Addressing Substance Use within a Busy Clinic

TAKE AWAY RESOURCE

Overview of How to Have a 30-60 Second Conversation about SUDs

1) Tell patient that their substance use is a health problem.
2) If possible, relate their use to the impact it has on a current complaint.
3) Offer resources and tools to use, if they wish.
4) Use exit strategies, if needed, to finish talk & get on with why the patient came in to see you today.

When Hypertension is >140/90:

"Mr./Mrs./Ms. ____, your blood pressure is (has been) in a range that is a problem for your health."

Considering showing your patient this on a hypertension graph.

Advise about specific risk/benefits:

Tailor to patient's current situation/chief complaint:

- "Since you do not have substance use disorder, now is a great time for you to reduce use."
- "Reducing use is one of the best things you could do for your: BP/sugars/lipids/heart/joint pain/etc."
- "Reducing your alcohol intake by X amount of drinks is enough to improve your health and return you're A1C scores to healthy levels.
- "Working on healthy lifestyle would be good medicine for you and your children/family."

Add the Substance Use to the Problem List!

Exit Strategies

• *If the patient gets upset about you addressing his/her substance use: "Doctor are you calling me an addict?"*

"It's your choice to work on this or not, but I wouldn't be the primary care provider you deserved if I didn't bring this up, since reducing substance use is the single most important change you could make to improve your health."

• *If the patient wants to talk more about substance use at this visit: "Doctor what's the best way for me to reduce my use?" or "I've tried everything, let me tell you about what I've done."*

"You came in today because of [___], let's take care of that now, then get an appointment to me/my MA/a BHP/[___] in several weeks so we can talk more about this."

• *If the patient does not want to work on reducing their substance use: "I have zero interest in stopping use!"*

"This is your choice; just know that if and when you want to work on your use, we can help you here at our health center."

Assess Readiness to Change Using the Readiness Ruler:

"On a 1 (very low) - 10 (very high) scale, how ready are you to get to work on a healthier lifestyle now?"
"What makes you say X rather than X-1?"

If readiness to change is low, work to increase
If high readiness, plan behavior change now

*Adopted From www.nationaljewish.org "**Succeeding With Weight Management Within a Busy Clinic**

STANDARDIZE

Coding for alcohol SBI

In 2014, the Patient Protection and Affordable Care Act (ACA) began requiring insurance plans to cover many clinical preventive services. Two of the covered preventive services include:

- Alcohol screening for adults
- Alcohol screening and brief intervention

Use the following codes for patients receiving a screening only.

CPT CODE	PAYER	DESCRIPTION
96160	Commercial Insurance	Administration and interpretation of health risk assessment instrument
G0442	Medicare	Screening for alcohol misuse in adults including pregnant women once a year; 15 min.

Use the following codes for patients with a positive screen result and receiving brief intervention counseling.

CPT CODE	PAYER	DESCRIPTION
99408	Commercial Insurance, Medicaid	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 min.
99409	Commercial Insurance, Medicaid	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 min.
G0396	Medicare	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 min.
G0397	Medicare	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 min.
G0443	Medicare	Up to four, 15 min. brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse
H0049	Medicaid	Alcohol and/or drug screening (not widely used)
H0050	Medicaid	Alcohol and/or drug service, brief intervention, per 15 min. (not widely used)

ICD-10 CM	DESCRIPTION
Z13.89	Encounter for screening for other disorder
Z13.9	Encounter for screening, unspecified
Z71.41 F10.10	Alcohol abuse counseling and surveillance of alcohol
Z71.42	Counseling for family member of a person with an AUD

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DOCUMENTING, CODING, & BILLING FOR TOBACCO DEPENDENCE TREATMENT

A GUIDE TO MAXIMIZING REIMBURSEMENT

A Project of CAI

Promoting Health Systems Improvement
for a Tobacco Free New York

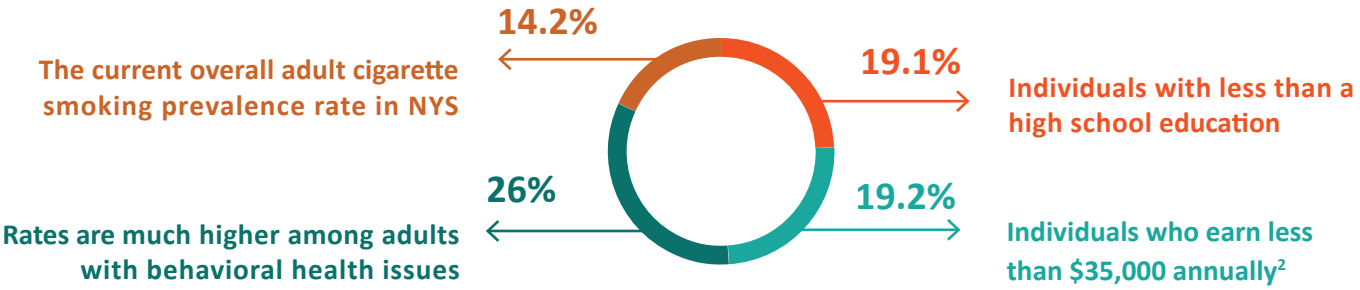
TABLE OF CONTENTS

Disclaimer: Guidance regarding coding for nicotine dependence, as well as the example scenarios provided are for educational purposes only. Clinical providers and health systems administrators are responsible for contacting their third-party payers for specific information about coding, coverage, and payment policies. It is recommended that all healthcare sites establish and maintain a relationship with a specific individual/contact at each of the third-party payer organizations that they bill. Also, users should refer to the ICD-10–CM official guidelines for further clarification.

INTRODUCTION

TOBACCO USE IS THE LEADING CAUSE OF PREVENTABLE DISEASE

Tobacco use is the leading cause of preventable disease, disability, and death in the United States. An estimated 36 million adults in the United States smoke cigarettes, and over 16 million individuals in the U.S. live with a tobacco-related disease.[1] In New York State (NYS), although the adult smoking rate is at a record low, tobacco use still claims approximately 28,000 lives annually, and approximately 2 million adult New Yorkers continue to smoke cigarettes.[2]



ABOUT THIS GUIDE

Screening and counseling for smoking cessation are distinct preventive services mandated by many regulatory organizations and encouraged by public health organizations.

The goal of this guide is to assist primary care, behavioral health, and substance abuse treatment providers and outline practices to maximize reimbursement for providing life-saving tobacco cessation services by documenting, coding and billing for tobacco and nicotine dependence screening and treatment.

To achieve this goal, this guide outlines common diagnosis codes for tobacco and nicotine use and dependence within the new **International Classification of Diseases, Tenth Revision, Clinical Modification** diagnosis code set (ICD-10-CM or ICD-10), as well as reviews strategies for clinical documentation. This guide also provides foundational information for both the ICD-10 diagnosis codes for tobacco or nicotine dependence, as well as the procedure codes for billing and encounter coding.

The guide is structured in the following manner:

- **Section 1:** Diagnostic coding for tobacco use, dependence and exposure
- **Section 2:** Procedure codes for tobacco cessation services
- **Section 3:** Tobacco cessation benefits

The Center of Excellence for Health Systems Improvement (COE for HSI) provides technical assistance and support to ten regional Health Systems Improvement (HSI) grantees across NYS who work closely with hospital systems, Federally Qualified Health Centers (FQHCs), and behavioral health organizations to put systems into place to ensure that every tobacco user is screened, offered education and counseling, and receives timely tobacco dependence treatment (TDT), if desired.
To learn more visit tobaccofreeny.org

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SECTION 1:
DIAGNOSTIC CODING FOR TOBACCO USE, DEPENDENCE, & EXPOSURE

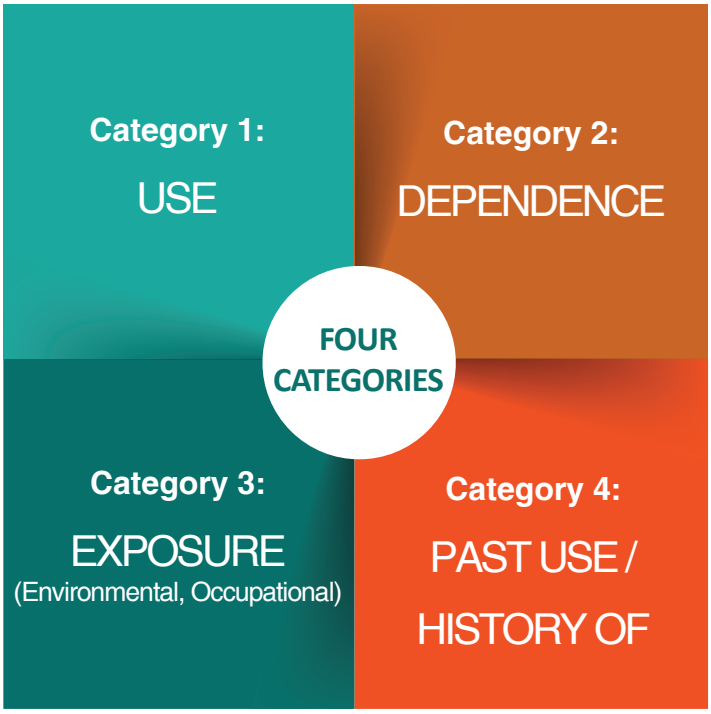
OVERVIEW OF THE DIAGNOSTIC CODING SYSTEM: ICD-10

ICD-10 is the 10th revision of the **International Statistical Classification of Diseases and Related Health Problems** (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. ICD-10 codes support the medical necessity for performing a service.

For both clinical and financial reasons, healthcare providers must clearly indicate the reasons for services rendered. When a provider choses ICD-10 diagnosis codes, both the codes chosen and documentation in the medical record must support the medical necessity for the subsequent services provided and the procedure codes that are linked to the ICD-10 diagnosis code.

To accurately select and support ICD-10 codes relating to tobacco use, it is essential for clinicians to specify whether the patient is engaging in the use of tobacco, has developed a dependence on nicotine, is exposed to tobacco smoke, or has a past history of nicotine dependence. **Figure 1** displays the four categories of nicotine/tobacco ICD-10 Coding.

Figure 1: Four Categories of ICD-10 Nicotine Coding



Documentation also should include the type of tobacco product used and whether or not there are nicotine-induced disorders such as remission or withdrawal. These distinctions will assist with proper reimbursement and help manage and track your population to understand the most prevalent conditions related to tobacco use and the products used by patients to consume nicotine.

NICOTINE USE VS. DEPENDENCE

Healthcare providers frequently have questions related to the ICD codes for tobacco "use" vs. tobacco "dependence." Determining the category into which a patient falls ultimately rests upon clinical judgment. However, everyone involved in the coding process can benefit from reviewing the clinical definition of "tobacco use disorder" released in 2013, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[3] is the most recent update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA). In the United States, the DSM serves as the principal authority for psychiatric diagnoses. Treatment recommendations, as well as payment by healthcare providers, are often determined by DSM classifications.

The definition is a useful diagnostic tool for determining what constitutes "dependence." An accurate diagnosis of "use" versus "dependence" should be updated and/or reflected on patients' active problem list.

Code Based on Healthcare Provider Documentation

One or any combination of nicotine use, abuse and/or dependence could be documented in a patient's chart by a healthcare provider. It is important to only code what has been documented.

If more than one aspect of a patient's nicotine use has been documented, assign only one code.

Code the highest degree of specificity that has been documented, in the following order:

① **Dependence**
② **Abuse**
③ **Use**

This means that when coding, dependence takes precedence over the other codes if it's been documented.

Table 1. DSM-5 Tobacco Use Disorder Diagnostic Criteria

The following table displays the definition of "Tobacco Use Disorder" exactly as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:		
1	Tobacco is often taken in larger amounts or over a longer period than was intended.	
2	There is a persistent desire or unsuccessful effort(s) to cut down or control tobacco use.	
3	A great deal of time is spent in activities necessary to obtain or use tobacco.	
4	Craving, strong desire, or urge to use tobacco.	
5	Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued tobacco dependence despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., arguments with others about tobacco use).	
7	Important social, occupational, or recreational activities are given up or reduced because of tobacco use.	
8	Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).	
9	Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco.	
10	Tolerance, as defined by either of the following:	
	a	A need for markedly increased amounts of tobacco to achieve a desired effect.
	b	A markedly diminished effect with continued use of the same amount of tobacco.
11	Withdrawal, as manifested by either of the following:	
	a	The characteristic withdrawal syndrome for tobacco (refer to DSM5 criteria for Tobacco Withdrawal)
	b	Tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms.

Source: American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Washington, DC.

The Centers for Medicare and Medicaid Services (CMS) relates the DSM-5 criteria to ICD codes as follows:

DSM-5 contains the standard criteria and definitions of mental disorders now approved by the American Psychiatric Association (APA), and it also contains both ICD-9-CM and ICD-10-CM codes (in parentheses) selected by APA. Since DSM-IV only contains ICD-9-CM codes, it will cease to be recognized for criteria or coding for services with dates of service of October 1, 2015 or later. Updates for DSM-5 criteria and associated ICD-10-CM codes (identified by APA) are found at www.dsm5.org.

