Reimbursement Roadmap

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AMERICAN COLLEGE OF Lifestyle Medicine

Health Professionals that treat and reverse chronic disease with lifestyle interventions

Prepared by ACLM's Reimbursement Taskforce: A subcommittee of the Reimbursement Member Interest Group
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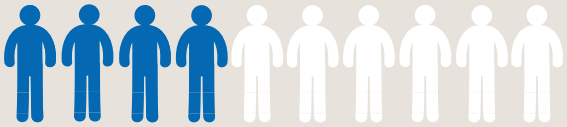
6 in 10 Americans have a **Chronic Disease**



4 in 10 Americans have **2 or more Chronic Diseases**

Literature shows that up to 80% of all chronic diseases can be prevented, treated and even possibly reversed using lifestyle changes. Yet, the U.S. Centers for Disease Control and Prevention (CDC) estimates that 6 in 10 Americans have one or more chronic diseases and 4 in 10 have two or more. Almost all clinical practice guidelines for the top chronic diseases recommend lifestyle changes as the first line of treatment. Lifestyle Medicine (LM) is defined by the American College of Lifestyle Medicine (ACLM) as the use of evidence-based lifestyle therapeutic intervention—including a whole-food, plant-predominant eating pattern, regular physical activity, restorative sleep, stress management, avoidance of risky substances, and positive social connection—as a primary modality, delivered by clinicians trained and certified in this specialty, to prevent, treat, and often reverse chronic disease.

Research demonstrates that intensive LM programs are not only clinically efficacious for the treatment and reversal of existing chronic disease, but also provide an impressive cost savings and return on investment (ROI). Shurney, et al. reported a 1.38:1 ROI within a six-month period in employees with type 2 diabetes engaged in a comprehensive, workplace-based, lifestyle intervention; with 23.8 percent of participants able to eliminate one or more of their chronic medications.[1] Over a three-year period, the Multicenter Lifestyle Demonstration Project reported an average cost savings of $29,000 per participant engaged in the Dr. Ornish's Program for Reversing Heart Disease.[2] Savings generated from LM interventions delivered at the appropriate therapeutic dose are more than sufficient to cover the cost of administering the services.

The dominant fee-for-service healthcare reimbursement model does not adequately value LM approaches because these interventions do not fit easily into the "quick fix" reactive mentality that relies primarily on short visits that result in the prescription of pills or ordering of procedures to treat or manage chronic disease. The fee-for-service health care model has placed ever-increasing pressure on doctors to see more patients, resulting in only enough time to diagnose the ill, prescribe the pill and send the patient home with the bill. Lifestyle medicine behavioral change interventions are, by nature, time-intensive and require significant participant engagement to be successful. Existing reimbursed models of LM-related health care delivery, such as the Diabetes Prevention Program, Shared Medical Appointments (SMAs) and Intensive Cardiac Rehabilitation (ICR), are not well supported within the current reimbursement model; they also tend to be high in administrative burden, are not universally reimbursed, and are often not lucrative compared to the dominant procedural/pill-based treatments available.[3]

A well-known misalignment for LM clinicians in fee-for-service (FFS) health care delivery systems are the quality measures for which providers and practices are scored. Quality measures and measure sets were developed based on the paradigm that once a chronic condition is diagnosed the only option is medication/procedural focused disease management. The measures, therefore, focus on medication compliance and process metrics versus improved disease outcomes. These measures often do not recognize the ability to improve or reverse chronic disease through lifestyle prescriptions and do not reward lifestyle change interventions, such as intensive counseling on dietary improvement, physical activity, stress reduction and the importance of restorative sleep. The sidebar on the next page highlights how this misalignment of quality measures has played out in lifestyle medicine pioneer Wayne Dysinger's practice.

Another challenge that exists for all clinicians who offer group medical appointments is the requirement for the location of service of those visits to be associated with an NPI (National Provider Identifier), which are often only associated with individual healthcare providers working in medical clinics and hospitals. While it makes sense for some group visits to be facilitated on a medical campus, other locations such as local community centers,

places of worship, educational institutions and neighborhood organizations offer an opportunity for clinicians to reach and impact more patients within the community. The requirement of having an NPI number associated at these institutions for payment is a barrier for making health care services, including lifestyle medicine, more accessible to the patients who often need them the most.

The challenges of clinician time restriction, poor reimbursement, lack of systemic support, high administrative burden, NPI number requirements and misaligned quality measures not only interfere with a trained and certified LM clinician's ability to offer lifestyle medicine interventions for chronic diseases in a fee-for-service world, they also perversely incentivize and penalize clinicians for their attempts to provide high-quality, low-cost care that is linked to better health outcomes.

New efforts by Centers for Medicare and Medicaid Services (CMS) to move away from the dominant FFS model of payment toward a more value-based payment system aligns very well with the field of lifestyle medicine. An increased emphasis on shared risk does offer an opportunity to benefit LM providers who can deliver better clinical outcomes for chronic conditions, help address health disparities, achieve better patient and provider satisfaction and, at the same time, lower costs through medication de-escalation and prevention of future diseases/health care expenditures.

Value-based payment (VBP) has been touted as the ultimate solution to the perverse incentives of a sick care system outlined above.[4] A key driver of VBP is its heavy reliance on risk coding to determine how sick a patient is expected to be. The diagnoses that have been billed for a patient over the course of a year are tallied, and an expected cost for each patient is calculated based on that set of diagnoses. Payment in a value-based system is totally dependent on each patient's risk score. In effect, providers are paid to apply high-scoring diagnoses (i.e., diagnoses that reflect greater degree of illness) to their patients. This has two undesirable effects that do not serve the patient: 1) The provider must spend a great deal of time and effort in the pursuit of aggressively coding patients with every legitimate high-value diagnosis they can, and 2) they can be a disincentivized to reverse disease if the reversal removes the high-scoring diagnoses, which will subsequently decrease payments. Despite these limitations, VBP remains the one of the greatest opportunities for LM practitioners to receive fair compensation for their work.

MISALIGNMENT

Wayne Dysinger, MD, had a patient diagnosed with hyperlipidemia (total cholesterol - 226, triglycerides 132). Rather than prescribing the customary statin, Dr. Dysinger prescribed LM behavior modifications. Within 21 days, the patient's total cholesterol dropped to 171 and triglycerides to 75. Both Dr. Dysinger and the patient were ecstatic with the results. However, due to the CMMS 5-Star Rating System for Medicare Advantage that scores based on medication compliance, rather than receiving an A grade, Dr. Dysinger received a C grade.

More recently another one of Dr. Dysinger's patients who was using an LM prescription to treat high blood pressure received a phone call from her insurance company recommending she start taking medication to control her disease. They did not inquire about the treatment plan she was following with Dr. Dysinger.

The current health care documentation and payment systems were not designed with lifestyle medicine disease reversal or remission in mind. Therefore, LM clinicians also have concerns about what to do when a disease is reversed using LM interventions and a proper ICD diagnosis code no longer exists for a patient, but the patient still needs ongoing support and follow-up care related to that disease to prevent relapse. An obvious example is for a patient with a diagnosis of obesity. What happens when a patient BMI returns to a "normal range" after being treated using LM? Should a provider still use the obesity diagnosis with ongoing appointments, even if they no longer fall into an obese range (without surgical or pharmaceutical intervention)? Would it constitute malpractice or fraud if a chart is audited and a provider is continuing to offer follow-up visits to a patient whose BMI no longer classifies as obese but is still receiving care billed for a diagnosis of obesity?

