CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2421	**Date: March 7, 2012**
	Change Request 7641

NOTE: Transmittal 2409, dated February 3, 2012, is being rescinded and replaced by Transmittal 2421, dated March 7, 2012 to correct the ICD-10 code range in BR 7641-04.1.3 All other information remains the same.

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 andNo.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.

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	18/Table of Contents
N	18/200/Intensive Behaviorhal Therapy for Obesity
N	18/200.1/ Policy
N	18/200.2/ Institutional Billing Requirements
N	18/200.3/Professional Billing Requirements
N	18/200.4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
N	18/200.5/ Common Working File (CWF) Edits

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2421	Date: March 7, 2012	Change Request: 7641

NOTE: Transmittal 2409, dated February 3, 2012, is being rescinded and replaced by Transmittal 2421, dated March 7, 2012 to correct the ICD-10 code range in BR 7641-04.1.3 All other information remains the same.

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 $\geq$30 kg/m^2) "produces modest, sustained weight loss."

B. Policy: Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity (BMI $\geq$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;
- 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 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 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 IBT 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.

NOTE: HCPCS G0447, Face-to-face behavioral counseling for obesity, 15 minutes, will be effective November 29, 2011, and will appear in the January 2012 updates of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (IOCE). Note: While HCPCS G0449: Annual face-to-face obesity screening, 15 minutes, will appear in the January 2012 quarterly update of the MPFSDB and the IOCE, it is being removed and is not to be used when submitting claims for Intensive Behavioral Therapy for Obesity. Please following the claims processing instructions provided below.