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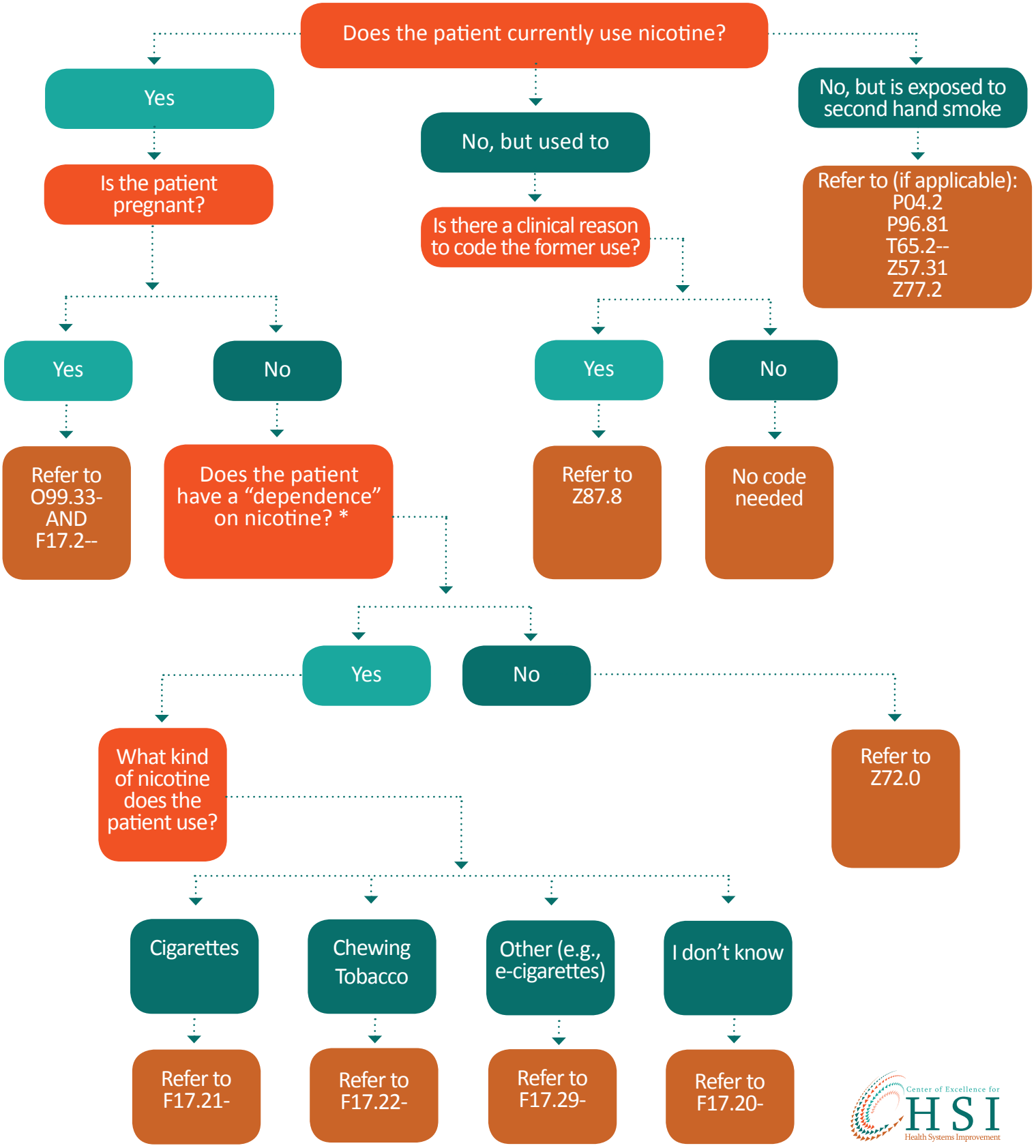
Choosing the correct diagnostic code given the patient's history can often be challenging. **Figure 2: Diagnostic Coding-at-a-Glance for Nicotine Use / Dependence** is a workflow diagram meant to provide guidance in choosing the correct diagnosis code(s). It also encompasses the four categories of nicotine/tobacco ICD-10 Coding previously mentioned in **figure 1**.

Figure 2: Diagnostic Coding-at-a-Glance for Nicotine Use / Dependence



CODING NICOTINE USE

The following ICD-10 code(s) should be used if the clinician determines that the patient **USES** nicotine products but is **NOT DEPENDENT** on nicotine.

Table 2. Nicotine Use Codes

Z72.0	Tobacco Use
Excludes1 *(See Box 1: ICD-10 Coding Note below for guidance)*	
Z87.891*	History of tobacco dependence
F17.---	Nicotine and tobacco dependence
O99.33-	Tobacco use during pregnancy *(see additional guidance on page 8 re: O99.33-)*

** Z Codes are not billable, they are used to provide information regarding reasons for an encounter.*

BOX 1: ICD-10 CODING NOTES

The ICD-10-CM guidelines include a number of instructional notations to help users properly select codes. These notes include two types of code exclusions to identify situations where a different code might be more appropriate, or if another code could be added that further supports patient care.

EXCLUDES 1: A type 1 "Excludes" note means "NOT CODED HERE," indicating that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

EXCLUDES 2: A type 2 "Excludes" note represents "NOT INCLUDED HERE." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

REMEMBER:
Excludes1: "Consider these codes instead"
Excludes2: "Consider these codes in addition"

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Documentation Tips:

- ✓ Clinicians should be specific in documenting the type of product used, frequency of tobacco use and any pertinent modifying factors to support ICD-10 code selection. For example, instead of documenting *"current tobacco user" document "currently smokes a few cigarettes a week when out with friends."*
- ✓ Documentation of non-tobacco users might include *"non-smoker - no exposure" or "patient denies tobacco exposure."*
- ✓ When possible, use structured data fields within your electronic health record (EHR) for recording tobacco use and/or dependence, as free-text information in narrative notes is not searchable, and is more difficult to find or view by other members of the care team and billing/coding team.

CODING NICOTINE DEPENDENCE

In ICD-10-CM, nicotine dependence (F17-) is represented by 20 different codes. These codes are specifically to identify the **type of nicotine product used, such as cigarettes, chewing tobacco, other tobacco product, or unspecified.**

Clinicians should use the code representing "other tobacco product" when the specific type of nicotine product is unknown or does not fall into the category of cigarettes or chewing tobacco. Electronic Nicotine Delivery Systems (ENDS) such as e-cigarettes are a common product under this category.

Electronic nicotine delivery systems (ENDS) are battery-operated devices designed to deliver nicotine to users with flavorings and other chemicals in vapor form rather than smoke.
Use F17.29- "other tobacco product" codes.

Table 3. Nicotine Dependence Codes

The following table displays a complete list of ICD-10 Nicotine Dependence Codes.

Code	Description
F17-	**Nicotine dependence**
F17.20-	**Nicotine dependence, unspecified**
F17.200	… uncomplicated
F17.201	… in remission
F17.203	… with withdrawal
F17.208	… with other nicotine-induced disorders
F17.209	… with unspecified nicotine-induced disorders
F17.21-	**Nicotine dependence, cigarettes**
F17.210	… uncomplicated
F17.211	… in remission
F17.213	… with withdrawal
F17.218	… with other nicotine-induced disorders
F17.219	… with unspecified nicotine-induced disorders
F17.22-	**Nicotine dependence, chewing tobacco**
F17.220	… uncomplicated
F17.221	… in remission
F17.223	… with withdrawal
F17.228	… with other nicotine-induced disorders
F17.229	… with unspecified nicotine-induced disorders
F17.29-	**Nicotine dependence, other tobacco product** **(use this series for Electronic Nicotine Delivery Systems [ENDS])**
F17.290	… uncomplicated
F17.291	… in remission
F17.293	… with withdrawal
F17.298	… with other nicotine-induced disorders
F17.299	… with unspecified nicotine-induced disorders
	Excludes1: *(See Box 1, for guidance)*
Z87.891	History of tobacco dependence
Z72.0	Tobacco use
	Excludes2:
O99.33	Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium
T65.2	Toxic effect of nicotine

The "unspecified" codes in **nicotine dependence ONLY** should be used if the clinician's documentation notes that the patient has nicotine dependence but does not specify the type of product used to deliver nicotine. The use of unspecified codes should be limited, as the clinician's documentation should include the type of product used and other important information to accurately code under ICD-10 whenever possible.

REMISSION, WITHDRAWAL, AND NICOTINE-INDUCED DISORDERS

Nicotine dependence codes are further defined by whether the patient's dependence is **uncomplicated, in remission, with withdrawal symptoms, or with other nicotine-induced disorders. Box 2** provides useful definitions on these subcategories of dependence.

BOX 2: DEFINITIONS TO CONSIDER WHEN CODING FOR NICOTINE DEPENDENCE

REMISSION: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines early remission of nicotine dependence as at least 3 but less than 12 months without substance use (except craving), and sustained remission is defined as at least 12 months without criteria (except craving).[1]

WITHDRAWAL: Daily use of nicotine for at least several weeks, AND an abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four or more of the following signs: (1) irritability, frustration, or anger; (2) anxiety; (3) difficulty concentrating; (4) restlessness; (5) decreased heart rate; (6) increased appetite or weight gain; (7) dysphoric or depressed mood; and (8) insomnia.[1]

NICOTINE-INDUCED DISORDER: An adverse health event that a provider documents as having a direct cause-and-effect relationship with the patient's nicotine use (e.g., chronic obstructive pulmonary disease, or COPD). Default to using "uncomplicated" codes unless there is a documented relationship between nicotine use and the disorder.

Documentation Tips Supporting Diagnostic Codes

- ✓ Clinicians are encouraged to include the type of nicotine product along with how often the patient uses that product, as well as any related complications. For instance, instead of documenting "current smoker" or "smokes 1PPD," it is recommended that the clinician document "Smokes 1 PPD cigarettes without complications" or "Smokes 1 PPD cigarettes with nicotine-induced COPD."
- ✓ Clinicians should document a cause-and-effect relationship between a patient's tobacco use and other disease processes in order for the coder to link the disease process to that patient's tobacco use.

EXAMPLE – A patient is a current cigarette smoker with a 20-year history of smoking who now presents with emphysema. The physician does not link the smoking to the emphysema in the medical record; therefore, it would not be appropriate for the coder to use F17.218, Nicotine dependence, cigarettes, with other nicotine-induced disorders.

If the patient does not have nicotine-induced disorders and is not exhibiting signs of withdrawal or remission, the clinician should default to using one of the "uncomplicated" codes.

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CODING TOBACCO USE DURING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM

Codes under subcategory O99.33- *Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium*, should be assigned when a patient uses any type of tobacco product during the pregnancy or postpartum period.

Please note that ICD-10 coding instructions advise that these codes be accompanied by a secondary code from Category F17 to identify the type of nicotine product the patient uses.

Table 4. Codes for Tobacco Use During Pregnancy, Childbirth, and the Puerperium

Code	Description
O99.33	**Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium**
O99.330	… unspecified trimester
O99.331	… first trimester
O99.332	… second trimester
O99.333	… third trimester
O99.334	… childbirth
O99.335	… the puerperium
Use a secondary code from category F17.--- *Nicotine dependence,* to identify the type of nicotine dependence.	

CODING TOBACCO AND SECONDHAND SMOKE EXPOSURE

Providers often encounter patients who may not use tobacco products themselves, but are regularly exposed to secondhand smoke. Exposure to secondhand smoke should be documented and coded. The codes in Table 5 below may be useful depending on the specific situations encountered by the patient. Organizations should consult the complete ICD-10 code set for detailed instructions on use of these codes:

Table 5. Tobacco Exposure Codes

Code	Description
P04.2	Newborn (suspected to be) affected by maternal use of tobacco*
P96.81	Exposure to (parental) (environmental) tobacco smoke in the perinatal period*
T65.2---	Toxic effect of tobacco and nicotine**
Z57.31	Exposure to environmental tobacco smoke - Occupational*
Z77.22	Exposure to second hand tobacco smoke (acute) (chronic)*
**Refer to complete ICD-10 code set for Excludes notes* ***Refer to complete ICD-10 code set to select correct 5th, 6th and 7th digits*	

Note: Codes for tobacco and nicotine exposure or use are required to be reported in addition to all respiratory conditions (ICD-10 codes within Categories J00 to J99) and with many other conditions such as otitis media and diseases of the oral and nasal mucosa.

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CODING PAST HISTORY OF NICOTINE DEPENDENCE

Occasionally, a clinician will encounter a scenario that would benefit from documenting a patient's past dependence on nicotine. **There is no code for past history of nicotine use, only a code for past history of nicotine dependence.** For example, a clinician may want to document a patient's past use of cigarettes while treating that patient for asthma, as this history is likely pertinent to the course of treatment. In these scenarios, clinical providers would use the Z87.891 code (note: F17-- is not coded with this code).

Table 6. Coding Past History of Nicotine Dependence/Smoking

Z87.891	Personal history of nicotine dependence
Excludes1 (See Box 1: ICD-10 Coding Note above for guidance)	
F17.---	Nicotine dependence (current)

Documentation Tips:

- ✓ Be as specific as possible when documenting current and past history of nicotine use/dependence. For example, document "quit smoking cigarettes in 2014" or "quit cigars at age 42," rather than just "quit smoking" or "does not currently use tobacco."

- ✓ Remember to update the problem list to identify "remission" for any period of tobacco cessation lasting more than twelve months.

SECTION 2:
PROCEDURE CODES FOR TOBACCO CESSATION SERVICES

CODING TOBACCO CESSATION COUNSELING

The tobacco cessation counseling that healthcare providers deliver related to tobacco use and dependence is reimbursable and may often merit the use of a diagnosis code. This could be the case if a patient presents solely for cessation assistance, or when a visit for another reason naturally progresses into the provision of tobacco cessation counseling and the clinician needs to explain an extended length of visit time or the use of a CPT code for counseling. In these scenarios, clinicians would use the Z71.6 code along with a secondary F17-- code that describes the nicotine dependence.