While there are still many unanswered questions and misalignments of incentives for reimbursement in the field of lifestyle medicine, progress on the reimbursement front is improving since the first LM reimbursement roadmap was published in 2019. In

a post-pandemic healthcare system that has opened the doors for virtual care opportunities and stated its intent to deliver more value to patients at a lower cost, there is no better time to align lifestyle medicine practices with value-based care and capitalize on its potential to achieve the quadruple aim — better clinical outcomes, increased provider satisfaction, increased patient satisfaction and lower cost of care.

The first version of the ACLM reimbursement roadmap was published in 2019 by the Reimbursement Taskforce (a subcommittee of the Reimbursement Member Interest Group) to help LM clinicians within ACLM understand the ways in which they can achieve reimbursement for practicing LM in the dominant fee-for-service model, but also to get paid for alternative payment models. This second version of the roadmap, published in the fall of 2021, offers an update to the first version and hopes to paint the picture of the future of reimbursement for LM in a value-based model. The roadmap will continue to be updated over time.

References:

1. Shurney D, Hyde S, Hulsey K, Elam R, Cooper A, Groves J. CHIP Lifestyle Program at Vanderbilt University Demonstrates an Early ROI for a Diabetic Cohort in a Workplace Setting: A Case Study. Journal of Managed Care Medicine. Vol. 15, No. 4:5-15
2. Ornish D. Avoiding revascularization with lifestyle changes: the multicenter lifestyle demonstration project. The American Journal of Cardiology. November 26, 1998 Volume 82, Issue 10, Supplement 2, Pages 72–76
3. Safeer R, Chen LK, Huynh P, Horst J. Coverage Trends for Two Programs Addressing Chronic Disease. Journal of Managed Care Medicine. Vol. 20, No. 4:74-81
4. McCombs, Jeff, et al. "VALUE-BASED CONTRACTING IN HEALTHCARE: WHAT IS IT AND HOW CAN IT BE ACHIEVED?" (2019).

Step-by-Step Guide to Lifestyle Medicine Reimbursement

Reimbursement Requirements

Fee For Service: Connect with Insurance/Billing Experts

The first step in fee for-service-billing for any service is to partner with someone in your organization who is knowledgeable about billing and filing claims. Prior to any upcoming patient visit, conduct an electronic eligibility and benefits check to verify that the Current Procedural Terminology (CPT) and International Statistical Classification of Diseases (ICD) and Related Health Problems codes for a visit or group appointment are covered, especially if you are using a less established CPT code. If you are conducting shared medical appointments (SMAs), which are popular in the field of lifestyle medicine, be sure to understand the payer requirements and limitations. The rules for insurance reimbursement vary by state, insurance type and health plan. Investigation up front may prevent unpleasant surprises at the time of service.

Sometimes a provider-relations representative within an insurance company can offer more help than the general customer service team. Once you have established relationships with insurance representatives in your area, you should gain a better understanding of the coverage of each health plan and what reimbursement amounts to expect from each visit type.

It may be helpful to connect with a specialist who is familiar with negotiating contracts with insurance companies to maximize your reimbursement. While large health systems often have departments to negotiate these contracts, independent practitioners opening their own practices may find themselves going it alone. Not only will independent practitioners have to negotiate with insurance companies to become an in-network provider, they also have to negotiate reimbursement at a rate that allows them to keep their practice thriving. Even though providers set their own billable rates, insurance companies determine their reimbursement rates, therefore, negotiating these contracts can make or break a smaller practice. It is because of this complexity that some independent providers choose to forgo billing to insurance and instead, open their own cash-pay, DPC or membership-based practices. These types of models are briefly outlined later in this document, but for more information on independent primary care payment options, see ACLM's Independent Primary Care Practice Roadmap in the members-only section of the ACLM website.

Reimbursement Models

Current Reimbursement Strategies

As insurance reimbursement is generally poor or non-existent for using strictly LM-specific codes (e.g. smoking cessation counseling, tobacco counseling, obesity counseling, nutrition counseling, physical activity, health and wellness coaching, etc.) most providers and clinicians in a FFS-world have chosen to use well-established CPT codes for individual and group LM visits. These clinicians simply weave LM into every one of their visits using LM assessment tools and counseling for beneficial lifestyle change. Outlined below are some established practices that have resulted in successful implementation and reimbursement for LM.

Here are some general tips that may help guide your conversation:

- Tell the insurance company what services you plan to provide to the patient and which billing codes you plan to use or ask for their guidance on which codes they suggest you use.

Follow-up with these questions:

- What are the limitations to the code I plan to use?
  - Examples of limitations include the number of visits allowed, size of group, length of visit, diagnosis restrictions, etc.
- If I provide this service in a setting outside of my office, can I still bill and be reimbursed for this service?
  - Keep in mind that insurance might ask how you assure patient confidentiality in the alternative setting.
- If I bill using XXX billing code, will the patient be responsible for a copay or coinsurance?
  - How much with the patient be required to pay?
  - Are there ways around that copay?
- Is there a deductible?
- Is there an out-of-pocket max?
- Is a referral required?
  - Depending on provider type and service delivered, referrals may be required for reimbursement.
- What are the billing guidelines for preventive care services?
  - What are the limitations of preventive care codes? For example, how many times can the preventive care code be used for a patient in a calendar year.
- If the services are being delivered by two different licensed providers in a shared medical visit, can both providers bill for that time?
- What is the reference number for this call? In case you get disconnected or the claim gets denied, you can refer back to this number.

Pediatric patient considerations

- One challenge of providing LM in pediatric patient populations is determining how to choose a diagnosis code — often pediatric patients don't have an ICD-10 code diagnosis that makes sense for an LM visit. If appropriate, consider using preventive care codes and/or weight management codes. Make sure you ask about the limitations of these codes.

Patient Co-pays

- Insurance companies might agree to waive the required copay for patients participating in research-studies.
- Consider applying for a grant to cover patient copays.
- Specialists' copays are often higher than general provider copays.
- Notify patients up front if they may be required to cover a copay.
- Find out whether a patient can use a health savings account to cover the cost of their copay.

Group Visits

Group medical visits are a proven, effective method for enhancing a patient's self-care of chronic conditions, increasing patient satisfaction and access to care, and improving outcomes.

Lifestyle Medicine Shared Medical Appointments (SMAs)

Third-party payers should cover and pay for submitted Evaluation & Management (E&M) coded services for shared medical appointments delivered by a provider. CMS confirms "from a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." Physicians and providers (MD/DO/NP/PA) using individual level E&M codes for group visits must ensure that each patient is engaged individually during the session to meet the guidelines for each code used.

Group visits are often billed as individual office visits using existing CPT codes (e.g., 99212 to 99214). CPT codes should be selected based on the level of complexity of the individual visit and not on length of time spent with the patient in the group education session; time can be used as a controlling factor when counseling dominates individual visits but not when it is shared in a group context. Completing forms and reviewing charts prior to the group visits facilitates the documentation of complexity level after the encounters.

Providers might also be able to obtain reimbursement for time spent on the same day as the E/M coded visits for additional lifestyle medicine interventions, such as group education and behavioral change coaching. E/M visits should be billed with a modifier 25 when provided in addition to another individual or group visit or procedure provided on the same day. The additional service code could be either for preventive care, such as 99401 to 99412, for occupational therapy or other billable lifestyle intervention. The option to use code 99078; physician educational services in a group visit setting, should be verified because many payers will not reimburse for this code. Note that Medicare and Medicaid do not reimburse for these additional codes. Health plans that do reimburse do so mostly for diabetes-related education. Using this modifier for services other than preventive care may require patients to pay out-of-pocket for services, in addition to pay the copay required at each visit.

