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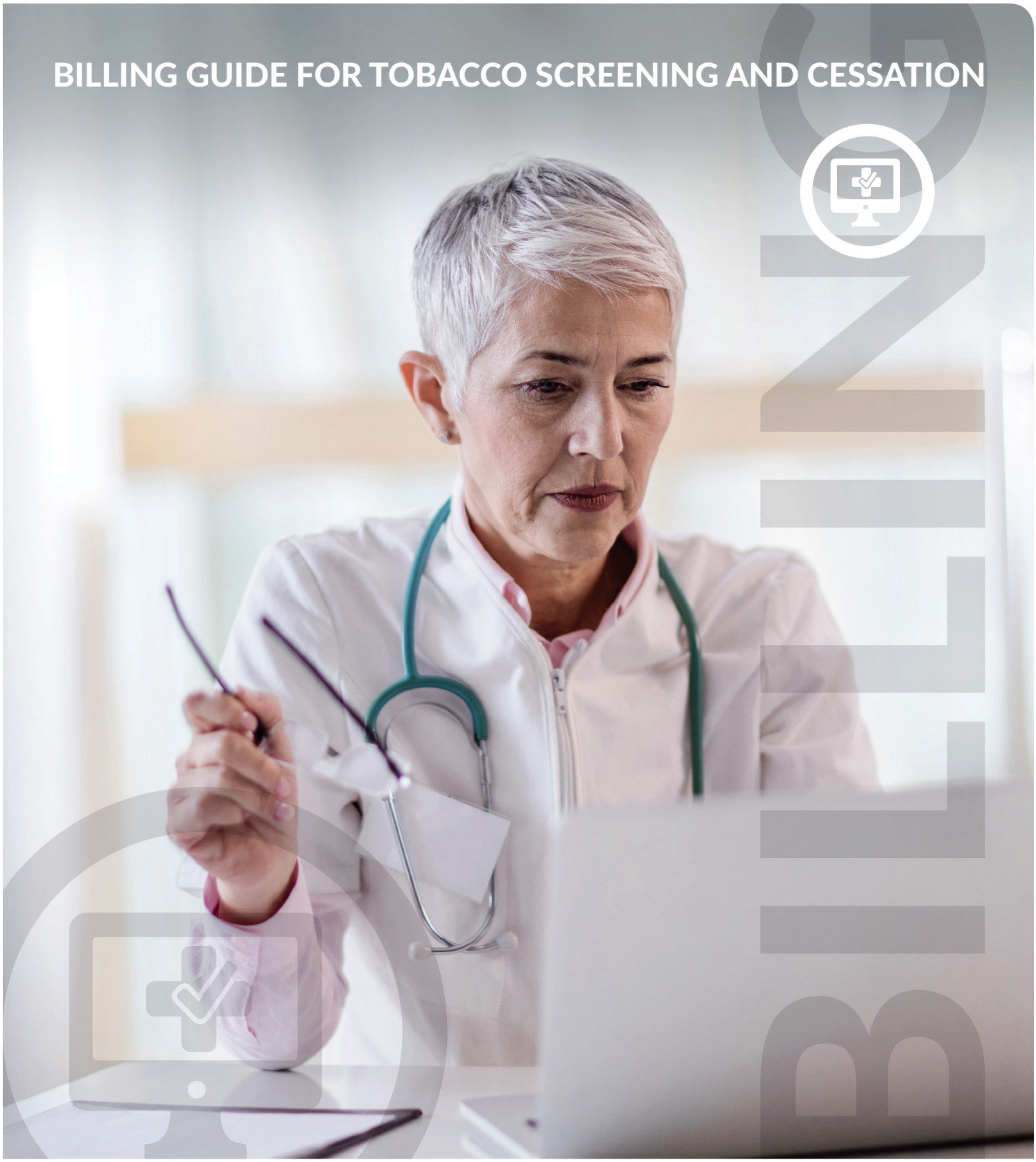
BILLING GUIDE FOR TOBACCO SCREENING AND CESSATION



BILLING GUIDE FOR TOBACCO SCREENING AND CESSATION

Tobacco use status is now embedded in most of the major electronic health records and evidence-based tobacco cessation counseling and pharmacotherapy covered by Medicare, Medicaid and most private health plans. Despite improved documentation and coverage, **few providers bill for cessation services**.