Table 7. Linking a Procedure Code to a Diagnostic Code

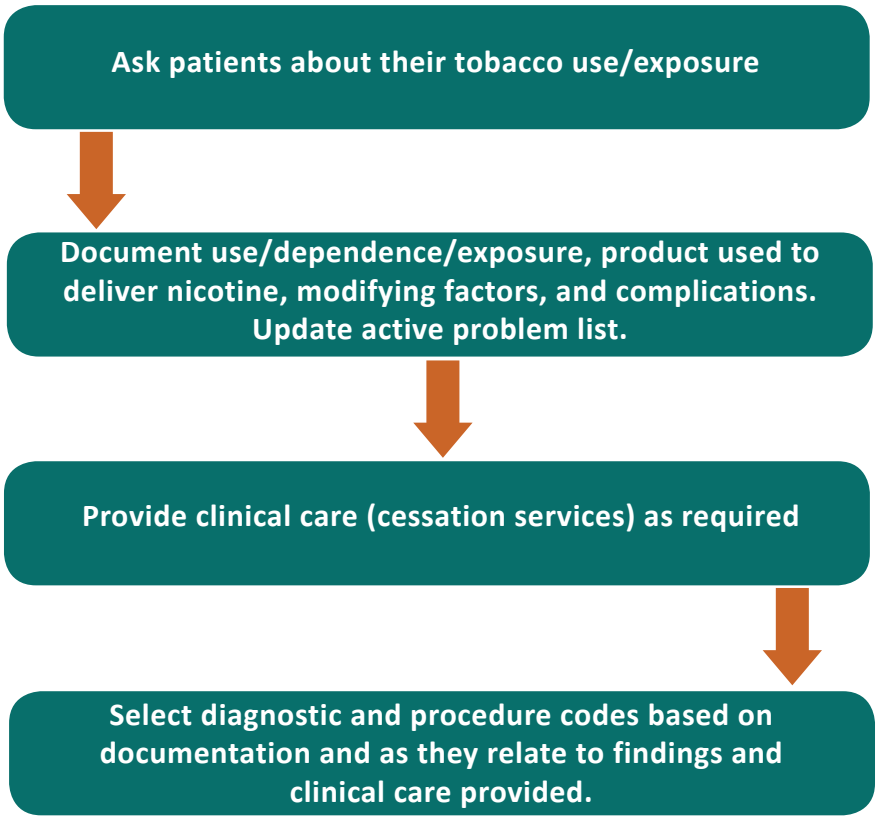
Z71.6	Tobacco abuse counseling
Use a diagnostic code from Category F17.2-- *Nicotine dependence,* to identify the type of nicotine dependence	

Documentation Tip:

✓ Smoking cessation counseling CPT codes (e.g., 99406, 99407) are time-based codes. In order to support the use of these codes, documentation of the cessation counseling should include the amount of time spent with the patient.

Asking patients about tobacco use and documenting their tobacco use status typically increases the rate of clinician intervention.

In Summary…



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CPT CODES

Currently Procedural Terminology (CPT) codes are used to describe tests, surgeries, evaluations, and other medical procedures performed by a healthcare provider on a patient. These codes are a method of documenting what service or procedure was performed by a provider during a given visit (fee for service model) or during a given time (monthly case rate for Value-Based Care models). Category I CPT codes are divided into six sections:

- Evaluation and Management (E/M)
- Anesthesiology
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

CPT Codes used for tobacco screening and treatment are part of the "Evaluation and Management" (E/M) section of the CPT code book. Codes specific to tobacco/nicotine should be used in addition to the E/M code if other services were provided in addition to tobacco cessation counseling. The E/M preventive counseling codes are often used to reflect time spent with a patient, rather than complexity or medical decision making typical of most E/M codes. If more than fifty percent (50%) of the visit is spent counseling the patient, the E/M code could be selected based on time.

MODIFIERS

If a provider uses different E/M codes on the same day, a **modifier** must be added to the claim for payment. Modifiers are two-digit codes that when added to a procedure code give more specificity to the service or procedure rendered and will modify a service/procedure under certain circumstances for appropriate additional reimbursement. When coding for Tobacco Dependence Treatment, Modifier 25 notes a significant, separately identifiable evaluation and management service by the same clinician on the same day of the procedure or other service. As Medicare and other payers are increasingly scrutinizing the use of Modifier 25, its use should be considered carefully.

Procedure codes, such as E/M codes, document what services were performed and indicate the time and complexity of those services. E/M codes chosen by providers will depend on whether a service performed was a screening only, or if the service provided actually included treatment of tobacco or nicotine dependence. For tobacco use screening, the preventive counseling E/M codes are used. Codes 99406 and 99407 are selected *according to the time spent counseling the patient regarding tobacco cessation during a face to face visit.*

Table 8. Evaluation and Management Codes

99201-99205	New patient, outpatient visit, office based
99211-99215	Existing patient, outpatient visit, office based
99401-99404	Individual preventive counseling
99406	Preventive medicine, smoking/tobacco use cessation counseling, **greater than three minutes and up to ten minutes**
99407	Preventive medicine, smoking/tobacco use cessation counseling, intensive, **greater than ten minutes** (if a group is being conducted, combine with Modifier HQ)
99411-99412	Group preventive counseling

Preventive service codes are often reimbursed by payers, but reimbursement will vary, particularly for organizations or providers in special arrangements such as capitated rates or other value-based payment arrangements. Preventive codes can be used for individuals or groups, as noted above. If a provider spends less than three minutes counseling a patient about tobacco dependence, the time spent counseling does not qualify for the preventive codes and is considered part of the E/M office-based visit and code.

There are preventive codes used such as 99384-99387 (for initial visit) and 99394-99397 (for existing patients) for preventive services, that include risk reduction, as part of the visit. As a result, some of the other codes, like tobacco or nicotine use related counseling, may not be reimbursed. If a provider is reporting the use of the codes 99406 or 99407 they must be documented and clearly separate from the services provided under the prevention E/M code.

It is critical to document time spent on counseling in the medical record and include topic and specifics of the counseling. It is important to link all of the prevention or E/M codes to the appropriate diagnosis codes, as discussed in Section 1. Providers can only use one of the counseling codes per visit. The codes must directly apply to a service performed for the patient. For example, providers cannot bill for counseling the parent of a pediatric patient.

Documentation Tip

Documentation in the record must show sufficient patient history and verification of the counseling intervention, such as:

- ✓ Asked about tobacco use and given information on benefits of quitting
- ✓ Assessed the willingness to quit (stages of change)
- ✓ Provided support for quit attempt
- ✓ Follow-up scheduled
- ✓ Time spent documented (these codes are time based)

HCPCS CODES

The **Healthcare Common Procedure Coding System** (HCPCS) is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes.

Table 9. HCPCS Code Related to Tobacco Cessation (No Longer in Use)

S9075	Smoking Treatment
S9453	Smoking Cessation Classes

"S Codes" are temporary nationally-used codes.

These codes were meant to be used by non-physician providers, **but are no longer available for use.**[4]

Health and Behavior Assessment and Intervention Codes

Health and Behavior Assessment and Intervention CPT codes that are used for health and behavioral assessment and intervention services. These services can be provided by psychologists, but no other licensed mental health providers (with the exception of a few states who have ruled their use as allowable for the expansion of integrated primary care and behavioral health services). **These codes are often not used by primary care providers, of any licensure, as they are reimbursed at a lower rate than the E/M code applicable for that visit.**[5]

Table 10. Health and Behavior Assesment and Intervention Codes

96150	The initial assessment of a patient to determine biological, psychological and social factors affecting the patient's health
96151	A reassessment of a patient subsequent to above
96152	The intervention service provided to an individual to modify the behavioral, psychological or social factors affecting the patient's physical health
96153	Group intervention for above
96154	Family intervention for above with the patient present

SECTION 3:
TOBACCO CESSATION BENEFITS

The tables in this section provide guidance regarding tobacco cessation benefit availability from New York State Medicaid, Medicare, and TRICARE including allowable provider types and coding.

NY STATE MEDICAID

As of December 1, 2016, **Medicaid** and **Medicaid Managed Care Organizations** (MCOs) have aligned criteria to provide the following Tobacco Cessation Benefits to all members throughout New York State:[6]

- Unlimited annual quit attempts for tobacco cessation agents (removed the previously placed "two quit-attempts" annual limit)
- Prior Authorization of tobacco cessation agents is not needed (exceptions apply for brand name medications that have generic equivalents available)
- Formulary coverage of all FDA-approved tobacco cessation agents (with the exception of nicotine lozenges)
- Allows for concomitant use of two tobacco cessation agents
- Follows FDA approved age restrictions and quantity limits

Medicaid and MCOs provide coverage for the provision of tobacco and nicotine counseling and cessation services. This benefit is not available to individuals on Emergency Medicaid. Providers and practices that are contracted with payers in capitation agreements (in value-based care arrangements) may not be paid above the capitated rate for providing tobacco cessation services. It is recommended that organizations speak directly with the payer regarding this. Organizations that are Federally Qualified Health Center (FQHC) providers may not be reimbursed by Medicaid or MCO above their all-inclusive rates.

Table 11. NYS Medicaid/MCO Tobacco Cessation Benefits

INSURANCE	ICD-10 DIAGNOSTIC CODE	MAXIMUM NUMBER OF BILLABLE QUIT ATTEMPTS AND COUNSELING SESSIONS	**INTERMEDIATE COUNSELING (3-10 MINUTES) CPT OR CDT***	INTENSIVE COUNSELING (11+ MINUTES) CPT OR CDT*	TYPE OF COUNSELING	APPROVED HEALTH CARE PROVIDERS	CLINICAL SETTING
NYS MEDICAID AND MANAGED CARE ORGANIZA-TIONS	Z72.0 (Tobacco Use)	-Two quit attempts per year -Four face-to-face counseling sessions per quit attempt. Dental professionals can only provide two counseling sessions per year	99406 D1320 Individual session only	99407 Individual or group session (use Modifier HQ in Behavioral Health Settings to indicate group session) D1320 Individual session only	-Face-to-face -Individual (intermediate or intensive counseling) -Group (intensive counseling only) -Dental professionals can only provide individual counseling	○ Article 28, D&TC, FQHC that bills APGs^: MD, DO, PA, NP, LMW, DMD, DDS, Dental Hygienists ○ Article 31(OMH): ** ○ As above, in addition RN for Tobacco Cessation Counseling ○ OASAS: Same providers as above, + RN or other clinical staff with appropriate training	Outpatient

*CDT= ***Current Dental Terminology*** *(a code set with descriptive terms developed and updated by the American Dental Association for reporting dental services and procedures to dental benefit plans.*

***If tobacco cessation counseling is part of a psychotherapy session, (group or individual) time spent can be counted towards this session but cannot be billed as additional tobacco cessation counseling. If not part of a psychotherapy session, tobacco cessation counseling is billable using the same codes and approved providers as Article 28 clinics.*[7]

^**Ambulatory Patient Groups** *(APGs) rate codes (and their corresponding CPT codes) are used for services covered by NYS Medicaid for APG reimbursement. The APG system is the NYS state-mandated payment methodology for most Medicaid outpatient services.*

MEDICARE/MEDICARE ADVANTAGE

Medicare Part B reimburses counseling for tobacco cessation to Medicare beneficiaries, taking into consideration the following criteria:

- The individual uses tobacco of any kind, regardless of signs of disease
- Beneficiaries must be competent, alert and able to understand health information being provided
- Services are provided by a qualified, recognized healthcare provider

Each "quit" attempt (limit of two) may include up to four intermediate or intensive outpatient counseling visits, with a maximum of eight sessions in a twelve-month period that will be reimbursed. Services can be provided by a qualified Medicare provider such as a physician, physician assistant, nurse practitioner, psychologist or clinical social worker and must be linked to an appropriate diagnosis code.

Medicare does reimburse for some inpatient counseling, but reimbursement varies based on reason for admission and the HBAI series of codes. Over-the-counter drug treatments for smoking cessation, such as nicotine patches and gum, are not covered by Medicare. These and other over-the-counter drugs are excluded by law from Part D coverage. However, Part D plans may cover certain prescription drugs for smoking cessation.

This benefit is not available to individuals on Emergency Medicaid. Providers and practices that are contracted with payers in capitation agreements (in value-based care arrangements) may not be paid above the capitated rate for providing tobacco cessation services. It is recommended that organizations speak directly with the payer regarding this. Organizations that are **Federally Qualified Health Center** (FQHC) providers may not be reimbursed by Medicaid or MCO above their all-inclusive rates.

Table 12. Medicare/Medicare Advantage Benefits

INSURANCE	ICD-10 DIAGNOSTIC CODE	MAXIMUM NUMBER OF BILLABLE QUIT ATTEMPTS AND COUNSELING SESSIONS	INTERMEDIATE COUNSELING (3-10 MINUTES)	INTENSIVE COUNSELING (11+ MINUTES)	TYPE OF COUNSELING	APPROVED HEALTH CARE PROVIDERS	CLINICAL SETTING
MEDICARE / MEDICARE ADVANTAGE	Z72.0 (Tobacco Use)	-Two quit attempts per year -Four face-to-face counseling sessions per quit attempt.	99406	99407	-Face-to-face -Individual (intermediate or intensive counseling)	Physician or other Medicare-recognized practitioner	Outpt, Emergency Department, Inpatient, Skilled Nursing Facility, Home Health Agency, Indian Health Service

TRICARE

The provision of tobacco cessation services is important to the veteran population and is supported by the primary payer for veterans, TRICARE.[8]

TRICARE offers additional support for plan members and education for providers on the TRICARE smoking cessation hotline 1-866-459-8766. TRICARE covers a comprehensive array of medications and has programs where gum and patches are available through the cessation hotline.