II. BUSINESS REQUIREMENTS TABLE

Use of "Shall" denotes a mandatory requirement

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7641-04.1	Effective for claims with dates of service on or after November 29, 2011, contractors shall recognize HCPCS code G0447, Face-to-Face Behavioral Counseling for Obesity, 15 minutes.	X		X	X			X		X	MPFSDB IOCE
7641-04.1.1	Contractors shall allow payment of G0447 only when billed with one 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.	X		X	X		X	X		X	
7641-04.1.1.1	Effective for claims with dates of service on or	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	after November 29, 2011, contractors shall deny claims for HCPCS G0447 that are not submitted with one of the diagnosis codes listed in 7641.04.1.1										
7641-04.1.1.2	Contractors shall deny claims lines for HCPCS G0447 that are not submitted with the diagnosis codes listed in BR 7641.04.1.1 using the following messages: MSN 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim. 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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X		X	X						
7641-04.1.2	Effective for claims with dates of service on or after November 29, 2011, beneficiary	X		X	X		X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	coinsurance and deductible does not apply to claim lines with G0447 obesity counseling.										
7641-04.1.3	Contractors shall note that the appropriate ICD-10 code(s) are listed below. Contractors shall track the ICD-10 code/edits (and add the code(s)/edit(s) to their system when applicable) and ensure that the updated edit is functional as part of the ICD-10 implementation. **NOTE: You will not receive a separate Change Request instructing you to implement updated edits.** BMI 30.0 and over – Z68.30-Z68.39.9, Z68.41-Z68.45	X		X	X		X	X		X	
7641-04.2	Effective for claims processed for dates of service on or after November 29, 2011, through December 31, 2011, contractors shall apply contractor pricing to claims containing G0447.	X			X						
7641-04.3	Contractors shall load G0447 to their HCPCS file with an effective date of November 29, 2011.	X		X	X						
7641-04.4	Effective for claims with dates of service on or after November 29, 2011, contractors shall pay claims for G0447 when services are submitted by the following provider specialty types found on the provider's 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	X			X						
7641-04.4.1	Contractors shall deny claim lines for G0447 performed by provider specialty types other than those specified in 04.4 using the following: Medicare Summary Notice (MSN) 21.18 - This item or service is not covered when performed or ordered by this provider.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Claim Adjustment Reason Code (CARC) 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. Remittance Advice Remark Code (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). 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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7641-04.5	Effective for claims with dates of service on or after November 29, 2011, contractors shall pay for obesity counseling claims containing HCPCS G0447 when services are provided with the following place of service (POS) codes: 11 – Physician's Office 22 – Outpatient Hospital 49- Independent Clinic 71 - State or local public health clinic	X			X						
7641-04.5.1	Contractors shall deny claim lines for G0447 submitted without the appropriate POS code using the following: MSN 21.25 - This service was denied because Medicare only covers this service in certain settings. CARC 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	invalid place of service. 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). 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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7641-04.6	Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, CWF shall create an edit to allow obesity counseling G0447 no more than 22 times in a 12-month period. NOTE: CWF shall count from the date of the 1st G0447 claim received date. 11 full months must pass from the month of the 1st G0447 claim received date before another round of 22 sessions could begin, i.e., July 15, 2012 begins the count so July 1, 2013 another round could begin (based on NCD criteria).									X	
7641-04.6.1	CWF shall reject more than 22 submissions of G0447 in a 12-month period.									X	
7641-04.6.2	Contractors shall deny claim lines for G0447 if billed more than 22 times in a 12-month period using the following: MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time. CARC 119 - Benefit maximum for this time	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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). 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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7641-04.7	When applying frequency limitations required in 04.6 CWF shall allow both a claim for the professional service and a claim for a facility fee.									X	
7641-04.7.1	CWF shall identify the following institutional claims as facility fee claims for screening services: • TOB 13X • TOB 85X when the revenue code is not 096X, 097X, or 098X									X	
7641-04.7.2	CWF shall identify all other claims as professional service claims for screening services (professional claims, and institutional claims with TOB 71X, 77X, and 85X when the revenue code is 096X, 097X, or 098X).									X	
7641-04.8	Contractors shall allow Rural Health Clinics (RHCs) type of bill (TOB) 71X & Federally Qualified Health Centers (FQHCs) TOB 77X to submit additional revenue lines containing obesity counseling G0447.	X		X			X				
7641-04.8.1	Contractors shall pay for obesity counseling G0447 in RHC TOB 71X and FQHCs TOB 77X based on the all-inclusive payment rate. NOTE: Obesity counseling is ***not*** separately payable with another encounter/visit on the same	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	day. This does not apply for IPPE claims, claims containing modifier 59, and 77X claims containing DSMT & MNT services.										
7641-04.8.2	Contractors shall assign group code CO and reason code 97 to revenue lines with obesity counseling G0447 when an encounter/visit is present with the same line-item date of service. 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 Services Payment Information REF), if present.	X		X			X				
7641-04.9	Contractors shall 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.	X		X			X				
7641-04.10	Contractors shall pay for G0447 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.	X		X			X				
7641-04.11	Contractors shall line-item deny any claim submitted with obesity counseling 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).	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7641-04.12	CWF shall calculate a next eligible date for obesity counseling G0447 for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules NOTE: The calculation for the next eligible date for obesity counseling shall parallel claims processing.									X	NGD MBD
7641-04.12.1	The next eligible date shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD MBD
7641-04.12.2	When there is no 'next eligible date' the CWF provider query screens shall display an 8-position alpha code in the date field to indicate why there is no 'next eligible date.'									X	NGD MBD
7641-04.12.3	Any change to beneficiary master data or claims data that would result in a change to any 'next eligible' date shall result in an update to the beneficiary's 'next eligible date.'									X	
7641-04.13	The Multi-Carrier System Desktop Tool (MCSDT) shall display G0447 obesity counseling sessions in a format equivalent to the CWF HIMR screen.							X			
7641-04.13.1	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, the G0447 obesity counseling sessions identified in 04.01.							X			
7641-04.14	Contractors shall hold institutional claims received before July 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting G0447.	X		X							
7641-04.14.1	Effective July 2, 2012, contractors shall release	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	any held claims noted above, appending condition code 15.										
7641-04.15	Contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7641-04.16	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 Bell, coverage, 410-786-7491, wanda.belle@cms.hhs.gov,
Pat Brocato-Simons, coverage, 410-786-0261, patricia.brocatosimons@cms.hhs.gov,
Will Gehne, institutional claims processing, 410-786-6148, Wilfried.Gehne@cms.hhs.gov,
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 Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 2421, Issued: 03-07-12)

200 - Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

The United States Preventive Services Task Force (USPSTF) found good evidence that body mass index (BMI) is a reliable and valid indicator for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. It also 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.

200.1 – Policy

(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

For services furnished on or after November 29, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover Intensive Behavioral Therapy for Obesity. 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;*
- *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.*

The counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below:

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.*

Medicare will cover Face-to-Face Behavioral Counseling for Obesity, 15 minutes, G0447, along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), up to 22 sessions in a 12-month period for Medicare beneficiaries. The Medicare coinsurance and Part B deductible are waived for this preventive service.