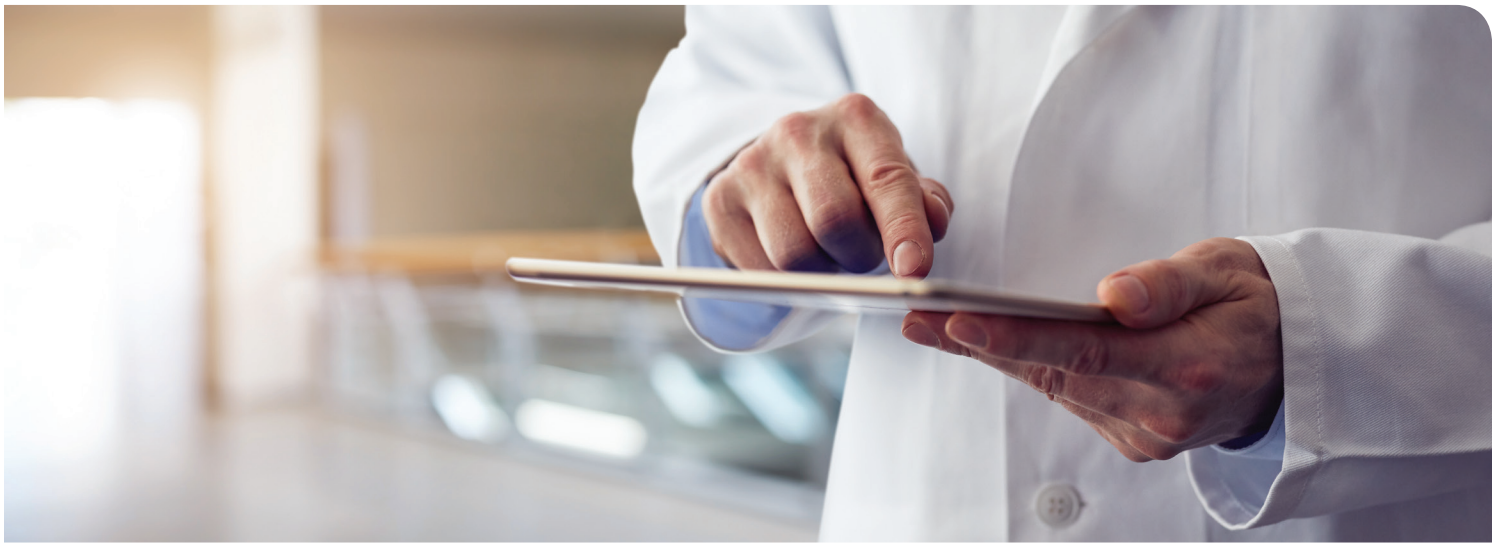
To help stakeholders ensure both the provision of cessation services and payment for those services, this document gives an overview of tobacco cessation coverage requirements for Medicare, Medicaid and private insurance. While coverage is a critical component, payment for these services requires using the proper service and diagnosis codes. This document also provides guidance on how to code for both diagnoses and services related to tobacco.

The document is structured as follows:

I. Coverage requirements
   A. Medicaid
   B. Medicare
   C. Private Insurance
II. Coding and documentation requirements
   A. Diagnosis codes
   B. Procedure codes
   C. Documentation
III. Reasons for claims denials
IV. Resources

The information is intended for use by different stakeholders, including:

- State and local public health professionals working to increase delivery of tobacco cessation by health care providers
- Health systems and providers who are currently offering cessation services and would like to be compensated for them
- Health systems and providers who have chosen not to provide cessation services in the past due to lack of compensation



I. Coverage Requirements

Medicaid Requirements

The Affordable Care Act (ACA) expanded tobacco cessation coverage for the Medicaid population, but gives states the ability to distinguish between the standard Medicaid and Medicaid expansion populations in terms of cessation coverage.