Table 13. TRICARE Tobacco Cessation Benefits

INSURANCE	ICD-10 DIAGNOSTIC CODE	MAXIMUM NUMBER OF BILLABLE QUIT ATTEMPTS AND COUNSELING SESSIONS	INTERMEDIATE COUNSELING (3-10 MINUTES)	INTENSIVE COUNSELING (11+ MINUTES)	TYPE OF COUNSELING	APPROVED HEALTH CARE PROVIDERS	CLINICAL SETTING
TRICARE	Z72.0 (Tobacco Use)	-Two quit attempts per year -18 face-to-face sessions per quit attempt (up to four can be individual sessions)	99406 96152 96153 Individual session only	99407 Group session only	-Face-to-face -Individual (intermediate or intensive counseling) -Group (intensive counseling only) Phone counseling available, but not billable	Physician or other TRICARE-recognized provider	Outpatient

PRIVATE INSURANCE

The **Patient Protection and Affordable Care Act** (ACA) requires most private health insurance plans to cover many clinical preventive services, including:

- Tobacco use screening for all adults and adolescents
- Tobacco cessation counseling for adults and adolescents who use tobacco, and expanded counseling for pregnant women. Private plans are required to provide evidence-based tobacco cessation counseling and interventions to all adults and pregnant women in accordance with the **United States Preventive Services Task Force** (USPSTF). However, the USPSTF language does not provide certainty regarding exactly what is required or what plans are required to cover. USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco and provide behavioral counseling.[9]

The ACA also requires most private health insurance plans to fund each quit attempt, which includes funding, without cost-sharing or prior authorization:

- Four counseling sessions of at least 10 minutes each (including telephone, group, and individual counseling), and
- Coverage of all 7 medications approved by the **U.S. Food and Drug Administration** (FDA) as safe and effective for smoking cessation for 90 days per quit attempt, when prescribed by a health provider.

CLAIMS DENIALS

Payers may deny claims for tobacco cessation counseling for many reasons. Practices may not be able to successfully dispute such denials if the patient:

- has exceeded annual coverage limits or
- is receiving tobacco cessation services from another provider

If a provider receives a denial for reasons other than these, it is often advisable to contact the plan to determine if there was an error processing the claim, or if there are specific documentation or coding requirements that they may have. The claim may be able to be corrected and resubmitted for reimbursement.

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Center of Excellence for CHSI Health Systems Improvement

CHEST

Integrating Tobacco Use Treatment Into Practice

Billing and Documentation

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Balancing population-based efforts to modify the social and environmental factors that promote tobacco dependence with efforts to improve the delivery of case-based treatments is necessary for realizing maximum reductions in the cost and consequences of the disease. Public health antismoking campaigns following the 1964 Surgeon General's report on the health risks of smoking have changed social norms, prevented initiation among youth, and promoted abstinence among the addicted. However, the rate of progress enjoyed to date is unlikely to continue into the coming decades, given that current annual unassisted cessation rates among prevalent smokers remains fairly low. With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem. Clinicians report a perceived lack of reimbursement as a significant barrier to full integration of tobacco dependence into health care. A more complete understanding of the coding and documentation requirements for successful practice in this critically important area is a prerequisite to increasing engagement. This paper presents several case-based scenarios illustrating important practice management issues related to the treatment of tobacco dependence in health care.

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Given that tobacco smoking remains responsible for a major portion of preventable death and disability, who, if not health-care providers, should be responsible for preventing that portion of preventable death and disability?

Tobacco control is clearly one of the greatest public health achievements of the 20th century, preventing millions of smoking-related deaths.[1,2] Consequently, the current "end-game" strategy relies heavily on extending gains made by policy initiatives and environmental modifications.[3-6] Relative to the emphasis placed on population-based controls, efforts to increase the ability of health-care systems to provide effective case

ABBREVIATIONS: CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9

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treatment have been comparatively pedestrian, and places low on expert lists of tobacco control priorities.[7,8] With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem.

Though physicians clearly understand their unique role in promoting abstinence,[9] they do not generally recognize their role in achieving tobacco control goals.[10] Even when high rates of brief intervention behaviors are confirmed, physicians do not generally engage in the "next steps" consistent with sophisticated interventions of chronic illness.[11] This observation has prompted various regulatory agencies to introduce evolutionary pressures, designed to encourage behavior change.[12-14] The US Preventive Services Task Force lists tobacco dependence counseling as a "grade A" recommendation for all adults using tobacco.[15] System readiness to adopt these changes appears low, but is improving.[16,17]

The growing interest in harnessing health care's potential and the increasing demand for professional services will require addressing the issues that have stunted its impact on the tobacco epidemic to date. Several efforts have focused on improving physicians' familiarity with practical evidence-based treatment strategies and time management techniques. However, reported barriers have also included the perceived lack of reimbursement—a topic not routinely addressed in the literature.[18,19] If this is indeed a significant barrier, then fully integrating tobacco dependence into health care will require a more complete understanding of the coding and documentation requirements for successful practice in this critically important area.

A Few Words of Caveat

Imprecise language has led to several unfortunate misimpressions over the years. The prevailing notion that "smoking cessation is not paid for" is, strictly speaking, true. Cessation is something the patient accomplishes, whereas tobacco-dependence treatment is a service provided by the clinician. This distinction is not merely semantic. Payers do not currently reimburse for cessation assistance, such as community-based counseling or quit line support. In contradistinction, cognitive services provided by eligible providers are reimbursable, irrespective of the problem to which they are applied. This paper does not discuss cessation services, but instead addresses several important practice management issues related to the treatment of tobacco dependence.

Although the specifics of tobacco treatment reimbursement vary by both insurer and contract, as a general rule, clinicians should expect to be fairly compensated for tobacco use treatment services, in a manner similar to compensation for services delivered for other problems.[20] Because tobacco use treatment represents a special circumstance with overlapping behavioral and biological dimensions, it is important to understand prevailing requirements and definitions that govern reimbursement. Though accurate in a general sense, the examples presented here are intended only as a guide and should not be interpreted as a guarantee of payment. When discrepancies exist, contact payer representatives for specific plan details and definitive guidance. Readers are referred to *Coding for Chest Medicine 2013*, published by the American College of Chest Physicians for specific coding details and definitions.[21]

All case vignettes are fictional. Any similarity to actual cases or events is purely coincidental.

The Established Outpatient Visit

Mr Jackson is a 49-year-old patient with a long history of asthma. His asthma has been well-controlled on inhaled corticosteroids and bronchodilators for some time, and he presents for routine follow-up monitoring. After identifying diffuse mild end-expiratory wheeze on examination, your discussion with him suggests control over his asthma is loosening. You engage Mr Jackson in conversation about the relevance of his continued smoking to his asthma and suggest that he take steps toward discontinuation.

At this point, the exact nature of your service depends on the type of cognitive services that you provide during the rest of the encounter. The first distinction to be made is whether your service meets the definition of counseling or of evaluation and management (E/M) (Fig 1). Because good clinical practice requires a therapeutic relationship and effective communication, regardless of which problem is being addressed, there can be considerable confusion over the distinction between the two services. It is important to remember that the distinction depends neither on the diagnosis nor on the presence of a physical examination, but on the nature of the cognitive interaction.

Evaluation refers to the cognitive processes applied while determining the significance or status of a problem or condition. This is typically accomplished through careful appraisal of the patient's problem through history-

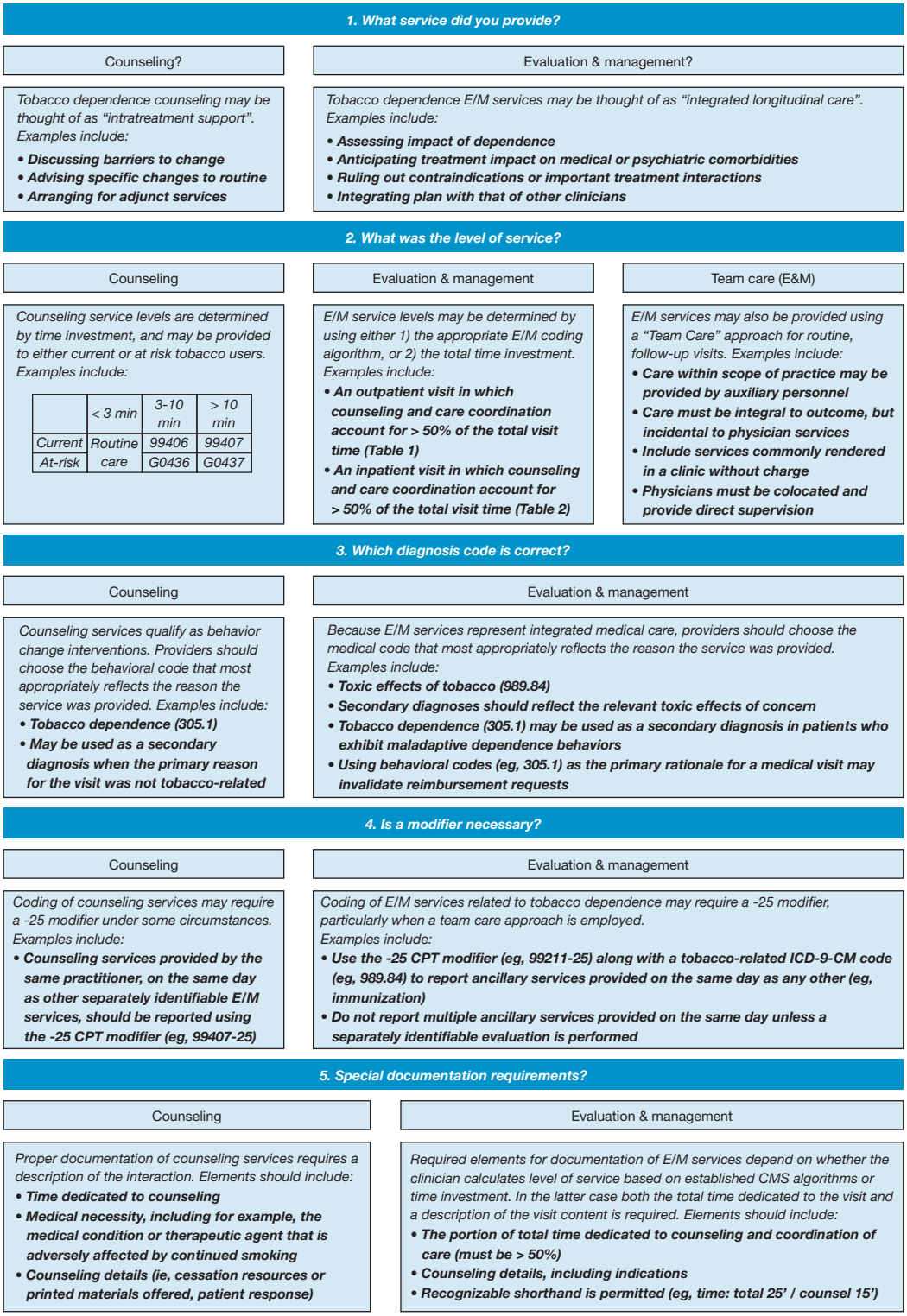

Figure 1 – *Essentials of tobacco dependence billing and coding. CMS = Centers for Medicare and Medicaid Services; CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9.*

taking and diagnostic testing. Management refers to the conduct or supervision of clinical activities in pursuit of a therapeutic goal and implies that the plan is based on the results of the preceding evaluation. Management decisions might include adjusting the medication plan, recommending a procedure, or referring for assistance

with environmental modification. An important feature of E/M services is their fundamentally iterative nature; the evaluation leads to a management plan, the response to which becomes part of the subsequent evaluation, and so on. Within medical practice, counseling refers to the guidance or education provided to an individual patient. As such, counseling may be conceived of as a subset of management activities. That is to say that good medical management will often include counseling services, but not all counseling interactions can be considered management. Counseling services related to tobacco dependence might include activities such as discussing barriers to change, advising specific changes to behavioral routines, or arranging for services and follow-up. E/M services are more likely to include activities such as estimating the impact of dependence, assessing the nature and severity of important behavioral or medical comorbidities, ruling out contraindications to specific pharmacotherapy, or assessing the potential for important drug-drug interactions.

Example 1: Tobacco Dependence Counseling as an Adjunct to Follow-up Care

During Mr Jackson's visit, you discuss the relevance of his continued smoking to his asthma and suggest that he consider stopping. The 5-min conversation included information regarding the interaction between cigarette smoke exposure and airway inflammation, a discussion of the potential impact of smoking on asthma medication effectiveness, and advice to engage available services within the system. Written after-visit instructions include a phone number to call for quit line registration.

