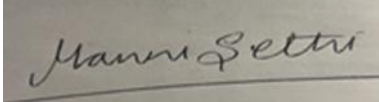


Prior Authorization Review Panel
MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: AmeriHealth Caritas Pennsylvania & Keystone First		Submission Date: 6/1/2026	
Policy Number: CCP.1028		Effective Date: 9/1/2013 Revision Date: 5/1/2026	
Policy Name: Behavioral health weight management interventions for children with increased body mass index screenings			
Type of Submission:		Type of Policy:	
☐ New Policy	☒ Prior Authorization Policy		
☒ Revised Policy*	☐ Base Policy		
☐ Annual Review- no revisions	☐ Experimental/Investigational Policy		
	☐ Statewide PDL		
	☐ Other:		
*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:			
Name of Authorized Individual (Please type or print):		Signature of Authorized Individual:	
Manni Sethi, MD, MBA, CHCQM			

Behavioral health weight management interventions for children with increased body mass index screenings

Clinical Policy ID: CCP.1028

Recent review date: 5/2026

Next review date: 9/2027

Policy contains: Childhood body mass index; childhood obesity; weight management interventions.

Keystone First- CHIP has developed clinical policies to assist with making coverage determinations. Keystone First- CHIP'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 Keystone First- CHIP, on a case by case basis, 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. Keystone First- CHIP'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. Keystone First- CHIP's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First- CHIP will update its clinical policies as necessary. Keystone First- CHIP's clinical policies are not guarantees of payment.

Coverage policy

Intensive Health Behavior and Lifestyle Treatment for children and adolescents with a body mass index at or above the 95th percentile for age and sex is clinically proven and, therefore, may be medically necessary when all the following criteria are met (Grossman, 2017; Hampl, 2023; US Preventive Services Task Force, 2024):

- Both the member (child) and family are included in treatment sessions.
- The member (child or adolescent) is 6 years of age or older and has either:
 - An age- and gender-specific body mass index equal to or above the 95th percentile for age and sex based on CDC growth charts, indicative of obesity, with specific assessment for related comorbidities (Grossman, 2017; US Preventive Services Task Force, 2024).
 - An age- and gender-specific body mass index in the 85th to 94th percentiles, indicative of being overweight, with specific assessment for related comorbidities (e.g., prediabetes, hypertension, dyslipidemia) (Hampl, 2023).
- Referral to moderate- to high-intensity behavioral intervention program that includes all of the following characteristics (Grossman, 2017; Hampl, 2023; US Preventive Services Task Force, 2024):
 - 26 or more hours of contact with the member and/or caregivers over a period of two to 12 months.

- 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 member 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 member 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 includes 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.

Limitations

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

- Members who do not achieve their targeted weight loss or reduction in body mass index percentile within 6 months may be re-evaluated at that time. Those showing “readiness to change” and with a body mass index percentile $\geq$ the 95th percentile may receive another round of counseling.
- Dietician referral/nutritional counseling addresses the following topics (Grossman, 2017):
 - 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 shopping, 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.

Alternative covered services

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

Background

Body mass index measures childhood weight status. It is calculated by dividing a child’s weight in kilograms by the square of height in meters. Body mass index correlates with direct measures of body fat (e.g., skinfold thickness measurements, bioelectrical impedance, and densitometry), but is more practical to use. For children and teens, body mass index is age- and sex-specific (Centers for Disease Control and Prevention, 2023a).

The body mass index-for-age weight status categories and corresponding percentiles are used for defining overweight and obesity in children. These ranges are intended to reliably define a level above which a child is more likely to have or be at risk of developing obesity-associated adverse health outcomes or diseases (Centers for Disease Control and Prevention, 2023a):

- Overweight — 85th percentile to less than the 95th percentile.
- Obesity — 95th percentile or greater.
- Severe obesity — 120% of the 95th percentile or greater, or 35 kg/m² or greater.

Among children and adolescents age 2 to 19 years, the prevalence of obesity from 2017 to March 2020 was 19.7%, split evenly among genders. Obesity prevalence increased with age and was higher among Hispanic (26.2%) and non-Hispanic black (24.8%) youth than non-Hispanic white (16.6%) and non-Hispanic Asian (9.0%) youth, and higher among low income families (Stierman, 2021).

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 such as atherosclerosis, hypertension, and hyperlipidemia. Mental health issues such as depression and low self-esteem are more problematic in children with obesity compared to children without obesity (Sutaria, 2019).