The ACLM has a variety of complimentary resources, including a step-by-step guide for conducting Lifestyle Medicine Shared Medical Appointments. To learn more please login to your members-only account and navigate to https://www.lifestylemedicine.org/ACLM/Members_Only/Resources/Types/LMSMA_Toolkit.aspx.

The Diabetes Prevention Program (DPP)

The National DPP is a collaboration between the public and private sectors to make it easier for people with prediabetes to participate in evidenced-based intensive lifestyle therapy for the prevention of type 2 diabetes. Programs are offered across the nation. To establish the highest quality standards among DPP providers, CDC established a credentialing process to recognize high quality program providers. Go to the Registry of All Recognized Organizations to see a full list of CDC-recognized programs.

In 2018, CMS included DPP as a Medicare benefit; referring to it as Medicare Diabetes Prevention Program (MDPP). CMS adopted the standards set by the CDC for credentialing providers. Consequently, only CDC-recognized organizations may apply to deliver MDPP for Medicare beneficiaries. Facilitators of MDPP must be a DPP-trained health coach affiliated with a CDC-recognized organization. No other professional qualifications are required.

The DPP curriculum includes a one-hour facilitated group visit each week for at least 16 weeks, followed by two months with two visits per month, then one visit per month for the next 6 to 18 months. Providing DPP requires facilitator time, printed handouts at each visit and occasional incentive products to support behavioral change. Participants weigh-in and record their exercise time at each session. Data management is a significant requirement of the program. Data must be reported to CDC and CMS every quarter and every six months.

Reimbursement by CMS has been designed around participant attendance and achieved weight loss. Consequently, the reimbursement will range from $376 to $760 for full participation and a 5% weight loss during the first year. The second year of participation may pay up to $552 depending on the state and method of delivery (in-person or distance). As commercial plans begin to reimburse for DPP, they are likely to pay more. But until there is widespread and competitive reimbursement for DPP groups, there is little financial incentive to invest in providing MDPP or NDPP. Read more about coding and billing for the National DPP program here and more about reimbursement here.

Teamlets: An Effective Practice Model

Some LM practices leverage teams of primary providers and non-primary providers, such as registered dietitians (RDs) and health and wellness coaches (HWCs), to keep costs lower, see more patients and provide more comprehensive care. Successful models have leveraged a one-provider-per-two-health coach ratio. An example of how these teamlets collaborate is when the primary provider completes the provider-specific portions of each patient encounter and the health coach follows-up with the patient on LM-related goals. In this teamlet model, the primary provider has time to see a few more patients throughout the day and, with revenue from the additional two to three patients seen, the practice can afford to employ the health coach(es). Since there are not currently category I codes to reimburse health coaches for their services, only the provider's time is billed through insurance using standard E&M codes in a teamlet model. As of 2020, health coach category III codes are available to document the newer CPT procedure, which could lead to reimbursement by payers in the future. RDs are able to bill for some of their services, so as long as health plans reimburse for those specific services, they may also bill to insurance in a teamlet model.

Another model that has worked effectively for a LM provider is one in which the physician has no patients scheduled but rather precepts/oversees the activities of two or more Physician Assistants and/or Nurse Practitioners.

Healthcare team

Non-primary provider team members such as registered dietitians, psychologists, psychiatrists, physical and occupational therapists, nurses and social workers often have the ability to bill and get reimbursed for group visits. The CPT code 97804 can be used to bill group dietitian visits for two or more individuals for each 30 minutes of time. CPT code 90853 can be used to provide group psychotherapy. The Health and Behavior (H&B) CPT code 96153 can be used for health and behavior interventions delivered in a group. A model of care where a primary provider facilitates an interprofessional clinical LM team to impact disease treatment reversal addresses both the patient's habits and environment, which is one example of how lifestyle medicine can improve outcome-based quality measures.

Individual Visits

Office and Outpatient Evaluation and Management Codes

A wide range of healthcare professionals across a variety of specialty areas report evaluation and management (E/M) CPT® codes on insurance claims to request reimbursement for services performed in an outpatient setting. In January 2021, the E&M office and outpatient visit CPT codes (99201-99215) were revised to streamline the coding for these commonly reported codes.

According to the American Medical Association (AMA) beginning in January 2021, with the exception for 99211, time alone may be used to select an appropriate code level for the office or other outpatient E&M service codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). In addition, new patient codes 99202-99205 and established patient codes 99211-99215 no longer require the three key components or reference typical face-to-face time but rather require a "medically appropriate history and/or examination." The code selection is based on either medical decision making (MDM) level or total time spent for the visit (see breakdown of each code in Example Billing Codes chart below).

This new code set does not include a 99201 code to avoid redundancy with 99202, both of which require straightforward MDM. The established patient code 99211 no longer includes a reference to time.

For prolonged office or other outpatient services do not report 99354 or 99355 in conjunction with 99205 or 99215, rather use 99417 for each 15 minutes. When billing Medicare or other plans that do not recognize 99417, use G2212 for each 15 minutes of a prolonged visit. Face-to-face prolonged care codes 99354, 99355 are still active, billable codes, but they may not be reported with codes 99202-99215. They may still be reported for prolonged care services with psychotherapy codes 90837, 90847, with office consultation codes 99241-99245, with domiciliary care codes 99324-99337, with home visit codes 99341-99350, and with cognitive assessment code 99483.

Here is an example: After a patient visit it was determined that the coding will be based on time. The notes state 69 minutes spent on counseling with coordinated care planning and communication with the family. Billing for this visit would require 99215 and 1 unit of 99417. If this were a Medicare beneficiary, we would use G2212 instead of 99417. These codes represent each 15 minutes of prolonged service, but when the 15 minutes is completed will be different. See the chart below.

Codes	Time Range	CPT: times to add on 99417	CMS: times to add on G2212
99205	60-74 minutes	75-89 minutes	89-103 minutes
99215	40-54 minutes	55-69 minutes	69-83 minutes

For more information about the use of these codes as well as MDM specifics, please refer to the American Medical Association's website and complimentary E&M Guidelines document.

Chronic Care Management (CCM)

Chronic Care Management (CCM) rewards practices for proactively caring for chronic conditions. A provision of Medicare, CCM enables any clinical staff of the practice to recoup about $40 per 20 minutes spent in the management of chronic conditions for patients. Since it is one of the few ways that the fee-for-service system will pay practices to work with patients on lifestyle and behavior change, it is a critical component of any lifestyle medicine primary care practice, and it can be a big win for the patient's health and customer experience as well. CCM can be performed by medical assistants, health coaches, dietitians, nurses, providers, or any other clinical staff. When performed by talented medical assistants, it can be sufficiently lucrative to incentivize the practice to expand its CCM services as a revenue generator.

