Lifestyle and Weight Management Coding and Reimbursement Guide

Intermountain® Healthcare

What you'll find in this guide

The information in this guide is accurate as of **June 2013.** As this information may change frequently, check intermountain.net/lifestyle or intermountainphysician.org/lifestyle for the most current version. Email ppp@imail.org to report any changes needed. This guide covers the following lifestyle and weight management services:

- **Preventive visits** *(see page 2):*
  - **For patients with commercial/private plans.** These visits involve a comprehensive history/exam (focused on risk factors and not problem management), screening tests and vaccines appropriate to age and risk as required by the Accountable Care Act (see section below), plus risk factor interventions such as lifestyle and weight management counseling.
  - **For patients with Medicare plans.** See the *CMS Quick Reference for Medicare Preventive Services* for frequency, coding, and coverage for Medicare preventive services, including the Initial Preventive Physical Exam ("Welcome to Medicare" visit), annual wellness visits, screening exams, tobacco cessation counseling, and so forth.
- **Lifestyle and weight management visits** *(see pages 2–4)*, which can focus solely on counseling and coaching patients in setting goals and making lifestyle changes:
  - **For patients with commercial/private plans.** These include individual counseling, group counseling, and medical nutrition therapy.
  - **For patients with Medicare and Medicare Advantage plans.** These include intensive obesity counseling, medical nutrition therapy, and annual depression screening.
  - **For patients with Utah Medicaid.** *See page 4* for coverage notes and a link to local information.
- **Bariatric surgery coverage.** *See page 4* for a summary of coverage and criteria for commercial/private payers, Medicare, and Utah Medicaid.

How healthcare reform affects lifestyle and weight management services

The Affordable Care Act stipulates that new **commercial and individual health policies** (beginning on or after September 23, 2010) **must cover preventive services with "strong scientific evidence"** of health benefits under a preventive benefit where the patient has **no cost sharing** (no copayment, co-insurance, or deductible). Services with "strong scientific evidence" are defined as those recommended by the USPSTF with an A or B rating.

Required services include the following:

- **For patients with BMI >30: Intensive, multicomponent counseling and behavioral interventions to promote sustained weight loss.** Required components include behavioral management, improving diet/nutrition and increasing physical activity, addressing barriers to change, self-monitoring, and strategies for maintenance. Guidelines stipulate 12 to 26 individual or group sessions in a year, provided by primary care clinicians or specialists, such as dietitians who participate in a multicomponent behavioral intervention program.

  ***The Weigh to Health®* is a good way to meet this ACA requirement.** This program meets USPSTF guidelines and is coded and billed appropriately with no patient copay. If *The Weigh to Health®* is not available, recommend your patient contact their insurer to ask about an appropriate program. If a program is not available and you provide this service, you can bill using the codes described in the table above; however, it is challenging to combine appointments on your own for a program that meets these ACA requirements and is coded appropriately for no copay.
- **For patients with diet-related chronic disease: Intensive behavioral dietary counseling** provided by a dietitian or specially trained primary care clinician. Guidelines stipulate at least 2 to 3 group or individual sessions of at least 30 minutes each. To bill for dietitian services that meet this requirement, use the medical nutrition therapy (MNT) code in Table 2, page 2. SelectHealth commercial coverage includes 5 visits to a registered dietitian with no copay.

Preventive visits: *Commercial/private plans*

TABLE 1. Coding preventive visits for commercial/private plans

Description	Service codes	ICD-9 code	Services/documentation
Well-male exam OR well-female exam *Covered by commercial/ private plans ONLY*	Preventive medicine, new patient: • 99385 (18 to 39 yrs old) • 99386 (40 to 64 yrs old) • 99387 (≥65 yrs old) Preventive medicine, established patient: • 99395 (18 to 39 yrs old) • 99396 (40 to 64 yrs old) • 99397 (≥65 yrs old) *(Do NOT use modifier 52 to designate reduced services if history/exam is not comprehensive.)*	V70.0 (Note: if well-female exam includes GYN, use V72.31)	• Comprehensive history/exam, based on risk factors rather than a presenting problem • Brief status description for chronic, stable problems; brief notes on management of minor problems • ACA-required screening, labs, tests, and/or vaccine orders appropriate to age and risk, with USPSTF recommendation of A or B • ***Counseling, anticipatory guidance and/or risk factor interventions***

