DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

Intensive Behavioral Therapy (IBT) for Obesity

Medicare | PREVENTIVE SERVICES



ICN 907800 August 2012

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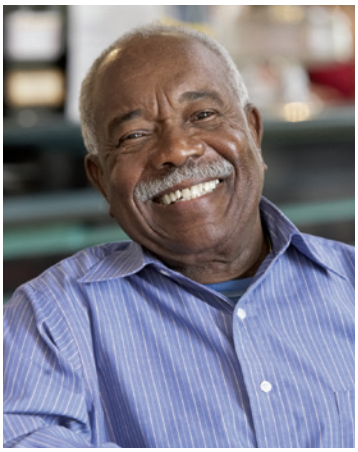
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The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare patients understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your patients about Medicare-covered Intensive Behavioral Therapy (IBT) for obesity, as well as assist you in correctly billing for these services.

Overview

The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. increased dramatically over the last 30 years, and obesity is now an epidemic in the U.S. In the Medicare population, over 30 percent of men and women are obese. Obesity is directly or indirectly associated with many chronic diseases, including:

- Cardiovascular disease,
- Musculoskeletal conditions, and
- Diabetes.

Removal of Barriers to Preventive Services Under the Affordable Care Act

Medicare waives the coinsurance or copayment and deductible for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population, and that are appropriate for the individual.

The Affordable Care Act authorizes CMS to add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. For CMS to add a preventive service, it must be:

- Reasonable and necessary for the prevention or early detection of an illness or disability;
- Recommended with a grade of A or B by the USPSTF; and
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program.

Coverage Information

Effective with dates of service on or after November 29, 2011, Medicare covers IBT for obesity, defined as a body mass index (BMI) of 30 kilograms per meter squared, for the prevention or early detection of illness or disability. IBT for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI, which is calculated by dividing weight in kilograms by the square 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.

Medicare provides coverage of IBT for obesity (BMI ≥ 30 kilograms per meter squared) for Medicare beneficiaries:

- 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.

Stand Alone Benefit

The IBT for obesity benefit covered by Medicare is a stand alone billable service. It is separate from the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit (AWV). Medicare beneficiaries may obtain IBT for obesity services at any time following Medicare Part B enrollment, including during their IPPE or AWV encounter.

Each IBT for obesity must be consistent with the 5A's approach adopted by the USPSTF. This approach includes:

1. **Assess:** Ask about or assess behavioral health risk(s) and factors affecting choice of behavior change goals or 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 beneficiary's interest in and willingness to change the behavior;
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the beneficiary in achieving agreed-upon goals by acquiring the skills, confidence, and social or environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; and
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance or support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.



Primary Care Setting Defined

For the purpose of this benefit, a primary care setting is defined as one in which there is a 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. The following are not considered primary care settings under this definition:

- Ambulatory surgical centers,
- Emergency departments,
- Hospices,
- Independent diagnostic testing facilities,
- Inpatient hospital settings,
- Inpatient rehabilitation facilities, and
- Skilled nursing facilities.

Medicare covers IBT for obesity provided in:

- An independent clinic,
- An outpatient hospital,
- A physician's office, or
- A state or local public health clinic.

Who Are Primary Care Physicians and Practitioners?

For the purpose of the IBT for obesity benefit:

Primary Care Physician

A physician who has a primary specialty designation of:

- Family practice,
- General practice,
- Geriatric medicine,
- Internal medicine,
- Obstetrics/gynecology, or
- Pediatric medicine.

Primary Care Practitioner

A qualified non-physician practitioner is a:

- Certified clinical nurse specialist,
- Nurse practitioner, or
- Physician assistant.

Primary care physicians' and practitioners' corresponding specialty codes apply when billing professional claims. When billing institutional claims, follow billing instructions based on your facility type.

NOTE: In addition, Medicare may cover behavioral counseling for obesity services when billed by one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under our regulation at 42 Code of Federal Regulations (CFR) Section 410.26(b) (conditions for services and supplies incident to a physician's professional service) or 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician service).

Frequency

Medicare covers a maximum of 22 IBT for obesity sessions in a 12-month period.

Medicare beneficiaries who meet the previously mentioned criteria 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; and
- One face-to-face visit every month for months 7 – 12, if the beneficiary meets the 3 kg (6.6 pounds) weight loss requirement during the first 6 months.

At the 6-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 6 months, beneficiaries must have achieved a reduction in weight of at least 3 kg (6.6 pounds) over the course of the first 6 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 3 kg (6.6 pounds) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

EXAMPLE: A beneficiary gets the first IBT for obesity session in January 2012 and gets all 22 sessions. The count starts February 2012. The beneficiary may get another first IBT for obesity session in January 2013.

Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for IBT for obesity. Financial responsibilities may apply for the beneficiary if the provider does not accept assignment.

Documentation

Medical records must document all coverage requirements, including the determination of weight loss at the 6-month visit.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) code, listed in Table 1, to report IBT for obesity.

Table 1. HCPCS Code for IBT for Obesity

HCPCS Code	Code Descriptor
G0447	Face-to-face behavioral counseling for obesity, 15 minutes

Diagnosis Requirements

You must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis code(s), listed in Table 2, for IBT for obesity.

Coming Soon!
International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

For more information, visit http://www.cms.gov/Medicare/Coding/ICD10 on the CMS website.