Central to childhood obesity is inadequate diet and physical activity, and lack of access to healthy, affordable foods and places to be active. Evidence-based initiatives at the national, state, and local levels are aimed at addressing childhood obesity. The strategies employ recommended standards and best practices for prevention and treatment of obesity (Centers for Disease Control and Prevention, 2023b).

Treatment of childhood obesity seeks to achieve weight loss, prevent further weight gain, and improve complications of obesity. Behavioral change is central to obesity management. Treatment options target dietary and physical activity changes that often include family-based interventions and psychological methods (e.g., cognitive behavioral therapy or motivational interviewing). Interventions may be individual-, group-, or community-based. Comprehensive, multidisciplinary approaches that increase the intensity and frequency of the behavior change component may be employed before adjunctive pharmacologic therapy and bariatric surgery are considered (Tiwari, 2023).

Findings

This policy addresses comprehensive multicomponent interventions targeting dietary change and lifestyle modifications for treating childhood obesity. The effects of the individual components are often unclear and are beyond the scope of this policy.

There is strong consensus that the body mass index is a reliable screening measure of a child's body composition, and body mass index-for-age categories are reliable for defining levels above which a child is more likely to have or be at risk of developing obesity-associated adverse health outcomes or diseases. High specificity

Clinical guidelines

Approximately 19.7% of U.S. children and adolescents aged 2 to 19 years have a body mass index at or above the 95th percentile on Centers for Disease Control and Prevention growth charts, with higher prevalence in Hispanic/Latino, Native American/Alaska Native, and non-Hispanic Black youth (US Preventive Services Task Force, 2024). The USPSTF recommends screening children and adolescents aged 6 years and older for high body mass index ($\geq 95^{\text{th}}$ percentile) in primary care and school settings and referring them to comprehensive, intensive behavioral interventions (≥ 26 contact hours), which yield a moderate net benefit with minimal harms (Grossman, 2017; US Preventive Services Task Force 2024). These programs, delivered by multidisciplinary teams, include supervised physical activity, nutrition education, and behavior change strategies like goal setting, engaging both parents and children to improve weight status and quality of life after 6 to 12 months, with no evidence of increased stigma or harm to self-esteem (US Preventive Services Task Force, 2024).

The National Heart, Lung, and Blood Institute Expert Panel recommends measuring length/height and weight from infancy, annual blood pressure assessments from age three, and non-fasting non-high-density lipoprotein cholesterol screening at age 10 to identify candidates for intensified lifestyle interventions (National Heart, Lung, and Blood Institute, 2012). For children aged 6 years or older with body mass index ≥ 95 th percentile without comorbidities, comprehensive weight loss programs in research settings, including behavior change counseling, dietary modification, and increased physical activity, receive a Grade A recommendation (National Heart, Lung, and Blood Institute, 2012). Family-based programs for ages 6 to 12 are also Grade A, with optimal long-term weight loss when parents are the focus, while adolescent-focused programs are Grade B for short-term efficacy driven by adolescent autonomy (National Heart, Lung, and Blood Institute, 2012).

The American Academy of Pediatrics endorses body mass index screening to identify children with overweight (85th to < 95 th percentile) and obesity (≥ 95 th percentile), advocating a chronic care model with Intensive Health Behavior and Lifestyle Treatment delivering at least 26 hours of face-to-face, family-based counseling on nutrition, physical activity, and behavior change over 3 to 12 months for children aged 6 and older (Grade B), with limited evidence for ages 2 to 5 (Grade C); coordination with subspecialists and community resources is essential (Hampl, 2023). The Pediatric Endocrine Society, American Heart Association, American Psychological Association, and clinical algorithms endorse similar multicomponent, non-stigmatizing interventions (Styne, 2017; Kelly, 2017; American Psychological Association, 2018; Cuda, 2018).

Systematic reviews

Systematic reviews underscore the effectiveness of multicomponent behavioral interventions for weight management in children and adolescents with high body mass index, with emerging evidence on eating behavior traits and psychological approaches. A review of 24 studies ($n = 25,807$) confirmed body mass index's diagnostic accuracy for obesity, reporting a sensitivity of 81.9% and specificity of 96.0%, though self-reported body mass index showed lower sensitivity (76%) (Simmonds, 2016; He, 2017, 2018). The U.S. Preventive Services Task Force reviewed 45 trials ($n = 7,099$), finding those multicomponent interventions with at least 52 contact hours significantly reduced weight and blood pressure after 6 to 12 months, with smaller effects for 26 to 51 contact hours and no adverse effects (Grossman, 2017). An updated Task Force review of 58 randomized controlled trials ($n = 10,143$) found small body mass index reductions after 6 to 12 months (mean difference: -0.7 , 95% CI -1.0 to -0.3 ; 28 randomized controlled trials, $n = 4,494$; $I^2 = 86.8\%$), with larger effects in interventions offering at least 26 contact hours and supervised physical activity sessions; pooled analyses also showed modest quality-of-life improvements (mean difference: 1.9 , 95% CI 0.2 to 3.5 ; 11 randomized controlled trials, $n = 1,922$; $I^2 = 48.4\%$) and small reductions in blood pressure and fasting glucose, with no impact on lipids or physical activity levels outside sessions (O'Connor, 2024).

