How to Use the Summary of Coding and MN Health Plan Policies on Weight Management and Smoking/Tobacco Use Cessation Services

The goal of the Statewide Health Improvement Program (SHIP) is to help Minnesotans live longer, healthier lives by preventing the leading causes of chronic disease: tobacco and obesity. One part of SHIP’s effort is to work with the provider community in achieving this goal. As a result of this work we found that confusion exists on how to appropriately report weight management services to Medicare, Medicaid, and third party payers. In addition, some misperception exists about patients’ insurance benefit coverage.

Therefore, two matrices were developed to summarize current health plan reimbursement policy information for Medicare, Medicaid, and select Minnesota payers for: (1) Weight Management Services; and (2) Smoking and Tobacco Use Cessation Services. Interviews with staff at several SHIP partner clinics and an in-depth review of published payer policies provided the background information for these summaries.

This work grew out of the real-life experiences of partner SHIP clinics providing weight management services in today’s payment environment. While some services are currently covered, some are not. These materials aim to clarify ways to incorporate weight management and smoking and tobacco use cessation services into clinical practices and, to the extent possible, limit occasions where lack of reimbursement is a barrier. Also, coverage for preventive services is evolving in Minnesota as well as nationally, so providers can ask payers whether “preventive” or “medical” benefits apply, as the coverage levels are often different.

How to Read the Matrices:
The matrices are designed around the way providers are currently delivering Weight Management and Smoking and Tobacco Use Cessation services, based on interviews with partner SHIP clinics. The general service description (e.g., “Discussion/Counseling, with Problem Diagnosis, Individual”) is in tan shading. Under that, specific information (listed below) is provided based on the credentials of the person delivering the service because coding and reimbursement often varies for that reason.

- **Provider Credentials**
- **Codes/Descriptions** – Actual CPT language (any payer variations are noted to the right under the Key Payer Comments/Coverage Exclusions section)
- **Additional Instructions/Documentation Requirements** – Additional information about the codes listed, mostly from CPT Assistant (AMA).
- **2012 tRVU** – The 2012 RBRVS Non-Facility total Relative Value Unit (RVU). Because reimbursement varies widely and cannot be presented in this type of forum, tRVUs are shown to provide a sense of the “value” of one service compared to another.
- **Key Payer Comments/Coverage Exclusions** – Summary of current, published guidelines or policies for payers listed. Often, information was published in many sites; the primary site is listed at the bottom of the column for each payer.
Key Findings:

- It is not true, as many believe, that services with a diagnosis of obesity are universally non-covered.
- E/M services are reimbursed like any other E/M services, according to the patient’s benefit plan. Use of E/M codes doesn’t change benefits; the diagnosis does.
- Medical Nutrition Therapy (MNT) services for diabetic education tend to be covered.
- Telephone calls are currently not well covered. CPT descriptions require that calls be initiated by the patient (so the service cannot be considered part of an earlier or future E/M service). However, that is rarely how phone calls for Weight Management and Smoking Cessation services happen; instead, clinic staff members initiate calls to patients to “check in,” provide counseling, make sure patients are on track, etc. There is no code for this service, other than the “generic” E/M code listed: 99499.
- Smoking Cessation services are far less complicated to report because specific codes exist to describe these services.

NOTE: This information serves as a summary of benefit plan coverage that varies by payer, and often, by the specific plan purchased by employers, and reporting (coding) rules occasionally vary. Therefore, it’s recommended that providers check each patient’s insurance coverage and verify whether there are special coding requirements.

For additional information about these materials, please contact:
The Minneapolis Department of Health and Family Support
Phone: 612-673-2301;
Email: health.familysupport@minneapolismn.gov

Additional Links:
## Weight Management Services – Summary of Coding & MN Health Plan Policies Categorized by Service and Provider Type