In this scenario, the patient has been well-counseled to quit smoking. Counseling services, also referred to as Behavior Change Interventions, are reimbursable services provided by qualified health-care personnel (ie, physician and nonphysician billing providers) for the purpose of promoting health or preventing injury, and there is good evidence supporting the effectiveness of brief counseling interventions of this type.[22] The level of Behavior Change Intervention depends on the amount of time dedicated to the endeavor. Clinicians should first report the established patient visit code (99211-99215) reflecting the level of service provided for the underlying condition (in this case, asthma: International Classification of Diseases, Clinical Modification 9 [ICD-9-CM] code 493.90), and consider the time spent in counseling separately. Cessation counseling that lasts less than 3 min is considered to be part of the standard E/M service. For patients who require additional counseling time, the clinician may also report current procedural terminology code 99406 for intermediate (3-10 min), or 99407 for intensive (> 10 min) of service. Primarily use the ICD-9-CM code 305.1 (Tobacco Dependence) to report the smoking cessation counseling service, along with the appropriate code for the underlying condition.[23] For patients who do not currently smoke but who are at risk for initiation or relapse, Centers for Medicare and Medicaid Services has created two G codes that reflect counseling services aimed at preventing tobacco use. Clinicians may report G0436 for intermediate (3-10 min) and G0437 for intensive (> 10 min) of service. Counseling services provided by the same practitioner, on the same day as other, separately identifiable E/M services, should be reported using the -25 current procedural terminology code modifier (eg, 99407-25).

In addition to recording the time dedicated to counseling, Medicare requires documentation of medical necessity, including for example, the medical condition or therapeutic agent that is adversely affected by continued smoking. Comments about the counseling delivered should include details of the discussion, such as the cessation resources discussed, printed materials offered, and an indication of the patient's response. Medicare will cover two attempts at cessation during a 12-month period, with each attempt consisting of four visits (intermediate and/or intensive). Other payers may have variable reimbursement policies, and financial responsibility for unpaid charges could fall to the patient under some circumstances (eg, https://www.bcbsal.org/providers/hcReform/HCRpreventivecoding.pdf).

Example 2: Tobacco Dependence E/M Services in the Longitudinal Care of the Patient

In the process of identifying case-specific strategies for addressing Mr Jackson's tobacco dependence, you assess several clinically relevant variables such as the severity of his nicotine dependence, the potential interactions with his other comorbid conditions and preexisting therapies, his specific risk of downstream toxic effects of prolonged exposure, his insight into the problem and confidence in his ability to stop, his previous experience with tobacco dependence treatment, and his prior response to pharmacologic interventions, among other items. You identify Mr Jackson's medical conditions, signs/symptoms of disease progression, and current

prescriptions that may be affected by the treatment of tobacco dependence or by abstinence from smoking. The discussion leads you to a set of recommendations that include a tailored pharmacotherapy prescription, advice to engage hospital-based counseling resources, and a planned return visit in 1 month for reevaluation and continued management.

It is apparent that the tobacco dependence service provided is no longer of a limited nature, but instead characterized by the integration of complex data into specific recommendations. Here, the clinical interaction is more consistent with the provision of E/M services, with counseling and education being a subset of the total cognitive services provided. When counseling time exceeds 50% of the total time dedicated to the visit, the level of E/M service may be calculated using established time parameters (Table 1). Documentation must include the total visit time, the portion of that time dedicated to counseling and coordination of care (eg, Time: total 25 min/counsel 15 min), and should reference indications for counseling such as prognosis, risks/benefits of treatment, adherence instructions, or need for discussion with another health-care provider. It is permissible to use recognizable shorthand to create this documentation.

Particularly in instances in which the underlying condition is stable, the value of tobacco dependence treatment is reflected in the higher levels of service reported. For example, although Mr Jackson's follow-up visit for asthma, requiring only modest medication adjustment without need for complicated testing or complex medical decision-making, would be classified as a level 3 established office visit (99213), accurately accounting for the counseling and coordination time during a 25-min visit raises the service provided to level 4 (99214). In this case, clinicians would use the appropriate ICD-9-CM code for the underlying condition as the primary diagnosis, with 305.1 (Tobacco Dependence) as one of the relevant secondary diagnoses.

Example 3: The Tobacco Dependence Follow-up Visit

Mr Jackson returns for an established office visit 1 month later, specifically to follow-up on his progress regarding smoking. He reports reasonable adherence with the dependence medication regimen, but complains of minor side effects, particularly when taking the medications close to bedtime. He has several questions regarding advice he received from the hospital's cessation assistance program 2 weeks earlier. Although he has been able to reduce his tobacco use substantially, he has been unable to stop smoking completely. During your evaluation, you recognize the compulsion to smoke is incompletely controlled and consider adjusting his dosage or adding a second agent to his regimen.

The primary purpose of this visit is to address the patient's tobacco dependence. The context of asthma is of value, but may not be directly relevant to today's clinical activities. The visit clearly retains the elements of an E/M visit of moderate complexity because the treatment has resulted in possible side effects and an incomplete response, requiring prescription drug management. Here again, the appropriate level of service is decided by the applicable E/M coding algorithm or by total time if counseling dominates the visit (> 50%).

Though the E/M nature of the visit is not a function of the diagnosis or symptom that prompts the visit, it is important that clinicians accurately reflect the rationale for the tobacco dependence treatment visit in the primary diagnosis. Although behavioral health providers are qualified to use behavioral or mental health diagnoses such as Tobacco Dependence (305.1) as the *primary* rationale for their services, medical health providers are not. Medical health providers should instead be careful to select an ICD-9-CM code that accurately reflects their focus on the biological impact of tobacco use. For instance, it may be appropriate to use the code for Toxic Effects of Tobacco (989.84) as a primary diagnosis, followed by the relevant secondary

TABLE 1] Time Thresholds (in Minutes) That Define Levels of Service by Visit Type

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Outpatient consultation[a]	99241-99245	15	30	40	60	80
New patient	99201-99205	10	20	30	45	60
Established patient	99211-99215	5	10	15	25	40

[a]Medicare instituted a change in reporting structure in 2010 and no longer recognizes consultative services per se. Patients who have never been evaluated by the practice before should be coded as new patient visits, whereas those evaluated previously, even if by another provider in the practice, should be coded using the appropriate established patient time threshold values.[29]

diagnosis codes reflecting the toxic effects of concern. Remember that the term addiction refers to the disturbances in brain biology that manifest as dependence behaviors; therefore, it is legitimate to list Nicotine Addiction (305.1) as one of the secondary toxic effects of tobacco smoke exposure if signs of addiction are present. If reporting an E/M service with a primary diagnosis code of tobacco dependence (305.1), clinicians should be aware that some payers may consider this to be a behavioral health service, and not covered by the patient's medical insurance. Code 305.1 should not be used to simply indicate a history of tobacco use, however, which is instead indicated by V15.82.

Example 4: Use of "Team Care" Models in Tobacco Dependence Follow-up Visits

Mr Jackson returns to your clinic 2 weeks later to meet with your office tobacco treatment specialist for a review of his progress. Planned elements of the return visit include an assessment of medication adherence, identification of knowledge gaps, development of a practical behavioral action plan, and assistance with engaging extra-treatment cessation support (eg, quit line). Mr Jackson is found to be doing well on his regimen, and is progressing toward abstinence with good insight into his plan. The tobacco treatment specialist updates you on the patient's progress and arranges for a return visit with you in another 4 weeks for evaluation of treatment outcomes and medication management.

It is permissible for physicians to use the services of auxiliary personnel in the care of an established patient, particularly when collaboration with a professional of another discipline helps to reduce fragmentation of care and improve target outcomes.[24] The care provided within this team model must be integral to the outcome, but incidental to the services initially provided by the physician. "Incident to" services are not restricted to any particular type of nonphysician provider, as in shared/split billing. Auxiliary personnel should function under a formal agreement that outlines the specific care functions to be performed within their scope of practice, should provide only services that are commonly rendered in a clinic without charge, and must function only under the physician's colocated, direct supervision. Under these circumstances, the "incident to" service may be billed under the supervising physician's name, using the level 1 E/M service code (99211). Though this service does not require a personal evaluation by the physician, it does require the physician's presence in the suite during provision. Documentation should clearly reflect the collaborative nature of the discussion between the two professionals, alongside the resulting recommendations. Do not report 99211 on the same day as any other ancillary service (eg, immunization) or physician evaluation is performed.

The Outpatient New or Consultation Visit

Ms Dorsey is a 24-year-old woman, without significant medical history, referred to you by her primary care physician for consultation regarding her tobacco dependence. Your evaluation includes a review of her medical records, an assessment of her personal tobacco use and treatment history, a screening evaluation for other substance abuse or the possibility of depression, a directed physical examination, and a review of her concurrent medication use, among other relevant data. You discuss her personal history of oral contraceptive use and the impact smoking has on her future risk for thromboembolic events. Together, you settle on a strategy that includes medication and counseling. You ask that she return to your office for follow-up in 4 weeks and you dictate a letter back to the referring physician outlining your shared management plan.

In this scenario, the patient again visits specifically for assistance with tobacco dependence. The principal difference, however, is the consultative nature of the visit. Not all initial visits with specialists constitute a consultation. For a new patient visit to be considered a consultative service, it must be provided by a physician whose opinion or advice regarding the management of a specific problem is requested by another physician or other appropriate source. Documentation should therefore include evidence of *both* the request for advice and the communication of impressions and recommendations back to the requesting physician. Evidence of special training or expertise in the problem area is useful for authenticating the rationale for seeking the opinion of the consultant in the first place, but is not a necessary component of the visit documentation. When these conditions are met, it is appropriate to bill using the consultative E/M service codes (99241-99245), with level of service decisions made using the applicable E/M coding algorithm, or determined by the total time investment, as appropriate (Table 1). Choice of primary and secondary diagnosis codes remains consistent with the previous discussion. Services that fail to meet the criteria for consultative services should be billed using the codes for new patient evaluations (99201-99205).

TABLE 2] Time Thresholds (in Minutes) That Define Levels of Service for Inpatient Initial Care and Consultative Services

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Inpatient initial care visits	99221-99223	30	50	70	…	…
Inpatient consultation visits	99251-99255	20	40	55	80	110

The Hospital Consult

Mr Trujillo is a 57-year-old man with several significant medical comorbidities, admitted to the hospital 1 week ago for acute myocardial infarction. He underwent emergency coronary artery bypass surgery on hospital day 1 and is recovering nicely except for minor memory/cognitive difficulties following circulatory bypass and a postoperative DVT. His adherence with prescribed hypercholesterolemia and diabetes regimens in the past has been spotty, resulting in poor outcomes. Control of his tobacco dependence is a key part of managing his future risk, but the primary care team has several questions regarding treatment. You are called to see the patient to comment on whether his recent cardiac event constitutes a contraindication to nicotine replacement, the potential for drug interactions between nicotine replacement and his planned warfarin therapy, the best way to maximize adherence with his tobacco dependence regimen, and the availability of postdischarge follow-up.

Questions regarding the management of tobacco dependence, especially in the face of complex comorbidities, are not uncommon. Consultants may be asked to help with patients who have expressed a reluctance to stop smoking, patients who have recently begun to abstain, or even to help manage a patient at high risk of relapse. In this scenario, you are asked to see the patient during his inpatient stay to provide advice on important acute management decisions as well as to assist with arrangements for postdischarge follow-up. Consultants should document the question being asked or problem being addressed and should indicate whether verbal communication accompanied the written advice. The note should reflect key details of the tobacco use history, relevant medical/psychiatric history, and any prior experience with dependence medications, among other important variables.[25] Level-of-service decisions are again made using the applicable E/M coding algorithm or are determined by the total time investment if counseling and care coordination dominate (> 50%) the visit (Table 2).

In addition to complex pharmacotherapy decisions, the consultant is also in a position to help arrange a specific follow-up plan after discharge. For example, arrangements might be made for the patient to come to your office for an established patient visit as described previously. It is clear that the most important predictor of continued nonsmoking posthospitalization is the effective transition of care to the outpatient environment, for follow-up treatment of tobacco dependence within 4 weeks of discharge.[26]

Conclusion

Though control of tobacco use within populations has traditionally relied heavily on public policy and educational approaches, an increasing emphasis on the health-care system's potential to treat prevalent cases has led to significant changes in regulatory and payment models meant to encourage these changes. The magnitude of impact might be expected to be quite high after providers fully integrate tobacco dependence into their personal, organizational, and institutional roles, but system pressures are likely to produce suboptimal change unless significant barriers to engagement have been removed.[27,28] Clarity regarding coding and documentation requirements relevant to the problem are a necessary prerequisite to full adoption. Several key points are important to recognize—primary among them is the distinction between counseling and E/M services. The treatment of tobacco dependence is not equivalent to smoking cessation. Team care models may represent an efficient way to improve care outcomes with minimal disruption in clinic workflow. When counseling and coordination of care make up the majority of the time spent in the patient visit, the level

TABLE 3] Approximate Conversions Between ICD-9-CM Codes and ICD-10-CM Codes

Category	ICD-9-CM Code	Converted ICD-10-CM Code
Asthma	493.90	J45.909
Nicotine dependence	305.1	F17.200
Toxic effects of tobacco	989.84	T65.221x

Note that actual code choice requires clinical interpretation to determine the most appropriate ICD-10 code(s) for any specific situation. The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. CPT = current procedural terminology; ICD-9-CM = International Classification of Diseases, Clinical Modification 9; ICD-10-CM = International Classification of Diseases, Clinical Modification 10.

of service is often more accurately documented using the appropriate time threshold definitions. Remember that medical care providers should not select behavioral codes as the primary diagnosis when providing E/M services. It is most appropriate for medical providers to instead select primary diagnosis codes that reflect their attention to the physical effects of smoke exposure, including for example, their general concern over the Toxic Effects of Tobacco (989.84) (Table 3).

