Weight Management Services – Summary of Coding & MN Health Plan Policies
Categorized by Service and Provider Type
October 2011

				Key Payer Comments/Coverage Exclusions (if known)				
Provider Credentials	Codes/Descriptions (any payer variations are noted to the right)	Additional Instructions/ Documentation Requirements	2011 tRVU (1)	Medicare (Incident to rules typically apply)	Medicaid	BCBS	HealthPtrs	Medica
Discussion/Counseling, with (Underlying) Problem Diagnosis, Individual								
MD/DO NP PA CNS	**Evaluation and Management** (E/M) codes (New Patient **99201-99205** Establ. Patient **99211-99215**)	CMS/AMA E/M Documentation rules: - Three key components or total and counseling time (For DC provider type, CPT states E/M codes may be used; see intro to CMT section)	New Patient 1.25 2.16 3.13 4.8 5.95 Establ. Patient 0.56 1.24 2.09 3.08 4.15	Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions, or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions. Treatments for obesity alone remain non-covered.	**Covered Weight Loss Services** MHCP covers physician visits, MNT, and laboratory work for weight management. Services must be billed by enrolled providers with current CPT codes. If an MHCP recipient elects to participate in a weight loss program, the recipient may be billed for components of the program that are not covered, as long as the recipient is informed of charges in advance. **Non-Covered Weight Loss Services** • Weight loss services on a program basis • Nutritional supplements/foods for weight reduction • Exercise classes/Instructional materials and books • Motivational classes • Services provided by non-MHCP providers	In general, Blue Cross covers services for treatment of obesity, weight management, nutrition, and physical activity counseling. However, coverage for these services depends on the type of provider submitting the claim, the procedure/service and diagnosis codes submitted, and the patient's contract with Blue Cross. Check coverage before extensive services are provided. Due to the many variables, exact payment cannot be determined until BCBS receives the claim for processing. Screening and counseling for obesity and counseling for a healthy diet are covered under health care reform (HCR). Services for obesity/weight management counseling may be billed under E/M codes.	Weight loss services may or may not be covered by all HealthPartners plans.	No published general policy statement.
MD/DO PharmD, Lic nutr. MA/LPN/RN	**99211** (Lowest level establ patient office visit)	99211: Document physician's order, reason for visit, services delivered, discussions with other providers, and plan.	0.58	Incident to rules apply				
PT DC	There are no discussion oriented codes other than initial and follow up evaluation codes, which do not seem to apply here	NA	NA	Written policies do not reference weight management services by PT providers. Medicare coverage for services by Doctors of Chiropractic medicine extends only to treatment by means of manual manipulation of the spine to correct a subluxation; all other services furnished or ordered by chiropractors are not covered.	Written policies do not reference weight management services by PT or DC providers.	Written policies do not reference weight management services by PT or DC providers.	Care must be rehabilitative and medically necessary for... acute neuromusculoskeletal conditions such as back pain, neck pain, chronic and tension headaches.	Written policies do not reference weight management services by PT or DC providers.
RD (and MD/ DO, RN for Medicaid) MD/DO	**97802** (init, each 15 min) **97803** (reassess, each 15 min) **97804** (group, each 30 min) **Medical Nutrition Therapy (MNT)** Medical nutrition therapy; initial and re-assessment and intervention, individual or group, coded based on time.	97802-97804 (MNT): Nutritional diagnostic therapy and counseling services provided by registered dietitians (RDs) and state-licensed dietitians for the purpose of managing an acute or chronic condition or disease. A physician order for educational or counseling services is typically required. Documentation of the recipient's participation, number of participants in the group, name and credentials of person providing the service, and topic content must be in the medical record or class record.	.94, .82, .41	MNT coverage is available for qualifying beneficiaries with chronic kidney disease (stages 3-5), kidney transplant, diabetes, and gestational diabetes, when provided by a licensed RD or a dietician or nutritionist licensed or certified in a state... CMS coverage policies include additional hours of MNT when there is a change in diagnosis, medical condition, or treatment regimen. Use HCPCS for MNT reassessment and subsequent intervention following a second referral in the same calendar year for a change in diagnosis, medical condition, or treatment regimen. - G0270 MNT ...individual, face-to-face w/patient, each 15 min - G0271 MNT ...group (2+ ind'ls), each 30 min	Follows Medicare rules. Must be under physician supervision. For clinic-employed providers, use the clinic or individual physician's NPI as the billing provider, and the Dietician's or Nutritionist's NPI as the rendering provider. MNT is not a covered service under the following programs: • Emergency Medical Assistance (EMA) • Minnesota Care Limited Benefit (MLB) Licensed RNs may only provide nutritional counseling to the extent that their scope of practice and education experience allow. PSM is only covered for diabetic	Physician referral is necessary. Claims for registered dieticians must be submitted under the NPI of a supervising physician. The U7 modifier should also be submitted (policy also references codes S9452 (nutrition classes, non-physician provider, per session) and S9470 (nutritional counseling, dietician visit). Use ICD-9 V65.3 for prevention/risk factor reduction and 278.00 or 278.01 for obesity. These codes will cause claims to pay according to the illness portion of the patient's contract. MNT codes (97802, 97803, S9470) may be billed when counseling patients on obesity or weight management. These codes are compatible with any diagnosis but are most appropriate or intended for illness or disease-related diagnoses such as obesity or diabetes. Group therapy services are generally only covered when submitted with diagnosis codes for anorexia, bulimia, diabetes, congestive heart failure, and some maternity diagnosis codes.	Physician-directed dietary consultation services are covered: 1. To teach diet modification for a newly diagnosed condition (e.g. diabetes, HBP, PG). A consultation assesses/ establishes a program (not monitoring progress in programs, which are not covered). 2. For managing chronic disease. Nutritional counseling is medically necessary for chronic diseases..., when it is prescribed by a physician and furnished by a recognized RD. 3. For dietician services/evals for weight mgmt when directed by a HP Plan physician and furnished by a RD recognized under the plan. See Weight Loss Management coverage policy. Indications that are not covered (not all inclusive): 1. Maintenance Consultation: Once the set goal has been reached, further services will generally not be covered. 2. Individual Health Education: Not covered when group sessions (97804) are available for classes unless recommended by a HP Plan Provider. 3. Weight Reduction Monitoring: Individual visits with a dietician for weight monitoring is not covered, except for weight loss surgery patients.	Dietician consultations are generally COVERED subject to the following: 1. Dietician consultations must be directed by a physician; and, 2. Services must be provided in a one on one setting with a registered dietician. Use the current applicable CPT/ HCPCS code(s).

