Clinical Policy Title: Childhood body mass index (BMI) screening and program interventions for weight management

Clinical Policy Number: 11.04.01

Effective Date: September 1, 2013
Initial Review Date: May 23, 2013
Most Recent Review Date: May 1, 2018
Next Review Date: May 2019

Policy contains:
- Childhood body mass index.
- Childhood obesity.
- Weight management.

Related policies:
None.

ABOUT THIS POLICY: Prestige Health Choice has developed clinical policies to assist with making coverage determinations. Prestige Health Choice’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Prestige Health Choice when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Prestige Health Choice’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Prestige Health Choice’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Prestige Health Choice will update its clinical policies as necessary. Prestige Health Choice’s clinical policies are not guarantees of payment.

Coverage policy

Prestige Health Choice considers childhood body mass index screening for children and adolescents age six or greater to be clinically proven, and therefore medically necessary (USPSTF, 2017).

In addition, Prestige Health Choice considers a provider offer or referral of children over age six to comprehensive, intensive behavioral interventions to promote improvements in weight status to be clinically proven and, therefore, medically necessary when these criteria are met:
- Both the individual (child) and family are included in treatment sessions.
- The individual is 2 – 19 years of age and has either:
  - An age- and gender-specific body mass index equal to or above the 95th percentile, indicative of obesity, with specific assessment for related comorbidities.
  - An age- and gender-specific body mass index in the 85th to the 94th percentiles, indicative of being overweight, with specific assessment for related comorbidities.
Childhood screening is essential for individuals, identified by the two criteria above, for referral to moderate- to high-intensity program interventions to improve their weight status (USPSTF, 2017):

- The moderate- to-high-intensity program involves 26 or more hours of contact with the child and/or caregivers over a period of 2 – 12 months and includes the following:
  - Nutritional counseling: focusing on proper nutrition and eating behaviors for weight loss and/or a healthy diet and health maintenance.
  - Counseling for physical activity or a physical activity program.
  - Instruction and counseling for behavior management techniques to help make and sustain changes in diet and physical activity.
  - Intensive behavioral intervention for obesity.

- The individual and/or caregivers have a documented knowledge deficit regarding weight management that requires the services of licensed health care professionals (e.g., dietitian) to develop a nutritional treatment plan, physical activity program, and counseling for behavioral techniques for weight management.

- The individual and their caregivers are motivated to attend, participate in, complete, and use the content from a moderate- to high-intensity intervention program for weight management.

- The content of these programs include information on healthy eating, safe exercising, reading food labels, encouraging stimulus control (to foods associated with weight gain).

- These programs include goal setting, self-monitoring, contingent rewards, and problem solving (USPSTF, 2017).

**Limitations:**

Coverage determinations are subject to benefit limitations and exclusions as delineated by the state Medicaid authority. The Florida Medicaid website may be accessed at http://ahca.myflorida.com/Medicaid/.

Prestige Health Choice considers lower-intensity interventions for childhood screening and interventions for weight management to be clinically unproven and not medically necessary, as their effectiveness has not been established in peer-reviewed professional literature.

All other uses of childhood body mass index screening and program interventions for weight management are not medically necessary, considering:

- Moderate- to-high-intensity programs involve at least 25 hours of contact with the child and/or the family over six months and should result in improved weight status, defined as an absolute and/or relative decrease in the baseline body mass index 12 months after beginning the program. The body mass index at 12 months is compared to the baseline index (USPSTF, 2010; Whitlock, 2010).

- Individuals who fail to lose their targeted amount of weight in six months or do not lower their body mass index percentile may be re-evaluated at six months after the initial
screening. Those showing "readiness to change" and with a body mass index percentile at ≥
the 95th percentile may receive another round of counseling.

- Nutritional counseling addresses the following topics:
  - The impact of nutrition.
  - Actions needed to promote an adequate balanced diet for the individual.
  - The child's nutritional care plan.
  - Maintenance and prevention of vitamin and mineral deficiencies.
  - Management of food, including shipping, storage, and preparation.
  - Monitoring of previously recommended dietary interventions.
  - Avoidance of drugs and/or alcohol.
  - Relationships of medication to diet.
  - Special nutrition needs and the value of supplements (USPSTF, 2010).

Medications for weight reduction, including Metformin and Orlistat, are not considered clinically proven,
and therefore are not medically necessary for overweight and obese children (USPSTF, 2017).

