DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters®
Information for Medicare Fee-For-Service Health Care Professionals

News Flash:

- REVISED products from the Medicare Learning Network® (MLN) "Medicare Physician Fee Schedule," Fact Sheet, ICN 006814, Downloadable

MLN Matters® Number: MM7641 Revised

Related CR Release Date: March 7, 2012

Related CR Transmittal #:R2421CP, R142NCD

Related Change Request (CR) #: 7641

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

Intensive Behavioral Therapy (IBT) for Obesity

Note: This article was revised on March 9, 2012 to reflect the revised CR7641 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR7641 were revised. All other information is unchanged.

Provider Types Affected

This MLN Matters® article is intended for primary care physicians and other primary care practitioners billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in a primary care setting. .

Provider Action Needed

STOP – Impact to You

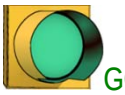
This article is based on Change Request (CR) 7641, which informs Medicare contractors about implementing coverage of Intensive Behavioral Therapy (IBT) for obesity.

CAUTION – What You Need to Know

Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as Body Mass Index (BMI) equal to or greater than 30 kg/m^2, 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; and
- 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 6 months.

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



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding this change. Be sure your staffs are aware of this new coverage determination and that Healthcare Common Procedure Coding System (HCPCS) code G0447 (Face-to-Face Behavioral Counseling for Obesity, 15 minutes) will be used to bill for these services.

This code was effective November 29, 2011, and will appear in the January 2012 quarterly update of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (IOCE).

Background

Based upon authority in the Social Security Act to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, and the services are reasonable and necessary for the prevention or early detection of illness or disability, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on IBT for obesity. Screening for obesity in adults is a "B" recommendation by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Medicare Part A and Part B.

In 2003, the USPSTF found good evidence that 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/m^2) "produces modest, sustained weight loss."

Effective for claims with dates of service on or after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥30 kg/m^2), 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; and
- 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 6 months as discussed below.

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss should 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 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 3kg (6.6 lbs.) 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.

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/m^2);
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.

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

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.

Billing Requirements

Diagnostic Codes

Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize HCPCS code G0447, Face-to-Face Behavioral Counseling for Obesity, 15 minutes. G0447 must be billed along with 1 of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45). The type of service (TOS) for G0447 is 1. (ICD-10 codes will be Z68.30-Z68.39, Z68.41- Z68.45)

Effective for claims with dates of service on or after November 29, 2011, Medicare contractors will deny claims for HCPCS G0447 that are not submitted with the appropriate diagnostic code (V85.30-V85.39, V85.41-V85.45).

Claims submitted with HCPCS G0447 that are not submitted with these diagnosis codes will be denied with the following messages:

- Claim Adjustment Reason Code (CARC) 167 – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance Advice Remark Code (RARC) N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Per MLN Matters® article MM7228, when modifier GZ is used, contractors will use CARC 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.). This is true with all denials noted below that have the Group Code CO. MM7228 may be found at http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf on the CMS website.

Specialty Codes

Effective for services on or after November 29, 2011, Medicare will pay claims for G0447, only when services are submitted by the following provider specialty types found on the provider's Medicare enrollment record:

- 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

If your specialty type is not one of the above, your claim will be denied using the following codes:

- CARC of 185 – "The rendering provider is not eligible to perform the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.),"
- RARC N95 - "This provider type/provider specialty may not bill this service."
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: In addition, Medicare may cover behavioral counseling for obesity services when billed by the one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under our regulation at 42 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).

Place of Service (POS) *Codes*

Effective for services on or after November 29, 2011, Medicare will pay for obesity counseling claims containing HCPCS G0447 only when services are provided with the following POS codes:

- 11 - Physician's Office
- 22 - Outpatient Hospital
- 49 - Independent Clinic
- 71 - State or local public health clinic.

Line items on claims for G0447 will be denied if not performed in these POSs using the following codes:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid POS. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N428 - "Not covered when performed in this place of service."
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file)and
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Frequency Limitation

Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22 limit will be denied using the following codes: (Note: When applying this frequency limitation, a claim for the professional service and a claim for a facility fee will be allowed.)

- CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 - "The number of days or units of service exceeds our acceptable maximum."
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and

- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Your contractor will not search their files for claims that may have been paid in error. However, contractors may adjust claims that are brought to their attention.

Institutional Claims Notes

Claims submitted with either a Type of Bill (TOB) 13X or TOB 85X (where the revenue code is not 096X, 097X, or 098X) will be identified as facility fee service claims.

Claims submitted with TOBs 71X, 77X, or 85X (where the revenue code is 096X, 097X, or 098X) will be identified as professional service claims.

Medicare will pay for G0447 on institutional claims in hospital outpatient departments TOB 13X based on OPPS and in Critical Access Hospitals TOB 85X based on reasonable cost.

The CAH Method II payment is for G0447 with revenue codes 096X, 097X, or 098X is based on 115% of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.

Medicare will line-item deny any claim submitted with G0447 when the TOB is not 13X, 71X, 77X, or 85X with the following:

- CARC 5 - "The procedure code/bill type is inconsistent with the Place of Service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC M77 - "Missing/incomplete/invalid place of service."
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file) and
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Medicare will hold institutional claims received before July 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting G0447.

Rural Health Clinics and Federally Qualified Health Centers Claims Notes

Rural Health Clinics, using TOB 71X, and Federally Qualified Health Centers, using TOB 77X, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not appliced to this service. Such claims will be paid based on the all-inclusive payment rate.

For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item DOS, the service line with HCPCS G0447 will be denied with the following messages:

- Claim Adjustment Reason Code (CARC) 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present" and
- Group Code CO (Contractual Obligation)

Note: Obesity counseling is ***not*** separately payable with another encounter/visit on the same day. This does not apply for Initial Preventive Physical Examination (IPPE) claims, claims containing modifier 59, and 77X claims containing Diabetes Self-Management Training and Medical Nutrition Therapy services.

Additional Information

The official instruction, CR7641, issued to your FI, carrier, and A/B MAC regarding this change, was issued in 2 transmittals at http://www.cms.gov/transmittals/downloads/R2421CP.pdf and http://www.cms.gov/transmittals/downloads/R142NCD.pdf on the CMS website.

If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

News Flash: It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.