Standard Medicaid

- Medicaid Pregnant Women: All FDA-approved tobacco cessation medications as well as individual, group, and phone counseling.
    - No cost-sharing is permitted for pregnant women.
- Adults: All FDA-approved tobacco cessation medications. There is no counseling requirement.
    - Cost-sharing is permitted.
- Adolescents and Children: Coverage of counseling and tobacco cessation medications is mandatory under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Medicaid Expansion

- Coverage of counseling and tobacco cessation medications are required as part of the ACA's Essential Health Benefit under preventive and wellness services.
    - If a Medicaid expansion state chooses not to provide counseling to its standard Medicaid population, the expansion population will have better cessation benefits.
    - No cost sharing is permitted.

Managed Care and Fee for Service

- Medicaid managed care organizations (MCOs) are required to provide at least a comparable level of benefits to the fee-for-service option (77 percent of state Medicaid recipients are currently served by Medicaid MCOs).
    - Most states with Medicaid MCOs use a risk adjustment methodology (See Documentation below).
- The same distinctions with respect to coverage and cost sharing may apply between standard Medicaid recipients being served by an MCO versus expansion Medicaid recipients.

Medicare Requirements

Medicare Part B (provider component) covers two levels of tobacco cessation counseling for symptomatic and asymptomatic patients: intermediate (great than 3 minutes but no more than 10 minutes) and intensive (greater than 10 minutes).

- Two cessation attempts are covered per 12-month period. Each attempt may include a maximum of four intermediate or intensive counseling sessions, for a total of eight counseling sessions in the year.
- The patient may receive another eight counseling sessions during a second or subsequent year once 11 full months have passed since the first Medicare-covered cessation counseling session took place.

To qualify for Medicare payment, the following criteria must be met at the time of service:

- Patients must be competent and alert at the time of the counseling is provided.
- Counseling must be provided by an MD or other Medicare-recognized health care professional.

Symptomatic Patients

Symptomatic patients are those who use tobacco and:

- Have been diagnosed with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use; or
- Take a therapeutic agent for which the metabolism or dosing is affected by tobacco use, based on information approved by the U.S. Food and Drug Administration (FDA)
- Both co-insurance and deductible apply.

Asymptomatic Patients

Asymptomatic patients are those who use tobacco but do not have symptoms of tobacco-related disease. Both coinsurance and deductible are waived.

Private Insurance Requirements

The Patient Protection and Affordable Care Act (ACA) requires most private health insurance plans to cover many clinical preventive services (www.healthcare.gov). Two of the covered preventive services include:

- 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. The USPSTF states:

- The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco and provide behavioral interventions and U.S. Food and Drug Administration (FDA) – approved pharmacotherapy for cessation to adults who use tobacco. – This is an "A" Recommendation

The U.S. Departments of Health and Human Services, Labor, and Treasury issued a sub-regulatory guidance in May 2014, which further clarified that health plans should cover screening for tobacco use and at least two quit attempts per year for tobacco users. According to the guidance:

- Each quit attempt should include covering, without cost-sharing or prior authorization, of: 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 care provider[1].

[1]https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

Private Insurance Performance

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) annually fields a Request for Information called eValue™. It is an in-depth assessment of health plan performance on critical processes that ensure patient safety, identify and close gaps in care, control costs, reduce and eliminate waste, and improve health and health care[2]. In 2015, the Centers for Disease Control Office of Smoking and Health (CDC) worked with the National Alliance to update the tobacco questions. Plans responded in 2016 and analysis was completed in 2017. High level findings relevant to billing include:

- Benefit coverage for tobacco cessation by health plans continues to improve, with particularly strong coverage for pharmaceuticals.
- Plans do not appear to differentiate between their insured and self-insured groups – as such, coverage is typically consistent across the health plan.
- Guideline-consistent in-person or telephonic counseling coverage is frequently offered; gaps in group counseling are the most prevalent.

In general, with improved coverage, providers are encouraged to submit claims for tobacco cessation services provided to patients. However, benefits are subject to specific plan policies. **Patients and providers should check with individual Medicaid, MCO and private insurance plans to determine what specific treatments are included and the extent to which these treatments are covered.**

What is Covered?

