

Reimbursement as a Catalyst for Advancing Lifestyle Medicine Practices

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Advancing lifestyle medicine into current medical practice is predicated on strategies for reimbursement. Research studies demonstrate that intensive therapeutic lifestyle change interventions are both clinically efficacious and provide an impressive return on investment.^{1,2} However, traditional fee-for-service (FFS) health-care models often do not adequately value lifestyle medicine approaches or provide sustainable reimbursement for the time intensive, longitudinal interaction required for success. Fortunately, the reimbursement landscape continues to evolve—both for private and public payers. With the introduction of alternative payment models, value-based payment systems, and the Centers for Medicare & Medicaid Services (CMS) Innovation Center, many reimbursement programs are moving professional reimbursement away from the traditional FFS model toward population health management.³ This trend will continue as the United States addresses rising healthcare costs.

Lifestyle medicine practice may be delivered through a variety of implementation strategies. To simplify the illustration of reporting requirements, we provide 2 common practice models: the independent or solo practitioner and the practice team approach.

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DISCLOSURES

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THE INDEPENDENT OR SOLO PRACTITIONER

As a solo practitioner or a single lifestyle medicine provider within a larger practice, lifestyle treatment strategies can be provided at each office visit. Preparing a claim for an office visit involves utilizing standard evaluation and management (E/M) codes 99202–99215. For an individual visit, select the code on the basis of time as outlined in the 2021 E/M coding update.⁴ This strategy should include the time spent on the day of the visit reviewing the patient's chart, preparing educational materials, documenting the counseling interaction, and subsequent follow-up emails. However, these visits will be subject to deductibles and copays. If you are providing a service rated by the United States Preventive Services Task Force (USPSTF) as an A or B recommendation, include the modifier 33. The modifier identifies the service as preventive care according to the USPSTF guidelines and, therefore, the service is not subject to deductibles or copays.

Screenings and specific counseling are included as A or B recommendations by the USPSTF.⁵ For example, colorectal screening may be differentiated from a diagnostic test by using modifier 33. Counseling for cardiovascular risk reduction as specified by the USPSTF may also be designated using modifier 33 along with an E/M code.

Modifier 33 is not appropriate to use with codes specifically designated as preventive care, such as tobacco use cessation counseling (ie, 99407), or preventive care counseling (99401–99404). It is important to be aware that the relative value units (RVU) and reimbursement rate for preventive care counseling codes are significantly smaller than the E/M codes. However, these preventive codes may be advantageous to use when billing these services as “incident to” where another member of the staff provides the service (eg, a health coach or other clinical staff).

For increased efficiency and effectiveness, the individual practitioner may choose to schedule multiple patients at the same time. This is called a shared medical appointment (SMA).

TABLE 1. Commonly used billing codes in primary care lifestyle medicine

Service	CPT/HCPCS	Insurance	Details
Office visit	99202-99215	All	This is the core activity of most lifestyle medicine practices. Use modifier 33 for preventive services
Chronic care management (CCM)	G0506, 99490	Medicare FFS	
Annual wellness visit (AWV)	G0438, G0439	Medicare	
Electrocardiogram	G0403	Medicare	
Depression screening	G0444	Medicare	
Alcohol screening and counseling	G0442, G0443	Medicare	
Tobacco screening and counseling	1000F, 99406, or 99407	All	
Lung cancer screening	G0296	Medicare	
Annual advance care planning	99497, 99498	All	Part of AWV; Z71.89
Remote physiologic monitoring (RPM)	99453, 99454, 99457, 99458	Medicare FFS	Also called remote patient monitoring

CPT, Current Procedure Code; HCPCS, Healthcare Common Procedure Coding System.

An SMA is a clinical encounter in which multiple patients receive education and counseling, physical examination, and clinical support in a group setting (see **Considerations and Requirements for Shared Medical Appointments**).^{6,7} SMAs are especially advantageous when seeing patients with the same condition, allowing the practitioner to provide more in-depth education and spend substantially more time with patients than is practical in an individual encounter. SMAs may also be useful for family physicians who do not have the additional resources commonly found in a team-based practice. Standard E/M codes are utilized for reimbursement of the appointment for each individual patient.

Direct primary care (DPC) is an alternative to the FFS practice where the patient pays regular monthly, quarterly, or annual membership fees for all or most primary care services.⁸ The DPC model creates more flexibility in treating patients and allows more communication options outside the office visit such as phone, text, email, and telehealth. This may be more conducive to providing lifestyle medicine interventions with a larger proportion of patients.

