Quick Guide for Tobacco Treatment Billing

For Behavioral Health Programs in Maine

As with other disorders recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), tobacco use disorder can, with some exceptions, be treated in the behavioral-health setting as a billable service. Use of the appropriate diagnostic and billing codes and appropriate documentation are essential for successful billing.

1. Situations not requiring separate billing for tobacco treatment:

a. Assessing and addressing tobacco use during a session which is otherwise devoted to treatment of a co-occurring behavioral health disorder (such as anxiety, alcohol use disorder, etc.) does not require separate billing for tobacco treatment if

a) The clinician or client raise and discuss the topic of tobacco use in relation to its impact on the primary behavioral health disorder. This can be subsumed as part of the primary disorder, under that disorder's billing code. This billing code can be used even if the majority of the session is devoted to tobacco, as long as the progress note makes reference to the co-occurring disorder. All relevant diagnosis codes should be documented.

b) Tobacco counseling lasts less than three minutes; it is considered part of the standard Evaluation and Management (E/M) service.

c) The tobacco counseling takes place in a setting where services are bundled, such as some Intensive Outpatient Programs (IOP) which may bill per diem or hospitals where prices are set by Medical Severity Diagnosis Related Grouping (MS-DRG). Check program contracts.

2. Billing for tobacco treatment:

a. When the focus moves exclusively to treatment of tobacco use disorder, a tobacco diagnosis code and tobacco billing code should be used. Note however that a psychotherapy billing code and a tobacco treatment billing code **cannot be submitted for the patient on the same day**. Doing so will result in a Correct Coding Initiative (CCI) editing error (1)

b. Some commonly used ICD-10 diagnosis codes, given your patient's or client's situation, may include:

Tobacco Diagnosis Codes (2)

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 (includes ENDS products)	
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

c. The following tobacco treatment billing codes can be used in conjunction with the above-listed diagnosis codes:

Tobacco Billing Codes

Billing Codes	Treatment Length	Tobacco Cessation Treatment Services
99406	3-10 minutes	Smoking and Tobacco Cessation Counseling; individual, intermediate
99407	Greater than 10 minutes	Smoking and Tobacco Cessation Counseling; individual, intensive
99411	30 minutes	Preventive Medicine, Group Counseling (Tobacco Cessation Group Counseling)
99412	60 minutes	Preventive Medicine, Group Counseling (Tobacco Cessation Group Counseling)

Documentation

In all cases, documentation is important, including the following elements:

- The patient's diagnosis that indicates the need for treatment such as tobacco use disorder, with descriptors. The extent of patient's use: type of tobacco used, how much/often, and motivation. A brief description of the therapy provided; proposed quit date or other goal, and additional referral or medications that were suggested (or prescribed). When billing under a co-occurring psychotherapy code, the link between tobacco use disorder and the co-occurring disorder should be stated.

Who can bill for tobacco treatment with tobacco billing codes?

MaineCare (Maine's Medicaid Program) (3):

Licensed Alcohol and Drug Counselors *(LADC)* ***Certified Alcohol and Drug Counselors*** *(CADC);* ***Licensed Clinical Psychologist*** ***Licensed Clinical Social Worker*** *(LCSW),* ***Licensed Clinical Professional Counselor*** *(LCPC),* ***Licensed Marriage and Family Therapist*** *(LMFT*	***Physician (MD or DO),*** ***Registered Nurse (APRN),*** *who meet the education and experience as defined in the regulations for Licensing/Certifying of Substance Abuse Programs in the State of Maine.* ***Registered Professional Nurse*** *certified as a Psychiatric Nurse or Advanced Practice Psychiatric and Mental Health* ***(4)***

Medicare: (5)

Clinical psychologists ***Clinical social workers*** ***Physical therapists*** ***Occupational therapists***	***Physicians*** ***Physician assistants*** ***Nurse practitioners*** ***Clinical nurse specialists*** ***Certified nurse midwives***
Clinicians who are approved Medicare providers may provide services without direct physician supervision and bill directly for these services. Note that LADC's and LCPC's are not included in this list for Medicare.	

Private Insurance Coverage:

Generally follows guidelines set by Medicare. Most private plans are required (per ACA) to cover the U.S. Preventive Services Task Force (USPSTF) requirements. Exceptions include grandfathered plans, short-term plans and health sharing ministries (rare) (6). Coverage in private health plans varies by employer and/or plan. Clients/patients should contact their insurance plan for information on benefits (including who can provide the service, duration, frequency, co-pay etc.) See note on other suggested questions to ask **(7)**

Health Insurance Marketplace:

All Health Insurance Marketplace plans are required to cover tobacco cessation treatment. Specific coverage varies by plan. Check with individual plan to find out what is covered.