Patients and providers should check with individual Medicaid, MCO and private insurance plans to determine what specific treatments are included and the extent to which these treatments are covered. Questions to ask payers would include:

1. Are both individual and group counseling covered?
2. Are there limits on the number of counseling sessions (either individual or group)?
3. Are there any restrictions on what provider types may bill for counseling? (MD, NP, PA, etc.)
4. Are there specific notes that must be included in documentation for counseling?
5. Is there coverage for nicotine replacement therapy (patch, gum, inhaler)? Can it be over the counter or must it be prescription to be covered?
6. Is there coverage for bupropion? Is there coverage for varenicline?
7. Are there any prior authorization or step therapy requirements?
8. How many fills are allowed per patient per year?
9. What should my patient expect in terms of cost sharing?

[2]http://evalue8.nationalalliancehealth.org/

II. Coding and Documentation Requirements

There are two major coding categories that all payers require – codes that indicate a diagnosis and codes that indicate what services were provided.

Diagnosis Codes

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
ICD-10 codes are used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures in U.S. health care settings on claims for services provided. These codes are used by payers to determine coverage, not the amount that will be paid. Separately, payers have schedules which match the codes to the specific provider's negotiated rate.

International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)
ICD-10-PCS codes are used only for procedures performed in an inpatient setting, on or after October 1, 2015.

Procedure and Service Codes

Current Procedural Terminology (CPT)
CPT is a medical code set maintained by the American Medical Association (AMA). It provides a uniform mechanism for describing services and procedures among providers, payers, and patients, as well as coders and analytical entities. For this document, CPT establishes what services or procedures have been provided and the basis for payment by payers.
CPT codes are divided into three categories:

1. Category I: Procedures that are consistent with contemporary medical practice and are widely performed. Within this category there are six main sections:
    a. Evaluation and Management
    b. Anesthesia
    c. Surgery
    d. Radiology
    e. Pathology and Laboratory
    f. Medicine
2. Category II: Supplementary tracking codes that can be used for performance measures. They do not have any financial value, so they have a billable charge of $0.00.
3. Category III: Temporary codes for emerging technology, services, and procedures.

Healthcare Common Procedure Coding System (HCPCS)

Similar to the CPT code set, HCPCS is a standardized coding set used by the Centers for Medicare and Medicaid Services, as well as other payers. Like CPT, it includes three levels or categories of codes:

1. Level I: This matches the AMA's CPT numeric codes.
2. Level II: These are alphanumeric and include items not covered by CPT-4 codes, including non-physician services such as ambulance, prosthetic devices, items and supplies.
3. Level III: These are local codes used by Medicaid, Medicare and private payers in specific programs or geographic localities. They typically start with an X or Z but are not widely accepted.

Diagnosis Coding Guide

The first decision a provider must make when diagnosing for tobacco use is whether to use an ICD-10 F17 code or a Z code. The F codes are from the Mental and Behavioral Disorder category. The F17 codes are used if the patient is dependent on tobacco. The Z codes are used if there is NOT dependence on tobacco. The Z codes cannot be combined with an F17 code.

The codes specific to maternal and newborn health (O99) and the toxic effects of tobacco (T65) are used by medical providers to reflect the biological impact of tobacco use.

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
F17 Codes	*Indicates codes which can be used for Medicare's Asymptomatic patients (as well as Symptomatic)
F17.200*	Product unspecified, uncomplicated
F17.201*	Product unspecified, in remission
F17.203	Product unspecified, with withdrawal
F17.208	Product unspecified, with other nicotine-induced disorders
F17.209	Product unspecified, with unspecified nicotine-induced disorders
F17.210*	Cigarettes, uncomplicated
F17.211*	Cigarettes, in remission
F17.213	Cigarettes, with withdrawal
F17.218	Cigarettes, with other nicotine-induced disorders
F17.219	Cigarettes, with unspecified nicotine-induced disorders
F17.220*	Chewing tobacco, uncomplicated
F17.221*	Chewing tobacco, in remission
F17.223	Chewing tobacco, with withdrawal
F17.228	Chewing tobacco, with other nicotine-induced disorders
F17.229	Chewing tobacco, with unspecified nicotine-induced disorders
F17.290*	Other tobacco product, uncomplicated
F17.291*	Other tobacco product, in remission
F17.293	Other tobacco product, with withdrawal
F17.298	Other tobacco product, with other nicotine-induced disorders
F17.299	Other tobacco product, with unspecified nicotine-induced disorders

