Lifestyle Medicine: Successful Reimbursement Methods and Practice Models

Abstract: *Preventable and reversible chronic diseases affect millions of Americans, costing the United States billions of dollars annually for treatments that slow the trajectory but fail to address the root cause of illness. Lifestyle medicine is efficacious, and research has shown that this medical approach garners a significant return on investment in the treatment of many chronic diseases. To obtain an overview of successful reimbursement and practice models used by practitioners, American College of Lifestyle Medicine members were invited to participate in an online survey regarding their experience with lifestyle medicine services and reimbursement models. Three hundred and fifty-one respondents with diverse practice structures, geographical locations, and educational backgrounds completed the survey. The results demonstrate that practitioners are utilizing a variety of lifestyle medicine programs and reimbursement and practice models. Seventy-four percent of respondents are currently providing lifestyle medicine, though the majority do not receive reimbursement for their services. This study provides examples of successful lifestyle medicine reimbursement and practice models,*

as well as demonstrates the need for continued advocacy for sustainable reimbursement of lifestyle medicine services.

Keywords: lifestyle medicine; compensation; reimbursement; business model; practice model

There is an epidemic of chronic disease in the United States. Approximately 92 million Americans are currently living with coronary artery disease or the sequelae of stroke, with one person dying every

and intervention attempts, the adult obesity rate continues to rise; 39.6% of the US population in 2015-2016 were obese.³

The cost of chronic disease is a growing burden. An estimated \$316 billion is spent annually treating cardiovascular disease, with an additional \$245 billion in diabetes-related costs.^{1,4} In 2015, spending on insulin glargine amounted to \$11.1 billion—an increase of 81% over 2013 levels.⁵ The annual cost of medications for hypertension and hyperlipidemia is increasing at more than double the rate of total health care

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40 seconds from these largely preventable and reversible diseases.¹ Diabetes is not far behind. Over 30 million people in the United States have been diagnosed with diabetes and another 84 million classified as prediabetic.² Despite decades of concern

spending.⁶ In addition, many medical professionals are experiencing burnout under the current system and are looking for more effective ways to care for patients and themselves.⁷ The current level of chronic disease, unsustainable health care costs, and physician burnout

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highlight the need to reassess current approaches to medical care.

Research demonstrates that lifestyle medicine (LM) programs are efficacious and provide an impressive return on investment (ROI). Shurney et al reported a 6-month 1.38:1 ROI in employees with type 2 diabetes by implementing the Complete Health Improvement Program (CHIP). As a result, 23.8% of participants eliminated one or more chronic medications following the intervention.⁸ Over a 3-year period, the Multicenter Lifestyle Demonstration project reported an average cost savings of \$29,000 per participant in the Ornish Intensive Cardiac Rehabilitation program.⁹

LM results are capturing widespread attention. Physicians in training now have the newly established medical residency in LM as a training option, as well as board certification through the American Board of Lifestyle Medicine. However, the question remains, how will they be reimbursed?

This research provides a snapshot of American College of Lifestyle Medicine (ACLM) member experiences to describe how practitioners deliver LM services.

Methods

A total of 1622 ACLM providers were sent an email invitation to participate in an online survey during the Spring of 2017. The survey was administered using Qualtrics (2018, Provo, UT). Participant consent was obtained. Responses were stratified, and subsets created according to those practicing LM (denoted as n_i) and those who are not (denoted as n_{ii}). Frequency calculations were conducted to describe the sample population including demographics, profession, geographic location, practice structure, and types of LM programs used. The survey included open-ended questions to elicit details regarding reimbursement for services, methods of incorporating LM, and to ascertain avenues to support LM practitioners. One-on-one phone interviews were conducted to gain in-depth information with regard to successful business models and reimbursement practices (see the

appendix). Purposive sampling was used to identify interview participants. Content and thematic analyses were conducted to identify emerging themes.¹⁰

Results

The survey garnered a 21.6% ($N = 351$) response rate. Two hundred and sixty-one ($n_i = 261$) respondents practiced LM as part of patient care. Ninety ($n_{ii} = 90$) respondents were interested in, but not currently providing LM.