TYPICAL ICD-9 CODES:
278.00 Obesity, unspecified; 278.01 Obesity, morbid:V65.3 Dietary surveillance/counseling; V85.xx or BMI; (also code comorbidities); 278.03 Obesity Hypoventilation Syndrome

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Discussion/Counseling, with (Underlying) Problem Diagnosis, Individual								
MD/DO RD Licensed nutritionists	**98960** (indiv), **98961** (2-4 pts), **98962** (5-8 pts) (each 30 minutes) **Patient Self Management (PSM)** Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)	Educational/training services prescribed by a physician, provided by a qualified, nonphysician professional (NPP) using a standardized curriculum for treating established illness/ disease or to delay comorbidity. Standardized curriculum may be modified for the clinical needs, cultural norms, and health literacy of the individual patient. Purpose is to teach the patient/ caregiver how to effectively self-manage or delay disease comorbidity in conjunction with the healthcare team. (CPT also states: 98960-98962 are intended to promote wellness, prevention, and delay comorbidities. CPT Assistant Feb 2009.) Qualifications of the NPP and the program content must be consistent with guidelines/standards or recognized by a physician/NPP society/association, or other appropriate source. Documentation should identify the persons present (or number present in a group), curriculum used, time spent, and name/ credentials of provider. A physician referral is usually needed.	.77, .37, .28	PSM is only covered for diabetic management (DSMT). Use codes: G0108 ind'l session; 1 unit=30 min training G0109 group session; 1 unit=30 min training	PSM is only covered for diabetic management (DSMT). Use codes: G0108 ind'l session; 1 unit=30 min training G0109 group session; 1 unit=30 min training Initial training 10 hour limit/12 months; Additional training limited to 1 hour per year. PSM is not a covered service under the following programs: • Emergency Medical Assistance (EMA) • Minnesota Care Limited Benefit (MLB) Licensed RNs may only provide nutritional counseling to the extent that their scope of practice and education experience allow.	Claims for registered dieticians should be submitted under the individual provider number or NPI of a supervising physician. The U7 modifier should also be submitted. Use ICD-9 V65.3 for prevention/risk factor reduction and 278.00 or 278.01 for obesity. These codes will cause claims to pay according to the illness portion of the patient's contract.	Diabetes education is covered for standard outpatient diabetes self management & training programs. Group or individual sessions are covered. Must follow the national standards for diabetes self-management education programs and American Diabetes Association (ADA) review criteria. The hours of instruction may vary based on individual needs. An average education program is about 12 hours. (These services may or may not be covered by all HealthPartners plans.)	Dietician consultations are generally COVERED subject to the following: 1. Dietician consultations must be directed by a physician; and, 2. Services must be provided in a one on one setting with a registered dietician. Use the current applicable CPT/ HCPCS code(s).
Discussion/Counseling, with Problem Diagnosis, Group								
MD/DO NP PA (and other providers for Medicaid)	**99078** **Physician educational services** rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	CPT code 99078 is available for reporting counseling of groups of patients with established illness (CPT Assistant Jan 1998).	NA	Code not accepted by Medicare. Check MNT codes.	Eligible providers: Physicians, Enrolled PAs, NPs, CNSs, CNMs Physician extenders: (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists and pharmacists. Use modifier U7 when a physician extender provides the service.	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dieticians. Use ICD-9 V65.3 for prevention/risk factor reduction and 278.00 or 278.01 for obesity. These codes will cause claims to pay according to the illness portion of the patient's contract.	No published policy statement.	No published policy statement.
Discussion/Counseling (Risk Factor Reduction)								
MD/DO NP PA CNS (and other providers for Medicaid)	**99401, 99402, 99403, 99404** **Preventive medicine counseling** and/or risk factor reduction interventions, **Individual** 15, 30, 45, 60 minute sessions **99411, 99412** **Preventive medicine counseling** and/or risk factor reduction intervention, **group setting** 30 & 60 minute sessions	To promote health and prevent illness or injury (codes are NOT for counseling patients with symptoms or established illnesses). Behavior change interventions are for persons who have a behavior...such as tobacco use/addiction, substance abuse/misuse, or obesity. Behavior change services involve assessing readiness and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up. These services should address issues such as family problems, diet and exercise, substance abuse, injury prevention, and diagnostic and lab results. Total visit time and a summary of the discussion must be documented.	1.03, 1.79 2.51, 3.54 .46, .60	Non-covered	Eligible providers: Physicians, Enrolled PAs, NPs, CNSs, CNMs Physician extenders: (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists and pharmacists. Use modifier U7 when a physician extender provides the service.	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet- related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. Use ICD-9 V65.3 for prevention/risk factor reduction. These codes will cause claims to pay according to the illness portion of the patient's contract.	No published policy statement.	No published policy statement.
PT DC	There are no discussion oriented codes other than initial and follow up evaluation codes, which do not seem to apply here	NA						