Diagnosis Coding Guide

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
Z Codes	
Z57.31	Occupational exposure to environmental tobacco smoke • May not be used with Z77.22 exposure to environmental smoke.
Z77.22	Contact with and suspected exposure to environmental smoke • May not be used with a F17.2 tobacco dependence or Z72 tobacco use code.
Z71.6	Counseling and Medical Advice – tobacco abuse counseling
Z72.0	Problems Related to Lifestyle and tobacco use not otherwise specified
Z87.891	Personal history of nicotine dependence • May not be used with F17.2 current nicotine dependence code.
Z13.89	Encounter for screening for other disorder. Use for tobacco use screening.
Maternal Tobacco Use and Newborn Exposure • For maternal use add an additional F17 code to indicate type of tobacco	
O99.330	Smoking (tobacco) complicating pregnancy, unspecified trimester
O99.331	Smoking (tobacco) complicating pregnancy, first trimester
O99.332	Smoking (tobacco) complicating pregnancy, second trimester
O99.333	Smoking (tobacco) complicating pregnancy, third trimester
O99.334	Smoking (tobacco) complicating childbirth
O99.335	Smoking (tobacco) complicating the puerperium
P04.2	Newborn suspected to be affected by exposure in utero to tobacco smoke May not be used with P96.81 newborn exposure to environmental tobacco smoke.
P96.81	Exposure to (parental) (environmental) tobacco smoke in the perinatal period.

Diagnosis Coding Guide

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
Toxic Effect of Tobacco and Nicotine • May not be used with F17.2 nicotine dependence	
T65.211	Toxic effect of chewing tobacco, accidental (unintentional) or not otherwise specified (NOS)
T65.212	Toxic effect of chewing tobacco, intentional self-harm
T65.213	Toxic effect of chewing tobacco, assault
T65.214	Toxic effect of chewing tobacco, undetermined
T65.221	Toxic effect of tobacco cigarettes, accidental (unintentional) or NOS • Add Z57.31 or Z77.22 exposure to second hand tobacco smoke
T65.222	Toxic effect of tobacco cigarettes, intentional self-harm • Add Z57.31 or Z77.22 exposure to second hand tobacco smoke
T65.223	Toxic effect of tobacco cigarettes, assault • Add Z57.31 or Z77.22 exposure to second hand tobacco smoke
T65.224	Toxic effect of tobacco cigarettes, undetermined • Add Z57.31 or Z77.22 exposure to second hand tobacco smoke
T65.291	Toxic effect of other tobacco and nicotine, accidental (unintentional) or NOS
T65.292	Toxic effect of other tobacco and nicotine, intentional self-harm
T65.293	Toxic effect of other tobacco and nicotine, assault
T65.294	Toxic effect of other tobacco and nicotine, undetermined

Diagnosis Coding Guide

ICD-10 Diagnosis Code	Description: All with Nicotine Dependence
CPT Category II Codes Associated with Quality Payment Programs	
1000F	Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
1031F	Smoking status and exposure to second hand smoke in the home assessed (Asthma)
1032F	Current tobacco smoker and currently exposed to second hand smoke (Asthma)
1033F	Current tobacco non-smoker and not currently exposed to second hand smoke (Asthma)
1034F	Current tobacco smoker (CAD, CAP, COPD, PV) (DM)
1035F	Current smokeless tobacco user (e.g. chew) (PV)
1036F	Current tobacco non-user (CAD, CAP, COPD, PV) (DM) (IBD)
4000F	Tobacco use cessation intervention, counseling (COPD, CAP, CAD, Asthma) (DM) (PV)
4001F	Tobacco use cessation intervention, pharmacologic therapy (COPD, CAP, CAD, PV, Asthma) (DM) (PV)
4004F	Patient screened for tobacco use and received cessation intervention (counseling and/or pharmacotherapy), if identified as a tobacco user (PV, CAD)

Procedure and Service Code Guide

A fundamental decision that influences how a provider codes is whether the tobacco services constitute counseling that merits a separate code or will be included in a time-based Evaluation and Management (E/M) service code (a typical doctor's visit).