Lifestyle Medicine Practitioners

Compensated Practitioners. Forty-two percent ($n = 111$) of LM practitioners ($n_i = 261$) received compensation for LM services. Thirty-four percent ($n = 90$) were physicians, 5% ($n = 13$) were health coaches, and 2.7% ($n = 7$) were health educators (Table 1). Seventeen percent ($n = 45$) practiced in a suburban region, and 15.3% practiced in an urban region ($n = 40$). Twelve percent ($n = 33$) worked in an independent practice setting, 10.3% ($n = 27$) worked in a solo practice, and 9.2% ($n = 24$) worked in a hospital setting (Table 2).

Thirteen percent ($n = 34$) of compensated LM providers used CHIP, 10.0% ($n = 26$) used the Full Plate Diet (FPD), 8.0% ($n = 21$) used the Diabetes Prevention Program (DPP), and 7.3% ($n = 19$) used the Ornish Diet. Twenty-two percent ($n = 59$) utilized other LM treatment programs primarily (Table 3), which included individualized patient plans, provider developed programs, other defined programs, including (by order of frequency) Diabetes Undone, DASH, Mediterranean, or functional medicine.

Practitioners reported a multipronged approach to acquiring reimbursement for LM services with 14.9% ($n = 39$) using more than one reimbursement method. Cash and insurance were the highest reported reimbursement methods. Twenty-five percent ($n = 67$) received cash payment, 23.0% ($n = 60$) billed insurance companies, 8.8% ($n = 23$) received reimbursement through employer-funded programs, and 4.6% ($n = 12$) acquired funding through grant sources (Table 3).

Insurance reimbursement methods included the use of standard office visit or preventive care Current Procedural Terminology (CPT) codes, behavior modification codes, ancillary counseling services, family medicine codes, and subscription or membership fees. Even within the compensated category, 36% provide LM services free of charge, suggesting that compensated providers may be utilizing sliding scale reimbursement methods or providing LM services free of charge to a portion of their patient population.

Compensated practitioners were asked, "What resources would be helpful to you regarding providing lifestyle medicine as part of patient care?" Respondents emphasized the need for patient education materials, including multimedia resources such as podcasts, information brochures, online learning modules, multi-language fact sheets, specifically in Spanish. Practitioners sought insurance reimbursement training and guidelines for achieving reimbursement for LM services.

Instructions regarding how to "bundle billing for interdisciplinary services" are also desired. Participants are interested in scientific research, providing published evidence to support reimbursement, as well as the development of evidence-based treatment protocols. Participants recognized the effectiveness of support groups on patient outcomes and expressed interest in continuing education opportunities in motivational interviewing and cognitive behavior therapy. Additional suggestions for practice support included condition-specific patient information handouts, large media graphics for office display, a patient intake form, an electronic medical record with a template that captures lifestyle history and documents health information required for reimbursement, instruction on how to conduct group medical visits, website templates, and payer-required documentation guidelines.

Successful Lifestyle Medicine Business Models. LM practitioners acquired reimbursement through CPT codes for

Table 1.

Demographics of Study Participants.

	Compensated (n = 111), n, % of n _i = 261	Uncompensated (n = 150), n, % of n _i = 261	Not Providing LM (n = 90), n, % of n _{ii} = 90
Gender			
Female	57, 21.8	77, 29.4	53, 58.9
Male	50, 19.2	67, 25.7	30, 33.3
Decline response	2, 0.8	1, 0.4	1, 1.1
Missing	2, 0.8	5, 1.9	0, 0.0
Ethnicity/race			
American Indian or Alaska Native	0, 0.0	1, 0.4	0, 0.0
Asian	8, 3.1	17, 6.5	8, 8.9
Black or African American	4, 1.5	9, 3.4	5, 5.6
Decline response	5, 1.9	5, 1.9	4, 4.4
Hispanic of any origin	5, 1.9	5, 1.9	2, 2.2
Other	3, 1.2	7, 2.7	0, 0.0
Native Hawaiian or Pacific Islander	0, 0.0	0, 0.0	1, 1.1
White	86, 33.0	106, 40.6	65, 72.2
Profession ^a			
Behavioral health practitioner	2, 0.8	9, 3.4	3, 3.3
Dietitian	6, 2.3	7, 2.7	1, 1.1
Exercise physiologist	4, 1.5	3, 1.1	0, 0.0
Health coach	13, 5.0	12, 4.6	4, 4.4
Health educator	7, 2.7	9, 3.4	3, 3.3
Nurse	1, 0.4	2, 0.8	2, 2.2
Nurse practitioner	2, 0.8	10, 3.8	6, 6.7
Other	6, 2.3	20, 7.7	9, 10.0
Physician	90, 34.5	104, 39.8	65, 72.2
Physician's assistant	5, 1.9	1, 0.4	4, 4.4

