Billing and Coding for Physical Activity Counseling

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Forty to fifty million US adults do not meet recommended physical activity levels. Like tobacco use, poor nutrition, and excessive alcohol intake, physical inactivity is a lifestyle factor that is associated with significant morbidity and premature mortality. Clinicians are advised to assess lifestyle factors such as these when evaluating patients. This assessment becomes the first step in counseling patients to alter those behaviors that may result in adverse health consequences. Regardless of the desired behavior change, counseling is a process that takes place over several visits, several months, and even several years.

Physicians face many barriers when it comes to counseling their patients: their own knowledge, skill and comfort in a particular area, competing demands in the patient visit, and poor reimbursement to name only a few. Yet, the importance of behavior change on health cannot be underestimated. If for example a patient increases his or her physical activity from the lowest to the highest quintile, even in the absence of weight change, the risk of premature mortality decreased by a factor of four. (1) With that as the backdrop, it is essential that we assess physical activity levels in our patients, and assist them in achieving age appropriate physical activity to promote health and prevent disease.

Reporting regulations are one of many reasons behind changes in healthcare delivery. In the case of physical activity (PA) assessment, the addition of HEDIS (Healthcare Effectiveness Data and Information Set) measures related to PA assessment in children and older adults require that we develop a systematic approach to PA assessment, so as to not be penalized by payers for failing to acquire this information from our patients. HEDIS measures are used to assess the quality of healthcare delivered. HEDIS data is collected through surveys, medical charts and insurance claims for hospitalizations, medical office visits and procedures, and reported to the NCQA (National Committee for Quality Assurance), who in turn create a report card or score card for practices and health plans regarding the quality of care delivered to patients and populations. (2) To meet the HEDIS requirement, the chart note must include the date and at least one of the following: discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities), checklist indicating that physical activity was addressed, counseling or referral for physical activity, enrollee received educational materials on physical activity, or anticipatory guidance for physical activity.

A HEDIS measure for physical activity assessment in adults 65 years and older has been present since 2009 (2). In addition, healthcare reform legislation includes payment for an annual "wellness visit" for Medicare enrollees that includes a personalized prevention plan that addresses among other things, health advice and referral to education and prevention counseling or community-based interventions to address modifiable risk factors such as physical activity.

Even more recent is the addition of a HEDIS measure related to physical activity in children age 2 through 17. Specifically, clinicians should address body mass index and physical activity as components of obesity prevention, evaluation and treatment. (4)

Given strong evidence linking physical inactivity to poor health outcomes, reasonable evidence that physician counseling for physical activity is beneficial, and reporting requirements regarding physical activity assessment, clinicians should be sufficiently motivated to counsel. Last but not least, we need reasonable reimbursement for the time we spend counseling the patient.

Tools exist to assist the clinician in assessing PA in both children and adults (Tables 1 & 2), as do counseling strategies (Table 3). Likewise, a longitudinal approach to behavior change, means that clinicians can spend a little bit of time spread out over several visits to enlist the patient in shared goal setting leading to improved outcomes.

There is no ICD9 code for sedentarism or physical inactivity. Therefore, you cannot link a CPT Procedural or Evaluation and Management (E&M) code to inactivity as a diagnosis. However, time-based E&M coding is a reasonable strategy to employ, linking the E&M code to ICD-9 codes for co-morbidities of physical inactivity, such as depression, overweight or obesity, hypertension, diabetes, osteoporosis, osteoarthritis, back pain, insomnia, or fatigue, to name only a few. Most payers in

Utah reimburse clinicians for E&Mof obesity. Given that nearly 60% of adults in Utah are overweight or obese (12), it is relatively easy to justify time spent counseling patients regarding physical activity. Time is measured based on the face-to-face encounter between the physician and the patient. You can only use time as the determining factor for the level of care if counseling or coordination of care activities account for more than 50% of the visit. Documentation must include the total time spent with the patient, as well as a description of the counseling or coordination of care activities.

Efforts by the American College of Sports Medicine, the American Medical Association, and *Exercise Is Medicine*, are focused on inclusion of physical activity promotion within the patient-centered medical home, the development and implementation of a HEDIS measure for PA assessment in adults age 18-64, development of a reimbursable ICD9 code related to physical inactivity, as well as reimbursement for PA counseling performed by allied health professionals, such as wellness coaches, certified health and fitness instructors, clinical exercise physiologists, and others. Stay tuned, as evidence continues to emerge regarding the dangers of sitting, clinicians will need to take a meaningful role in promoting activity, and we should be adequately reimbursed for our time, and our expertise.

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Table 1

Physical Activity Assessment Tools in Adults

Tool	Questions	Need for Scoring (Y / N)	Time to Administer
2Q / 3Q [5]	2 or 3	N	1 – 2 min
RAPA [6] (Rapid Assessment of Physical Activity) in older adults	9	Y	1 – 5 min
PAAT [7] (Physical Activity Assessment Tool)	21	Y	5 – 7 min
PAVS [8, 9] (Physical Activity Vital Sign)	2	N	< 30 seconds

Table 2

Lifestyle Assessment in Children and Adolescents: 5 – 2 – 1 - 0

	Goal	Assessment Tool (circle the response that typically reflects behavior)
5	5 or more servings of fruits and/or vegetables per day	0 1 2 3 4 5 >5 (servings/day)
2	Less than 2 hours of screen time	0 ½ 1 2 >2 (hours/day)
1	1 hour per day of vigorous physical activity	0 15 30 45 60 >60 (minutes/day)
0	No servings per day of sugar-sweetened beverages	0 1 2 >2 (servings/day)

Table 3

Physical Activity Counseling Strategies

5As[10]	**Ask**	Address behavior change agenda • Have you ever participated in regular physical activity? • What activities do you enjoy?
	Advise	Provide personalized information on benefits of change • Regular physical activity for 30 min/day, on most days of the week will substantially improve your health
	Assess	Address previous attempts, identify barriers, readiness for change • Have you tried to increase your physical activity in the past?
	Assist	Strategize to overcome barriers, match advise to stage of change • Discuss situations when patient most likely to fail and strategize plan
	Arrange	Arrange follow-up, inquire about behavior, readiness for change • Arrange follow-up; praise attempts at change; stress long-term commitment
Transtheoretical Model[11]	**Precontemplative** (No exercise, and not even thinking about it)	• Emphasize the benefits of physical activity • Allow patients to voice reservations about becoming physically active • Clarify what constitutes "physical activity" and the threshold at which benefits can be reaped • Give clear advice that you recommend beginning a physical activity program
	Contemplative (No exercise, but thinking about it now and then)	• Engage in active listening before giving advice or making recommendations • Use specific patient information as motivational "hooks" • Explain level of physical activity necessary to achieve health benefits • Develop a specific plan for increasing physical activity
	Preparation (Irregular participation in exercise)	
	Action (Regular exercise for < 6 months)	• Praise and positive reinforcement
	Maintenance (–Regular exercise	

	for ≥ 6 months)	