CCM services are performed per calendar month for patients with multiple (two or more) chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only one practitioner can bill CCM codes 99490, 99491 and 99487 per month. For more details on CCM visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Collaborative Care Management

Collaborative Care is a specific type of integrated care that operationalizes the principles of the Chronic Care Model to improve access to evidence-based mental health treatments for primary care patients. Collaborative Care is team-driven, led by a PCP with support from a "care manager" (CM) and consultation from a psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals. Collaborative Care codes include 99492, 99493 and 99494. For more information on Collaborative Care visit: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid

AN EXAMPLE OF A VIRTUAL VISIT

As a provider of nutrition services, John E Gobble, DrPH, RDN, LD, FACLM, Dip-ACLM, developed a relationship with a rural medical group in Wheeler County, Oregon for his organization, Lifestyle Medicine Group (LMG), to provide remote, online telehealth nutrition and lifestyle services.

Patients are referred to LMG by their primary care provider, generally a physician assistant (PA) from one of two rural clinics. LMG staff determine eligibility and make the subsequent telehealth appointments. Patients have two telehealth options: 1) use the telehealth computer at their local rural clinic or 2) use their personal device from home.

Telehealth Medical Nutrition Therapy continues to appear on the CMS List of Telehealth Services. MNT codes are also eligible for audio only visits. Most health plans also include the same CMS approved codes on their list of telehealth services.

The session begins when the LMG provider (an RD in this case) joins the patient online for their nutrition consult. Biometric data is self-reported unless they are collected by a clinical staff person when they attend a clinic telehealth appointment. Notes and electronic handouts may be emailed or faxed to the clinic for the patient to pick-up or they may be mailed or emailed to the patient as appropriate. The clinical notes are recorded into the EMR system by the LMG provider and made available to the clinic provider in the patient's record. LMG bills the encounter the same as if they were seen in person but with the location code that indicates it was a remote telehealth visit. When the patient participates in a telehealth visit from the rural clinic, the clinic may also bill for distant telehealth services.

Currently in the state of Oregon, all payer organizations will pay for remote delivery on any secure device or system including in the patient's own home.

Telemedicine

The AAFP defines virtual e-visits as an evaluation and management service provided by a physician or other qualified health professional to a patient using a web-based or similar electronic-based communication network for a single patient encounter. There are now several HIPAA-compliant platforms that providers can choose from to deliver telemedicine services. Telemedicine offers a huge opportunity for LM providers to offer their services with very little overhead while eliminating several common barriers to care, such as transportation and/or long wait times. Medicare and commercial plans publish CPT codes that may be provided through telehealth. Find a current list at CMS.GOV at this link: "List of Telehealth Services."

Cardiac Rehab and Intensive Cardiac Rehab

The intensive cardiac rehabilitation (ICR) programs are based on Lifestyle Medicine philosophy and have proven their efficacy in randomized controlled clinical trials.

The CMS has approved the following intensive cardiac rehabilitation (ICR) programs:

1) Dr. Ornish Program for Reversing Heart Disease

2) Pritikin Program

3) Benson-Henry Institute Cardiac Wellness Program

The Ornish ICR focuses on physical activity, nutrition, stress management and group support. The Pritikin ICR addresses physical activity, nutrition, healthy mindset, and practical teachings like cooking demonstrations and educational workshops.

CR (Traditional Cardiac Rehabilitation) and ICR programs must include the following components:

1) physician-prescribed exercise each day CR and ICR items and services are furnished

2) cardiac risk factor modification

3) psychosocial assessment

4) outcomes assessment

5) an individualized treatment plan detailing how components are utilized for each patient.

The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

The difference between CR and ICR:

1. CR focuses on exercise, education, and counseling, whereas ICR focuses on exercise, nutrition, stress management, and practical applications for sustained health behavioral change.
2. In terms of reimbursement, there is a significant difference between CR reimbursement for inpatient and outpatient locations, whereas ICR reimbursement is the same irrespective of the location.
3. The total duration for CR is 36 hours: for ICR, it is 72 hours.

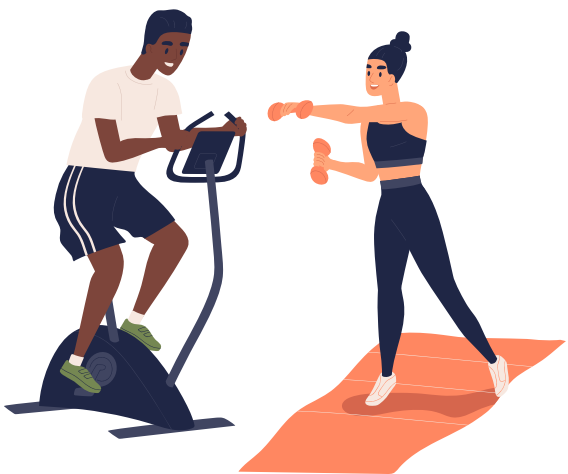
Billing and Coding:

- 93797 (Physician services for outpatient CR; without continuous electrocardiographic [ECG] monitoring [per session])
- 93798 (Physician services for outpatient CR; with continuous ECG monitoring [per session])
- G0422 (ICR; with or without continuous ECG monitoring, with exercise, per session)
- G0423 (ICR; with or without continuous ECG monitoring, without exercise, per session) only when billed with place of service (POS) codes 11 (services provided in a physician's office) or 22 (services provided in a hospital outpatient setting)

Reimbursement:

- In-hospital CR reimbursement is $110.00 per hour, but off-campus CR reimbursement is around $25.00 per hour.
- Average Medicare Reimbursement for ICR is about $110.00 per hour, irrespective of the place of service.

For more information on ICR, visit https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/JA6850.pdf or watch ACLM's Members-only webinar "Cardiac Rehabilitation: An Underutilized Lifestyle Medicine Service" By: Cate Collings, MS, MD, FACC, DipABLM, and Quinn Pauly MD, FAAFP.



Remote Physiologic Monitoring

This service is defined as the "collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time. The five primary Medicare RPM codes are CPT codes 99091, 99453, 99454, 99457, and 99458. Read more about RPM here: 2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule | Blogs | Health Care Law Today | Foley & Lardner LLP

Health and Wellness Coaching

Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The coach is a nonphysician health care professional certified by the National Board for Health and Wellness Coaching or National Commission for Health Education Credentialing, Inc. In 2020, the American Medical Association (AMA) announced the approval of three distinct "Category III" codes for "Health and Well-Being Coaching" which went into effect Jan. 1, 2020. In the fall of 2020, the National Board for Health and Wellness Coaches applied for a taxonomy code for health and wellness coaches and became effective April 1, 2021. More information on health and wellness coaching codes can be found here: American Medical Association Approves New Category III CPT Codes for Coaching (24-7pressrelease.com)

Primary Care First

CMS Center for Innovation recently announced the new Primary Care First model, designed to reward value and quality. Find out more about Primary Care First models and opportunities here: Primary Care First Model Options | CMS Innovation Center

Cognitive Assessment and Care Planning Services

Any practitioner eligible to report E/M services, including physicians (MD and DO), nurse practitioners (NPs), clinical nurse specialists, and physician assistants (PAs) can assess and care for a patient with Alzheimer's disease and related dementias (ADRD). CPT code 99483 provides reimbursement to eligible billing practitioners for a comprehensive clinical visit that results in a written care plan. The code requires an independent historian; a multidimensional assessment that includes cognition, function, and safety; evaluation of neuropsychiatric and behavioral symptoms; review and reconciliation of medications; and assessment of the needs of the patient's caregiver. Find out more here: Cognitive Impairment Care Planning Toolkit (alz.org)

Occupational Therapy (OT)

Occupational therapists are important interprofessional members of the LM care team; they have the time and billing privileges to address many of the most common diagnoses seen in primary care, including diabetes, hypertension, GI discomfort, mental/behavioral issues, neck and back issues (pain) and more, according to a 2019 study. Each OT session starts with complexity-based evaluations using codes (97165, 97166, and 97167) or re-evaluation code (97168). According to the same study, therapeutic interventions can include "lifestyle modification, physical activity encouragement, stress management techniques, social support resources, instruct in good sleep habits" and more.