**Alternative covered services:**

- Body mass index measurement from routine primary care and well-child visits.

**Background**

Body mass index is defined as weight in kilograms divided by the square of height in meters. The
prevalence of obese children and adolescents (defined as an age- and gender-specific body mass index
of at least the 85th to 94th (overweight) and 95th (obese) percentile for persons age 2 - 19) has increased
threefold since the late 1970s, after no change was observed in the 1960s and 1970s. In addition, the
percent of overweight children and adolescents age 2 – 19 has also risen. The current percentages of
children who are obese or overweight are about 17 and 15 percent, respectively (Fryar, 2015). After
the period 2003 – 2004, prevalence has remained essentially unchanged (see table below):

<table>
<thead>
<tr>
<th>% Obese</th>
<th>Obese Age 2 – 5</th>
<th>Obese Age 6 – 11</th>
<th>Obese Age 12 – 19</th>
<th>Obese Age 2 – 19</th>
<th>Overweight Age 2 - 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1971 - 74</td>
<td>5.0</td>
<td>4.0</td>
<td>6.1</td>
<td>5.2</td>
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<tr>
<td>1976 - 80</td>
<td>5.0</td>
<td>6.5</td>
<td>5.0</td>
<td>5.5</td>
<td>9.2</td>
</tr>
<tr>
<td>1988 - 94</td>
<td>7.2</td>
<td>11.3</td>
<td>10.5</td>
<td>10.0</td>
<td>13.0</td>
</tr>
<tr>
<td>1999 - 00</td>
<td>10.3</td>
<td>15.1</td>
<td>14.8</td>
<td>13.9</td>
<td>14.2</td>
</tr>
<tr>
<td>2001 - 02</td>
<td>10.6</td>
<td>16.2</td>
<td>16.7</td>
<td>15.4</td>
<td>14.6</td>
</tr>
<tr>
<td>2003 - 04</td>
<td>13.9</td>
<td>18.8</td>
<td>17.4</td>
<td>17.1</td>
<td>16.5</td>
</tr>
<tr>
<td>2005 - 06</td>
<td>10.7</td>
<td>15.1</td>
<td>17.8</td>
<td>15.4</td>
<td>14.6</td>
</tr>
<tr>
<td>2007 - 08</td>
<td>10.1</td>
<td>19.6</td>
<td>18.1</td>
<td>16.8</td>
<td>14.8</td>
</tr>
<tr>
<td>2009 - 10</td>
<td>12.1</td>
<td>18.0</td>
<td>18.4</td>
<td>16.9</td>
<td>14.9</td>
</tr>
<tr>
<td>2011 - 12</td>
<td>8.4</td>
<td>17.7</td>
<td>20.5</td>
<td>16.9</td>
<td>14.9</td>
</tr>
</tbody>
</table>
The prevalence of obesity varies with age and racial or ethnic group. The most recent (2011 – 2012) official statistics document these variations. Rates are much higher among Hispanics (22.4 percent) and non-Hispanic blacks (20.2) than for non-Hispanic whites (14.1) and non-Hispanic Asians (8.6) (Fryar, 2015).

Obese and overweight children and adolescents have an increased risk for comorbid conditions, such as type 2 diabetes mellitus, asthma, nonalcoholic fatty liver disease, and cardiovascular risk factors. Mental health issues such as depression and low self-esteem are more problematic in obese children compared to non-obese children (USPSTF, 2010). Obesity typically begins between the ages of five and six or sometime during adolescence. Children over age 13 who have a body mass index at or above the 95th percentile (obese) have more than a 50 percent chance of obesity in adulthood (Whitlock, 2005).

For children with a body mass index greater than or equal to the 95th percentile without comorbidities, the American Medical Association, the U.S. Centers for Disease Control and Prevention, the Maternal and Child Health Bureau Expert Committee, and the American Academy of Pediatrics recommend weight maintenance resulting in decreasing body mass index as age increases. The 2010 Dietary Guidelines for Americans recommends slowing weight gain while allowing normal growth and development (AAP, 2011). On a national level, and recognized in the Federal Register, the Let's Move! initiative works with stakeholders across the private and public sectors to expand access to nutritious food, promote physical activity, encourage healthy food choices, create healthy starts for children, and ensure families have the tools they need to make healthy decisions. The USPSTF describes intensive behavioral interventions for obesity using a “5-A” framework:

- Assess — Ask about/assess behavioral health risks and factors affecting choice of behavior change goals or methods.
- Advise — Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- Agree— Collaboratively select appropriate treatment goals and methods, based on the patient’s interest in and willingness to change the behavior.
- Assist — Using behavior change techniques (self-help and/or counseling), help the patient achieve agreed-upon goals by acquiring the skills, confidence, and social or environmental supports for behavior change, supplemented with adjunctive medical treatments, when appropriate.
- Arrange — Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance and support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

A thorough physical examination should be done for all individuals prior to the start of program interventions for weight management. Expert recommendations state the examination should include a focused family history for obesity, type 2 diabetes, cardiovascular disease, and early deaths attributed to
heart disease or stroke for risk assessment of current and/or future comorbidities related to the individual child’s weight status:

- The measurement of the individual child’s pulse and blood pressure and laboratory tests of the following:
  - For children evaluated with a body mass index between the 85th and 94th percentiles for age and gender:
    - Fasting lipid profile.
    - Aspartate aminotransferase and alanine aminotransferase, fasting glucose.
  - For children evaluated with a body mass index in the 95th percentile or greater for age and gender, in addition to the above:
    - Blood urea nitrogen and creatinine.

A limited number of pediatric weight-management studies reported effects on lipids, blood pressure, glucose or insulin measures, or adiposity laboratory tests. Two trials that reported on fasting insulin and insulin resistance, as measured by the model assessment of insulin resistance, showed more favorable laboratory results in intervention groups relative to the control group (Savoy, 2007; Reinehr, 2006). Minimal effect was reported on blood pressure, diet, lipid levels, physical activity, and psychosocial measures. However, low confidence has been placed in the results of such testing in relation to the incomplete reporting of the outcomes across studies, including the possibility of selective reporting bias (Whitlock, 2010).

**Searches**

Prestige Health Choice searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality Guideline Clearinghouse and evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

Searches were conducted on March 8, 2018, using the terms “childhood” and “obesity,” “BMI,” “counseling,” “prevention,” “intervention,” “efficacy,” and “weight”.

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.
Findings

An early guideline on childhood obesity by the American Medical Association recommends primary care physicians assess all children for obesity risk, with elevated body mass index as a key indicator along with unhealthy eating and physical health habits. Body mass index should be plotted at least annually (Barlow, 2007). The American Academy of Pediatrics has endorsed these guidelines, especially plotting annual progress (AAP, 2016). A 2011 National Heart, Lung, and Blood Institute guideline for preventing cardiovascular disease included a section on limiting weight gain in childhood, one of the causal factors in cardiovascular disease (NHLBI, 2011).

The United States Preventive Services Task Force (USPSTF) developed a guideline in 2010 governing measurement of body mass index and interventions to reduce weight in overweight children (USPSTF, 2010). In June 2017, another USPSTF guideline updated the 2010 version. A primary recommendation was to encourage providers screen children age six or greater for body mass index, and to offer obese or overweight children behavioral interventions to promote weight status improvements. The guideline did not recommend weight-loss drugs like Metformin and Orlistat for children, evidence of efficacy is limited data on long-term adverse effects is lacking (USPSTF, 2017). Recommendations are similar to those in the 2017 European Society of Endocrinology and the Pediatric Endocrine Society (Styne, 2017).

The World Health Organization also produced a guideline addressing overweight and obese children in 2017. The guideline recommended all pre-school children should have height and weight measured; for children deemed overweight, their parents and caregivers should be counseled on nutrition and physical activity, including promotion on breast feeding in the first 24 months of life. A more detailed management plan should be addressed to obese children (WHO, 2017).

Body mass index measurements to diagnose childhood obesity have been shown to be accurate. One systematic review of 24 studies (n=25,807) reported sensitivity and specificity of 81.9 and 96.0 percent for obesity. Corresponding numbers for diagnosing overweight children using body mass index were somewhat lower, at 76.3 and 92.1 percent (Simmonds, 2016). In addition, a systematic review of 23 studies of self-reported body mass index revealed a moderate sensitivity (76 percent) and a high specificity (96 percent), and thus this approach represents a viable alternative when other options are unavailable (He, 2017). A meta-analysis of 37 reports found that self-reported body mass index was significantly lower than using measurement, and identified certain factors in under-reporting (He, 2018).