If problem-focused services are also provided:

- You can prevent bundling if significant extra work is involved (enough to justify a separate appt.) AND the circumstances are appropriate:
  - Patient: The exam shows unexpected, abnormal findings or an acute problem is treated OR patient has chronic medical problems (with one or two in poor control) OR patient has three serious chronic problems (all in good control) if they are addressed separately.
  - Treatment: The assessment and plan shows treatment of disease, along with addressing preventive medicine issues.
- Coding: Also provide problem-oriented service code (99201-99215) with modifier 25 (do not use as the primary code); provide diagnosis code for the problem treated; provide separate E/M note for service provided (one item of documentation can't count toward both services).
- Patient expectations: Explain that while there will be no copay for the preventive visit, the problem-oriented service will involve a copay and/ or billing as per their insurance plan.

Preventive visits: *Medicare plans*

See the *CMS Quick Reference for Medicare Preventive Services* for frequency, coding, and coverage for Medicare preventive services, including the Initial Preventive Physical Exam ("Welcome to Medicare" visit), annual wellness visits, and screening exams.

Lifestyle management visits: *Commercial/private plans*

TABLE 2. Coding lifestyle management visits for commercial/private plans

Description	Service codes	ICD-9 codes	Documentation
Individual preventive medicine to reduce risk factors, including counseling on diet and exercise	• 99401 (15 minutes) • 99402 (30 minutes) • 99403 (45 minutes) • 99404 (60 minutes)	• 278.x: Obesity • 250.x: Diabetes • V65.3: Dietary counseling • V65.41: Exercise Counseling	• Document counseling given in patient's record • Provide appropriate E/M documentation and codes
Group preventive medicine to reduce risk factors	• 99411 (30 minutes) • 99412 (60 minutes)	272.x: Disorders of lipid metabolism	
Group counseling for patients with symptoms or established illness	• 99078	• 278.x: Obesity • 250.x: Diabetes	• Document counseling in each patient's record
Medical nutrition therapy (MNT) delivered by a dietitian, including nutritional counseling and behavior change interventions	• 97802 (each 15 minutes in an *initial* individual session) • 97803 (each 15 minutes in a *subsequent* individual session) • 97804 (each 30 minutes in a group session)	Varies depending on the plan • Note that *regardless of diagnosis,* SelectHealth commercial plans cover 5 visits with $0 copay	• Document counseling given

Lifestyle and weight management: *Medicare plans*

TABLE 3. Coding lifestyle management visits for Medicare and Medicare Advantage plans

Description & coverage notes	Service codes	ICD-9 codes	Documentation
Intensive behavioral therapy for obesity: Face-to-face behavioral counseling by a primary care provider in a primary care setting for patients with obesity, 15 minutes: • One visit per week in month 1 • One visit every other week for months 2 to 6 (assess obesity at 6-month visit; patient must have lost 3 kg to continue) • One visit every month for months 7 to 12 (if 3 kg weight loss at month 6) *Covered with $0 copay; bill no more than 22 times in a 12-month period. Registered dietitians may not bill directly for this service but may provide this service if billed "incident to a physician service."*	G0447 (15 minutes)	• V85.30 to V85.39 (BMI 30 to 39) • V85.41 (BMI 40-44) • V85.42 (BMI 45-49) • V85.43 (BMI 50-59) • V85.44 (BMI 60-69) • V85.45 (BMI >70)	Provide and document behavioral counseling to promote weight loss through interventions on diet and exercise (using the 5As approach described in the *Weight & Lifestyle Management CPM*)
Medical nutrition therapy (MNT) delivered by a dietitian, including nutritional counseling and behavior change interventions *Covered with $0 copay for 3 hours total in first year and 2 hours in later years, for certain beneficiaries (see ICD-9 code column)*	• 97802 (each 15 min. in an *initial* individual session) • 97803 (each 15 min. in a *subsequent* individual session) • 97804 (each 30 min. in a group session)	Covered only for beneficiaries with diabetes, renal disease, or kidney transplant in past 3 years (ICD-9 codes not defined by Medicare)	• Document therapy given
Medical nutrition therapy (MNT) by a dietitian for reassessment and subsequent interventions for a **change in diagnosis** *Covered with $0 copay if MNT benefit listed above has been used and diagnosis code changes, for certain beneficiaries (see ICD-9 code column).*	• G0270 (each 15 min in an individual session) • G0271 (each 30 min in a group session)	Covered for beneficiaries with diabetes, renal disease, or kidney transplant in past 3 years; use G0270-G0271 if the patient's diagnosis has changed	• Document therapy given
Group counseling for patients with symptoms or established illness	• 99078	• 278.x: Obesity • 250.x: Diabetes	• Document counseling in each patient's record
Intensive behavioral therapy to reduce **cardiovascular disease** risk *Covered for certain beneficiaries (see ICD-9 column). Must be given by primary care provider; registered dietitians may not bill directly but may provide this service if billed "incident to a physician service."*	• G0446 (individual, face-to-face, bi-annual, 15 minutes)	No specific diagnosis code. For: • Adults age 18 and older: Hypertension screening • Men age 45–79 and women aged 55–79: Encouraging aspirin use when benefits outweigh risk • Adults with well-known CV disease risk factors: Intensive behavioral counseling to promote a healthy diet	• Document therapy given
Annual depression screening by a primary care provider, 15 minutes *Covered with $0 copay*	• G0444	No specific diagnosis code	• Document screening