Abbreviation: LM, lifestyle medicine.

^aProviders were allowed to select more than one profession.

Table 2.

Practice Characteristics of Study Participants.

	Compensated (n = 111), n, % of n_i = 261	Uncompensated (n = 150), n, % of n_i = 261	Not Providing LM (n = 90), n, % of n_ii = 90
Geographic region			
Rural	26, 10.0	27, 10.3	10, 11.1
Suburban	45, 17.2	62, 23.8	39, 43.3
Urban	40, 15.3	60, 23.0	40, 44.4
Missing		1, 0.4	1, 1.1
Practice structure^a			
Employed	19, 7.3	26, 10.0	24, 26.67
FQHC	2, 0.8	6, 2.3	2, 2.2
Hospital	24, 9.2	24, 9.2	19, 21.1
Independent	33, 12.6	39, 14.9	13, 14.4
Independent contractor	3, 1.2	15, 5.7	4, 4.4
Interdisciplinary group	7, 2.7	10, 3.8	4, 4.4
Other	7, 2.7	19, 7.3	7, 7.8
Multispecialty group	16, 6.1	19, 7.3	14, 15.6
Solo	27, 10.3	16, 6.1	9, 10.0
Single-specialty group	17, 6.5	19, 7.3	18, 20.0

Abbreviations: LM, lifestyle medicine; FQHC, federally qualified health center.

^aProviders were allowed to select more than one practice structure.

standard visits, ancillary counseling services, and behavioral modification, as well as subscriptions and memberships fees. To capture greater detail regarding successful reimbursement methods and business models, one-on-one interviews were conducted. These interviews revealed a breadth of experiences among providers, ranging from financial losses each year to upwards of a million dollars of annual gross income.

A practice located in a semi-rural region of the United States, steeped in the culture of meat production and consumption, is an example of a successful independent LM primary care practice. Patients ranged in age from 35 to 65 and exhibited a high prevalence of chronic diseases. Patients were largely

mid to low-income and had an office visit threshold of \$100 (ie, patients are unable or unwilling to pay more than \$100 for an office visit). The practice drew patients from a 200-mile radius and accepted only private insurance. Billing methods included the use of 99401-99404 CPT codes, adding additional codes for time, use of level 4 and 5 codes, and use of education, exercise, counseling, nutritional counseling, cognitive impairment, and physical therapy billing codes. The practice owner stated that the secret to success was to “get big,” use ancillary services, and hire nurse practitioners and health educators. During the past 4 years, the practice had grossed \$500, 000 to \$1 million annually. The practice owner

warned of the pitfalls of insurance billing including the cost of billing personnel, and the ability of insurers to adjust reimbursement practices at-will, which can quickly destabilize practice revenue and structure. A suggested remedy was to lobby for the creation of specialty primary care CPT codes that allowed for higher reimbursement rates.

Another example of a successful LM business model was the Direct Primary Care model. This form of practice structure does not incur the costs associated with billing insurance companies. Rather, a flat rate is charged annually to each patient equivalent. Office visits are free of additional charge. Diagnostic services are contracted with outside providers and available to

Table 3.

Programs and Reimbursement Methods of Study Participants.

