Clinical Practice Guideline: **Medical Nutrition Therapy for Weight Management**

Date of Implementation: **April 19, 2012**

Product: **Specialty**

GUIDELINES

American Specialty Health, Inc. (ASH) considers Medical Nutrition Therapy (MNT) and patient specific nutritional evaluation and counseling for weight management in which appropriate diet and eating habits are essential to the overall treatment program provided by a qualified healthcare professional as medically necessary.

INTRODUCTION

Practitioners and the American public are grappling with the obesity epidemic. Medical nutrition therapy offers a science-based, expert guided framework and specific tools to help obese individuals develop skills and behaviors to promote weight loss and maintain stable healthy weight in the long term.

The USPSTF concluded with moderate certainty that offering or referring adults with obesity to intensive behavioral interventions or behavior-based weight loss maintenance interventions has a moderate net benefit. Effective behavioral interventions targeted achieving and maintaining weight loss greater than or equal to 5%. Most interventions studied combined dietary changes and increased physical activity and lasted for 1-2 years, with the majority having ≥ 12 sessions in the first year. The Guidelines note the US Food and Drug Administration (FDA) considers a weight loss of 5% as clinically important.

SCREENING RECOMMENDATIONS

Applicable recommendations for the preventive health screenings covered in this policy are based on the United States Preventive Services Task Force (USPSTF).

The Agency for Healthcare Research and Quality (AHRQ) is under the U.S. Department of Health and Human Services (HHS) and sponsors the USPSTF, a leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening and counseling.

The USPSTF makes recommendations about which preventive services should be incorporated routinely into health care and for which particular populations. The guidelines covered in this policy focus on “recommended” screenings by the USPSTF. These are services/screenings which have an A or B rating as defined below.

Grade	Definition	Suggestions for Practice
A	The USPSTF *recommends* the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF *recommends* the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends *selectively* offering or providing this service based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on circumstances.
D	The USPSTF recommends *against* the service. There is moderate or high certainty of either no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I	The USPSTF concludes that the current evidence is *insufficient* to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

A comprehensive review of the USPSTF rating process can be found in the ASH policy *Preventive Care Guidelines* (CPG 140 – S) or at the USPSTF website: http://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions.

USPSTF Recommendations (2018)

Grade B Recommendation:
The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

USPSTF Recommendations (2017)
The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. All children and adolescents are at risk for obesity and should be screened; specific risk factors include parental obesity,

poor nutrition, low levels of physical activity, inadequate sleep, sedentary behaviors, and low family income.

SCREENING TOOLS

The USPSTF has determined measurement of BMI by the practitioner as the appropriate screening method for obesity/overweight. There are several online BMI calculators available upon searching.

BMI of 25-29.9 kg/m2 indicates overweight and BMI ≥ 30 kg/m2 indicates obesity. Obesity is further differentiated into 3 classes: I = BMI 30-34.9 kg/m2 (obese); II =BMI 35-39.9 kg/m2 (severely obese); III =BMI 40+ kg/m2 (morbidly obese).

Waist circumference maybe an acceptable alternative to BMI measurement in some patient sub-populations.

CHILDREN AND ADOLESCENTS

The USPSTF is using the following terms to define categories of increased BMI: overweight is defined as an age- and sex-specific BMI between the 85th and 95th percentiles, and obesity is defined as an age- and sex-specific BMI at ≥95th percentile.

DOCUMENTATION REQUIREMENTS TO SUBSTANTIATE MEDICAL NECESSITY

Short term evaluation and counseling should include performing an initial dietary evaluation, counseling the patient about sample menu planning, and teaching the patient the impact of diet on their health condition(s). The goals of MNT are to promote health, reduce the incidence of preventable disease and improve quality of life.

The 5A's is a framework frequently used in clinical practice and should be documented within the clinical record to guide behavioral interventions.

1. Assess the health risk
2. Advise the patient on behavior change
3. Agree collaboratively with patient on an action plan
4. Assist the patient in making changes and adhering to the plan
5. Arrange follow-up

The practitioner's medical record should also reflect:

- Performance of a nutrition assessment determining the nutrition diagnosis
- BMI measurement
- Identification of treatment goals
- Planning and implementing a nutrition intervention that is culturally appropriate and uses evidence-based nutrition practice guidelines

- Development of a nutritional recommendation/plan
- Monitoring and evaluating an individual's progress over subsequent visits with the clinician
- Establishment of a patient's self-management training and goal setting
- Nutrition intervention most appropriate for the management or treatment of patients' condition are chosen after review of all available data

PRACTITIONER RESOURCES

- Tool to identify MNT professionals:
  - Academy of Nutrition and Dietetics: https://www.eatright.org/find-an-expert
- Tools to offer for assessing health risk (waist circumference and BMI):
  - BMI: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm
  - BMI/Waist circumference: Center for Disease Control: https://www.cdc.gov/healthyweight/index.html

MEMBER RESOURCES

- myplate.gov: https://www.myplate.gov/resources/tools
- https://www.eatright.org/food
- https://healthy10challenge.org (interactive 10 week program that focuses on building in healthy food and activity habits)
- https://www.fda.gov/food/new-nutrition-facts-label/whats-new-nutrition-facts-label

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained to competency, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies in a Health Care Facility (CPG 159 – S)* clinical practice guideline for information.

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