this obesity epidemic. Efforts to manage obesity and related comorbidities are key priorities for primary care physicians.

Obesity is linked to a wide range of comorbidities, contributes to worsening health outcomes, and is associated with reduced physical and psychological quality of life for patients. The American Medical Association classifies obesity as a chronic disease, indicating the condition requires ongoing management.

"While current efforts to reverse the epidemic focus primarily on diet and exercise," says Nikhil Dhurandhar, president of the Obesity Society"losing weight and maintaining weight loss through these lifestyle changes alone can be difficult for some and impossible for others with obesity."

The management of obesity can require physicians to allocate significant amounts of time and resources in a primary care practice. Physician/patient collaboration is critical to setting realistic goals and expectations, while management strategies must be adjusted based on patient challenges and successes, and regular follow-up visits are necessary to support ongoing weight maintenance.

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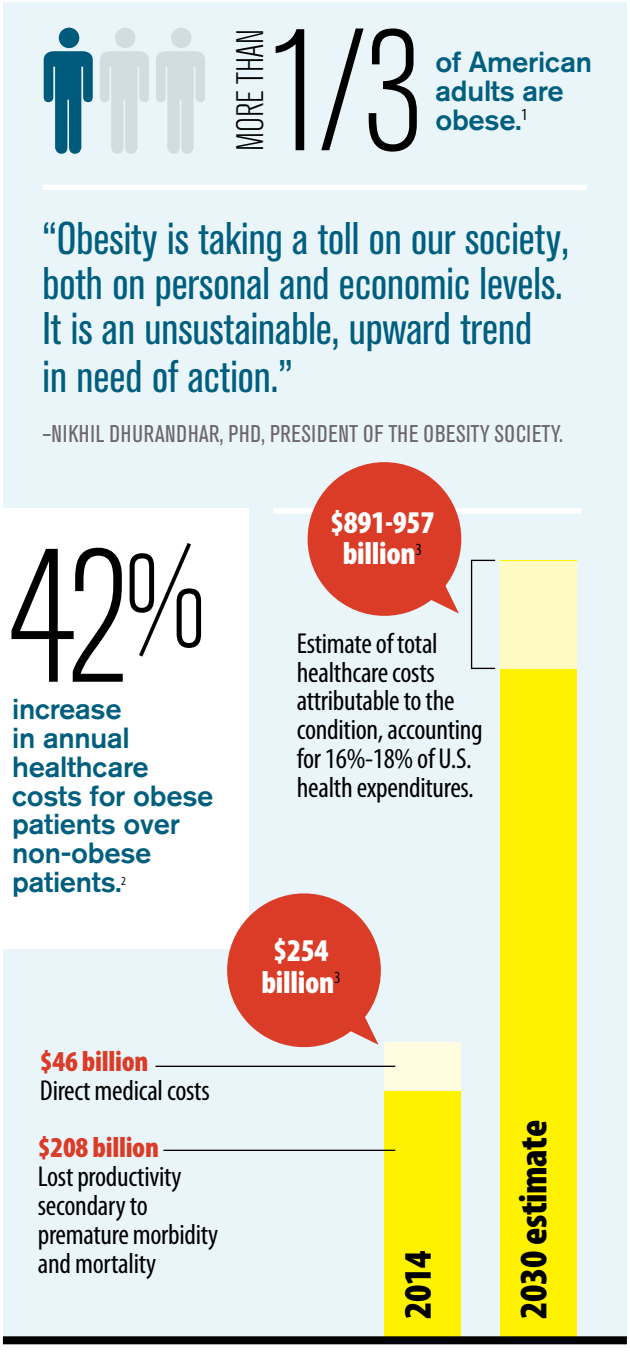
PATIENT COMMUNICATION TIPS SEE PAGE 24

- Evaluate patients effectively
- Determine patient readiness
- Provide education
- Develop a weight management plan
- Establish realistic goals
- Use team approach
- Establish long-term relationships for continuity of care



Source: 1. Centers for Disease Control, 2. Finklestein, 3. American Heart Association

PATIENT COMMUNICATION TIPS

Evaluate patients effectively. At the start of an office visit, have staff calculate BMI while evaluating the patient's vital signs. BMI provides the clinician immediate useful information. Staff should then communicate this information to the clinician before he or she enters the exam room. Tools to facilitate this protocol might include placing BMI charts near each scale in the office or including BMI calculators in electronic health record (EHR) systems which display BMI when height and weight are entered.

Tracking systems can be established to review patient charts periodically and identify patients who are overweight or obese. These systems can then be used to generate reminders for clinicians to discuss weight management with the patient during his or her next office visit.

Determine patient readiness. Because body weight can be an emotional topic for patients, it is important first to determine whether the patient is willing to discuss his or her weight, is open to receiving educational materials, and is ready to undertake a management regimen. Practitioners can use a patient readiness scale to determine whether a patient is prepared to move forward with weight management. The 5 A's provide a useful framework to evaluate readiness and initiate management:

ASK for permission to discuss weight and explore readiness
ASSESS obesity-related risks and root causes of obesity
ADVISE on health risks and treatment options
AGREE on health outcomes and behavioral goals
ASSIST in accessing appropriate resources and providers

Provide education. Educate patients about their BMI and the associated health risks, and explain the importance of healthy lifestyle changes focused on nutrition and physical activity. Patient education may include the use of tools such as posters and brochures throughout the office, or recommendation of external sources such as the patient education resources listed below.