Examples of evaluation requirements for tobacco include evaluation of variables such as severity of dependence, co-morbidities and prior cessation attempts. Examples of management decisions in tobacco include medication and are typically based on evaluation information. Examples of counseling, or behavior change modifications, related to tobacco include advising specific changes to behavioral routines, arranging for services and follow-up, or addressing barriers to change. Counseling that lasts less than three minutes is considered part of the standard E/M service. When counseling time exceeds 50 percent of the total time dedicated to the visit, the level of E/M service may be calculated using established time parameters. If the provider uses an E/M code that is based on time-based billing, tobacco cessation counseling codes 99406-08 may not be added since time-based billing encompasses the likelihood of counseling.

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Medicare and Medicaid consider tobacco cessation counseling reasonable and necessary. If counseling is provided as a portion of or adjunct to the primary purpose of the visit, a provider may consider using counseling codes in addition to the E/M code for the primary purpose of the visit. Private payers are not as consistent in their support for counseling services but since coverage for counseling has improved, so has payment for counseling services.

HCPCS/CPT Codes	Type of Service	Description
99406	Intermediate counseling cessation treatment	Smoking and tobacco use cessation counseling visit greater than three minutes, but not more than 10 minutes.
99407	Intensive counseling	Smoking and tobacco use cessation counseling visit is greater than 10 minutes.
99078	Provider educational services (group counseling)	Group counseling for patients with symptoms or established illness.
S9075	Smoking cessation treatment	Non-physician provider. S codes are temporary national codes, and these are **no longer available for use.**
S9453	Smoking cessation classes	
G0436	Tobacco cessation counseling	
G0437	Tobacco cessation counseling	**As of September 30, 2016, no longer available for use.**
99381-99397	Preventive medicine services	Comprehensive, preventive evaluation based on age and gender to include appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and related plan of care.
-25 modifier		Append to the appropriate CPT-code for services provided during the same day or visit as different, separately identifiable Evaluation & Management (E/M) services (e.g. 99406-25).
99241-99245	Outpatient consultation E/M	Time-based E/M, Levels 1 – 5 based on minutes, which can include tobacco E/M.
99201-99205	New patient E/M	
99211-99215	Established patient E/M	

Documentation

Regardless of the payer (e.g. Medicare, Medicaid, private), providers need to use ICD-10 codes and provide documentation regarding medical necessity and the specifics of what was provided. The goal is to clearly establish medical necessity and ensure payment for services. **Coding is not sufficient**. Medicare and other payers find improper payments by selecting a sample of claims or flagging suspicious claims and requesting medical documentation from the provider. The claim is reviewed against the provider's medical documentation – either an electronic medical record or paper record. As such, the following items should be documented in the medical record:

- Patient's willingness to attempt to quit
- What was discussed during counseling
- Amount of time spent counseling
- Tobacco use
- Advice to quit and impact of smoking provided to patient
- Methods and skills suggested to support cessation
- Medication management
- Setting a quit date with the patient
- Follow-up arranged
- Resources made available to the patient

Documentation Tips

- The F17 codes are used if the patient is dependent on tobacco. The Z codes are used if there is NOT dependence on tobacco. The Z codes cannot be combined with an F17 code.
- Using the term "history of" or "personal history of" means a past medical condition that no longer exists. If used for a current condition, payment will be denied.
    - History of may be an appropriate reason to use the Z code.
- Documentation must include a treatment plan for each diagnosis (e.g. refer to oncologist) and an assessment, such as "stable," "worsening," "not responding to treatment."
- Use linking terms to connect the diagnoses and manifestations, such as "due to" or "secondary to."
- Behavioral health providers are qualified to use behavioral or mental health diagnoses such as F17.200 as the primary rationale for their services. Medical providers may not and so must select a diagnosis code that accurately reflects the biological impact of tobacco use such as one of the T65.2 options.
- Be sure to document "counseling" activities (advising about specific changes to routines, arranging for services or follow up) and not just "evaluation" (determining severity of dependence, comorbidities and prior cessation attempts) and management (medication selection based on evaluation) if you are billing for a counseling code vs. an E/M code.