A review of 8 trials ($n = 693$) assessed behavioral weight management interventions on eating behavior traits in children and adolescents with overweight or obesity, finding a short-term increase in dietary restraint at intervention completion (standardized mean difference: 0.42 , 95% CI 0.13 to 0.70 ; 3 randomized controlled trials, $n = 227$; $I^2 = 0\%$), with narrative synthesis indicating improvements in emotional eating, external eating, food responsiveness, and enjoyment of food, though effects were not sustained at follow-up (Kudlek, 2025). A review of 36 trials ($n = 20,993$) targeting dietary behaviors in adolescents aged 10 to 19 found significant improvements in fruit consumption, sugar-sweetened beverage intake, and snacking in 14 trials, with school-based, multicomponent interventions showing the greatest impact on dietary and anthropometric outcomes (Nonguierma, 2022).

A review of 54 studies ($n = 4,093$) evaluating psychological interventions, primarily cognitive behavioral therapy and motivational interviewing, reported significant reductions in body mass index z-score (standardized mean difference: -0.66 , 95% CI -1.15 to -0.17 ; 15 randomized controlled trials, $n = 2,210$; $I^2 = 88.6\%$) and waist circumference (standardized mean difference: -0.53 , 95% CI -1.03 to -0.04 ; 9 randomized controlled trials, $n =$

1,079; $I^2 = 98.7\%$), with effects maintained at follow-up, particularly for moderate-intensity interventions (26 to 75 hours) (Baygi, 2023). An overview of 6 Cochrane reviews, covering 163 trials, reported small reductions in body weight status across children aged 2 to 18 with multicomponent interventions, despite low-quality evidence and high bias (Ells, 2018). For minority ethnic populations, a review of 53 studies ($n = 26,045$), including 44 randomized controlled trials, found that supervised multicomponent interventions incorporating cultural factors were more effective when targeting body mass index and cardiometabolic risk factors (Obita, 2023).

A Cochrane review of 33 randomized controlled trials ($n = 5,949$) evaluated multimodal health behavior-changing interventions for adolescents aged 10 to 19 years with obesity, separating healthcare-based from community-based delivery. Healthcare-based interventions may slightly improve health-related quality of life at 12 months (SMD 0.13; 95% CI 0.02 to 0.24; low certainty) and may result in little to no difference in body mass index z-score at 12 to 18 months (MD -0.11 ; 95% CI -0.19 to -0.02 ; low certainty). Community-based interventions may slightly reduce body mass index z-score at 24 months (MD -0.47 ; 95% CI -0.96 to 0.02 ; low certainty). Little to no effect on mental well-being or physical activity was observed in either delivery setting. Overall certainty of evidence was low (Franco, 2025).

A review of 73 randomized controlled trials ($n = 6,305$) categorized behavioral and psychological interventions for children and adolescents aged 0 to 18 years with obesity by type, including physical activity, nutrition, psychological, technology, and multicomponent interventions. Physical activity interventions produced small effects on body mass index z-score and health-related quality of life, with moderate-to-very-large effects on blood pressure, lipids, and insulin resistance. Multicomponent interventions produced large benefits for anxiety, large-to-very-large benefits for lipids, and small benefits for depressive symptoms, diastolic blood pressure, insulin resistance, and body mass index z-score. Psychological interventions produced small health-related quality of life benefits and moderate benefits for depressive symptoms. Technology-based interventions produced small benefits for blood pressure and body mass index z-score. Adverse events were infrequently reported and described as mild, and the review identified evidence gaps for populations under age six, special populations, and participant-reported outcome measures (Henderson, 2025).

A systematic review and meta-analysis of 59 randomized controlled trials ($n = 10,454$) evaluated behavioral weight management interventions for children under age 18 with overweight or obesity that were delivered or referred to by health care professionals in primary care. At 12 months, the pooled mean difference in body mass index z-score was -0.08 (95% CI -0.13 to -0.03), favoring intervention groups. At program end, the mean difference was -0.15 (95% CI -0.22 to -0.08). Interventions referred to community settings achieved greater body mass index z-score reductions (-0.14 ; 95% CI -0.20 to -0.08) than interventions delivered within primary care (0.04 ; 95% CI -0.10 to 0.18) (Graham, 2026).