Clinicians who have established a special expertise in the area may elect to provide consultative services in both out- and inpatient environments. Specialized training or certification is a good way to establish this expertise, but is not a necessary prerequisite to providing consultative service. Institutionalizing the care of the tobacco-dependent patient allows the health-care system to elevate its capacity for providing high-quality care and to successfully participate in several important quality initiatives and program certifications.

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Billing & Coding for Tobacco Dependence Treatment

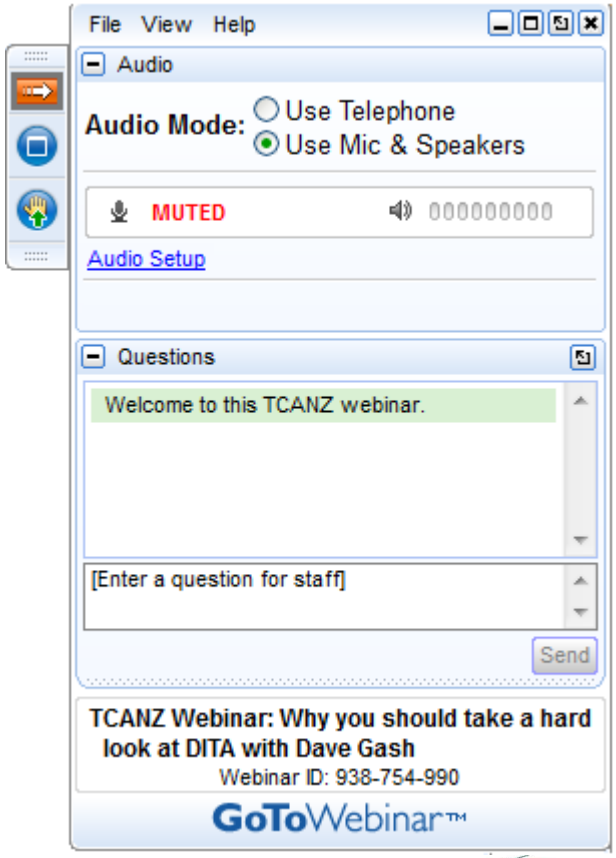
Smoking Cessation Services Considerations for Sustainability and Population Management

Virna Little, PsyD, LCSW-r, SAP, CCM

May 10th, 2018

Logistics

- Panel
- Live questions
- Typed questions/chat
- Raise hand
- Tech Difficulties
  - 1-888-259-8414



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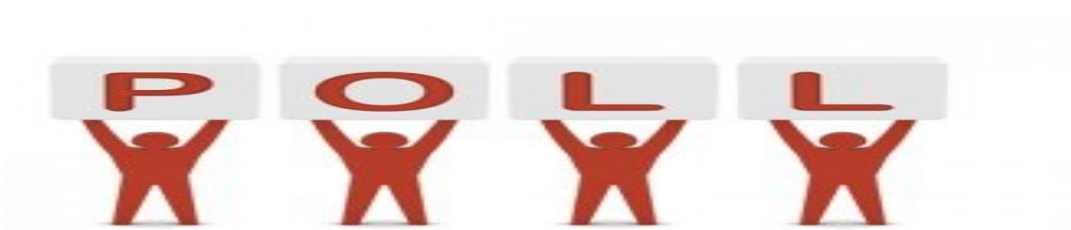
Poll Question #1

Who is here today?

- ❑ C-level Executive
- ❑ Behavioral Health Clinical Team member
- ❑ Billing Staff
- ❑ Administration/Operations
- ❑ Primary Care Provider
- ❑ Other



NYS Medicaid

Recent coverage changes by New York State (NYS) Medicaid Fee-for-Service (FFS) and all 18 Managed Care Organizations (MCOs), as well as medication guidance changes by the U.S. Food and Drug Administration (FDA), make it easier to prescribe these safe and effective regimens for your patients:

- **NYS Medicaid removed the two-course annual limit for smoking cessation medications.** This includes all seven FDA-approved cessation medications and combinations of long- and short-acting medications.
- **NYS Medicaid removed prior authorization** for prescribing cessation medication (except for brand-name products when generics are available).
- **FDA approved removal of the warning about using two forms of nicotine containing products simultaneously**, indicating there are no significant safety concerns with prescribing combination nicotine replacement therapy (NRT) or using NRT with another nicotine-containing product, such as a cigarette.
- **FDA approved the removal of the guidance to limit NRT use to 8 to 12 weeks and the boxed warning** about potential neuropsychiatric side effects for both varenicline and bupropion when used for smoking cessation.

Staffing Matters

- Types of Licensure or discipline matter for billing, coding and sustainability
- Think about sustainability before hiring
- Grants end –billing and coding doesn't change
- Think about all of your team / staff member , payers and codes and map out on a grid

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Facility Type and Licensure Matter

- Know your type of facility
- Types of licensure may matter based on your type of facility
- Type of licensure may limit the codes you are able to use and the amount of payment you get for services
- Look for ways to optimize with co-occurring disorders or groups vs individual services

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Is TCC a separately reimbursed service? Are we contracted to bill and reimburse for these services?	Provider Type Allowed	Max # of Billable Quit Attempts and counseling sessions	CPT codes (Article 28 and 31 Clinics)	Health Monitoring CPT Codes (Article 31 Clinics only)	Payment - Intermediate Counseling 3-10 min (99406)	Payment - Intensive Counseling 11+ min (99407)	Dispense TCC drugs onsite or RX given?	Other (covered patients, denial issues, specific coding required, etc.)
Yes. **Exceptions:** 1. FQHC's that bill under the PPS, TCC is most likely not reimbursable as a stand-alone service 2. See footnote** regarding Article 31 clinics	**Article 28 OP, DTC & FQHC that bill APGs:** MD,DO, PA, NP, LMW/CNW, DMD, DDS, Dental Hygienists **Article 31:** As above, in addition RN for TCC **Article 31 health monitoring, group or individual:** MD, NP, PA, RN/LPN **OASAS:** Same providers as above, and RN/other clinical staff with appropriate training	- Unlimited quit attempts per year -4 face-to-face counseling sessions/quit attempt - Dental professionals can only provide 2 individual counseling sessions/yr -Allow concomitant utilization of 2 agents	**Intermediate:** 99406, individual session only, or D1320 (dentists) **Intensive:** 99407 for individual, use HQ modifier to indicate group (max 8), Article 31 (OMH) see note**	**Individual:** 99401 - 15 min 99402 - 30 min 99403 - 45 min 99404 - 60 min **Group** (max 12): 99411 - 30 min 99412 - 60 min	$10.00	$19.00	Yes - Prior auth for smoke cessation agents NOT required. Formulary coverage for ALL tobacco cessation agents	Individual or group session for intensive counseling - use HQ modifier for group

Payer Spreadsheet

Provider Title	CODES															
	All Professionals							ALL but RN	BSW, SW, Psychologist, Lic. Counselor ONLY				Psychiatrist, Psychiatric NP, Psychiatric PA ONLY			
	96150	*96151*	*99366*	*99367*	*99368*	*98967*	*98968*	*90853*	*90791*	*90832*	*90834*	*90837*	*90853*	*99211*	*99213*	*99214*
BSW																
• Medicaid																
• Medicare																
• Commercial																
Social Worker																
• Medicaid																
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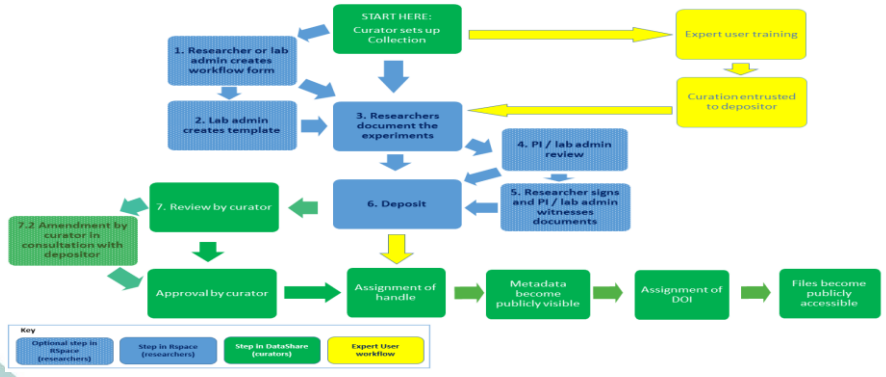
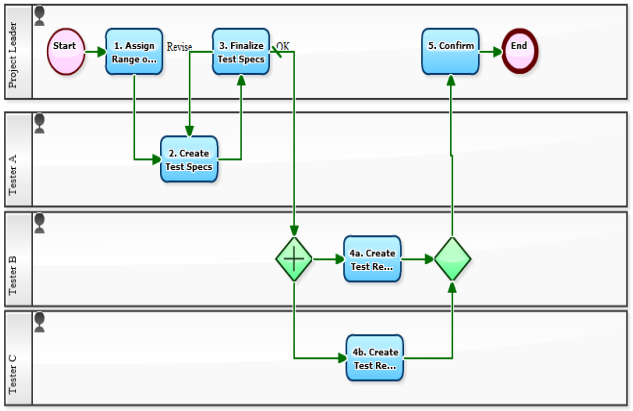
Medicaid in New York

- Primary Care (Article 28 or non) can bill
  - MD, DO, PA, NP, LMW, DMD, DDS, Dental Hygienists
- Article 31 as well as independent providers
- Article 32 and independent providers
  - MD, NP, PA & RN are billable titles for tobacco counseling
  - Other clinical staff with appropriate training can bill for tobacco cessation counseling (Social Workers, Mental Health Counselors, CACACs, etc.)
  - Utilize available trainings like “FIT” or Smoking Cessation from CPI

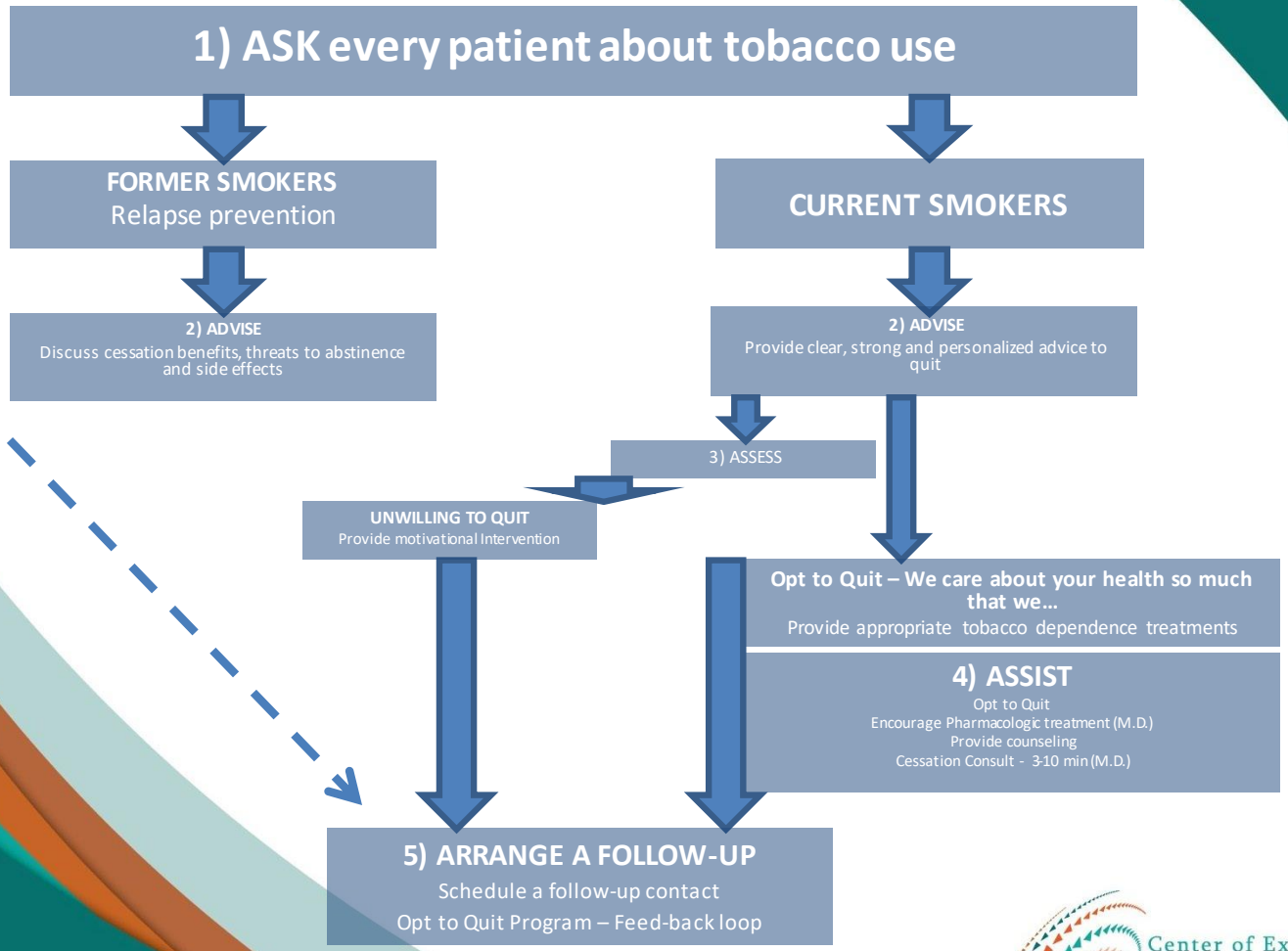
Workflows and Sustainability

- Workflows should be modified based on sustainability plan or efforts
- Workflows can be used to map both clinical services and processes like cessation counseling or education