### August, 2012

<table>
<thead>
<tr>
<th>Provider</th>
<th>Codes/ Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/ Documentation Requirements</th>
<th>2012 T RVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD/DO</strong>&lt;br&gt;NP&lt;br&gt;CNS</td>
<td>Evaluation and Management (E/M) codes (New Patient 99201-99205 Estab. Patient 99211-99215)</td>
<td>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)</td>
<td>1.25 2.13 3.09 4.72 5.86 Estab. Patient 0.58 1.25 2.07 3.06 4.11</td>
<td>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. 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</td>
</tr>
<tr>
<td><strong>MD/DO</strong>&lt;br&gt;PharmD, Lic. nutr. MA/LPN/ RN</td>
<td>99211: Document physician’s order, reason for visit, services delivered, discussions with other providers, and plan. Should not be reported in addition to a physician service on the same date.</td>
<td>0.58 Incident to rules apply</td>
<td></td>
<td>Weight loss services may or may not be covered by all HealthPartners plans.</td>
</tr>
<tr>
<td><strong>PT</strong>&lt;br&gt;DC</td>
<td>There are no discussion oriented codes other than initial and follow up evaluation codes, which do not seem to apply here</td>
<td>NA</td>
<td>Written policies do not reference weight management services by PT providers.</td>
<td>Written policies do not reference weight management services by PT or DC providers.</td>
</tr>
</tbody>
</table>

### Discussion/Counseling, with (Underlying) Problem Diagnosis, Individual

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

**Provider Credentials**

<table>
<thead>
<tr>
<th>Codes/Descriptions (any paper variations are noted to the right)</th>
<th>Additional Instructions / Documentation Requirements</th>
<th>2012 BNU (I)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid</strong> (incident to rules typically apply)</td>
<td><strong>Medicaid</strong></td>
<td><strong>BCBS</strong></td>
<td><strong>HealthPtrs</strong></td>
</tr>
<tr>
<td><strong>Medica</strong></td>
<td></td>
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<td><strong>Medica</strong></td>
</tr>
</tbody>
</table>

**Discussion/Counseling, with (Underlying) Problem Diagnosis, Individual**

<table>
<thead>
<tr>
<th>RD (and MD/DO, RN for Medicaid)</th>
<th>MD/DO</th>
<th>Licensed nutritionists</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802 (init, each 15 min)</td>
<td>97803 (reassess, each 15 min)</td>
<td>97804 (group, each 30 min)</td>
</tr>
</tbody>
</table>

**Medical Nutrition Therapy (MNT)**

- Initial and reassessment 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.

- 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.
- 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.

<table>
<thead>
<tr>
<th>TYPICAL ICD-9 CODES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960 (60 min), 98962 (2-4 pts), 98962 (5-8 pts) (each 30 minutes)</td>
</tr>
</tbody>
</table>

**Patient Self Management (PSM)**

- 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 comorbidity. 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 person (or number present in a group), curriculum used, time spent, and name/credentials of provider. A physician referral is usually needed.

- 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. 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.

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- 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.

**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.
- 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 ...individ, face-to-face w/ patient, each 15 min
- - G0271 MNT ...group (2+ ind'ls), each 30 min

**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.

**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.
3. Nutritional counseling is medically necessary for chronic diseases, when it is prescribed by a physician and furnished by a recognized RD.
4. For dietetic 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.

**Additional Instructions:**

- 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.

**Dietsician consultations are generally COVERED subject to the following:**

1. Dietitian 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).**

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For information on MHP and UCare please consult the Medicare and Medicaid columns.

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**Typical ICD-9 Codes:**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>278.00 Obesity, unspecified; 278.01 Obesity, morbid/V65.3 Dietary surveillance/counseling; V85.5 or B10 (also code comorbidities); 278.03 Obesity Hyperventilation Syndrome</td>
</tr>
</tbody>
</table>
## Discussion/Counseling, with Problem Diagnosis, Group

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 RVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO PA (and other providers for Medicaid)</td>
<td>99078 Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)</td>
<td>CPT code 99078 is available for reporting counseling of groups of patients with established illness (CPT Assistant Jan 1998).</td>
<td>NA</td>
<td>Code not accepted by Medicare. Check MNT codes. Eligible providers: Physicians, Enrolled PA, NPs, CNMs, CNM, 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 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.</td>
</tr>
</tbody>
</table>

## Discussion/Counseling (Risk Factor Reduction)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MD/DO PA CNS (and other providers for Medicaid)</td>
<td>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 &amp; 60 minute sessions</td>
<td>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.</td>
<td>1.05 1.80 2.52 3.23</td>
<td>Eligible providers: Physicians, Enrolled PA, NPs, CNMs, CNM, 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 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.</td>
</tr>
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</table>

