American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Illinois Chapter

A Critical Gap in Care: Early Intervention to Reduce Pediatric Obesity

Initial Recommendation to Illinois Medicaid on the Management of Pediatric Overweight/Obesity

Illinois currently ranks 4th in the nation among states with the highest percentage of obese 10-17 year olds, with an obesity rate of 20.7% among this cohort.[i] Additionally, 48.4% of overweight or obese children in Illinois have public insurance, compared with 43.2% nationally,[i] and 48% of overweight or obese children in Illinois come from families with an income of less than 100% of the federal poverty level, compared with 44.8% nationally[i].

In 2012, the Heart Forum's peer-reviewed model projected that by 2030, the adult obesity rate in Illinois could reach 53.7% based upon its current trajectory, increasing the state's health care costs by 16.1%.[ii] The model predicts that Illinois could prevent obesity-related diseases and reduce billions in health care costs if it reduced the average body mass index of residents by 5%.[iii]

The Department of Healthcare and Family Services (HFS) can take immediate achievable steps beyond routine preventive care in well-child visits[1] to reduce the rate of obesity in the Medicaid pediatric population by focusing on early intervention, which is currently a critical gap in pediatric obesity care in the Illinois Medicaid Program. Early intervention in primary care is needed to prevent obesity-related diseases and to avoid costly care as obese children become obese adults.

Immediate Steps that HFS Can Take to Reduce the Increasing Rate of Obesity in Illinois

- **Step 1: Comply with the Medicaid EPSDT Mandate by Promoting Appropriate Coverage and Reimbursement for Early Intervention of Pediatric Overweight/Obesity in Primary Care**

  ICAAP's 2012 *Survey of Physicians Providing Pediatric Obesity Care in the Illinois Medicaid Program* showed that more than 50% of physicians do not know whether they will receive reimbursement for management of overweight/obesity pediatric patients. Lack of clarity around reimbursement is a distinct roadblock to early intervention for pediatric overweight/obesity in the Illinois Medicaid program. In her 2010 report to Congress, Kathleen Sebelius, Secretary of Health and Human Services, affirmed that "the EPSDT benefit requires states to cover preventive services for children under age 21, including services necessary to ***prevent and treat obesity***."[iv]

  To meet the EPSDT mandate for early intervention, HFS must promote a policy that provides appropriate coverage and reimbursement for the management of pediatric overweight/obesity ***before*** patients develop costly obesity-related comorbidities. When patients are identified as overweight/obese in a well-child visit, physicians must be able to follow up with those patients to provide further assessment and counseling. HFS policy addressing the management of overweight/obesity should clearly specify the following:

  - An enrolled provider (MD, DO, APN, PA) can expect adequate payment for management of overweight/obesity, even when the pediatric patient has no diagnosed obesity-related comorbid condition.

  - An ICD-9 diagnosis code 278.xx can be utilized by the enrolled provider for a visit to address overweight/obesity for patients with no comorbid conditions if (1) the patient's BMI percentile is documented or plotted, (2) the patient's BMI is classified as overweight/obese, and (3) weight classification is included in the administrative claim as v85.53 or v85.54.

F

[1] Preventive services in well-child visits are already well established. Clinical guidelines recommend that physicians routinely assess and identify weight status as well as provide nutrition and physical activity counseling for every pediatric patient.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Illinois Chapter

A Critical Gap in Care: Early Intervention to Reduce Pediatric Obesity

Initial Recommendation to Illinois Medicaid on the Management of Pediatric Overweight/Obesity

- **Step 2: Remove Practice Barriers to Early Intervention through Changes in Coding/Billing Policy**

Illinois physicians identified two major practice barriers to early intervention in ICAAP's 2012 Medicaid survey: (1) lack of physician time at well-child and sick visits to thoroughly assess, counsel, and intervene with patients who are identified as overweight/obese and at risk of developing obesity-related comorbidities; and (2) difficulty getting patients to return for a weight management visit.

In 2007, the Pennsylvania Medicaid program addressed these barriers in their *Child and Weight Management Services* policy http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4304 by allowing for flexibility in patient visits. The policy stipulates that physicians may bill for a physical exam or a complete EPSDT screen and an initial assessment or re-assessment rendered to a child ***on the same day***. Same day visits for reassessment and counseling are also permitted at an office visit for another medical issue. HFS should adopt a similar policy that allows same day extended visits for the management of overweight/obesity.

- **Step 3: Include the Counseling Risk Factor Reduction and Behavior Change and Intervention Codes in the Illinois Medicaid State Plan Amendment per the CMS Medicaid Payment Final Rule**

The 2012 CMS Final Rule, Medicaid Program; Payments for Services by Certain Primary Care Physicians http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf offers a unique window of opportunity to promote early intervention in the Illinois Medicaid program. The Final Rule sets forth increased payments for the *Counseling Risk Factor Reduction and Behavior Change Intervention* codes (intervention codes).[v pg.66677] The inclusion of the *Counseling Risk Factor Reduction and Behavior Change Intervention codes* in the Illinois Medicaid State Plan Amendment (for submittal to CMS in March of 2013) is a necessary step to remedy the critical early intervention gap in pediatric obesity care in the Illinois Medicaid program.

The intervention codes are particularly appropriate for the management of overweight/obesity because their purpose is to *promote health and prevent illness or injury and risk factor reduction*. The application of the intervention codes when used in conjunction with other evaluation and management codes to extend well-child, sick, and follow-up visits would assure that physicians have the requisite time for risk factor and behavior change counseling with patients identified as overweight/obese. Utilization of the codes in this way would also provide a mechanism for flexibility in patient visits similar to that seen in the design of the *Child and Weight Management Services* policy adopted by the Pennsylvania Medicaid program.

This recommendation was developed by an expert panel of the ICAAP Committee on Obesity. This is one of several in a series of recommendations that will be presented to the Illinois Department of Healthcare and Family Services with the aim of improving pediatric obesity care in the Illinois Medicaid program. *For further information, please contact Mary Elsner, JD, Director, Obesity Prevention Initiatives, at 312/733-1026, ext. 220 or* melsner@illinoisaap.org

[i] Illinois Child Health and System Performance Profile from the National Survey of Children's Health. NSCH 2007. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. Available at: www.childhealthdata.org. Accessed on September 26, 2012

[ii] F as in Fat: How Obesity Threatens America's Future 2012. Trust for America's Health. September 2012. Available at: http://healthyamericans.org/assets/files/TFAH2012FasInFatFnlRv.pdf. Accessed on September 26, 2012

[iii] Wang CY, McPherson K, Marsh T, Gortmaker SL, Brown M. Health and economic burden of the projected obesity trends in the USA and the UK. *The Lancet*. 2011;378(9793):815-825

[iv] Sebelius, K. Report to Congress: Preventive and obesity-related services available to medical enrollees. 2010: 2-13

[v] Medicaid Program: Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program, 42 CFR parts 438, 441, and 447. Federal Register 77(215) (6 November 2012) 66670-66677