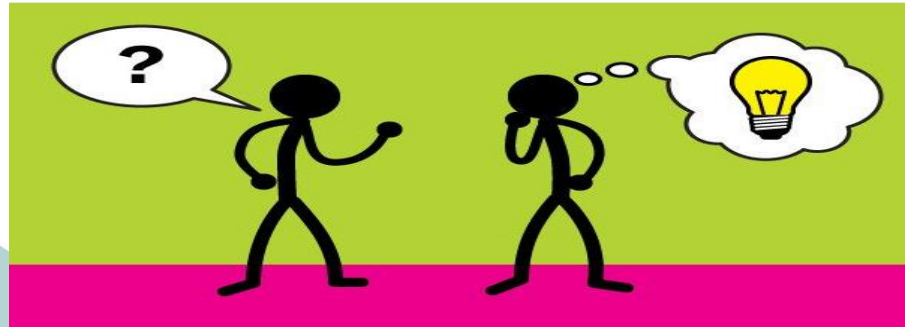


1. Goal: Treating Tobacco Use and Dependence: Standard of Care



Asking Patients

- Many times patients might be asked about tobacco use but depending on response ……
- If a patient declines to “quit” referrals, information , counseling is often provided but not billed or is not provided which misses a chance for both cessation and billing
- Holding all providers accountable for cessation efforts and related counseling-promotes “team care”, cessation and billing



Population Health

- If you don't know your population how will you know how to provide effective programming and interventions (adults vs. teens)
- What kind of products your patients are using
- Co-occurring disorders
- Quit or remission rates
- What interventions are effective

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Population of Tobacco Users

- How do you track your population ?
- Why is it important to know your population ?
- Are there other population/registry tools that you can add tobacco use on – such as your diabetes or HIV registries
- The importance of the “ Problem List”

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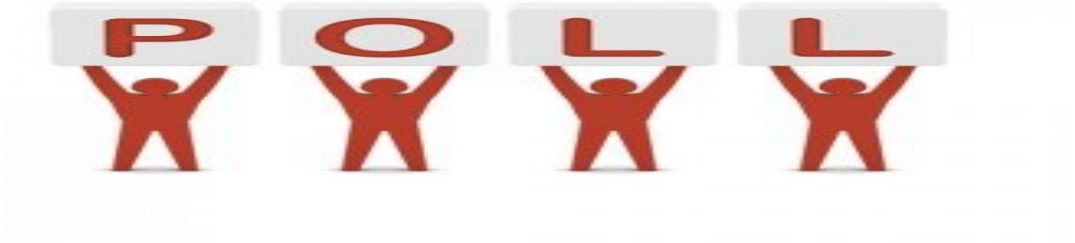
Poll Question #2

To your knowledge, is your site currently billing for Tobacco Cessation Services?

- ***Yes***
- ***No***
- ***Not Sure***



The Problem List

- Can help track population
- Consider who can add or resolve problems on the problem list
- How many of your patients use chewing tobacco ?
- How old are your patients who smoke ? What other chronic health conditions do they have ?
- Knowing your population helps you fund, staff and design your services

Definitions to Consider When Coding for Nicotine Dependence

REMISSION: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines early remission of nicotine dependence as at least 3 but less than 12 months without substance use (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). [1]

WITHDRAWAL: Daily use of nicotine for at least several weeks, AND an abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four or more of the following signs: (1) irritability, frustration, or anger; (2) anxiety; (3) difficulty concentrating; (4) restlessness; (5) decreased heart rate; (6) increased appetite or weight gain; (7) dysphoric or depressed mood; and (8) insomnia.[1]

NICOTINE-INDUCED DISORDER: An adverse health event that a provider documents as having a direct cause-and-effect relationship with the patient's nicotine use (e.g., chronic obstructive pulmonary disease, or COPD). Default to using "uncomplicated" codes unless there is a documented relationship between nicotine use and the disorder.

[1] American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Washington, DC.

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Coding

- Code for tracking and billing
- Optimize use of codes keeping in mind special populations such as prenatal
- Code to help track population

The ICD-10 Code Set For Nicotine Use Can be Grouped Into The Following Four Categories:

CLINICAL DOCUMENTATION MUST SUPPORT THE SERVICES PROVIDED AND SELECTED ICD-10 CODES.

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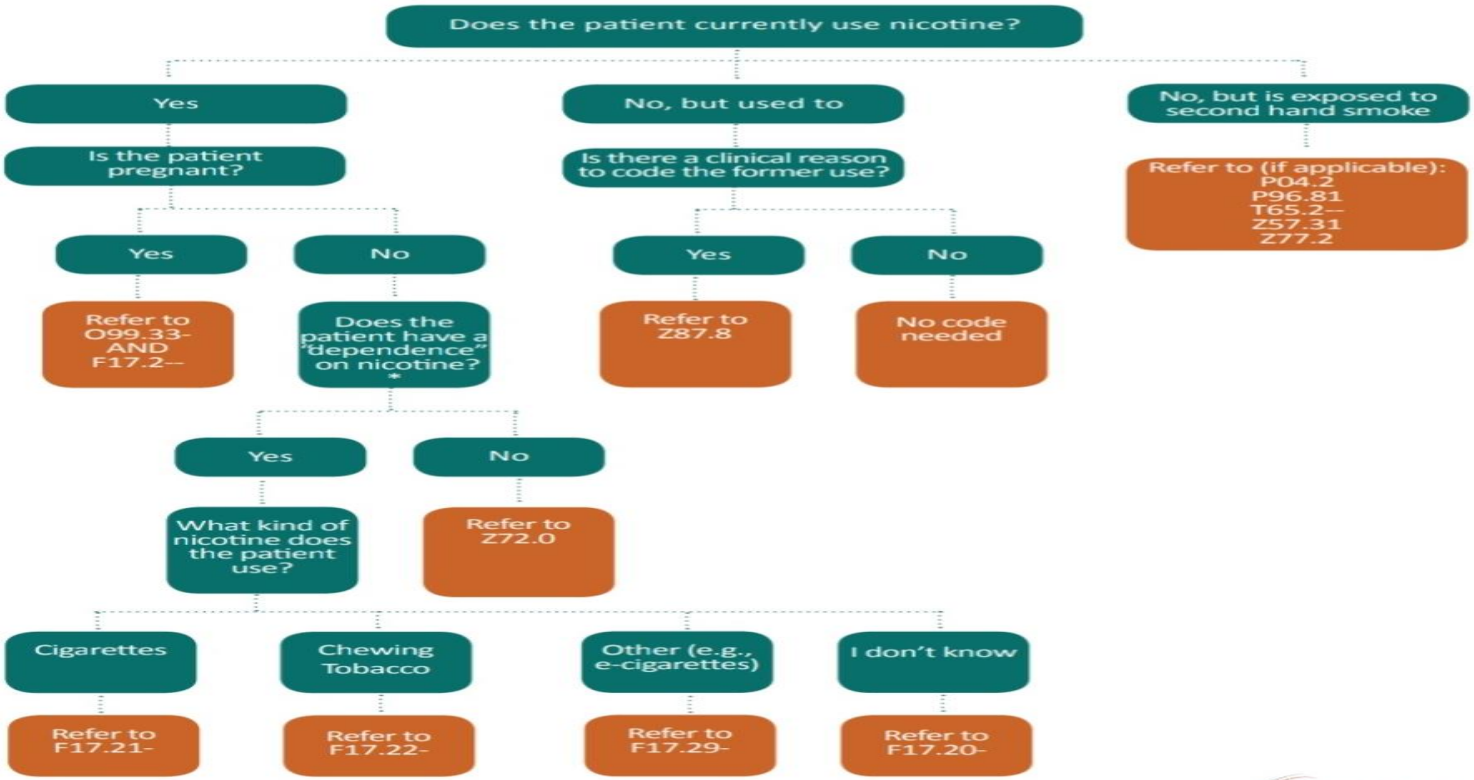
Coding at a Glance for Nicotine Use and Dependence



Documentation Tips:

- Clinicians are encouraged to include the type of nicotine product along with how often the patient uses that product, as well as any related complications. For instance, instead of documenting "current smoker" or "smokes 1PPD," it is recommended that the clinician document "Smokes 1 PPD cigarettes without complications" or "Smokes 1 PPD cigarettes with nicotine-induced COPD."

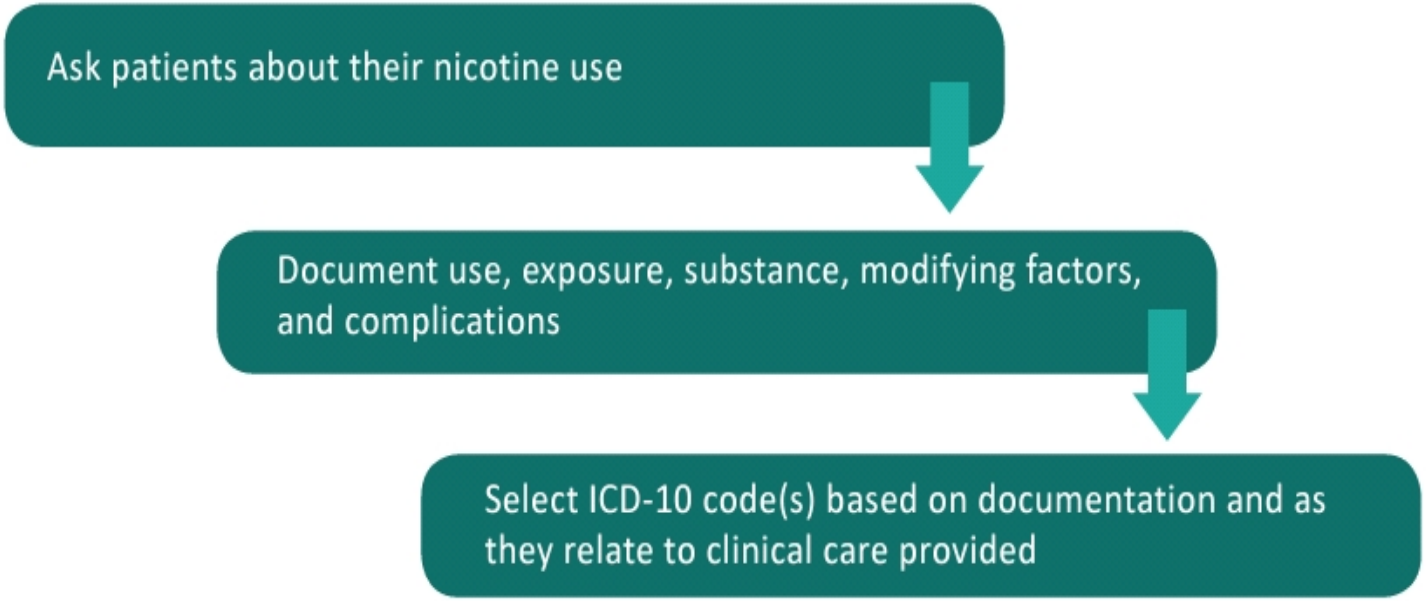
- Clinicians should document a cause-and-effect relationship between a patient's tobacco use and other disease processes in order for the coder to link the disease process to that patient's tobacco use.

- Example from AHA Coding Clinic, 4th Quarter 2013, page 109: Patient is a current cigarette smoker with a 20-year history of smoking who now presents with emphysema. The physician does not link the smoking to the emphysema in the medical record; therefore, it would not be appropriate for the coder to use F17.218, Nicotine dependence, cigarettes, with other nicotine-induced disorders.
  If the patient does not have nicotine-induced disorders and is not exhibiting signs of withdrawal or remission, the clinician should default to using one of the "uncomplicated" codes.

Documentation Tip:

Encourage specificity such as "Quit smoking cigarettes in 2014" or "Quit cigars at age 42," rather than "Quit Smoking" or "Does not currently use tobacco."

IN SUMMARY...



ICD-9 code 305.1

(tobacco use and dependence) transitioned to ICD-10 Codes to help track populations ……

- **F17.2** (nicotine dependence),
- **099.33** (smoking complicating pregnancy, childbirth, and the puerperium),
- **P04.2** (newborn affected by maternal use of tobacco),
- **P96.81** (exposure to environmental tobacco smoke in the perinatal period),
- **T65.2** (toxic effect of tobacco and nicotine),
- **Z57.31** (occupational exposure to environmental tobacco smoke),
- **Z71.6** (tobacco use counseling, not elsewhere classified),
- **Z72** (tobacco use not otherwise specified (NOS),
- **Z77.2** (contact with and exposure to environmental tobacco smoke), and § **Z87.8** (history of nicotine dependence).