## PT DC

<table>
<thead>
<tr>
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<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no discussion oriented codes other than initial and follow up evaluation codes, which do not seem to apply here.</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For information on MHP and UCare please consult the Medicare and Medicaid columns.
### Intensive Behavioral Services for Obesity (IBT)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 tRVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
</table>
| **MD/DO NP PA CNS RD Lic Nutr.** | G0447 – Face-to-face behavioral counseling for obesity, 15 minutes. Limited to the following specialty types: GP, FP, IM, OB/ GYN, PEDS, GERI, NP, CNS, PA. Place of service: 11, 22, 49, 71 | Measurement of BMI calculated by:  
• Weight in kg divided by the square of height in meters (expressed in kg/sq. meter).  
Individul IBT:  
• Dietary (nutritional assessment)  
• Intensive Behavioral Therapy (IBT) IBT (5A framework): Assess: Ask about/assess behavioral risk(s) and factors affecting choice of behavioral change goals/methods; Advise: Give clear, specific personalized behavior change advice (personal health, harms and benefits)  
Agree: Treatment goals and methods based on patient’s interests and willingness to change behavior; Assist: Aid patient in achieving agreed upon goals by acquiring skills, confidence and social/environment supports for behavior change, supplemented with adjunctive medical treatment when appropriate. Arrange: Schedule F/U contacts (in person or by telephone) to provide ongoing assistance/support and to adjust treatment plan as needed. | .74 | Coverage for Medicare beneficiaries with obesity (BMI of ≥ 30)  
Covered diagnosis:  
• V85.30-V85.30,  
• V85.41-V85.45  
All other diagnosis will be denied. Place of service: 11, 22, 49, 71  
For patients with BMI of (BMI of ≥ 30) | Included in existing preventive medicine and MNT policies.  
HCPCS code G0447 for subsequent face to face services.  
• 1 visit per week/first month  
• 1 visit E/O week 2nd through 6th month  
• 1 visit per month 7th through 12th month (if required 3k/6.6b weight loss at 6 months is met) Must be furnished by a qualified primary care physician or other practitioner in a primary care setting.  
Note: Medicare may cover “auxiliary” personnel from the above specialties under “incident to” provision. |

### Intensive Behavioral Services for Cardiovascular Disease Prevention

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 tRVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
</table>
| **MD/DO NP PA CNS RD Lic Nutr.** | G0446 – Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes Limited to the following primary care providers specialty types: GP, FP, IM, OB/ GYN, PEDS, GERI, NP, CNS, CNSM, PA. Place of service: 11, 22, 49, 71 | IBT for CVD consists of 3 components:  
1. Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;  
2. Screening for high blood pressure in adults age 18 and older; and,  
3. Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for CV and other diet-related disease. IBT (5A framework): (see IBT for obesity) | .74 | HCPCS code G0446  
Coverage includes one face-to-face CVD risk reduction visit annually. Must be furnished by a qualified primary care physician or other practitioner in a primary care setting.  
Medicare deductibles and coinsurance to not apply for this service.  
Note: ER, IP hospital settings, ASC’s, Independent testing facilities, SNF’s, IP rehab and hospices are NOT considered primary care setting.  
See CMS transmittal #7636 for facility specific billing instructions. | Included in existing preventive medicine and MNT policies. | Included in existing preventive medicine and MNT policies. | Included in existing preventive medicine and MNT policies. | Included in existing preventive medicine and MNT policies. | Included in existing preventive medicine and MNT policies. |

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**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

For information on MHP and UCare please consult the Medicare and Medicaid columns.
### Weight Management Services – Summary of Coding & MN Health Plan Policies Categorized by Service and Provider Type