	Compensated (n = 111), n, % of n _i = 261	Uncompensated (n = 150), n, % of n _i = 261	Not Providing LM (n = 90), n, % of n _{ii} = 90
Lifestyle medicine programs ^a			
Complete Health Improvement Program	34, 13.0	41, 15.7	
Diabetes Prevention Program	21, 8.0	21, 8.0	
Full Plate Diet/Full Plate Living	26, 10.0	20, 7.7	
Other	59, 22.6	82, 31.4	
Ornish diet	19, 7.3	26, 10.0	
Insurance types ^a			
Private insurance	69, 26.4	93, 35.6	62, 68.9
Medicaid	42, 16.1	59, 22.6	50, 55.6
Medicare	63, 24.1	74, 28.4	55, 61.1
Other	40, 15.3	57, 21.8	20, 22.2
Reimbursement methods ^a			
Cash	67, 25.7		
Employer-funded programs	23, 8.8		
Grant funding	12, 4.6		
Insurance	60, 23.0		
Other	12, 4.6		
More than one reimbursement method	39, 14.9		

Abbreviation: LM, lifestyle medicine.

^aParticipants were allowed to select more than one option per category.

patients at a significantly reduced price. One such practice located in the north mid-west region of the United States provided telemedicine services and payment assistance programs. After 1 year, the practice had netted sufficient financial gain to expand to a larger physical space to accommodate their growing patient population.

A successful LM business model located in the mid-Atlantic region of the United States provided services to an international patient population. Telemedicine services provided LM to

patients who had a high net worth and a mobile lifestyle. Supported solely by patient self-pay, there was no insurance billing and no future plans to enter into the insurance billing system.

Uncompensated Practitioners. Fifty-seven percent (n = 150) of practicing providers (n_i = 261) did not receive reimbursement for LM services. Thirty-nine percent (n = 104) were physicians, 7.7% (n = 20) were categorized as Other, and 4.6% (n = 12) were health coaches (Table 1). The primary practice location

of 23.8% (n = 62) was suburban, 23.0% (n = 60) was urban, and 10.3% (n = 27) was rural. Fourteen percent (n = 39) worked in independent practices, 10.0% (n = 26) were employed, and 9.2% (n = 24) worked in a hospital setting (Table 2).

Thirty-one percent (n = 82) of uncompensated practitioners were using a plant-based whole food diet they had designed or customized according to patient condition(s) and need. In addition, they were using 21-day Vegan Kickstart, BIOMais Program, Food for

Life, and the Nutritarian Diet. Fifteen percent ($n = 41$) were using CHIP, and 10.0% ($n = 26$) were using the Ornish Diet (Table 3).

Participants who provided LM without reimbursement were asked, "What resources would be helpful to you regarding providing lifestyle medicine as part of patient care?" Responses included requests for information on methods of reimbursement from private and public insurance, and patient-centered health education materials. Similar to the compensated group, they sought both physical and electronic LM patient education materials, including webinars, and an information clearinghouse that provided educational materials to patients, as well as practice management resources designed specifically for the needs of LM practitioners.

Practitioners Interested in Providing Lifestyle Medicine

Twenty-five percent of respondents ($n_{ii} = 90$, $N = 351$) expressed interest in, but were not currently providing LM services. Seventy-two percent ($n = 65$) were physicians, 10% ($n = 9$) were classified as Other, and 6.7% ($n = 6$) were nurse practitioners (Table 1). Forty-four percent ($n = 40$) worked in an urban region, 43.3% ($n = 39$) worked in a suburban region; 21.1% ($n = 19$) practiced in a hospital setting, 20% ($n = 18$) practiced in a single-specialty group, and 15.6% ($n = 14$) practiced in a multispecialty group (Table 2).

Respondents stated the following obstacles in providing LM: low reimbursement, lack of support from professional partners, impractical given current practice structure, time limitations associated with the 15- to 20-minute office visit, patient acculturation to the "quick fix of medical conditions," difficulty finding trained staff, lack of applicable electronic health record, outside the scope of practice (eg, palliative care, urgent care, anesthesiologist), and unsure as to how to incorporate LM into practice.

This group was asked how ACLM can support efforts to incorporate LM as part of standard patient care. Suggestions, listed in order of frequency, included the following: information on reimbursement

methods, continuing education opportunities, training in behavior modification, active marketing (eg, books, public broadcasting, lobbying), demonstrated ROI value to foster reimbursement from insurers, funding evidence-based research, patient education materials including Spanish language versions, assessment tools/questionnaires/intake forms, lobbying to incentivize reimbursement for wellness outcomes, instruction on starting an independent or group practice, reimbursement guidelines, pediatric-based recommendations, telemedicine model, tool packet of educational interventions that could be incorporated into 10-minute sessions, standardizing protocols, and establishing guidelines.

