Intensive Behavioral Therapy for Obesity (NCD 210.12)

Guideline Number: MPG165.06
Approval Date: September 9, 2020

Terms and Conditions

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Policy Summary

See Purpose

Overview

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 Medicare benefits under Part A and Part B.

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.

Guidelines

Nationally Covered Indications

CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m^2, for the prevention or early detection of illness or disability.

Intensive behavioral therapy for obesity consists of the following:

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

- 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.

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 (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 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.

Nationally Non-Covered Indications

All other indications remain non-covered.

Other

Medicare coinsurance and Part B deductible are waived for this service.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

Modifier	Description
For Telehealth Services:	
GQ	Via asynchronous telecommunications system

Place of Service Code	Description
02	Telehealth
11	Physician's office
19	Off Campus-Outpatient Hospital

Place of Service Code	Description
22	On Campus-Outpatient hospital
49	Independent clinic
71	State or local public health clinic

Provider Specialty Code: Primary Care Providers	Description
01	General practice
08	Family practice
11	Internal medicine
16	Obstetrics/gynecology
37	Pediatric medicine
38	Geriatric medicine
50	Nurse practitioner
89	Certified clinical nurse specialist
97	Physician assistant

Diagnosis Code	Description
Z68.30	Body mass index (BMI) 30.0-30.9, adult
Z68.31	Body mass index (BMI) 31.0-31.9, adult
Z68.32	Body mass index (BMI) 32.0-32.9, adult
Z68.33	Body mass index (BMI) 33.0-33.9, adult
Z68.34	Body mass index (BMI) 34.0-34.9, adult
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9 , adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

Definitions

For the purposes of this policy guideline, 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 policy guideline, a “primary care physician” and “primary care practitioner” will be defined below:

- Physician Defined: For purposes of this paragraph, the term "physician" means a physician 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.
- Primary Care Practitioner: The term "primary care practitioner" means an individual who:
  - Is a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
  - Is a nurse practitioner, clinical nurse specialist, or physician assistant.

References

CMS National Coverage Determinations (NCDs)

NCD 210.12 Intensive Behavioral Therapy for Obesity
Related NCD: NCD 100.1 Bariatric Surgery for Treatment of Morbid Obesity

CMS Claims Processing Manual

Chapter 12; § 190 Medicare Payment for Telehealth Services
Chapter 18; § 200 - 200.5 Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

MLN Matters

Article MM8874, Preventive and Screening Services — Update — Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy
Article MM9428, Telehealth Services
Article MM9726, New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy
Article MM10152, Elimination of the GT Modifier for Telehealth Services

UnitedHealthcare Commercial Policy

Preventive Care Services

Other(s)

CMS List of Telehealth Services, CMS Website
CMS Medicare Preventive Services Chart, CMS Website
MLN for Telehealth Services, CMS Website

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update • Reformatted policy; transferred content to new template
09/09/2020	Applicable Codes • Removed Modifier code GT Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version MPG165.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.