**August, 2012**

#### Telehealth/Telemedicine Service (Medical Nutrition Therapy)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 BRVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
</table>
| MD/DO NP PA CNS RD Lic Nutr. | Medical Nutrition Therapy (MNT)  
• Individual (97802-97803, G0270)  
• Group (97804) | Requires an inter-active audio and video telecommunications system must be used that permits real-time communication.  
Eligible originating sites:  
• Physicians’ office  
• CAH  
• RHC  
• FQHC | 1.00 0.87 0.43 | HCPCS/CPT code reported with one of the following modifiers:  
• GQ – Via asynchronous telecommunications system  
• GT – Via interactive audio and video telecommunications system  
Telemedicine coverage applies to MHCP fee-for-service programs and some prepaid programs (who have selected coverage).  
TM services limited to Physicians services (does not include PA’s, APRNs or other physician ancillaries).  
Coverage limited to consultations and diagnostic interpretation  
HCPCS codes G0270, 97802-97803; With modifier GT.  
Coverage of televideo consultations includes consultations, office visits, psychotherapy, substance use disorders, as well as the codes allowed per Medicare policy.  
HCPCS codes G0270, 97802-97803; With modifier GT.  
Telemedicine services covered under CPT codes 99441-99443 and 98966-98968.  
(See telephone services code list, 2012)  
CPT/HCPSC code reported with modifier GT. |

#### Telehealth/Telemedicine Service (Diabetes Self Management)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
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<th>2012 BRVU (1)</th>
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</tr>
</thead>
</table>
| MD/DO NP PA CNS RD Lic Nutr. | Diabetes self-management services (DMT)  
98960 - 98962 G0108-G0109: | Requires an inter-active audio and video telecommunications system must be used that permits real-time communication.  
Eligible originating sites:  
• Physicians’ office  
• CAH  
• RHC  
• FQHC | .80 .39 .29 1.57 0.48 | HCPCS codes G0108-G0109:  
1 hour (of 10 hour annual benefit) must be furnished in person.  
• GQ – Via asynchronous telecommunications system  
• GT – Via interactive audio and video telecommunications system  
Telemedicine coverage applies to MHCP fee-for-service programs and some prepaid programs (who have selected coverage).  
TM services limited to Physicians services (does not include PA’s, APRNs or other physician ancillaries).  
Coverage limited to consultations and diagnostic interpretation  
HCPCS codes G0108-G0109: 1 hour (of 10 hour annual benefit) must be furnished in person.  
BCBS TM policy does not currently include individual or group DSM therapy services.  
No published policy statement.  
Telemedicine services covered under CPT codes 99441-99443 and 98966-98968.  
(See telephone services code list, 2012)  
CPT/HCPSC code reported with modifier GT.  
Not billable if:  
• TM service results in a face-to-face appointment within 24 hour  
• TM service is within 7 days or within the postoperative period of a previous completed procedure |

#### 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

For information on MHP and UCare please consult the Medicare and Medicaid columns.
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<th>2012 tRVU (1)</th>
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<th>BCBS</th>
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<th>Medica</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Calls, Initiated by Patient</td>
<td>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</td>
<td>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.</td>
<td>.40</td>
<td>Telephone calls are not covered</td>
<td>Telephone calls are not covered</td>
<td>Non-covered</td>
<td>Covered, via Pilot Program</td>
<td>Covered (policy includes deleted codes)</td>
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<tr>
<td></td>
<td>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</td>
<td>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 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.</td>
<td>.40</td>
<td>Telephone calls are not covered</td>
<td>Telephone calls are not covered</td>
<td>Non-covered</td>
<td>No published policy statement</td>
<td>Covered (policy includes deleted codes)</td>
</tr>
</tbody>
</table>

(1) tRVU reflects the 2012 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.

For information on MHP and UCare please consult the Medicare and Medicaid columns.
<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 tRVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Calls, Initiated by Clinic</td>
<td>99499 (unlisted E/M code) Follow up telephone E/M service, initiated by clinic, not included in recent or upcoming E/M service.</td>
<td>This (unlisted) code may 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.</td>
<td>NA</td>
<td>Telephone calls are not covered Telephone calls are not covered Non-covered No published policy statement No published policy statement</td>
</tr>
</tbody>
</table>

(1) tRVU reflects the 2012 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.

