Payment System Thwarts Efforts to Treat Obesity

Many physicians try to get counseling paid for by coding for a related comorbidity, such as diabetes.

BY MARY ELLEN SCHNEIDER
Senior Writer

With the obesity epidemic growing, physicians are facing a payment system that hasn't caught up.

Although coverage varies by payer, most Medicare carriers do not pay for office visits coded only for obesity and the same is true for most private payers, physicians told FAMILY PRACTICE NEWS.

"The payment mechanism is certainly lagging behind," said Sandra Hassink, M.D., who is a member of the American Academy of Pediatrics' national task force on obesity and director of the weight management program at the Alfred I. duPont Hospital for Children in Wilmington, Del.

As a result, many physicians find ways to get counseling paid for by coding for related comorbidities such as diabetes or heart disease, said Donna E. Sweet, M.D., chair of the board of regents of the American College of Physicians and professor of internal medicine at the University of Kansas in Wichita.

But that's far from a perfect solution, she said. If physicians could code for obesity as the primary diagnosis they could spend less time trying to work around the payment system, she said. And they could perform early interventions to keep obesity and overweight from leading to diabetes and heart disease, she said.

Payment for obesity counseling and interventions is part of a larger problem with the episode-driven payment approach, she said. "So much of this revolves around fixing our payment system."

There isn't complete agreement about whether third-party payment for obesity treatment would help patients, said G. Michael Steelman, M.D., a bariatric physician in Oklahoma City and president of the American Society of Bariatric Physicians. Many members of his group are split on this issue, he said.

One side argues that if insurers would pay for this care, patients would seek it out and stay in treatment. But others say that requiring patients to pay for these services out of pocket provides financial motivation to follow their physician's advice. "In obesity, there's a lot of work the patients needs to do when they leave the office," he said.

Dr. Steelman said that he favors a compromise position in which reimbursement is conditional on some measure of success. For example, payers could cover visits as long as the patient is losing weight or maintaining weight below a certain point, he said.

The bottom line, Dr. Steelman said, is that insurers will generally be unwilling to invest in obesity interventions until physicians can demonstrate that they are getting results.

In the meantime, physicians should learn how to code so they have the best chance of getting paid for their time, said Jamie Calabrese, M.D., a member of the American Academy of Pediatrics' national task force on obesity and medical director of the Children's Institute in Pittsburgh, Pa.

Although most carriers will not pay for interventions that are associated only with obesity, most children who are obese also have other comorbidities. Dr. Calabrese therefore recommends that physicians code the comorbid condition as the primary diagnosis and include obesity as the secondary diagnosis. With that as the starting point, there are multiple ways to code for weight management counseling, she said.

Physicians can use the basic evaluation and management CPT codes (99212-99215) or, if the patient was referred by a school nurse or other professional, the physician can use the consultation codes (99241-99245). When physicians spend extra time with a patient, they should use the prolonged face-to-face codes (99354-99355). The prolonged time codes can be used when the physician goes beyond the usual time for that visit, but that time doesn't need to be continuous, Dr. Calabrese said.

Typically if physicians code accurately, they will get paid fairly, Dr. Calabrese said. And there is some movement on this issue as some insurers begin to provide payment for the obesity code, she said. There's a potential for a partnership between physicians and payers, who can provide physicians and patients with the tools they need to deal with obesity, she said.

Highmark Inc. of Pittsburgh is planning to do just that. Starting in January 2006, the health plan will include coverage for obesity interventions as part of its preventive health benefits package. That means that it will begin paying physicians who code for obesity as the primary diagnosis.

This is expected to result in two extra visits a year when coding for obesity alone, said Donald Fischer, M.D., chief medical officer for Highmark Inc., and a pediatric cardiologist. And it will allow the health plan to collect more information on obesity, he said. ■

Another Way to Address Obesity

Some physicians have realized that they are limited in what they can accomplish in an office visit so they have started their own weight management programs that incorporate good nutrition and physical activity.