THE OFFICE TEAM PRACTICE

When lifestyle medicine becomes the driving force for a group practice, everyone has a role in delivering services that promote beneficial lifestyle modification. The team may comprise multiple other professionals in addition to the primary care providers (MD, DO, PA, or NP). Nurses, medical assistants, dietitians, occupational therapists, physical therapists, certified health coaches, health educators, and others can all help the practice achieve healthy lifestyle change for its patients.

The patient-centered medical home (PCMH) is a team-based practice model with the goal of lowering cost and improving patient outcomes. The PCMH may be an effective practice model for lifestyle medicine because it treats the patient holistically, provides patients extended access to providers, effectively coordinates care with other providers, and engages patients in their own care.⁹

A lifestyle medicine practice employs primarily the same types of visits and billing codes as a traditional practice, summarized in **TABLE 1**, including billing based on time spent as outlined in the 2021 E/M coding update. The annual wellness visit provides the opportunity to collect appropriate data to prepare a patient care plan for the year. Medicare allows patients with 2 or more chronic conditions and a chronic care plan (G0506) to be followed by a care manager (99490 for 20 minutes, 99439 for each additional 20 minutes up to 60 minutes total) each month throughout the year, tracking patient progress on the basis of the care plan (see **Chronic Care Management**). Certified medical assistants or certified health education specialists are well suited for this role.

Any Medicare patient may be enrolled in remote physiologic monitoring (RPM) irrespective of chronic conditions. RPM supports the regular use of devices to monitor patient biometrics each month such as weight, blood pressure, heart rhythm, or self-management of blood glucose. Appropriate codes include 99453, 99454, and 99457.

One tool that lifestyle medicine providers commonly employ is the group intensive therapeutic lifestyle change (ITLC) program. An ITLC program is evidenced-based, multimodal, and provides multiple sessions (usually 8 to 20) for

at least 60 minutes per session with a duration of 10 days or longer. Specific outcome metrics are measured, and consistent results are obtained, accounting for variation in populations, adherence, and engagement.¹⁰ Such programs can be a powerful way to deliver education, counseling, and coaching of multiple patients at one time, thereby encouraging the adoption of healthy behaviors. Such programs offer the advantage of efficiency, adequate reimbursement, and the powerful group dynamic for patients to support one another. Several types of professionals may contribute to this effort. For example, a registered dietitian nutritionist (RDN) may provide an ITLC program as medical nutrition therapy (MNT, 97804). These programs may be a combination of individual and group visits offered throughout the year.

Frequently, it is most efficient for the primary care provider (PCP) to enlist help implementing an ITLC program from one or more assistants, including dietitians, behavioral therapists, nurses, or other health professionals. The PCP may report the encounter as an SMA with the other provider types providing the bulk of the content as “incident to” using regular E/M codes or as preventive care counseling.

Throughout the year, the PCP may extend an office visit with a one-hour extender code (99354) to have the patient spend an hour with a physical therapist, occupational therapist, or a behaviorist on the same day. Of course, there is also the option to refer patients for additional lifestyle support to appropriate provider types (eg, RDN, behavioral therapist) who are able to code for their own services.

DISCUSSION

The COVID-19 pandemic has highlighted the worsening health outcomes for individuals with underlying chronic medical conditions including obesity, hypertension, diabetes, heart failure, and chronic kidney disease.¹¹ There may be a silver lining emerging from this tragedy, as the disruption caused by the pandemic has also forced a re-evaluation of what services are reimbursed, with telehealth as a prime example. During the public health emergency, providing telehealth services expanded the reach of the family physician to their homebound patients. Telehealth reimbursement also expanded access to different components of lifestyle medicine through MNT, diet behavioral counseling, and preventive care counseling. As an evidence-based practice focusing on preventing and reversing many chronic conditions, lifestyle medicine is uniquely positioned to rise to the crest of the oncoming wave of change in healthcare, helping to cultivate resilience in patients for future health challenges.