A component network meta-analysis of 125 randomized controlled trials ($n = 16,513$) evaluated the individual components of cognitive behavioral therapy for children and adolescents with overweight or obesity. Behavioral therapy probably reduces body fat percentage (MD -1.16% ; 95% CI -1.68% to -0.64%), waist circumference (MD -1.70 cm; 95% CI -2.74 to -0.67 cm), and improves quality of life (SMD 0.16; 95% CI 0.03 to 0.30) at moderate certainty. At the component level, parental involvement (MD -0.09 ; 95% CI -0.16 to -0.03) and stimulus control (MD -0.07 ; 95% CI -0.12 to -0.01) probably reduce body mass index z-score. The review concluded that behavioral therapy is likely effective for pediatric obesity management regardless of cognitive therapy integration, and that parental involvement, stimulus control, preplanning, and feedback monitoring are the highest-priority techniques (Xie, 2026).

Meta-analyses

A meta-analysis of 29 studies on children with intellectual disabilities found physical activity interventions improved cardiopulmonary fitness (6-minute walk distance: 51.86 m, 95% CI 16.49 to 87.22, $P < .05$), but effects on outcomes related to obesity were inconclusive (Wang, 2022). A meta-analysis of 30 studies from a

larger review of 54 studies reported that moderate-intensity interventions (26 to 75 hours) produced the largest body mass index reductions, while low-intensity interventions (10 to 25 hours) were most effective for abdominal obesity, with sustained effects (Baygi, 2023). A meta-analysis of 31 studies from a review of 53 studies on minority ethnic children (n = 26,045) found no significant body mass index reduction when interventions focused solely on body mass index (pooled body mass index mean change = -0.09, 95% CI -0.19 to 0.01, P = .09), but culturally tailored, supervised interventions targeting multiple outcomes were more effective (Obita, 2023).

Other evidence

A survey within a large-scale screening program in Poland ((n = 19,634)) found that poor diet, sedentary behavior, and parental education predicted willingness to participate in a multicomponent intensive behavioral intervention for obesity management targeting adolescents (n = 2,862) aged 12 to 14 years with body mass index at or above the 90th percentile; measured body mass index did not influence participation, but perceived family support facilitated engagement (Rodriguez, 2023). A trial of (n = 269) children aged 6 to 12 years from low-income households (95% Hispanic or Black/African American) compared home-delivered versus clinic-delivered family-based weight management interventions, finding no significant difference in 12-month body mass index z-score change (home: -0.031, standard deviation = 0.26; clinic: -0.002, standard deviation = 0.30; P = .58), despite higher session attendance in the home arm (median: 11 vs. 6.5 sessions; P < .0001); exploratory analyses suggested a small pre-COVID-19 advantage for home delivery, emphasizing socioeconomic barriers and the role of delivery setting (Appelhans, 2025). These studies collectively demonstrate that family support and socioeconomic factors influence engagement in weight management interventions, with home-based delivery addressing access barriers in low-income populations, though modest weight loss outcomes highlight the need for further optimization to achieve sustained impact.

In 2025, we revised the findings section and added a new guideline (US Preventive Services Task Force, 2024), two new systematic reviews (O'Connor, 2024; Kudlek, 2025), and a randomized controlled trial (Appelhans, 2025). We made warranted policy changes as a result of the new 2024 guideline.

In 2026, we added four systematic reviews (Franco, 2025; Graham, 2026; Henderson, 2025; Xie, 2026). No policy changes were warranted.

References

On April 8, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “pediatric obesity (MeSH),” “health behavior (MeSH),” “body mass index (MeSH),” “motivational interviewing (MeSH),” “cognitive behavior therapy (MeSH),” “intensified lifestyle interventions,” “child,” and “obesity.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

5/2013: initial review date and clinical policy effective date: 9/2013

5/2014: Policy references updated.

5/2015: Policy references updated.

5/2016: Policy references updated.

5/2017: Policy references updated.

5/2018: Policy references updated.

5/2019: Policy references updated. Policy number changed to CCP.1028.

5/2020: Policy references updated.

5/2021: Policy references updated.

5/2022: Policy references updated.

5/2023: Policy references updated.

5/2024: Policy references updated.

5/2025: Policy references updated.

5/2026: Policy references updated.

Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1028 This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code description
G0447	Face-to-face behavioral counseling for obesity, individual, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2–10 people), 30 minutes