For information on MHP and UCare please consult the Medicare and Medicaid columns.

http://www.healthpartners.com/policies/policy.do?locale=1.2.11&PolicyID=41&PolicyName=All_Medical_Coverage_Criteria_for_MN_Plans&Policy=2872

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

**Weight Management Services** - Summary of Coding & MN Health Plan Policies Categorized by Service and Provider Type August, 2012
### Discussion/Counseling, Individual, when Smoking and Tobacco Services is the Primary Service (Risk Factor Reduction)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions</th>
<th>2012 ICD-10-CC</th>
<th>Key Payer Comments/Coverage Exclusions (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medica</td>
<td>99406, 99407</td>
<td>Medicare</td>
<td>Coverage for the treatment of tobacco dependence is subject to the member’s contract benefits.</td>
</tr>
<tr>
<td>MD/NP PA</td>
<td>99401, 99402, 99403, 99404</td>
<td>Medicaid</td>
<td>• Submit diagnosis code 305.1 or V15.82 if the intent is counseling and/or visit to obtain a prescription for smoking cessation medication/patches. (Use as secondary as appropriate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BCBS</td>
<td>• ...and acupuncture (codes 97810-97811, 97813-97814) are considered investigative for treatment...and are ineligible for reimbursement.</td>
</tr>
<tr>
<td></td>
<td>(and other providers for Medicaid)</td>
<td>HealthPtrs</td>
<td>• Nicotine replacement therapies and bupropion for the treatment of tobacco dependence are subject to the member’s pharmacy benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medica</td>
<td>A separate policy does not exist; HP offers a health coach for smoking cessation support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appears to follow ICSI guidelines.</td>
</tr>
</tbody>
</table>

**Description**

These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately when performed.

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change 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.

Total visit time and a summary of the discussion must be documented.

**Medicare**

Medicare provides coverage of smoking and tobacco use cessation counseling services for beneficiaries who meet the following criteria:

- Who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease;
- Who use tobacco (regardless of whether they have signs or symptoms of tobacco-related disease)
- Beneficiaries must be competent and alert at the time that counseling services are provided
- Counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

Documentation must show sufficient beneficiary history to adequately demonstrate that Medicare coverage conditions were met.

Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four sessions.

**MHCP**

MHCP covers smoking cessation education, counseling, and products when they are ordered by a primary care provider and provided by a Medicaid enrolled provider or Physician Extender. Smoking cessation products must be approved by the Food and Drug Administration (FDA) and covered under the Medicaid Drug Rebate Agreement.

### Preventive Medicine Counseling

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.

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions</th>
<th>2012 ICD-10-CC</th>
<th>Additional Instructions/Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/NP PA</td>
<td>99401, 99402, 99403, 99404</td>
<td>Non-covered</td>
<td>Eligible providers: Physicians, Enrolled PAs, NPs, CNAs, CNMns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physical extenders: (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists and pharmacists).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Claims submitted using these preventive counseling codes will process according to the illness portion of the patient’s contract.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No published policy statement.</td>
</tr>
</tbody>
</table>

**Medicaid**

Claims submitted using 99406, 99407 counseling visit codes will process according to the illness portion of the patient’s contract when it is clinically appropriate. Append modifier 25 to the E/M service.

**Medicare**

Medicare provides coverage of smoking and tobacco use cessation counseling services for beneficiaries who meet the following criteria:

- Who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease;
- Who use tobacco (regardless of whether they have signs or symptoms of tobacco-related disease)
- Beneficiaries must be competent and alert at the time that counseling services are provided
- Counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

Documentation must show sufficient beneficiary history to adequately demonstrate that Medicare coverage conditions were met.

Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four sessions.

**MHCP**

MHCP covers smoking cessation education, counseling, and products when they are ordered by a primary care provider and provided by a Medicaid enrolled provider or Physician Extender. Smoking cessation products must be approved by the Food and Drug Administration (FDA) and covered under the Medicaid Drug Rebate Agreement.

### Preventive Medicine Counseling

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.

<table>
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<tr>
<th>Provider Credentials</th>
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<tr>
<td>MD/NP PA</td>
<td>99401, 99402, 99403, 99404</td>
<td>Non-covered</td>
<td>Eligible providers: Physicians, Enrolled PAs, NPs, CNAs, CNMns</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Physical extenders: (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists and pharmacists).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Claims submitted using these preventive counseling codes will process according to the illness portion of the patient’s contract.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No published policy statement.</td>
</tr>
</tbody>
</table>
## Smoking Cessation Services – Summary of Coding & MN Health Plan Policies Categorized by Service and Provider Type