Tobacco Use as a Risk Adjustment Factor

In addition to the opportunity to be compensated for providing cessation services, it is important to document tobacco use because of its potential role in adjusting payment rates based on the risk profile of the individuals being served. While risk adjustment focuses on high-cost conditions, many of these are exacerbated by tobacco use. With the movement to value-based care and risk-based contracting, the emphasis on diagnostic specificity will continue to grow in importance.

- Medicare adjusts capitation payments to private health care plans for the health expenditures of their enrollees. The adjustment is based on baseline demographic elements, with incremental increases based on diagnoses submitted on claims. Medicare requires that anything documented in the claim be substantiated in the medical record.
- States may also use risk adjustment with their Medicaid MCOs. Unlike Medicare, most Medicaid risk adjustment methodologies do not require medical record substantiation.
- ACA Exchanges also risk adjust, using conditions targeted to a younger demographic (pregnancy) and congenital abnormalities. The federal government manages this program using a complex methodology in which it transfers sequestered risk adjustment payments from lower risk plans to higher risk plans. Risk adjustment is calculated on a state basis to ensure state-based budget neutrality.

III. Claims Denials

Despite improved coverage of evidence-based tobacco cessation counseling and pharmacotherapy to all adults and pregnant women, it appears that very few providers bill for these services. Reasons for not billing may include:

- Many providers are unaware of the increased levels of coverage for tobacco cessation services.
- Providers or their billing staff do not have a depth of knowledge regarding the proper diagnostic codes and billing codes to ensure payment.
- Historic lack of coverage has prevented providers from incorporating tobacco cessation billing into their standard processes.
- Inconsistencies between health plans in how they interpret coverage and the degree of medical management required by different plans makes providers reluctant to do anything more than screen for tobacco use.
- Payers' billing systems may not be in sync with payers' benefit descriptions causing claims to be rejected despite coverage.

The guidance provided in previous sections of this document are intended to address provider lack of awareness and knowledge. However, payer and health plan issues may remain an obstacle.

With the limited experience many providers have billing for tobacco cessation, assume that some of the initial claims will be denied. Denials will typically fall into two primary categories:

1. Unavoidable reasons for denied payment
2. Avoidable reasons for denied payment

Unavoidable reasons are frequent in provider interactions with payers and are not specific to tobacco. They may include:

- Patient exceeded his/her annual limits on coverage for cessation services (e.g. too many quit attempts)
- Patient is no longer a member of the health plan
- Duplication of service providers so that more than one provider is submitting claims for the same service

A provider should address these unavoidable denials for tobacco in the same manner as this kind of denial for any service. Most practice management or electronic health records have a mechanism for confirming member eligibility and benefit coverage – which is a way to avoid these denials in the first place.

Avoidable reasons for denied payment are the claims that should be followed up on – either internally in the provider's billing office or with the health plan. Reasons include:

- Improper coding or insufficient documentation
- Payer error or disputes regarding coverage levels

Improper coding may reflect lack of experience or failure to comply with a specific health plan's requirement. These can be rectified and resubmitted but will require either responding to the denial reasons provided by the payer or contacting the payer to clarify requirements.

If a claim is denied because the payer indicates the tobacco cessation service is not covered, but the provider has reason to believe it is, then follow up is absolutely warranted. Based on experience in some states and in the published literature[3], it is possible that the payer's claims adjudication systems are not in sync with benefit coverage language. This may also be true with Medicaid MCOs.

If in fact the payer is not covering cessation benefits, the provider is unlikely to have sufficient leverage with the payer to impact benefit design. If state or local health departments or professional clinical societies are also working on this issue, then multiple entities working collectively will have more likelihood of engaging in a constructive discussion with the health plan regarding coverage of cessation. The state insurance regulator is also a potential source of assistance in clarifying required coverage.

IV. Recommended Resources

- Integrating Tobacco Use Treatment into Practice – Billing and Documentation. Frank Leone, et. al. Chest, 149, #2, pages 568-575, February 2016.
    - This article provides a series of case-based scenarios illustrating nuances with respect to managing and coding for tobacco dependence treatment.
    - Note that the codes referenced are not entirely up to date but the guidance with respect to the case-based scenarios is helpful.

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[3]https://www.tobaccofreekids.org/assets/content/pressoffice/2012/georgetown/coveragereport.pdf

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For more information, please visit **Lung.org/cessationta**.

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