Table 2. Diagnosis Codes for IBT for Obesity

ICD-9-CM Diagnosis Code	Code Descriptor
V85.30	Body Mass Index 30.0 – 30.9, adult
V85.31	Body Mass Index 31.0 – 31.9, adult
V85.32	Body Mass Index 32.0 – 32.9, adult
V85.33	Body Mass Index 33.0 – 33.9, adult
V85.34	Body Mass Index 34.0 – 34.9, adult
V85.35	Body Mass Index 35.0 – 35.9, adult
V85.36	Body Mass Index 36.0 – 36.9, adult
V85.37	Body Mass Index 37.0 – 37.9, adult
V85.38	Body Mass Index 38.0 – 38.9, adult
V85.39	Body Mass Index 39.0 – 39.9, adult
V85.41	Body Mass Index 40.0 – 44.9, adult
V85.42	Body Mass Index 45.0 – 49.9, adult
V85.43	Body Mass Index 50.0 – 59.9, adult
V85.44	Body Mass Index 60.0 – 69.9, adult
V85.45	Body Mass Index 70 and over, adult

Billing Requirements

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims, to indicate where you provided the service. For more information on POS codes, visit http://www.cms.gov/Medicare/Coding/place-of-service-codes on the CMS website.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report the appropriate HCPCS code, revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.



Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for IBT for obesity when submitted on the following TOBs, listed in Table 3. For further guidance on the appropriate revenue code, contact your local Medicare Contractor.

Table 3. Facility Types and TOBs for IBT for Obesity

Facility Type	TOB
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician's interpretation of the results of an examination. For instructions on billing the professional component, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf on the CMS website.

The technical component is services rendered outside the scope of the physician's interpretation of the results of an examination. If you perform technical components or services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:



- **For Provider-Based FQHCs or RHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website and choose the appropriate chapter based on your facility type.
- **For Independent FQHCs or RHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the CMS website.

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Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for IBT for obesity under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all IBT for obesity services.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data, or revalidating enrollment must use Electronic Funds Transfer (EFT) to get payments. For more information about EFT, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html on the CMS website.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for IBT for obesity depends on the type of facility providing the service. Table 4 lists the type of payment that facilities get.

Table 4. Facility Payment Methods for IBT for Obesity

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

Reasons for Claim Denial

Medicare may deny coverage of IBT for obesity in several situations, including:

- The beneficiary got more than 22 IBT for obesity sessions in the last 12 months.
- The beneficiary got IBT for obesity outside of the primary care setting.

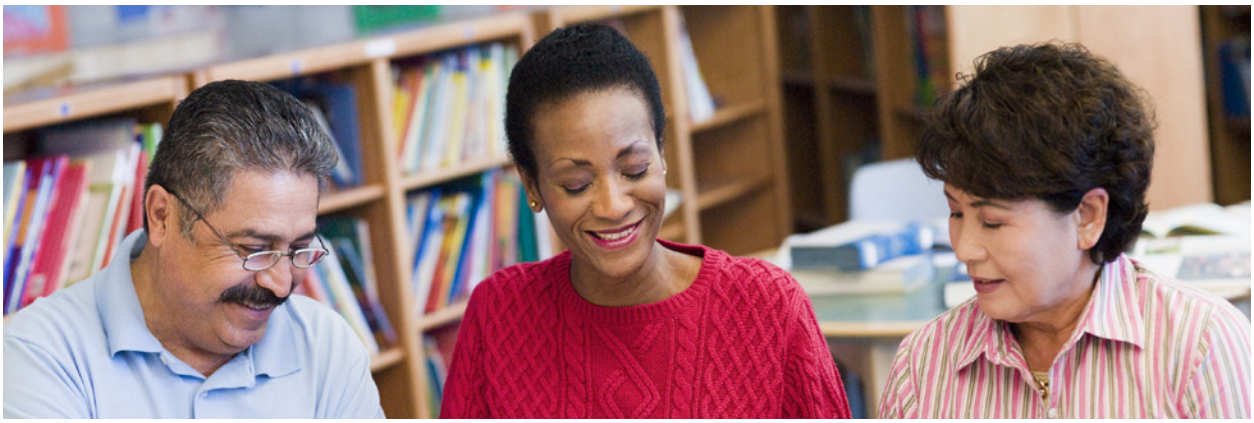
Medicare Contractor Contact Information

For carrier, FI, or A/B MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map on the CMS website.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit http://www.wpc-edi.com/reference on the Internet. You can obtain additional information about claims from your carrier, FI, or A/B MAC.

RA Information

For more information about the RA, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html on the CMS website.



Resources

For more information about IBT for obesity, refer to the resources listed in Tables 5 and 6. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.

Table 5. Provider Resources

Resource	Website
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/Medicare/Medicare-General-Information/BNI
"CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 200	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Table 5. Provider Resources (cont.)

Resource	Website
Medicare Learning Network® (MLN) Guided Pathways to Medicare Resources	The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources helps providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the "Coverage of Preventive Services" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.12	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
Medicare Physician Fee Schedule (MPFS)	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo
MLN Matters® Article MM7641, "Intensive Behavioral Therapy (IBT) for Obesity"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7641.pdf
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
Outpatient Prospective Payment System (OPPS)	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
USPSTF Screening for Obesity in Adults	For a summary of the USPSTF written recommendations on screening for obesity in adults, visit http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm on the Internet.

Table 6. Beneficiary Resources

Resource	Website/Contact Information
"Medicare & You: Stay Healthy with Medicare's Preventive Benefits" Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=relmfu
Medicare Beneficiary Help Line and Website	Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
"Publications for Medicare Beneficiaries"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf
Your Medicare Coverage: Obesity Screening & Counseling	http://www.medicare.gov/coverage/obesity-screening-and-counseling.html
Your Medicare Coverage: Preventive & Screening Services	http://www.medicare.gov/coverage/preventive-and-screening-services.html

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