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Telephone Calls, Initiated by Patient								
MD/DO NP PA CNS	**99441, 99442, 99443 Telephone E/M services** to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service within the next 24 hours or soonest available appointment; 5-10 min, 11-20 min, and 21-30 minute sessions	Used to report care initiated by an established patient or guardian. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code should not be reported (part of preservice work of the upcoming visit). Likewise, if the call relates to an E/M service performed within the previous seven days, the call is considered part of that E/M service. Similarly, do not report 99441-99443 if reported in the previous seven days. Medical record documentation must include the total time spent by the provider and a summary of the discussion.	.41, .79, 1.16	Telephone calls are not covered	Telephone calls are not covered	Non-covered	Covered, via Pilot Program	Covered (policy includes deleted codes)
RD PharMD/DO MA/LPN/RN PT DC All provider types	**98966-98968 Telephone E/M services** to an established patient by a qualified healthcare professional, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service within the next 24 hours or soonest available appointment; 5-10 min, 11-20 min, and 21-30 minute sessions	Used to report episodes of care initiated by an established patient or guardian. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code should not be reported (part of the preservice work of the upcoming visit). Likewise, if the call relates to an E/M service performed within the previous seven days, the call is considered part of that E/M service. Similarly, do not report 99441-99443 if reported in the previous seven days. Medical record documentation must include the total time spent by the provider and a summary of the discussion.	.41, .79, 1.16	Telephone calls are not covered	Telephone calls are not covered	Non-covered	No published policy statement.	Covered (policy includes deleted codes)
Telephone Calls, Initiated by Clinic								
	99499 (unlisted E/M code) Follow up telephone E/M service, initiated by clinic, not included in recent or upcoming E/M service.	This (unlisted) code mayn be used to report telephone calls initiated by the clinic (e.g., check in calls). If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment the code should not be reported; the service is part of the preservice work of the upcoming visit. Likewise, if the call relates to an E/M service performed within the previous seven days, the call is considered part of that previous E/M service. Claim must be accompanied by supporting documentation.	NA	Telephone calls are not covered	Telephone calls are not covered	Non-covered	No published policy statement.	No published policy statement.
				Multiple references	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008926	http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/post71a_082625.pdf	http://www.healthpartners.com/policies/policy.do?type=1,2,11,14&title=All%20Medical%20Coverage%20Criteria%20for%20MN%20Plans%20&policy=2872	https://provider.medica.com/C1/CoveragePolicies/default.aspx

(1) tRVU reflects the 2011 RBRVS total Relative Value Unit (RVU). An RVU is converted to currency by multiplying it by a conversion factor.

NOTE: When any of these services are billed on the same day as an E/M service, most payers will consider it part of the E/M service and will not reimburse separately.