One such physician is David Geller, M.D., a pediatrician in Bedford, Mass., who launched the Early Start program a little over a year ago. The program includes several weeks of medical sessions, nutrition counseling, and structured physical activity.

Dr. Geller said that he had grown frustrated with his inability to fully address overweight and obesity issues in his practice. "I just felt there was a better way to address it," he said.

His medical visits with patients are generally well covered by insurance, Dr. Geller said, and they have seen improved coverage since the program began for the nutrition counseling.

Families generally pay out of pocket for the remainder of the costs.

"The insurance companies are realizing now that obesity is an issue," Dr. Geller said.

Less Than Half of Overweight Youth Are Diagnosed by Doctor

BY MIRIAM E. TUCKER
Senior Writer

Less than half of overweight children in the United States are told that they are overweight by their physicians, the Centers for Disease Control and Prevention reported.

The percentage of children and teens aged 6-19 years who are overweight tripled to 16% during the period 1980-2002. Yet from 1999 to 2002, only 36.7% of children or their parents reported having been told by their physician or other health care provider that they were overweight. "By discussing weight status with overweight patients and their parents, pediatric health care providers might help these patients implement lifelong improvements in diet and physical activity," the CDC said (MMWR 2005;54:848-9).

The data come from the National Health and Nutrition Examination Survey (NHANES), which sampled 1,473 children and teens aged 2-19 years determined to be overweight (greater than or equal to the 95th percentile of body mass index for age and sex in the year 2000).

Parents of children 2-11 years old were asked whether they had ever been told that the child was overweight. For 12- to 15-year-olds, the parent was asked if the child had been told that he/she was overweight.

And teens aged 16-19 years were themselves asked if they had ever been told they were overweight.

The proportion who had been told of their overweight status increased by age, from 17.4% for ages 2-5 years to 32.6% of those aged 6-11 years, to 39.6% for ages 12-15 years, to 51.6% of the adolescents aged 16-19 years.

Overweight black females were significantly more likely to be given the diagnosis than were overweight white females (47% vs. 31%). Among those who were informed of their overweight status, 39% of the black females were severely overweight, compared with 17% of the white females, the CDC reported.

Previous findings suggest that children begin to respond to environmental cues regarding dietary patterns by age 5 years. "Thus, early recognition and discussion of overweight status is a necessary first step to developing healthier lifelong behaviors," the CDC noted. ■

TV Watching Is Linked to Overweight Around the World

Watching television may be a bigger culprit in the risk of youth in the industrialized world being overweight than candy and chocolate, according to Ian Janssen, Ph.D., of Queen's University, Kingston, Ont.

In a self-reported cross-sectional survey of 137,593 youths aged 10-16 years in 34 industrialized countries, a higher intake of sweets was associated with lower odds of being overweight in 91% of the countries, the investigators said. And there was no consistent link between overweight and fruit, vegetable, and soft drink intake (Obes. Rev. 2005;6:123-32).

However, greater television viewing time was linked to greater odds of being overweight in 65% of the countries.

But time spent on a computer did not correlate with being overweight, Dr. Janssen and his associates said.

The investigators noted that greater physical activity was associated with lower odds of being overweight in 88% of the countries.

The results imply that "physical inactivity and television viewing are important determinants of overweight in youth throughout the industrialized world," they said.

The highest prevalence of overweight youths was found in Malta (25.4%), the United States (25.1%), and Wales (21.2%).

The lowest prevalence of overweight youths was found in Lithuania (5.1%), Russia (5.9%), and Latvia (5.9%).

The highest prevalence of obese youths was found in Malta (7.9%), the United States (6.8%), and England (5.1%), while the lowest prevalence of obese youths was found in Lithuania (0.4%), Russia (0.6%), and Latvia (0.5%).

The study results are based on the 2001-2002 Health Behaviour in School-Aged Children Study.

—Kevin Foley