### August, 2012

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 RRVU (1)</th>
<th>Medicare (Incident to rules typically apply)</th>
<th>Medicaid</th>
<th>BCBS</th>
<th>HealthPts</th>
<th>Medica</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD NP PA</strong> (and other providers for Medicaid)</td>
<td>99411, 99412 Preventive medicine counselling and/or risk factor reduction intervention, group setting 30 &amp; 60 minute sessions</td>
<td>Total visit time and a summary of the discussion must be documented.</td>
<td>1.05, 1.80, 2.52, 3.23</td>
<td>Non-covered</td>
<td>Eligible providers: Physicians, Enrolled PA, NPs, CNs, CMNs Physician extenders: (non-enrolled APRNs, RNs, genetic counselors, licensed acupuncturists and pharmacists. Use modifier UT when a physician extender provides the service. Claims submitted using these preventive counseling codes will process according to the preventive portion of the patient’s contract.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PharmD MA/LPN/ RN</strong></td>
<td>99453 Smoking cessation classes, non-physician provider, per session</td>
<td>NA</td>
<td>Not likely recognized by Medicare. Not defined by DHS; suggest using 99411, 99412 with U7 modifier.</td>
<td></td>
<td>Code 99453 for stop-smoking classes is generally not an eligible service under the patient’s contract; however, may be covered under health care reform (HCR) and as such, will be processed according the preventive portion of the patient's contract.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Discussion/Counseling, Group, when Smoking/Tobacco Cessation is the Primary Service (see Note)

### Discussion/Counseling, Individual, when Smoking/Tobacco Cessation is a Secondary Service (See Note)

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 RRVU (1)</th>
<th>Medicare (Incident to rules typically apply)</th>
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<th>HealthPts</th>
<th>Medica</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD NP PA DC</strong></td>
<td>Evaluation and Management (E/M) codes (New Patient 99201-99205 Established Patient 99211-99215)</td>
<td>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)</td>
<td>New Patient 1.25, 2.13, 3.09, 4.72, 5.86 Established Patient 0.58, 1.25, 2.07, 3.06, 4.11</td>
<td>Covered.</td>
<td>MHCP covers smoking cessation education, counseling, and products when they are ordered by a primary care provider and provided by an MHCP enrolled provider or Physician Extender. Smoking cessation products must be approved by the Food and Drug Administration (FDA) and covered under the Medicaid Drug Rebate Agreement.</td>
<td>No published policy statement.</td>
<td>No published policy statement.</td>
<td>No published policy statement.</td>
</tr>
<tr>
<td><strong>PT DC</strong></td>
<td>There are no discussion oriented codes other than initial and follow up evaluation codes, which do not seem to apply here.</td>
<td>NA</td>
<td>Written policies do not reference smoking cessation 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 smoking cessation services by PT or DC providers. Written policies do not reference smoking cessation services by PT or DC providers.</td>
<td></td>
<td>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 smoking cessation services by PT or DC providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PharmD MA/LPN/ RN</strong></td>
<td>99211 (Lower level established patient office visit)</td>
<td>99211: Document physician’s order, reason for visit, services delivered, discussions with other providers, and plan.</td>
<td>0.58 Allows G0436-G0437 for preventive tobacco cessation - illnesses have not yet been diagnosed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. RRVU reflects the 2012 RBRVS total Relative Value Unit (RVU). RVUs are converted to currency for various purposes, including reimbursement, 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.

NOTE: Medical Therapy Management codes (99005-99067) do not apply to smoking cessation services and should not be used.

NOTE: For Medicare, doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage 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.

TYPICAL ICD-9 CODES:

- 278.00 Obesity, unspecified
- 278.01 Obesity, morbid
- V65.3 Dietary surveillance/counseling
- V85.xx or BMI
- 278.03 Obesity Hypoventilation Syndrome

For information on MHP and UCare please consult the Medicare and Medicaid columns.
Medicaid No published policy. 
BCBS Not recognized by Medicare.

NOTE: For Medicare, doctors of chiropractic medicine are not eligible to order and refer. Medicare covers services and should not be used.

NOTE: Medication Therapy Management codes (99605-99607) do not apply to smoking cessation, considering it part of the E/M service and will not reimburse separately.