Contractors shall note the appropriate ICD-10 code(s) that are listed below for future implementation. Contractors shall track the ICD-10 codes and ensure that the updated edit is turned on as part of the ICD-10 implementation effective October 1, 2013.

ICD-10	*Description*
Z68.30	*BMI 30.0-30.9, adult*
Z68.31	*BMI 31.0-31.9, adult*
Z68.32	*BMI 32.0-32.9, adult*
Z68.33	*BMI 33.0-33.9, adult*
Z68.34	*BMI 34.0-34.9, adult*
Z68.35	*BMI 35.0-35.9, adult*
Z68.36	*BMI 36.0-36.9, adult*
Z68.37	*BMI 37.0-37.9, adult*
Z68.38	*BMI 38.0-38.9, adult*
Z68.39	*BMI 39.0-39.9, adult*
Z68.41	*BMI 40.0-44.9, adult*
Z68.42	*BMI 45.0-49.9, adult*
Z68.43	*BMI 50.0-59.9, adult*
Z68.44	*BMI 60.0-69.9, adult*
Z68.45	*BMI 70 or greater, adult*

See National Coverage Determinations (NCD) Manual (Pub. 100-03) §210.12 for complete coverage guidelines.

200.2 – Institutional Billing Requirements
(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

Effective for claims with dates of service on and after November 29, 2011, providers may use the following types of bill (TOB) when submitting HCPCS code G0447: 13x, 71X, 77X, or 85X. Service line items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- *Rural Health Clinics (RHCs) - type of bill (TOB) 71X only – based on the all-inclusive payment rate*
- *Federally Qualified Health Centers (FQHCs) - TOB 77X only – based on the all-inclusive payment rate*
- *Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System (OPPS)*
- *Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost*

• CAH Method II – TOB 85X - based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

For RHCs and FQHCs, obesity counseling is not separately payable with another face-to-face encounter on the same day. This does not apply to claims for the Initial Preventive Physical Examination (IPPE), claims with unrelated services denoted with modifier 59, and FQHC claims containing Diabetes Self Management Training (DSMT) and Medical Nutrition Therapy (MNT) services. However, the counseling sessions alone when rendered as a face-to-face visit with a core practitioner do constitute an encounter and are paid based on the all-inclusive payment rate.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

200.3 – Professional Billing Requirements
(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

For claims with dates of service on or after November 29, 2011, CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, G0447, along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when services are submitted by the following provider specialties found on the provider's 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

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

For claims with dates of service on or after November 29, 2011, CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, G0447, along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when submitted with one of the following place of service (POS) codes:

11 – Physician's Office
22 – Outpatient Hospital
49 – Independent Clinic

71 – State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

200.4 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for obesity counseling sessions:

- *Denying services submitted on a TOB other than 13X, 71X, 77X, and 85X:*

  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

  MSN 21.25: "This service was denied because Medicare only covers this service in certain settings."

  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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

- *For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item date of service:*

  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

  Group Code CO (Contractual Obligation)

- *Denying services for obesity counseling sessions HCPCS code G0447 with 1 of the ICD-9 codes (V85.30-V85.39 or V85.41-V85.45) for more than 22 times in the same 12-month period:*

  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.

  MSN 20.5 – These services cannot be paid because your benefits are exhausted at this time.

  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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

- *Denying claim lines for obesity counseling sessions HCPCS code G0447 without 1 of the appropriate ICD-9 codes (V85.30-V85.39 or V85.41-V85.45):*

  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.

  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.

  MSN 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

  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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

- *Denying claim lines without the appropriate POS code:*

CARC 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428 - Not covered when performed in certain settings.

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

- *Denying claim lines that are not submitted from the appropriate provider specialties:*

CARC 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.

MSN 21.18 - This item or service is not covered when performed or ordered by this provider.

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: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

200.5 – Common Working File (CWF) Edits
(Rev.2421, Issued: 03-07-12, Effective: 11-29-11, Implementation: 03-06-12, for non-shared system edits, 07-02-12 for shared system edits, CWF provider screen .HICR, and MCSDT changes)

When applying frequency, CWF shall count 22 counseling sessions of G0447, along with 1 ICD-9 code from V85.30-V85.39 or V85.41-V85.45 in a 12-month period. When applying frequency limitations to G0447 counseling CWF shall allow both a claim for the professional service and a

claim for a facility fee. CWF shall identify the following institutional claims as facility fee claims for this service: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims. NOTE: This does not apply to RHCs and FQHCs.