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CMS's Final Decision on Intensive Behavioral Counseling for Obesity December 1, 2011

The American Dietetic Association understands and shares members' concerns about the announcement by the Centers for Medicare & Medicaid Services (CMS) on Tuesday, November 29 about their decision to cover Intensive Behavioral Counseling for Obesity for eligible Medicare beneficiaries. We'd like to share the following information in an effort to answer member questions about this decision and what it means for Registered Dietitians (RDs).

How did CMS make this decision?

Through the Medicare Improvements for Patients and Providers Act (MIPPA), CMS has the authority to add coverage of additional preventive services under a process called a National Coverage Determination. This process is not a legislative one, meaning the decision is not made through Congress. Rather, CMS is the decision-making body. CMS is required to evaluate relevant clinical evidence to determine whether or not the proposed service meets three criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Is recommended with a Grade A or B by the US Preventive Services Task Force; and
3. Is appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare program.

The process includes two opportunities for public comment. On March 11, 2011 CMS announced it was opening a national coverage analysis for Intensive Behavioral Therapy for Obesity with a 30-day public comment period. On August 31, 2011 CMS issued its proposed decision memorandum with a 30-day comment period.

Was ADA involved?

Definitely! ADA offered comments during both public comment periods. These comments incorporated input from members with expertise in weight management services and were reviewed and approved by member leaders. Visit <http://www.eatright.org/mnt/> and scroll down to "Medicare MNT Coverage Expansion" to read more. In November ADA also met with CMS staff, along with other members of the Obesity Care Coalition, to advocate for inclusion of RDs in the proposed benefit.

What exactly did CMS decide to cover?

CMS determined it will cover screening and intensive behavioral counseling for obesity by primary care providers in settings such as physicians' offices for Medicare beneficiaries with a body mass index (BMI) ≥ 30 kg/m². Specifically, Medicare will cover:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary has achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy.

The service must be furnished by a "qualified primary care physician or other primary care practitioner and in a primary care setting." CMS refers to the Social Security Act for its definition of a "qualified primary care physician" to mean a physician who is a general practitioner, family practice practitioner, general internist or obstetrician or gynecologist. In similar manner, CMS defines "primary care practitioner" as a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine or a nurse practitioner, clinical nurse specialist, or physician assistant in accordance with the Social Security Act.

Lastly, the service must be furnished in the primary care setting. CMS defines a primary care setting "as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition."

What was the rationale behind CMS's decision to not include RDs as providers of these services?

Based on CMS's responses to public comments in this final decision memo as well as the one issued earlier this month for Intensive Behavioral Counseling for Cardiovascular Disease, it appears that CMS excluded RDs for two reasons:

1. CMS believes it lacks the statutory authority to include RDs as providers outside of diabetes and end stage renal disease; and
2. CMS believes it is important that preventive services be furnished in a coordinated approach as part of a comprehensive prevention plan within the context of the patient's total health care. As such, they believe primary care practitioners are best qualified to offer care in this context.

How will these services be paid and when does the benefit become effective?

The answers to these questions have yet to be determined. CMS is in the process of establishing codes and developing the claims processing instructions for this NCD.

What do we do now?

As individual practitioners:

RDs as providers of nutrition services have 2 options when it comes to obesity services for Part B Medicare beneficiaries:

1. The CMS decision memorandum does state that the new benefit does not preclude primary care practitioners from referring eligible beneficiaries to other practitioners and/or settings for counseling; however coverage remains only in the primary care setting. So RDs can receive referrals for these services, but the Medicare beneficiary would need to be informed prior to providing the service that it is not covered by Medicare and they would be required to pay out of pocket for the service.
2. The CMS decision memorandum also states that in the primary care office setting and primary care hospital outpatient setting, Medicare may cover these services when furnished by auxiliary personnel (e.g., RDs) and billed as “incident to” services in accordance with 42 CFR section 410.26(b) or 410.27, meaning:
 - a. There is direct physician supervision of auxiliary personnel (the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is being provided).
 - b. “Auxiliary personnel” means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

Note: Medicare Part B MNT services for diabetes and non-dialysis renal disease cannot be billed as “incident to” services since they are recognized as a separate benefit category.

We recognize that both of these options fall short of the ideal scenario. However, as healthcare delivery and payment models move away from fee-for-service to bundled payment models (such as Patient-Centered Medical Homes and Accountable Care Organizations), now is a good time for RDs to align themselves with primary care practitioners in new ways. Continue to market yourself and your services to both primary care practitioners and Medicare beneficiaries to create demand for your services and demonstrate the value you bring to a comprehensive and coordinated model of care. As an RD, you can positively impact a practice’s bottom line by helping patients and the practice achieve positive clinical outcomes. **Most importantly, you can collect, report, and publish outcomes data to strengthen the foundation of clinical evidence used by CMS and others in making coverage decisions.**

As ADA:

The Nutrition Services Coverage team and the Policy Initiatives and Advocacy team are strategically working to position RDs as providers of MNT in other disease conditions through a variety of initiatives. With this new insight into CMS’s approach to expanding coverage, we are exploring potential strategies on both the legislative and regulatory fronts. We will continue to share information with members through all available communication channels.

Click [here](#) to read the full CMS Final Decision Memorandum.

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