NOTE: When any of these services are billed on the same day as an E/M service, most payers will require an incident to rules modifier. (See telephone services code list, 2012)

HCPCS code reported with one of the following modifiers:
- QQ – Via asynchronous telecommunications system
- GT – Via interactive audio and video telecommunications system.

HCPCS code Q 3014-Telehealth originating site facility fee

Coverage of televideo consultations includes consultations, office visits, psychotherapy, substance use disorders, as well as the codes allowed per Medicare policy.

Coverage limited to consultations and diagnostic interpretation.

Eligible providers: Physicians, Enrolled PAs, NPs, CNMs, physician extenders: (non-enrolled APNs, RNs, genetic counselors, licensed acupuncturists and pharmacists.

Use modifier UT 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.

NOTE: Smoking/Tobacco Cessation is a Secondary Service (See Note)

For information on MHP and UCare please consult the Medicare and Medicaid columns.

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
### Telephone Calls, Initiated by Patient

<table>
<thead>
<tr>
<th>Provider Credentials</th>
<th>Codes/ Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/ Documentation Requirements</th>
<th>2012 RVU (1)</th>
<th>Medicare (Incident to rules typically apply)</th>
<th>Medicaid</th>
<th>BCBS</th>
<th>HealthPtrs</th>
<th>Medica</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD NP PA</strong></td>
<td>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 seven 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</td>
<td>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.</td>
<td>.40 .77 1.14</td>
<td>Telephone calls are not covered</td>
<td>Telephone calls are not covered</td>
<td>Non-covered</td>
<td>Covered, via Pilot Program</td>
<td>Historically covered (policy includes deleted codes)</td>
</tr>
<tr>
<td><strong>RD PharmD MA/LPN/ RN PT DC</strong></td>
<td>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 seven 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</td>
<td>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 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.</td>
<td>.40 .77 1.14</td>
<td>Telephone calls are not covered</td>
<td>Telephone calls are not covered</td>
<td>Non-covered</td>
<td>No published policy statement</td>
<td>Historically covered (policy includes deleted codes)</td>
</tr>
</tbody>
</table>

(1) RVU reflects the 2012 RBRVS total Relative Value Unit (RVU). RVUs are converted to currency for various purposes, including reimbursement, 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.

**NOTE:** Medication Therapy Management codes (99605-99607) do not apply to smoking cessation services and should not be used.

**NOTE:** For Medicare, doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage 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.

**Typical ICD-9 Codes:**

- 278.00 Obesity, unspecified; 278.01 Obesity, morbid; V65.3 Dietary surveillance/counseling; V85.x or B85; (also code comorbidities); 278.03 Obesity Hypoventilation Syndrome

For information on MHP and UCare please consult the Medicare and Medicaid columns.
### Telephone Calls, Initiated by Clinic

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>Codes/Descriptions (any payer variations are noted to the right)</th>
<th>Additional Instructions/Documentation Requirements</th>
<th>2012 tRVU (1)</th>
<th>Key Payer Comments/Coverage Exclusions (If Known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>99499</strong> (unlisted E/M code) Follow up telephone E/M service, initiated by clinic, not included in recent or upcoming E/M service.</td>
<td><strong>NA</strong> Telephone calls are not covered</td>
<td></td>
<td></td>
<td><strong>Medicare</strong> (Incident to rules typically apply) <strong>Medicaid</strong> <strong>BCBS</strong> <strong>HealthPtrs</strong> <strong>Medica</strong></td>
</tr>
</tbody>
</table>

#### Additional Instructions/Documentation Requirements
- **Telephone Calls, Initiated by Clinic**
  - All provider types
  - This (unlisted) code can 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. The claim must be accompanied by supporting documentation.

#### Key Payer Comments/Coverage Exclusions (If Known)
- **Medicare**
  - Incident to rules typically apply
- **Medicaid**
- **BCBS**
- **HealthPtrs**
- **Medica**

#### Notes
- **Multiple references**
- **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**

#### 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

#### Telephone Calls
- Telephone calls are not covered
- Telephone calls are not covered
- Non-covered
- No published policy statement
- No published policy statement

#### Notes
- **(1) tRVU reflects the 2012 RBRVS total Relative Value Unit (RVU). RVUs are converted to currency for various purposes, including reimbursement, 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.
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