Medical Nutrition Therapy (MNT)

Medical Nutrition Therapy is a nutrition-based treatment provided by a registered dietitian nutritionist.[1] It includes an assessment and nutrition diagnosis with an intervention followed by appropriate monitoring and evaluation. It may be used as a therapeutic or preventive care counseling service for acute or chronic conditions related to food and nutrition. Many chronic conditions improve with intensive therapeutic lifestyle change billed as MNT for conditions such as obesity, diabetes, hypertension, and cardiovascular disease just to name a few.[2-4]

1. Medical Nutrition Therapy; Reimbursement and Sustainability' DSMES Toolkit; Diabetes; CDC.

Published February 8, 2021. Access July 27, 2021. https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medical-nutrition-therapy.html

2. Academy of Nutrition and Dietetics. MNT: Cost Effectiveness, Cost-Benefit, or Economic Savings of MNT. 2009 https://www.andeal.org/topic.cfm?cat=4085

3. Academy of Nutrition and Dietetics. MNT: Disorders of Lipid Metabolism. 2015. https://www.andeal.org/topic.cfm?cat=5231

4. Academy of Nutrition and Dietetics. MNT: Weight Management. 2015. https://www.andeal.org/topic.cfm?cat=5230

Physical Therapy (PT)

Physical therapists are important interprofessional members of the LM care team. Similar to OT sessions, each PT session starts with an evaluation based on complexity using CPT codes 97161, 97162, and 97163. CPT code 97164 is the PT reevaluation code. PTs can bill for therapeutic exercise 97110, aquatic therapy 97113, neuromuscular re-education 97112, and even group therapeutic procedures 97150, among other services. For more information about PT coverage visit: Local Coverage Article for Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566) (cms.gov)

Medication Therapy Management Services (MTMS)

Medication Therapy Management Service(s) (MTMS) describe face-to-face patient assessment and intervention by a pharmacist. MTMS is provided to optimize the response to medications or to manage treatment-related medication interactions or complications. Three codes 99605, 99606, and add-on code 99607 and guidelines have been established to report the provision of MTMS. The pharmacist will inventory the medication list to identify and/or resolve drug therapy problems such as duplications, underdosing or overdosing, and drug interactions or other types of therapy related issues. The pharmacist may discover medications that need to be added or stopped. This service may include communication of management recommendations to the prescriber. For more information on MTMS visit: CPT® Code - Medication Therapy Management Services 99605-99607 - Codify by AAPC

Medicare Annual Wellness Visit

Medicare covers annual wellness visits once every 12 months. In the first 12 months of a beneficiary's part B coverage cycle, they are eligible for a once a lifetime Initial Preventive Physical Examination (IPPE), which is covered by Medicare. An Annual Wellness Visit (AWV) is also a covered benefit but cannot be done within 12 months after the patient's first Medicare Part B benefits eligibility date, IPPE or AWV. HCPS coding for IPPE includes G0402 (initial preventive physical exam, face to face) and G0468, (federally qualified health center visit that includes IPPE or AWV). HPCS coding for AWV include G0438 (initial visit), G0439 (subsequent visit) and G0468 (federally qualified health center visit that includes an IPPE or AWV). Read more about Annual Wellness Visits Medicare Wellness Visits - ICN MLN6775421 February 2021 (cms.gov)

Medicare Advance Care Planning (ACP)

ACP is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. Medicare waives the ACP coinsurance and the Part B deductible when the ACP is delivered on the same day as a covered MWV both IPPE and AWV (HCPCS codes G0438 or G0439), offered by the same provider as a covered MWV and billed with modifier –33 (Preventive Services). Read more about ACP here: Advance Care Planning (cms.gov)

Intensive Behavioral Therapy (IBT) for Obesity

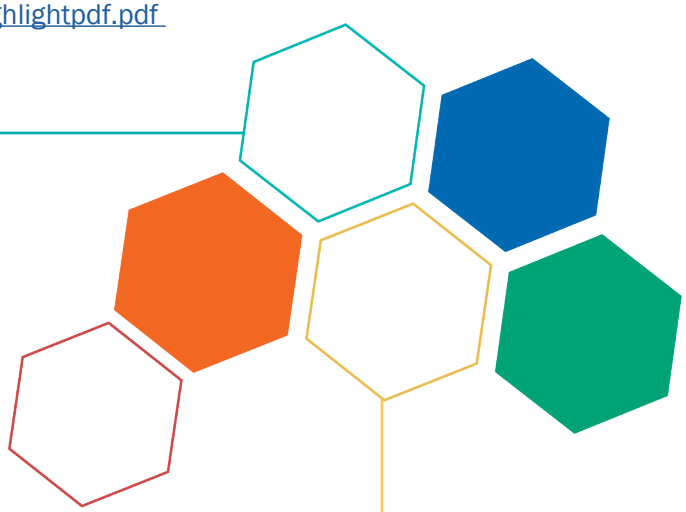
Intensive Behavioral Therapy for Obesity allows Medicare participants who meet the BMI criteria of ≥ 30 kg/m2 up to 22, 15-minute IBT counseling sessions per 12-month period. These visits should be delivered at specific intervals and must be delivered by or "incident to" a physician or practitioner who is present at the time of the visit. CMS will now pay for Intensive Behavioral Therapy for Obesity for Medicare Part B beneficiaries as a group service. In the Final Rule for the 2015 Medicare Physician Fee Schedule, CMS has established a new G-code for group obesity counseling, G0473 Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes. This code will pay similar to the MNT group code 97804 and services must still be furnished in compliance with the existing criteria for the benefit.

NOTE: Barriers to IBT therapy for obesity include the low rate of reimbursement compared to other billable services, specific provider requirements, location specificity of the delivery of care (must be provided in a primary care office) and short (15 minute) appointment slots. To maximize reimbursement for this service, it may be wise to have auxiliary personnel deliver the IBT therapy in a group rather than a primary provider.

More information on Intensive Behavioral Therapy, including who can provide this service and where it can be provided, can be found here: https://www.cigna.com/static/docs/medicare-2019/ibt-obesity.pdf

A note on Social Determinants of Health (SDOH) Z-codes:

SDOH are now widely recognized as important predictors in clinical care and strategies resulting in improved SDOH conditions are associated with improved patient outcomes and reduced costs. SDOH data collection lacks standardization and reimbursement across clinical settings. Official Guidelines for Coding and Reporting states that clinicians other than the patient's provider can document social determinants of health. More widely adopted and consistent documentation is needed to more comprehensively identify social needs, and monitor progress in addressing them. Find out more about SDOH z-codes here: cms-omh-january2020-zcode-data-highlightpdf.pdf



Billing Codes

Whether providing a group visit or an individual appointment with the goal of insurance reimbursement in a FFS setting, consider referring to the codes that other LM providers are using in the current FFS model. This list is not all-encompassing, nor does it specify provider type; rather it is meant to be a helpful point of reference. Note that prevention-focused visit codes for older children and adults may only be able to be utilized once in a calendar year. It is important to check with the individual insurance carrier to determine eligibility for using these codes more frequently. Additionally, reimbursement amount varies substantially among the different codes, different states, and for different insurance carriers. Some codes are also specific to a provider type (i.e., registered dietitian vs. physician). ACLM recommends checking with your insurance payers regarding expected reimbursement rate and required provider type for each code you plan to utilize for LM services