Utah Medicaid coverage for lifestyle and weight management services

For current information on Medicaid coverage and coding for lifestyle and weight management services, see the **Utah Medicaid Coverage and Reimbursement Lookup Tool** at health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Bariatric surgery

The table below uses the following procedure abbreviations: RYGBP (roux-en-Y gastric bypass), BPD/DS (biliopancreatic diversion with duodenal switch), AGB (adjustable gastric banding), VGB (vertical gastric banding).

TABLE 4. Bariatric surgery coverage by payer

Payer notes	Procedures	Criteria
Commercial payers	• Bariatric surgery is covered by some commercial payers, if bariatric surgery rider is purchased by the employer. Requirements vary; for SelectHealth coverage information, see https://physician.intermountain.net/selecthealth/policies/SelectHealth%20Policies%20%20Procedures/295.pdf.	
Medicare and Medicare Advantage National coverage criteria linked here or go to www.cms.gov, search for Publication 100-03, and visit section 100.1. Local coverage determination (with ICD-9 codes) linked here or go to http://www.cms.gov/medicare-coverage-database and search for Local Coverage Documents, Utah, keyword bariatric.	• **COVERED:** open and laparascopic RYGBP or BPD/DS, laparascopic AGB (laparascopic sleeve gastrectomy covered at contractor's discretion) • **NOT covered:** open AGB, open sleeve gastrectomy, open and laparoscopic vertical banded gastroplasty	• Covered for patients who have BMI >35 and at least one comorbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity. • Procedure must be performed at a CMS Center of Excellence (for a list see www.cms.hhs.gov/center/coverage.asp)
Utah Medicaid 2011 adult criteria: health.utah.gov/medicaid/pa/pdfs/Gastric_Bypass2011.pdf (registration may be required)	• **COVERED,** subject to prior authorization: RYGBP, BPD/DS, AGB • **NOT covered:** revisional surgery, jejunoileal bypass, horizontal gastric stapling, VGB, sleeve gastrectomy, long limb gastric bypass, mini-gastric bypass, gastric balloon, transoral gastroplasty	• Covered for patients with **clinically severe obesity**, which requires ***ALL*** of the following: – Obesity ≥ 3 years – BMI >40 *OR* BMI >35 with one of these comorbidities: Type 2 diabetes, hypertension, CAD/CHF/dyslipidemia, obstructive sleep apnea, GERD, osteoarthritis, pseudotumor cerebri – Continued obesity despite supervised diet program ≥6 months *OR* >10% weight loss in the past 6 months – Preoperative evaluation that includes all of the following: routine screening for cardiac/pulmonary disease, dietary consult, endocrinopathy excluded, active peptic ulcer excluded by testing (EGD, UGI, or *H. pylori* negative), drug/alcohol screen (no drug/alcohol use by history or alcohol/drug free for ≥1 year) • Patient understands surgical risk, compliance, and follow-up • Procedure must be performed at bariatric surgery center • Gastric bypass surgery cases must receive secondary review approval from the appropriate committee (CHEC or UR)
Federal/state health plans	• Bariatric surgery is covered by patients insured through federal employee health benefits and most state employee plans. Patient requirements vary.	

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