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F17.22 Nicotine dependence, chewing tobacco

F17.220 Nicotine dependence, chewing tobacco, uncomplicated
F17.221 Nicotine dependence, chewing tobacco, in remission
F17.223 Nicotine dependence, chewing tobacco, with withdrawal
F17.228 Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders

F17.29 Nicotine dependence, other tobacco product

F17.290 Nicotine dependence, other tobacco product, uncomplicated
F17.291 Nicotine dependence, other tobacco product, in remission
F17.293 Nicotine dependence, other tobacco product, with withdrawal
F17.298 Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299 Nicotine dependence, other tobacco product, unspecified nicotine-induced disorders

F17.2 Nicotine dependence

F17.20 Nicotine dependence, unspecified

F17.200 Nicotine dependence, unspecified, uncomplicated
F17.201 Nicotine dependence, unspecified, in remission
F17.203 Nicotine dependence unspecified, with withdrawal
F17.208 Nicotine dependence, unspecified, with other nicotine-induced disorders
F17.209 Nicotine dependence, unspecified, with unspecified nicotine-induced disorders

F17.21 Nicotine dependence, cigarettes

F17.210 Nicotine dependence, cigarettes, uncomplicated
F17.211 Nicotine dependence, cigarettes, in remission
F17.213 Nicotine dependence, cigarettes, with withdrawal
F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

Transitioning from DSM 5 to ICD-10

- **DSM-5 Tobacco Use Disorder**

  305.1 (Mild, Moderate or Severe)

  – Early Remission (3-13 months)
  – Sustained Remission (12+ months)

- **ICD-10 Nicotine Codes**

  F17.21 Nicotine dependence,cigarettes

  – F17.210 Nicotine dependence, cigarettes, uncomplicated
  – F17.211 Nicotine dependence, cigarettes, in remission

Some tobacco related codes are medical diagnoses:

- 099.33 (smoking complicating pregnancy, childbirth, and the puerperium),
- P04.2 (newborn affected by maternal use of tobacco),
- P96.81 (exposure to environmental tobacco smoke, the perinatal period) &
- T65.2 (toxic effect of tobacco and nicotine).

These are not used by mental health clinicians.

History of (noncurrent) Nicotine Dependence (Z87.891)

- Z57.31 (occupational exposure to environmental tobacco smoke),
- Z71.6 (tobacco use counseling, not elsewhere classified),
- Z72 (tobacco use not otherwise specified (NOS), and
- Z77.2 (contact with and exposure to environmental tobacco smoke

Z Codes are not billable, they are used to provide additional information.

Quit Rates- How Will You Know?!?

- Dependence/use
- Remission (only after 3 months)
- Sustained remission (after a year)
- Looking at interventions and correlation to successful quit rates
- Z87.891 Personal history of nicotine dependence
  - **Excludes1:** Current nicotine dependence (F17.2)

CPT Coding for Smoking and Tobacco Cessation

Medicare Learning Network Published the following new CPT Codes on October 1, 2016:

- **99406** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407** - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

G Codes

The CMS has created two G codes for billing for tobacco cessation counseling services to prevent tobacco use for asymptomatic patients. These are in addition to the two CPT Codes 99406 and 99407

- **G0436**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than three minutes, up to 10 minutes

- **G0437**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

Documentation Requirements

To support the billing of the cessation codes the record might include the following:

- Establish patient's tobacco use
- Advised to quit and impact of smoking
- Assessed willingness to attempt to quit
- Providing methods and skills for cessation
- Medication management of smoking sessior
- Resources provided
- Setting quit date
- Follow-up arranged
- Amount of time spent counseling patient

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HCPCS Code: H0025
Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)

Medicare pays for some Level II codes, including A, G, J codes; Medicare does NOT pay for H (State mental health codes), S, or T codes. H codes are for Medicaid only. As of 2008, two new Medicare alcohol/drug assessment brief intervention "G" codes: G0396 and G0397.

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Health and Wellness Supports (Behavioral Health Prevention Education Service) (Delivery of Services with Target Population to Affect Knowledge, Attitude and/or Behavior)	Practitioner Level 3, In-Clinic	H0025	U3	U6			$ 30.01	Practitioner Level 3, Out-of-Clinic	H0025	U3	U7			$ 36.68
	Practitioner Level 4, In-Clinic	H0025	U4	U6			$ 20.30	Practitioner Level 4, Out-of-Clinic	H0025	U4	U7			$ 24.36
	Practitioner Level 5, In-Clinic	H0025	U5	U6			$ 15.13	Practitioner Level 5, Out-of-Clinic	H0025	U5	U7			$ 18.15

Health and Behavior Assessment Codes *(96150 - 96153)*

- The Social Security Act definition of CSWs is limited to the diagnosis and treatment of mental illnesses.
- Questions about HBAI codes often arise around smoking cessation and counseling efforts for non MD staff
- Psychologists can use these codes- 96153 for a cessation group as an example
- 15 minute increments, 96150 is first visit and 96151 are follow ups
- Does your RN do any of this work ?

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Preventative Counseling 99401

Health risk assessment (HRA) CPT® codes include:

- **99401** ***Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes***

- **99402** ***…approximately 30 minutes***
- **99403** ***…approximately 45 minutes***
- **99404** ***…approximately 60 minutes***

Prevention Code 99401

- Be careful when using with EM Codes- may be reduced payment
- Codes not used for behavioral health non prescribing providers

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99211

- 99213 to 99214 for added time and complexity
- 99211 often underutilized – RN role in cessation and education
- 1. Patient must be seen face-to-face by the nurse/assistant who may be an RN, LPN/LVN, MA or other employed assistant.
- 2. The patient must be an established patient. The problem must be an established problem Ground rules for assigning 99211:
- 3. The problem must be an established problem with a treatment plan.
- 4. The service must be ordered by the clinician.
- 5. A supervising clinician must be in the office at time of service (good to follow “incident too” guidelines

99211 Requirements

- The service must be medically necessary.
- The service must be provided within the performer's "scope of practice" and in accordance with state laws.
- Nursing documentation should reflect:
- The order
- The reason for the service (diagnosis)
- Nursing assessment as indicated
- Nursing action as indicated
- Patient instructions
- Follow-up
- Nurse's legible SIGNATURE and credentials

Medicare Part B Covers:

- 2 smoking cessation counseling attempts each year
- Each attempt includes up to 4 face-to-face sessions with provider (total of up to eight sessions)
- No deductible or coinsurance)
- Medicare Advantage Plans also required to cover this counseling as well with no co-payments.

OTC treatments for smoking cessation, such as nicotine patches and gum, are not covered by Medicare and are excluded by law from Part D coverage.

Smoking Cessation Classes- Commercial Plans

- S codes are temporary codes
- HCPCS code S9453
- Check with your commercial providers
- Non – physician only
- Per member

Check Payer Sites/ Guidance

- This policy describes Optum's requirements for the reimbursement and documentation of "smoking and tobacco use cessation counseling visit" – CPT codes 99406 and 99407, and HCPCS procedure codes G0436 and G0437. The purpose of this policy is to ensure that Optum reimburses for services that are billed and documented, without reimbursing for billing submission or data entry errors or for non-documented services. Reimbursement Guidelines Optum will align reimbursement with Medicare including 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with a total of up to 8 face-to-face sessions during a 12-month period for individuals who use tobacco – regardless of whether there are signs or symptoms of tobacco-related disease. These sessions must be provided by a qualified health care provider.
- WWW.myoptumhealthphysicalhealth.com

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Map of Regional Contractors

North Central Region
- Central New York Regional Center for Tobacco Health Systems
- St. Joseph's Hospital

North Country Region
- Living Tobacco-Free
- Glens Falls Hospital

Western Region
- Health System for a Tobacco-Free Western New York
- Health Research Inc., Roswell Park Cancer Institute

Capital Region
- Seton Health/ St. Peter's Health Partners

Finger Lakes Region
- Health System for a Tobacco-Free Finger Lakes
- University of Rochester

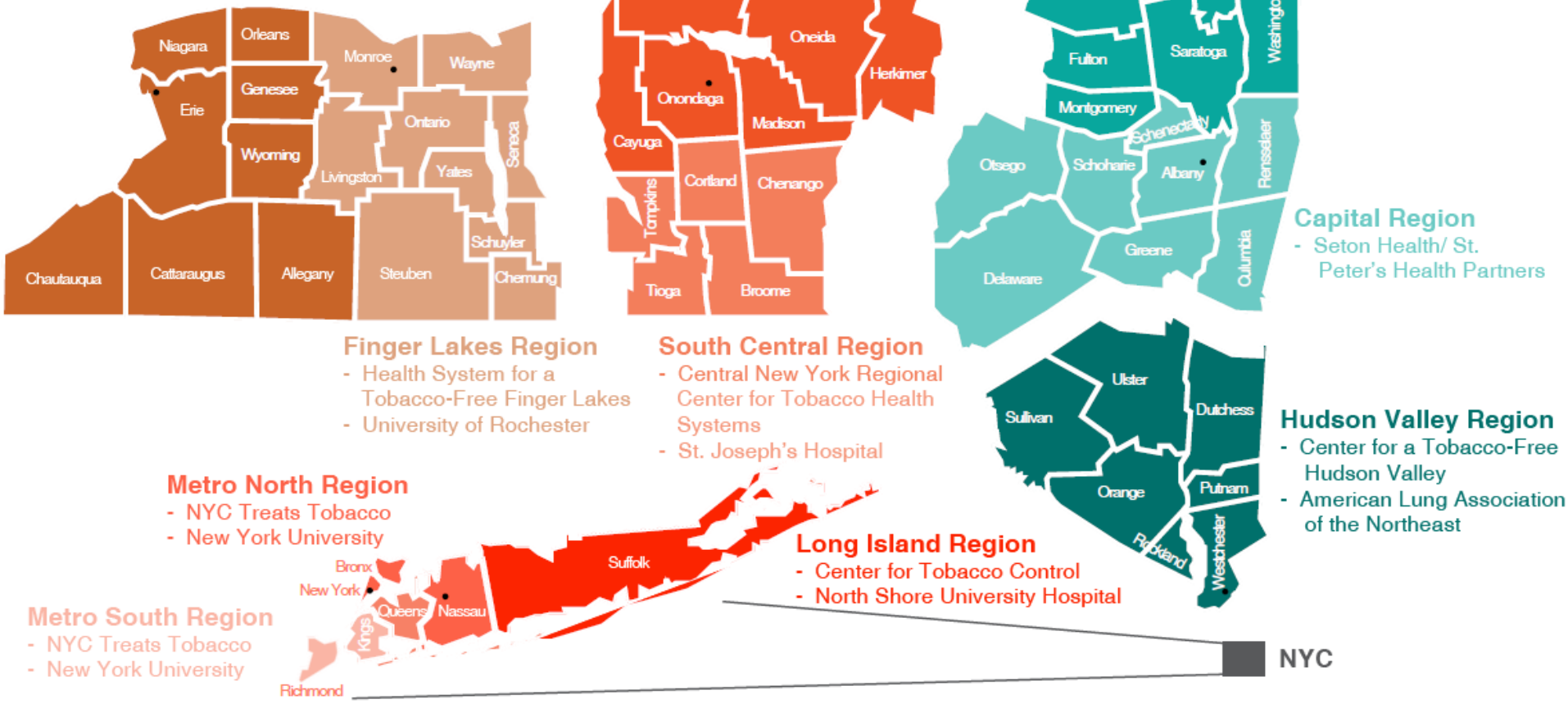
South Central Region
- Central New York Regional Center for Tobacco Health Systems
- St. Joseph's Hospital

Hudson Valley Region
- Center for a Tobacco-Free Hudson Valley
- American Lung Association of the Northeast

Metro North Region
- NYC Treats Tobacco
- New York University

Long Island Region
- Center for Tobacco Control
- North Shore University Hospital

Metro South Region
- NYC Treats Tobacco
- New York University



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Center for a Tobacco-Free Finger Lakes	Scott McIntosh, PhD	Director	585-275-0511	Scott_McIntosh@URMC.Rochester.edu
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Metro South: Counties Served: Kings and Richmond (Staten Island)	TBD	Project Coordinator		
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Q&A Session

Questions/Thoughts

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Resources

- Centers for Medicare and Medicaid Services
- ChiroCode DeskBook, 24th edition, 2016. ChiroCode Institute: www.ChiroCode.com
- Glynn TJ, Hatsukami DK (Co-chairs). Reimbursement for smoking cessation therapy: a health practitioner's guide, 3rd edition (2002). PACT (Professional Assisted Cessation Therapy); accessed 1.13.16: https://www2.aap.org/richmondcenter/pdfs/PACTReimbursementforSmokingCessation.pdf
- McRobbie H, Bullen C, Glover M, et al. New Zealand smoking cessation guidelines. New Zealand Medical Journal 2008;121:57–70. http://www.nzma.org.nz/journal/121-1276/3117/
- MLN (Medicare Learning Network). Tobacco-use cessation counseling services. Dept. of Health and Human Services – Centers for Medicare & Medicaid Services, February 2012; ICN 006767

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Resources

- MLN (Medicare Learning Network). Preventive Services: Intensive Behavioral Therapy for Obesity. Dept. of Health and Human Services Centers for Medicare & Medicaid, ICN 006559 October 2015;
- https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf
- NYS Dept. of Health. Practice transformation for smoking cessation counseling V3. NYS Dept. of Health Tobacco Control Program; Accessed 6.11.13: http://www.nysmokefree.com/download/MedicaidMedicareHighlights.pdf
- Office on Smoking and Health. Smoking & tobacco use: youth and young adult data fact sheets. Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/
- Phurrough S, Salive M, Larson W, et al. Coverage decision memorandum for smoking and tobacco use cessation counseling. Centers for Medicare & Medicaid Services, March 22, 2005; Administrative File: CAG 00241N

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Please fill out our brief evaluation form. Your feedback will be utilized in the development of future webinars!

Thank you!