A systematic review and meta-analysis of 37 studies found a strong positive association between high childhood body mass index and subsequent adult obesity (odds ratio 5.21). High body mass index in childhood was linked with elevated risk of adult coronary heart disease, diabetes and a range of cancers, but not with stroke or breast cancer. Most obese adults did not have a high body mass index in childhood (Simmonds, 2015).
A Cochrane study of 21 trials (n=2484), all but two which were randomized, evaluated the efficacy of weight-control drugs metformin, sibutramine, orlistat, and fluoxetine in overweight and obese children. Each of the drugs had a greater reduction in body mass index and weight than did placebo. However, trials were of low quality, had short follow-up periods, and a dropout rate of 25 percent. Many of these drugs are not FDA-approved for treating child and adolescent obesity (Mead, 2016).

A report by the Agency for Healthcare Research and Quality reviewed adverse effects of weight-control drugs compared to placebo. Vomiting in children taking Metformin ranged from 15 to 42 percent, versus only 3 to 21 percent for placebo. Numerous gastrointestinal effects were reported in children taking orlistat compared to the placebo group (O’Connor, 2017).

A Cochrane review of 20 RCTs, including 3057 participants, compared effectiveness of diet, physical, and behavioral programs for overweight/obese children age 5-11 for parents only. Parents only interventions were not different from parents and children (p<.56), but were more effective compared to waiting-list controls (p<.04) after 10-12 months (Loveman, 2015).

A meta-analysis of 52 studies (n=28,236) on childhood body mass index interventions showed a significant overall effect (p<.001). Programs for children age 15-19 were most effective. Both school and after-school interventions were significant. Effects were greater in interventions of more than one year, which featured both physical activity and nutritional education, and that included 3-5 sessions of physical activity per week (Vasques, 2014).

Single interventions to reduce body mass index among overweight/obese children have been studied. One meta-analysis of 20 studies (n=971) assessed the improvement from physical exercise for 13 weeks, an average of three days a week and 46 minutes per session. A decrease of 3.6 percent was observed, significant at p <.001 (Kelley, 2015). A meta-analysis of 14 trials (n=2238) showed that reduced screen time for the child had a significant (p<.001) effect on body mass reduction (Wu, 2016). Even greater consumption of individual foods have been linked with reduced body mass index; a meta-analysis of 22 trials (n=1251) found that overweight/obese children consuming various berry juices daily for 2 - 12 weeks had a greater reduction than controls, significant at p<.00001 (Huang, 2016).

Other meta-analyses found positive associations in reduced body mass index and other weight-related measures from education (Sbruzzi, 2013); exercise (Kelley, 2013; Kelley, 2014); and a combination of dietary, physical, and behavioral interventions (van Hoek, 2014). A Cochrane review of drug interventions for body mass index found significant reductions in the index compared to placebo (Mead, 2016).

Since 2013, a number of meta-analyses have been published on the efficacy of programs to reduce the number of obese and overweight children. Among these are school-based programs, which showed mixed results. One found significant reductions in BMI (Lavelle, 2012); another found school programs to be “mildly effective” in reducing body mass index (Sobel-Goldberg, 2013); a third documented the
presence of school nurses to contribute to greater reductions (Schroeder, 2016); and a fourth concluded that school-based programs were not effective in reducing body mass index (Hung, 2015).

Policy updates:

A total of three guidelines/other, 11 peer-reviewed references, and three government reports were added to, and two guidelines/other, one peer-reviewed reference, and one government report were removed from, this policy in March, 2018.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
<th>Key points:</th>
</tr>
</thead>
</table>
| Schroeder (2016)          | Role of school nurse in reducing child obesity | Nineteen articles (11 for systematic review, eight for meta-analysis), n = 6,050 children.  
When nurses are part of intervention for obese school children, reductions in BMI are significantly greater. |
| Mead (2016)               | Drugs used to treat obese children and adolescents | Cochrane review of 21 trials (n = 2,484), 18 compared drug group to placebo.  
Intervention 12 to 48 months, follow up 26 to 100 weeks.  
Significantly greater BMI decrease in drug group, for sibutramine, metformin, and orlistat.  
Drug group had (insignificantly) higher number of adverse events, mostly tachycardia, constipation, and hypertension. |
Interventions not effective in reducing BMI. |
| Van Hoek (2014)           | Meta-analysis of studies of various interventions to reduce BMI in overweight/obese children | Eleven studies with 1,015 participants.  
Group with multiple interventions (dietary, physical, behavioral) had greatest reduction in BMI. |
Exercise reduces BMI; more studies needed on the topic. |
<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelley (2013)</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>- Thirty-one studies, 1,182 subjects.</td>
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<td>- Exercise found to reduce body fat, but no other BMI-related measures.</td>
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<td>Sobel-Goldberg (2013)</td>
<td><strong>Key points:</strong></td>
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<td></td>
<td>- Thirty-two studies, 52,109 participants.</td>
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<td>- School programs “mildly effective” in reducing BMI.</td>
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<td>- Recent efforts more effective as they are now longer, more comprehensive, and include parental support.</td>
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<tr>
<td>Sbruzzi (2013)</td>
<td><strong>Key points:</strong></td>
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<tr>
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<td>- Twenty-six trials, 23,617 participants.</td>
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<td>- Education on behavioral modification, nutrition, and physical activity to participants.</td>
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<td></td>
<td>- Education associated with reduction of waist circumference, BMI, diastolic blood pressure.</td>
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<tr>
<td>Lavelle (2012)</td>
<td><strong>Key points:</strong></td>
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<td></td>
<td>- Forty-three studies.</td>
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<td></td>
<td>- Interventions include physical activity, nutrition, and education.</td>
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<td></td>
<td>- All found to reduce BMI.</td>
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<tr>
<td>O’Conner (2010)</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>- A systematic review for the USPSTF, based on research for obese children 4 – 18 years old.</td>
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<td></td>
<td>- To examine feasibility of behavioral and pharmacological weight-management interventions for overweight (BMI ≥ 85th to 94th percentile of age- and sex-specific norms) and/or obese (BMI ≥ 95th percentile) children and adolescents.</td>
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<td></td>
<td>- Comprehensive behavioral interventions involving medium- to high-intensity interventions were the most effective behavioral approach and consistently resulted in small to moderate short-term improvements.</td>
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<td></td>
<td>- More limited evidence suggests that these improvements can be maintained completely (or somewhat) over the 12 months following the end of treatments and that there are few harms with behavioral interventions.</td>
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<td>- One orlistat is Food and Drug Administration-approved for use in children and adolescents, and it is approved for prescription use in children 12 years old and older.</td>
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<td></td>
<td>- Research evaluating the treatment of obese children and adolescents has improved in quality and quantity in the past several years. Combined behavioral-pharmacological interventions may be useful in very obese adolescents, particularly if research confirms that weight loss is maintained.</td>
</tr>
</tbody>
</table>
References

Professional society guidelines/other:


Peer-reviewed references:


**Government reports:**


Whitlock EP, O’Conner EA, Williams SB, et al. Effectiveness of Primary Care Interventions for Weight Management in Children and Adolescents: An Updated, Targeted Systematic Review for the USPSTF.
CMS National Coverage Determinations (NCDs):

As of the writing of this policy, no NCD was found when searching for childhood obesity. There is a final decision memorandum for intensive behavioral therapy for obesity; (CAG-00423N). November 29, 2011. https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253

Local Coverage Determinations (LCDs):

No LCDs were identified as of the writing of this policy.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment</td>
<td></td>
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<tr>
<td>96151</td>
<td>Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment</td>
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<tr>
<td>96152</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; individual</td>
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<tr>
<td>96153</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)</td>
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<tr>
<td>96154</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)</td>
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<tr>
<td>96155</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)</td>
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<tr>
<td>98960</td>
<td>Education and training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient</td>
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<tr>
<td>99078</td>
<td>Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)</td>
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<tr>
<td>ICD-10 Code</td>
<td>Description</td>
<td>Comment</td>
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<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
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<tr>
<td>E66.09</td>
<td>Other obesity due to excess calories</td>
<td></td>
</tr>
<tr>
<td>E66.1</td>
<td>Drug-induced obesity</td>
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<td>E66.2</td>
<td>Morbid Obesity with alveolar hypoventilation</td>
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<td>E66.8</td>
<td>Other Obesity</td>
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<td>E66.9</td>
<td>Obesity, unspecified</td>
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<td>Z68.53</td>
<td>Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age</td>
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<td>Z68.54</td>
<td>Body Mass Index, pediatric, greater than or equal to 95th percentile for age</td>
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<tr>
<td>Z71.3</td>
<td>Dietary surveillance and counseling</td>
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<tr>
<td>Z72.4</td>
<td>Inappropriate diet and eating habits</td>
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<td>G0447</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
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