CODE	**Service/Procedure Description**			**2021 CMS National Non facility Rate[1]**
	E/M: New Problem-focused Office Visits			
	MDM	**Total Minutes**	**RVU**	
99202	Straightforward	15-29	2.12	$73.97
99203	Low	30-44	3.26	$113.75
99204	Moderate	45-59	4.87	$169.93
99205	High	60-74	6.42	$224.36
	E/M: Established Problem-focused Office Visits			
	MDM	Total Minutes	RVU	
99211	N/A	N/A	0.66	
99212	Straightforward	10-19	1.63	$56.88
99213	Low	20-29	2.65	$92.47
99214	Moderate	30-39	3.76	$131.20
99215	High	40-54	5.25	$183.19
99417	Prolonged service code to be used only when billing 99205 and 99215 based on time (not MDM) when a service extends beyond the minimum required time of the primary procedure time increments.			
2212	Prolonged service code to be used only when billing 99205 and 99215 to CMS or payers who do not recognize 99417 based on time (not MDM) when a service extends beyond the minimum required time of the primary procedure time increments.			
99354	Prolonged services codes, descriptor states that you should not use these codes as add on codes with office/outpatient codes 99202-99205 and 99212-99215.			$129.10
99355				$100.91
Preventive: New Prevention-focused Office Visits				**50th Percentile (3)**
99381	<1 yr.			$189.00
99382	1-4 yr.			$200.00
99383	5-11 yr.			$200.00
99384	12-17 yr.			$224.00
99385	18-39 yr.			$250.00
99386	40-64 yr.			$280.00
99387	65+ yr.			$292.00

Preventive: Established Prevention-focused Office Visits		50th Percentile (3)
99391	<1 yr.	$162.00
99392	1-4 yr.	$175.00
99393	5-11 yr.	$175.00
99394	12-17 yr.	$192.00
99395	18-39 yr.	$215,00
99396	40-64 yr.	$230.00
99397	65+ yr.	$245.00
Preventive: Medicare		
G0402	Welcome to Medicare – Initial Preventive PE (IPPE)	$169.02
G0403	EKG for IPPE	$17.30
G0404	EKG tracing for IPPE	$8.65
G0405	EKG interpret and report of IPPE	$8.65
G0101	Pelvic/breast exam	$39.64
Q0091	Pap	$44.33
G0102	Digital Rectal Exam (DRE)	$22.70
G0438	Annual Wellness Visit (AWV) initial	$174.43
G0439	Annual Wellness Visit (AWV) subs.	$118.21
99497 (add tp AWV)	Care planning including the explanation and discussion of advance directives, first 30 min	$86.49
99498 (add to AWV)	Care planning include. explanation and discussion of advance directives, additional 30 min	$76.04
Patient Counseling		
G0108	DM outpatient self-management training services, individual, per 30 min	$56.22
G0109	DM outpatient self-management training services, group session (2 or more), per 30 min	$15.50
99406	Tobacco cessation counseling visit; intermediate, greater than 3-10 min	$15.14
99407	Tobacco cessation counseling visit; intensive, greater than 10 min	$28.83
G0446	IBT-CVD Annual, face-to-face intensive behavior therapy for CVD, indiv., 15 min	$26.67
G0447	IBT-Obesity Face-to-face behavioral counseling for obesity, 15 min	$26.31
G0473	IBT-Obesity Face-to-face behavioral counseling for obesity, group (2-10), 30 min	$12.97
G0442	Alcohol: Annual screening, 15 min	$18.38
G0443	Alcohol: Face-to-face behavioral counseling, 15 min	$26.67
G0444	Annual screen for depression	$18.38
G0475	HIV Screening	--[2]
99078	Physician educational services rendered to patients in a group setting	--[2]
Medical Nutrition Therapy (RDs-Only)		
97802	Initial assess and intervention, ind, face-to-face with the patient, each 15 min	~$38

97803	Re-assess and intervention, ind, face-to-face with the patient, each 15 min	~$34
97804	Group (2 or more individuals), each 30 min	~$18
G0270	Reassessment and subsequent intervention(s) for change in dx, medical condition or treatment regimen, individual, each 15 min	$32.80
G0271	Reassessment and subsequent intervention(s) for change in diagnosis, medical condition or treatment, group (2 or more), each 30 min	$17.30
Behavioral Health		
90791	Psychiatric diagnostic evaluation	$140.19
90792	Psychiatric diagnostic evaluation with medical services	$157.49
90832	30 minutes with patient and/or family member	$68.47
90833	30 minutes with patient and/or family member when performed w E/M	$71.00
90834	45 minutes with patient and/or family member	$91.18
90836	45 minutes with patient and/or family member when performed w E/M	$89.74
90837	60 minutes with patient and/or family member	$136.95
90838	60 minutes with patient and/or family member when performed w E/M	$118.57
Remote Physiologic Monitoring		
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.	$19.46
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.	$64.15
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/ other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month.	$51.54
Chronic Care Management		
99490	CCm	$42.17
99487	Complex CCM	$92.98
99489 (use with 99487)	Complex CCM Add-on	$46.49
G0506	Add on to CCM Initiating Visit	$63.43
Cardiac Rehab		
93798	Physician services for outpatient cardiac rehabilitation w/ continuous ECG monitoring (per session)	$25.95
93797	Physician services for outpatient cardiac rehabilitation without continuous ECG monitoring (per session)	$16.58
G0422	Intensive Cardiac Rehabilitation; with or without continuous ECG monitoring, with exercise, per session	$118.21
G0423	Intensive Cardiac Rehabilitation; with or without continuous ECG monitoring, without exercise, per session	$118.21

Preventive Care Counseling		
99401	Preventive Care counseling visit; 15 min	$60.00
99402	Preventive Care counseling visit; 30 min	$100.00
99403	Preventive Care counseling visit; 45 min	$165.00
99404	Preventive Care counseling visit; 60 min	$185.00
99411	Preventive Care counseling group; 30 min	$44.00
99412	Preventive Care counseling group; 60 min	$50.00
Occupational Therapy		
97165	Occupational therapy evaluation, low complexity, each 15 minutes	$168.00
97166	Occupational therapy evaluation, moderate complexity, each 15 minutes	$175.00
97167	Occupational therapy evaluation, high complexity, each 15 minutes	$114.00
97168	Re-evaluation of occupational therapy, each 15 minutes	$97.00
Physical Therapy		
97161	Physical therapy evaluation, low complexity, each 15 minutes	$150.00
97162	Physical therapy evaluation, moderate complexity, each 15 minutes	$150.00
97163	Physical therapy evaluation, high complexity, each 15 minutes	$95.64
97164	Re-evaluation of physical therapy, each 15 minutes	$87.00
Other Therapy (performed by PT or OT)		
97110	Therapeutic exercise to develop strength and endurance, each 15 minutes	$56.35
97113	Aquatic therapy and therapeutic exercise, each 15 minutes	$60.00
0591T	Health and Well-being Coaching face-to-face; individual, initial assessment	For reporting only
0592T	Health and Well-being Coaching individual, follow-up session, at least 30 minutes	For reporting only
0593T	Health and Well-being Coaching group (two or more individuals), at least 30 minutes	For reporting only

1. Physician Fee Schedules derived from CMS Physician Fee Schedule Search. Search criteria included Search Year of 2019, National Payment amount, Global OR Physician Professional Service where Profession/Technical concept does not apply.
2. CMS provides no guidance on reimbursement for these codes, ACLM recommends contacting your insurer to determine whether these codes are covered and rate of reimbursement
3. Values published in “National Fee Analyzer 2019’ by OPTUM 360®

Non-FFS (Alternative) Payment Options

The future of reimbursement is exciting and overwhelming. Some LM practitioners and organizations are looking towards non-fee-for-service models to get paid to practice. In 2019, ACLM co-published two documents on alternative payment models, "Medical Payment Models Alignment with Lifestyle Medicine" and a supporting "Matrix on Medical Payment Models' Alignment with Lifestyle Medicine" to understand which alternative payment and organizational models best align with the practices and physician competencies of lifestyle medicine. Please refer to the ACLM members-only directory to download and read more. Many alternative payment models, including those delivered through an organizational structure, are highlighted below.

