

**Centers for Medicare & Medicaid Services
Medicare Preventive Services National Provider Call:
Five New Medicare Preventive Services
Moderator: Leah Nguyen
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Podcast 5 of 5: Intensive Behavioral Therapy for Obesity

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Presentation 5

Amanda Barnes: Welcome to the fifth of five podcasts from the New Medicare Preventive Services National Provider Call, brought to you by the Medicare Learning Network — your source for official CMS information for Medicare Fee-For-Service providers. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, August 15, 2012.

In this fifth podcast, Jamie Hermansen from the Center for Clinical Standards & Quality, Kathy Bryant from the Hospital and Ambulatory Policy Group, and Wil Gehne from the Provider Billing Group discuss Intensive behavioral therapy for obesity.

Leah: I will now turn the call over to Jamie Hermansen for our final presentation on intensive behavioral therapy for obesity.

Jamie Hermansen: Thank you, Leah.

On slide 82: Effective November 29, 2011, Medicare covers intensive behavioral therapy for obesity for beneficiaries with a body mass index greater than or equal to 30. Intensive behavioral therapies for obesity

consist of the following: a screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters, dietary nutritional assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions on diet and exercise.

On slide 83: For Medicare beneficiaries with obesity who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS covers one face-to-face visit every week for the first month, one face-to-face visit every other week for months 2 through 6, and one face-to-face visit every month for months 7 through 12, if the beneficiary meets the 3 kg weight loss requirement during the first six months.

For slide 84: At the six-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. Beneficiaries must lose 3 kg during the first six months of counseling to be eligible for counseling for an additional six months. Beneficiaries who do not achieve a weight loss of 3 kg or more may undergo reassessment of their readiness to change and BMI after an additional six months period.

On slide 85: This service must be furnished in a primary care setting by a primary care practitioner.

For slide 86: For purposes of this covered benefit, a primary care practitioner is a physician with specialty designation of general practitioner, family practice practitioner, general internist, obstetrician or gynecologist; a physician assistant, nurse practitioner, or clinical nurse specialist.

For slide 87: For purposes of this covered benefit of primary care setting is to find those one in which the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community.

For slide 88 and 89: The decision – the decision covers intensive behavioral therapy for obesity when furnished in primary care settings, as described in Section 210.12 of the Medicare National Coverage Determinations Manual. In the primary care office setting, Medicare may cover these services when billed by the primary care physician or practitioner and furnished by auxiliary personnel under the conditions specified under our regulation at 42 CFR section 410.26(b). In the primary care hospital outpatient setting, Medicare may cover these services when furnished and billed by the primary care physician or practitioner, as described in Section 210.12 of the Medicare National Coverage Determinations Manual.

In addition, Medicare may cover these services when furnished by the hospital in outpatient hospital settings under the conditions specified under our regulation at 42 CFR 410.270. We believe that providing for coverage under these conditions will promote appropriate staff to furnish intensive behavioral therapy for obesity while ensuring that services are delivered within the primary care setting in order to provide a coordinated approach as part of each patient's comprehensive prevention plan.

I would now like to hand the call over to Kathy Bryant.

Kathy Bryant: Thank you. For the face-to-face behavioral counseling for obesity, use code G0447. For physician rates in a nonfacility setting, it is at \$25.19; for the physician rate in a facility setting, it's \$23.15; and for the OPPOS rate, it is \$35.69. There is no beneficiary co-insurance or deductible for this service.

Now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

When coding professional claims using the G0447, once again there is a diagnosis coding requirement. In this case, a range of codes – one of a range of codes must be used, all indicating body mass index is over 30 – that's V85.30 through 39, or V85.41 through 45 – and again those services

– the combination of procedure and diagnosis codes needs to be billed by one of the provider types – I mean provider specialty types – that’s shown on slide 90, and by one of the places of services codes – place of service codes, that’s shown on slide 91.

We’ll be editing to ensure the specialty types and place of service codes on slides 92 and 93 using the same remittance coding that has been consistently applied for all the benefits we’ve talked about today.

On slide 94, Coding Institutional Claims: The same requirement for a HCPCS code and a code from the diagnosis range of V85.30 through 39 or V85.41 through 45 applies, and the familiar list of types of bill must be used.

When Medicare systems are editing to ensure institutional claims are using the appropriate type of bill for this service, the remittance advice coding varies back to using adjustment reason code 5 and remark code M77.

And once again on slide 96, the payment for the service varies by the type of bill.

On slide 97: Medicare claim system edits that apply to all claims – we’re ensuring that G0447 is billed with one of those specified diagnosis codes, and remittance advice codes for denial are reason code 167, “these diagnosis codes are not covered,” and remark code N386, indicating that the decision was based on a national coverage determination.

We’re also editing, on slide 98, to ensure the frequency limitation. Jamie described – the frequency limitation varies over time by month, and because we can’t be sure in Medicare systems that services are coming in sequentially, we can’t enforce that requirement exactly, but we can sure enforce systematically that the absolute limit for a 12-month period is met, and so we’re ready to ensure that G0447 is billed no more than 22 times during a 12-month period, and if that condition is exceeded – that limit is exceeded, using the benefit maximum remittance advice coding that we’ve seen several times in the earlier presentation.

One last thing I'd like to note, and this applies to all five of the benefits we've talked about today, next eligible dates for the services that have been described are viewable through standard inquiry methods. So if you're not certain whether a beneficiary is eligible on a given date, you can check through one of the standard inquiry methods and get the date that is appropriate.

Thanks.

Leah Nguyen: Thank you, Wil.

There's a list of resources for intensive behavioral therapy for obesity on slide 100.

On slide 101, we have information on how to submit comments for the calendar year 2013 Physician Fee Schedule proposed rule, and on slide 102 there's a list of general preventive services resources.

Amanda Barnes: Thank you for listening to this Medicare Preventive Services educational podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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