

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-03 Medicare National Coverage Determinations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 142	Date: February 03, 2012
	Change Request 7641

SUBJECT: Intensive Behavioral Therapy for Obesity

I. SUMMARY OF CHANGES: Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity (BMI and No. 8805; 30 kg/m²), 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 in a primary care setting are eligible for: One face-to-face visit every week for the first month; One face-to-face visit every other week for months 2-6; One face-to-face visit every month for months 7-12.

This revision to the Medicare National Coverage Determinations Manual is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, [contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions], quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

EFFECTIVE DATE: November 29, 2011

IMPLEMENTATION DATE: March 6, 2012 for non – shared system edits , July 2, 2012 for shared system edits, CWF provider screen, HICR and MCSDT changes

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/ revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/210.12/Table of Contents
N	1/210.12/Intensive Behavioral Therapy for Obesity

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachments - Business Requirements

Pub. 100-03	Transmittal: 142	Date: February 03, 2012	Change Request: 7641
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SUBJECT: Intensive Behavioral Therapy for Obesity

Effective Date: November 29, 2011

Implementation Date: March 6, 2012 for non-shared system edits
July 2, 2012 for shared system edits, CWF provider screen, HICR, and MCSDT changes

I. GENERAL INFORMATION

A. Background: Pursuant to §1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may add coverage of "additional preventive services" through the National Coverage Determination process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening for Obesity in Adults" preventive services and determined that all three criteria were met.

In 2003 the USPSTF found good evidence that body mass index (BMI) "is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity." The USPSTF also found fair to good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥ 30 kg/m²) "produces modest, sustained weight loss."

B. Policy: Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²), 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 in a primary care setting are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12 if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first six months as discussed below.

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs) over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs) during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

IBT for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²);
2. Dietary (nutritional) assessment; and

- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Intensive behavioral intervention for obesity should be consistent with the 5-A framework:

- Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- Agree:** Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
- Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

NOTE: The NCD for Intensive Behavioral Therapy for Obesity can be found in Section 210.12 of the Medicare NCD Manual. Please see section 200 of the Medicare Claims processing Manual (Pub. 100-04) for claims processing instructions.

II. BUSINESS REQUIREMENTS TABLE

Use of “Shall” denotes a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A I E R	R H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7641-03.1	Effective for claims with dates of service on and after November 29, 2011, contractors shall recognize HCPCS code G0447, Face-to-Face Behavioral Counseling for Obesity, 15 minutes. See Pub. 100-04 business requirements, Claims Processing Manual Pub. 100-04, chapter 18, section 200, and Pub 100-03 NCD Manual chapter 1, section 210.12.	X		X	X						MPFSDB IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I 	C A R R I E R	R H I 	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7641-03.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use of "Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Sarah McClain, coverage, 410-786-2994, sarah.mcclain@cms.hhs.gov,

Wanda Belle, coverage, 410-786-7491, wanda.belle@cms.hhs.gov,

Pat Brocato-Simons, coverage, 410-786-0261, patricia.brocatosimons@cms.hhs.gov,

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April Billingsley, practitioner claims processing, 410-786-0140, april.billingsley@cms.hhs.gov.

Post-Implementation Contact(s):

Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare National Coverage Determinations Manual

Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations

Table of Contents

(Rev.142, Issued: 02-03-12)

Transmittals for Chapter 1, Part 4

210 - Prevention

210.12 – Intensive Behavioral Therapy for Obesity

210.12 – Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

(Rev. 142, issued: 02-03-12, Effective: 11-29-11, Implementation: 03-06-12)

A. General

Based upon authority to cover “additional preventive services” for Medicare beneficiaries if certain statutory requirements are met, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on intensive behavioral therapy for obesity. Screening for obesity in adults is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Part A and Part B.

The Centers for Disease Control (CDC) reported that “obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States.” In the Medicare population over 30% of men and women are obese. Obesity is directly or indirectly associated with many chronic diseases including cardiovascular disease, musculoskeletal conditions and diabetes.

B. Nationally Covered Indications

Effective for claims with dates of service on or after November 29, 2011, CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², for the prevention or early detection of illness or disability.

Intensive behavioral therapy for obesity consists of the following:

- 1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²);*
- 2. Dietary (nutritional) assessment; and*
- 3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.*

The intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been highlighted by the USPSTF:

- 1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.*
- 2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.*
- 3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.*
- 4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.*

5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

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 2-6;*
- *One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement during the first six months as discussed below.*

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

For the purposes of this decision memorandum, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.

For the purposes of this decision memorandum a “primary care physician” and “primary care practitioner” will be defined consistent with existing sections of the Social Security Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)

(6) Physician Defined.—For purposes of this paragraph, the term “physician” means a physician described in section 1861(r)(1) and the term “primary care physician” means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)

Primary care practitioner—The term “primary care practitioner” means an individual—
(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5))

C. Nationally Non-Covered Indications

All other indications remain non-covered.

D. Other

Medicare coinsurance and Part B deductible are waived for this service

(This NCD last reviewed November 2011)