DPC Practice:

The direct primary care (DPC) model gives family physicians a meaningful alternative to fee-for-service insurance billing, typically by charging patients a monthly, quarterly, or annual fee. This fee covers all or most primary care services including clinical and laboratory services, consultative services, care coordination, and comprehensive care management. See DPC explained on YouTube, search "DPC Healthcare."

- Monthly membership fees paid by patients or, sometimes, the patient's employer
- Patient fees cover extended visits, clinical, lab and consultative services, care coordination, and comprehensive care management
- Do not accept insurance or participate in government programs, relying solely on patient fees

Concierge Practice:

- Annual patient membership contract with higher fees that can be paid annually or monthly
- Membership fees cover an in-depth physical exam and screenings
- May continue to accept insurance plans and government programs
- Continue to bill the patient's insurance company for covered services in addition to membership fee
- Cater to higher income populations

Micro-practices

In a micro-practice a clinician opens a small clinic and runs it alone or with limited administrative staff. The overhead expenses are low because she/he doesn't need to generate the income to pay for a large clinic, allowing the provider to dedicate more time to each patient. This is often accomplished by the use of technology and by increasing the patients' involvement in their own care. Most communication and scheduling is accomplished online, so the clinic has minimal administrative burden. The micro-practice model requires that patients feel comfortable with actively providing their input and getting involved in their own care by completing pre-visit questionnaires and by engaging in self-service using the technological tools made available. Micro-practices may utilize telehealth platforms to maintain contact and high levels of access to the provider. In this practice model, the provider could leverage membership fees, similar to a DPC/Concierge model, accept cash payments, or could bill insurance using codes outlined above to get paid for their services.

Hybrid Models

Many providers combine a variety of strategies to get reimbursed for LM Services. For example, they may

Commonly Used Diagnosis Code(s) for LM Visits:

Screening: Z13.220,

History: Z72.0, Z87.891, Z82.49, F17.210, F17.211, F17.213, F17.218, F17.219,

Overweight (BMI 25-29.9): E66.3, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29,

Obesity (BMI 30 –39.9): E66.1, E66.8, E66.9, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39,

Morbid Obesity (BMI 40 and Over): E66.01, E66.09, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45,

Impaired Fasting Glucose: R73.01,

Metabolic Syndrome: E88.81,

Hyperlipidemia/Dyslipidemia: E78.0, E78.1, E78.2, E78.3, E78.4, E78.5,

Essential Hypertension: I10,

Secondary Hypertension: I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,

Diabetes Mellitus: E11.9, E11.8, E11.69, E11.65, E11.649, E10.9, E10.8, E10.69,

Secondary Diabetes Mellitus: E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319,

Atherosclerosis: I70.0, I70.1, I70.201,

Coronary Atherosclerosis: I25.10, I25.110, I25.111, I25.118, I25.119, I25.700.

accept insurance from some of their patients and have a small practice membership fee above and beyond that to cover costs accrued that are not covered by low reimbursement rates from insurers. To supplement their earnings, they may offer Direct Primary Care/ Membership to their practice for another group of patients who are uninsured. Hybrid models may be a great way to diversify your patient and payer populations and ensure that you maintain enough income to keep a thriving LM operation.

Capitation

Managed care organizations are integrated entities in the healthcare system that aim to reduce healthcare expenditures costs through capitated payment. Capitation is when a fixed amount of money per patient per unit of time is paid in advance to a physician for the delivery of health care services. Payment varies from plan to plan and is determined by the range of services provided, the number of patients, and the period of time during which the services are delivered. Capitation payments control the use of health care resources by putting the physician at financial risk for services provided to patients. When a primary care provider signs a capitation agreement, the contract includes a list of services that must be provided. Find out more about capitation payments here: Capitation Payments | Understanding Capitation | ACP (acponline.org)

Direct Contracting

Direct contracting is when a self-funded employer contracts directly with a health care provider for health care services. Direct contracts might connect an employer to an entire health system, negotiating prices for a variety of services and providers, or they may be limited to a specific set of services for an agreed upon rate by a smaller practice or individual provider. With either approach, this process gives employers direct access to health care providers (whether health systems or individual providers) without having to utilize the network of an insurer or third-party administrator. While providers or systems may take on more risk with direct contracting, they may also negotiate consistent payment for their services. For more information and resources related to direct contracting visit: Direct-to-employer contracting: What doctors should know | American Medical Association (ama-assn.org)

Shared Risk/Reward models

Ken Beckman, Vice President and Actuary at Central States Indemnity, has proposed a shared risk-reward model of payment that would incentivize physicians to keep their patients healthy. At this point, his idea is theoretical but has huge monetary potential for both LM physicians and insurance companies. It could easily be pitched by an LM provider to self-insured employers who have a lot to gain by keeping their employees healthy.

The idea is to incentivize the physician or provider for improving the health of a chronic disease patient using LM approaches. We know that LM is time intensive; it takes a lot more work and is a lot more difficult than simply giving a patient a pill and sending them out the door. By aligning the monetary incentives with the improvement of the patient's health outcomes, we are much more likely to see a change in the system and the way care is delivered. Here is how this scenario plays out: Say you have a patient who is diabetic and is currently costing about $15,000 in claims per year. That patient partners with their LM provider or team and are fairly quickly able to reverse or dramatically improve their disease, come off their medications, eliminate future procedures, etc. Now they only cost the system around $1,000 per year in claims. In Ken's model, the physician or provider would receive a percentage or amount of the $14,000 of cost savings for as long as the patient remains healthy.

You could even have smaller compensations, on top of a provider's regular fee schedule, for simply mentioning the concept and/or providing resources/information for those who are interested. . There is a lot of evidence to suggest that physicians/providers aren't even bringing up lifestyle changes with their patients; starting those conversations is imperative and not having them could be considered negligent. Provider recommendations have a huge impact on patient actions so it makes sense for a provider to be the one to bring the option of LM as treatment to their patient's attention, even if they aren't the one to actually deliver the LM at the end of the day.

Health Savings Accounts/Flexible Spending/Health Reimbursement Arrangement (HSA/FSA/HRA) Eligible Services

Consider learning what LM services might be HSA/FSA/HRA eligible for your patients who may not have coverage for your services.