PATIENT EDUCATION RESOURCES

American Medical Association:
Resources on Obesity Management and Prevention bit.ly/keyword

Obesity Action Coalition:
Educational Resources bit.ly/keyword

American Academy of Family Physicians:
Obesity Patient Education and Self-Care bit.ly/keyword

Develop a weight management plan. Manage obesity with a chronic disease mindset. Individualized patient-centric programs should be developed based on patient motivation, resources, and lifestyle. Management strategies could include nutrition, physical activity, lifestyle changes, self-monitoring, journaling, and commercial weight-loss programs. When indicated, medication or surgery may be considered. Regularly evaluate patient progress and adjust the plan as necessary as patients discover which strategies work best for them.

Establish realistic goals. Explain that a 5% to 10% weight loss can reduce health risks in clinically significant ways. Assure patients that this can be achieved and maintained with medical management. Because a 5% to 10% weight loss may not result in large cosmetic changes, patients may feel disappointment and frustration after achieving this level of weight loss. Provide positive reinforcement, and remind patients that any amount of weight loss and maintenance is a clinical success.

Use a team approach. Obesity is a chronic disease, and weight management can place heavy demands on practice time and resources, making a team approach a necessity. While a primary care physician can recommend diet and exercise for weight management, obesity a complex condition requiring the expertise of a trained interventionist. The trained interventionist may be a primary care physician with a special interest in treating obesity, a dietician, psychologist or other health counselor with training in weight management. Establishing protocols and consistent monitoring is both fiscally responsible as well as paramount to effective surveillance and subsequent determination of successful weight loss and maintenance in the patient. Clinicians, nurses, and ancillary staff members should be educated on obesity management commensurate with their role in patient care. Establish a system for staff training in motivational interviewing, nutrition counseling, physical activity, lifestyle changes, and evaluation of treatment effectiveness. Use EHRs to track response to treatment strategies, record changes in BMI, keep clinicians informed of patient progress, and generate reminders for patient follow-up. Manage barriers to timely referrals by understanding what programs are available to patients and what the requirements are for referral.

Establish long-term relationships for consistency in care. Regular follow-up is necessary to maintain physician-patient relationships, reinforce weight management, and prevent weight regain. Follow-up communication can take the form of in-person office visits, scheduled phone consultations, and possible recommendation to commercial weight-loss programs. Because weight management is a lifelong commitment, the healthcare team plays a critical role in facilitating ongoing patient success. ■

—Written by Nicole Klemas, ELS
—Reviewed by Bruce M. Wolf, MD

KEY CODING CONSIDERATIONS

INSURANCE CARRIERS have come a long way when it comes to reimbursing for obesity-related treatment. However, you will need to make sure that your diagnosis coding is specific and complete in order to support medical necessity.

The first code set to review when coding for obesity is: (See Diagnosis Codes Table). You need to use V77.8 for obesity screening services.

When you look up any of the obesity codes in your ICD-9 code book, you will see the instruction to use an additional code to identify Body Mass Index (BMI), if known.

The ICD-9 codes applicable for obesity complicating pregnancy are 649.10 – 649.14. When utilizing these codes, you should also code to identify the obesity level and the BMI, if known.

According to the NCD for Treatment of Obesity, which can be found at Treatment of Obesity NCD, services performed in connection with the treatment of obesity are covered by Medicare when such services are an integral and necessary part of a course of treatment for diseases such as hypothyroidism, Cushing's disease, hypothalamic lesions, cardiovascular diseases, respiratory diseases, diabetes, and hypertension.

So you can see that your documentation and claim need to include all diagnoses that the patient presents with that would describe the complexity of his/her conditions. Medicare covers Intensive Behavioral Therapy for obesity and Bariatric Surgery when the guidelines have been met for each.

For Intensive behavioral therapy, obesity is defined as a body mass index (BMI) ≥ 30 kg/m2, for the prevention or early detection of illness or disability. The full NCD can be found at NCD for Intensive Behavioral Therapy for Obesity.

For Bariatric Surgery or other treatment of obesity, Medicare recognizes that obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions, or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions.

In order to be considered for bariatric surgery, Medicare beneficiaries need to have a body-mass index ≥ 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity. The full NDC can be found at CMS NCD for Bariatric Surgery for Treatment of Morbid Obesity.

—Written by Renee Dowling

Obesity Diagnosis Codes	
Code	Description
278.01	Morbid obesity
278.00	Obesity, unspecified
278.03	Obesity hypoventilation syndrome

Body Mass Index (BMI) Diagnosis Codes	
Code	Description (BMI - Adult)
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 and over
Code	Description (BMI – Pediatric)
V85.51	less than 5th percentile for age
V85.52	5th percentile to less than 85th percentile for age
V85.53	85th percentile to less than 95th percentile for age
V85.54	greater than or equal to 95th percentile for age

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