Understanding organizational arrangements and reimbursement models available to practitioners is key to the ability to engage and grow lifestyle medicine practices. Though

CONSIDERATIONS AND REQUIREMENTS FOR SHARED MEDICAL APPOINTMENTS¹²

Social isolation and loneliness are major contributors to mental and physical illness and death.^{13,14} SMAs offer an effective clinical answer to these problems. They can help deliver important lifestyle information en masse and in a psychologically safe and supportive setting. They can be a powerful way to support patients to make healthy behavior changes that would otherwise be difficult to make. When implementing SMAs, these considerations may be helpful:

- Get leadership support for implementation of SMAs
- Determine target audience and size of group (helps with theme of SMA)
- Design a strategy for your SMA to solve a need that patients feel
- Outline a curriculum tailored to the target audience and needs
- Consider making SMA groups permanent as this creates more psychological safety at the prospect of a longer-term relationship
- Prepare participation and privacy consent forms and processes
- Find a space to deliver SMAs. Generally, a physical space must be an existing medical facility with an NPI number
- Consider running your group virtually; however, note that this has multiple advantages (eg, lower cost, expandable) and disadvantages (eg, lack of face-to-face interaction)
- Market the SMAs to target audiences (eg, recruit patients), and encourage participants to recruit their friends
- Collect appropriate clinical data before and after the start of the group
- The most important metric to collect is attendance and retention. If participation drops off, you may not be engaging your audience
- Create a welcoming environment, keeping details (eg, location, time, facilitators) as consistent as possible
- Allow patients to do most of the talking, guiding the discussion as needed back to the curriculum
- Offer educational tools/resources
- Engage an assistant to help write a clinical note for every patient at each SMA
- Bill and code correctly. This is provider and intervention specific, but, generally, it is appropriate for providers to bill for a low- to moderately-complex medical visit (99213)

physician reimbursement is still largely on a FFS or salary basis, alternative payment model arrangements continue to increase. Newer reimbursement models are designed to measure and reimburse the assumption of risk and outcomes. Lifestyle medicine offers practitioners a new and effective approach to address the prevention and treatment of chronic disease while moving into new reimbursement models and improving population health.¹⁵ Retainer-based care, newer capitation arrangements, PCMHs, and the use of group visits are models most closely aligned with the physi-

cian competencies of lifestyle medicine. The alignment of pay for performance, accountable care organizations, and shared savings models with the competencies of lifestyle medicine largely depend on how the measures and plan are structured. Conversely, early capitation arrangements (in which physicians assume 100% of risk for all care), and episode-based bundled payments do not substantially align with the PCP competencies of lifestyle medicine.

It is worth noting that value-based reimbursement continues to grow, including alternative payment models such as DPC and PCMH. As these new models for reimbursement become more ubiquitous, incentives may shift to prioritize and reward quality of care rather than quantity of care. This change in focus could drive the use of evidenced-based ITLC programs, allowing practitioners to provide increased time for patient education and goal setting while also allowing patients to support each other in managing chronic conditions.

CHRONIC CARE MANAGEMENT

A Centers for Medicare & Medicaid Services provision that reimburses providers for non-face-to-face services provided by any clinical staff member (including medical assistant, nurse, dietitian, and health coach) to patients who have two or more qualifying chronic conditions. The patient must verbally agree, and time spent by the clinical staff working on the patient's behalf must be tracked. A Chronic Care Management (CCM) agreement between a provider and a patient specifies the following:

- CCM involves a charge to Medicare depending on the time spent by providers or clinical staff
- Depending on the health plan, the patient may be responsible for 20% of the cost
- Patients have the right to stop CCM services at any time (effective at the end of the calendar month)

CCM billing algorithm

1. When the provider signs off on a new or revised care plan, bill G0506 (~\$64, 1 time only)
2. Review minutes spent on chronic conditions by any clinical staff
 - If >90 minutes AND moderate medical decision making, then
 - Bill 99487 for CCM activity 60 minutes (~\$94), and
 - Bill 99489 for each additional 30 minutes (~\$47)
 - If < 90 minutes, then
 - Bill 99490 for first 20 minutes of CCM activity (~\$42), and
 - Bill 99439 for each additional 20 minutes (billable twice, ~\$37)

For more information, see the Medicare Learning Network booklet "Chronic Care Management Services" available at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>

SUMMARY

Lifestyle medicine aligns with the national movement toward value-based care and population health. As health-care continues to move beyond FFS models, the value of lifestyle medicine will be recognized for its impact, efficiency, and both patient and provider satisfaction. Value-based care can support lifestyle medicine tools, such as ITLC programs and effective chronic care management processes. Efficient intervention strategies such as the SMA allow providers to offer more in-depth education and behavior change content to empower patients for lifestyle change. As payment and organizational models continue to evolve and healthcare reimbursement moves increasingly away from productivity measures toward value-based payments, lifestyle medicine will be well positioned to employ evidence-based strategies for the prevention, treatment, and reversal of chronic disease. ●

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