A few notable ones include:

- Alcoholism Treatment
- Drug addiction treatment
- Nursing services
- Physical exam
- Physical therapy
- Psychiatric care
- Smoking cessation program and medications
- Telehealth services (pre-deductible)
- Weight loss program necessary to treat a specific medical condition

*possibly Fertility treatment

List of eligible covered services can be found here: List of HSA, Health FSA, and HRA Eligible Expenses (connectyourcare.com)

Organizational Structures

Certain organizational structures are more aligned with LM than other structures, which is largely tied to how providers are incentivized, paid and how quality is measured for the services delivered.

Accountable Care Organizations

Accountable Care Organizations (ACOs) provide Medicare beneficiaries with coordinated care and chronic disease management and are incentivized to lower cost of care. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program. ACOs are eligible to participate in special programs through CMS. Due to aligned incentives, ACOs are the perfect environment for LM to thrive. Find out more about ACOs on the CMS website here: Accountable Care Organizations (ACOs): General Information | CMS Innovation Center

Federally Qualified Health Centers (FQHC)

Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. Some providers are choosing to leverage these practices as a way of providing LM. FQHCs must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. Most health centers receive Health Center Program federal grant funding to improve the health of underserved and vulnerable populations. Some health centers receive funding to focus on special populations, including individuals and families experiencing homelessness, migratory and seasonal agricultural workers, and residents of public housing. The majority of health center operating funds come from Medicaid, Medicare, private insurance, patient fees, and other resources. To read more about this model: https://bphc.hrsa.gov/about/what-is-a-health-center/index.html

Veterans Health Administration

The Veterans Health Administration receives funding each year appropriated by Congress to pay for the delivery of health care services to eligible veterans. Providers at the VHA system also have salaries that follow a common pay scale posted publicly online. Perhaps due to having a pre-determined amount of money to care for veterans and salaries that are not connected to increased volume of patient visits, there is an increased incentive for the VA providers to keep health care costs low while providing better care to patients. Similar to value-based models, payment for hospitals within the system is usually tied to patient risk scores, which incentivizes taking on high risk patients but may financially disincentivize disease reversal/remission. Nonetheless, the VA healthcare system has taken a proactive initiative to launch a Whole Health model of care to address multiple lifestyle health behaviors that are associated with poor health outcomes. While this model of care has roots in integrative and functional medicine, all of the evidence-based pillars of lifestyle medicine (nutrition, physical activity, stress, sleep, social connectedness, substance abuse) are addressed via services and interprofessional teams in the Whole Health program. Find out more about Whole Health here: Whole Health Basics - Whole Health (va.gov)

If you are an LM provider who has discovered strategies to receive reimbursement, work in a health system using value-based, capitated care, shared savings or are a part of an accountable care organization and know of a reimbursement strategy that is not already listed in this document, or if you would simply like to elaborate on your experiences with these strategies, please reach out to groups@lifestylemedicine.org

Future Reimbursement

It's hard to imagine what the future of reimbursement for lifestyle medicine might look like. However due to rising costs and continued poor health outcomes in the United States, increased emphasis has been placed on moving away from FFS payment toward more value-based payment models. According to the American Academy of Family Physicians (AAFP), Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care. Value-based payment has been touted as the way of the future for health care transformation; it certainly offers hope for more aligned, efficient and effective payment for what LM clinicians, programs and departments uniquely have to offer. The ACLM will continue to monitor and advocate for the alignment and incentivization of value-based payment models with LM-based disease remission/reversal/prevention.

Three priority initiatives that ACLM advocacy efforts are currently targeting include National Provider Identifier (NPI) expansion to cover certain approved community-based organizations (CBOs), support for continued telehealth coverage for LM services, and quality measure alignment to incentivize, not penalize, disease remission and reversal using therapeutic LM interventions.

As a part of our strategic plan, ACLM is also supporting the further development and refinement of the effective and consistent delivery of LM through several projects and initiatives including, but not limited to: support for expansion of the previously published ACLM Specialist Competencies; a series of Expert Consensus Statements related to the application of LM including type 2 diabetes remission using WFPB diets, ideal LM practice models and Shared Medical Appointments; two new papers on LM and healthcare economics (reimbursement and medication deprescription); research pilot projects in underserved communities, collaborations and strategic partnerships with organizations, such as the YMCA, the Physical Activity Alliance, the Primary Care Collaborative, the Healthcare Transformation Taskforce, Wellcoaches, the National Board of Health and Wellness Coaching, the Accountable Care Learning Collaborative and members of our Health Systems Council.

ACLM is committed to championing the causes listed above on behalf of our members and health system partners. We will continue to listen to feedback from our members, offer resources and support, and involve our members in our advocacy efforts when necessary.

One service that may be of interest for LM providers to track for 2022 is the new Remote Therapeutic Monitoring CPT codes. Read more about Remote Therapeutic Monitoring CPT codes introduced in Proposed 2022 Medicare Physician Fee Schedule — Nixon Gwilt Law

Helpful Resources:

Cardiac Rehabilitation:
https://www.cms.gov/Medicare/MedicareContracting/ContractorLearningResources/downloads/JA6850.pdf

Shared Medical Appointments:
https://www.aafp.org/about/policies/all/shared-medical.html

Coding Tips for Group Visits:
https://www.aafp.org/practice-management/payment/coding/group-visits.html

Time based Coding:
https://www.aafp.org/fpm/2008/1100/p17.html

Coding for Preventive Medicine Services:
https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/avoiding_mistakes_preventive_coding.html

Preventive Medicine Coding:
https://hcfraudshield.wordpress.com/2018/01/05/preventive-medicine-counseling/

Coding for Obesity:
https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Obesity-Toolkit/Coding-for-Obesity/Synopsis-Coding-for-Obesity?IsMobileSet=false

Medicare Wellness and Care Coordination Services:
https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services.html

Remote Physiologic Monitoring:
https://www.healthcarelawtoday.com/2018/08/01/medicar2es-new-chronic-care-remote-physiologic-monitoring-codes-everything-you-need-to-know/

Chronic Care Management
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

Chronic Care Management FAQs
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

CMS Physician Fee Schedule Search:
https://www.cms.gov/apps/physician-fee-schedule/search

CPT Codes for Psychiatry Services:
https://psychcentral.com/lib/cpt-codes-for-psychology-services/

Health Behavior Assessment and Intervention Codes:
https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior

Psychotherapy Codes for Psychologists:
https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy?apaSessionKey=oqBEHxi1T7anJxWSRDCABvSQ

Medical Nutrition Therapy:
https://www.eatrightpro.org/payment

2020 New Digital Health CPT Codes
https://www.ama-assn.org/practice-management/cpt/6-new-digital-health-cpt-codes-you-should-know-about

USPSTF 2018 Preventive Guidelines
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Diabetes Prevention Program Coverage Toolkit:
Coding & Billing - National DPP Coverage Toolkit

Healthcare Transformation Taskforce:
Health Care Transformation Task Force | Patients, Payers, Providers and Purchasers (hcttf.org)

Accountable Care Learning Collaborative:
Accountable Care Learning Collaborative (accountablecarelc.org)

Physical Activity Alliance:
Strategic Policy Priorities - PAA (paamovewithus.org)

Other resources:

A variety of practice tools are available on ACLM's Members-Only website that can make it easier to create a lucrative Lifestyle Medicine practice. Tools include provider assessment tools, patient education tools, general patient intake forms, powerpoint presentations, key Lifestyle Medicine talking points, letter templates to insurance companies and patient waivers. Please refer to your ACLM members-only practice resource web page while logged into your account to access these materials.

ACLM is also working on a variety of initiatives to improve reimbursement barriers for providers through advocacy, awareness building and research.