Discussion

The results of this study demonstrate that the majority of LM practitioners are not reimbursed for LM. The high percentage of LM practitioners who provide care without reimbursement can be attributed to several factors. First, CPT codes reimburse primary care services at a lower rate compared to specialists. Second, CPT codes are poorly understood even by payers, as new codes are frequently created, and rules of use frequently change by policy and geographic region. It is not surprising that one of the primary requests from study participants is guidance on how to document, code, and lobby for reimbursement. Unfortunately, focused sustainable LM practice models described by this study are limited to patient populations able to afford either an annual fee for a Direct Primary Care practice or self-pay. This drastically reduces access for vulnerable patient populations who are often most at risk for the chronic diseases that LM is intended to treat.

This study speaks to a significant movement occurring within the medical field. Providers have grown frustrated with medical protocols they repeatedly experience as costly and ineffective. Over time, poor patient outcomes influence a medical provider's sense of efficacy, fueling frustration and burnout. The rising

rate of chronic diseases, the growing financial burden, and the burnout rate of physicians suggest reforms to the current medical model are needed.

As the US population ages, the need for medical providers will dramatically increase. As such, medical structures, that is, insurance companies, and regulatory bodies would be wise to consider the voices of LM practitioners as the field grows to become a standard of care in clinical practices across the globe.

This study has identified that practitioners of LM differ in their definition of LM. There is disagreement among the ACLM community about the optimal diet, use of supplements, and the bundling of other services under the title of LM. ACLM, along with American Board of Lifestyle Medicine, has been working on guidelines for defining LM providers, practices, and programs.

One of the challenges facing financially viable LM practice models is that insurance reimbursement varies by geographic location and by insurance provider, provider contract with insurers, and patient plans with an insurer. The number of variables that are subject to frequent change makes standardizing or sharing reimbursement mechanisms extremely difficult.

Limitations

The cross-sectional survey design of the study has inherent limitations on extrapolating data beyond this particular sample. However, it provides useful insight into what LM practice demographics and approaches look like. Although it utilized a select study of providers interested in LM from the ACLM member database, it was felt that this population may offer the most enlightening feedback regarding the practice of LM. While the study relies on self-reported data which is subject to bias, it was gathered anonymously from participants to help ensure accurate reporting.

Conclusion

The results of this study demonstrate how ACLM members are practicing LM. Although many providers are practicing LM, it is interesting to note that many of

them are doing so without receiving reimbursement for their LM services. Furthermore, multiple barriers were identified among those currently practicing LM and those interested in practicing LM, particularly around the importance of having sustainable reimbursement mechanisms for LM services. The expansion of certified evidence-based programs that are universally reimbursable, streamlined documentation for LM encounters, and educational resources that focus on existing financial models are needed to help bring LM services into mainstream clinical practice.

Appendix

Interview Guide Questions.

1. What is your target patient population?
2. How do you integrate lifestyle medicine into your practice?
3. Which payer types are reimbursing you for the lifestyle medicine services you provide?
4. Please describe how you bill successfully: what CPT codes do you use and how do they differ by health plan?
i. Which programs are garnering reimbursement? (eg, CHIP, DPP)
5. What billing methods/codes have been unsuccessful for each health plan?
6. What else have you discovered about billing that might be helpful for others to know?

(continued)

Appendix (continued)

7. What information about providing and being compensated for LM services would be helpful for ACLM to provide for you?
8. How else could ACLM be helpful to you?

Abbreviations: CPT, Current Procedural Terminology; CHIP, Complete Health Improvement Program; DPP, Diabetes Prevention Program; LM, lifestyle medicine; ACLM, American College of Lifestyle Medicine.

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Ethical Approval

This research protocol was approved by the Ohio University Institutional Research Board.

Informed Consent

Informed consent was obtained from all participants.

Trial Registration

Not applicable, because this article does not contain any clinical trials. **AJLM**

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