Special Circumstances

a. Alternatively, the following psychotherapy billing codes may be used in conjunction with the tobacco diagnosis codes. Reimbursement is higher but clinicians should take care about their use. Though tobacco use disorder is a DSM 5 listed disorder, it is not routinely billed as a typical behavioral health disorder; because it has its own codes (see above). Checking with the individual's plan is strongly encouraged before using these billing codes for stand-alone tobacco treatment. (8)

Psychotherapy Billing Code	Description
90791	The psychiatric diagnostic evaluation is an integrated biopsychosocial assessment which includes a history, mental status, and recommendation.
90832	Psychotherapy 30 minutes. (Time range: 16 to 37 minutes)
90834	Psychotherapy 45 minutes. (Time range: 38 to 52 minutes) Some health insurance companies may consider 90834 as the standard psychotherapy session
90837	Psychotherapy 60 minutes. (Time range: 53 minutes or more)
90847	Family psychotherapy with the patient present. This code may also be used on the same day as an individual psychotherapy service is provided as long as the services are separate and distinct for the patient. (The time is a 50 minute session and the time range is 26 minutes or more.)
90853	Group psychotherapy. (There is no time specification for this code.)

b. Health and Behavior assessment and intervention codes (15 minute units): in rare instances, these billing codes can be used. H&B procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment, or management of physical health problems. The focus is not on mental health or addiction disorders, but on the biopsychosocial factors important to specific physical health problems and treatments. The focus is on short term behavioral changes to support treatment of the medical condition. When using these codes, the ICD-10-CM medical diagnosis, **not** the tobacco use disorder diagnosis code, should be listed on the claim. (9)

H & B Billing Codes	Description
96150	Initial Health and Behavior Assessment
96151	Health and Behavior re-assessment
96152	Intervention (individual)
96153	Intervention (group, per person)
96154	Intervention (family with patient)

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Notes

1. There are two pertinent issues here:
   a. Discussions with the MaineCare office stress that a tobacco treatment billing code cannot be used for tobacco treatment conducted in the same session being billed for another mental health or addiction disorder. If this were to occur it is likely that either: a. the more expensive code would be disallowed resulting in a lower reimbursement rate for the entire session or: b. the charges would go through, creating a vulnerability to a negative audit finding at a later time.
   b. Additionally, Correct Coding Initiative (CCI) does not allow for a psychotherapy billing code and a tobacco treatment billing code to be used on the same day even if it is a separate, distinct session.

2. ICD-10 codes vs. DSM 5 codes: The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) uses the term "Tobacco Use Disorder" vs. the ICD-10 "Nicotine Dependence". Though the ICD-10 codes are required for documentation when billing for tobacco treatment, the DSM-5 criteria are useful for determining severity of the disorder based on identified number of diagnostic criteria. The DSM 5 criteria can be found here in Appendix A

3. As of July 20, 2016 MaineCare provides for coverage of comprehensive tobacco treatment without limitations, including individual and group counseling and products for all members, including the new expansion population. These changes are effective retroactive to August 1, 2014 for members who are 18 years and older or who are pregnant. Members under the age of 18 had already been receiving these benefits at no cost. Coverage under this section must be provided with no copayments or other out-of-pocket cost sharing, including deductibles. There are no annual or lifetime dollar limits or annual or lifetime limits on attempts to quit. (From MaineCare Policy Adoption – Maine Statutes Ch. 11, Section 90 – July 20, 2016)

4. Clinicians need to be enrolled/credentialed in the plan as providers. This is generally done through a national credentialing service (CAQH) and is based on national provider identification numbers, which are issued to eligible providers: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand

5 Medicare no longer differentiates between symptomatic and asymptomatic patients as of October 1, 2016. Codes G0436 and G04037 were deleted that represented asymptomatic cessation counseling. (American Academy of Family Physicians, Coding reference; Tobacco Use Prevention and Cessation Counseling, 2017) Two cessation attempts are covered per 12-month period. Each attempt may include a maximum of four intermediate or intensive counseling sessions. Therefore, the total annual benefit covers up to eight smoking cessation counseling sessions in a 12-month period. 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. Patients must be competent and alert at the time the counseling is provided. A notable change as of October 1, 2016 is that the copayment/coinsurance as well as the deductible for 99406 and 99407 are now waived.

Counseling must be provided by a physician or other Medicare-recognized health care professional. The Medicare beneficiary has a zero dollar out-of-pocket liability.

Regarding LCSW's, correspondence dated 1/7/19 from Centers from Medicaid and Medicare Services states "the clinical social worker benefit under section 1861(hh) of the Act specifically authorizes anyone who qualifies to bill Medicare Part B for services for the diagnosis and treatment of mental illnesses. Treatment for smoking and tobacco use cessation falls under the category of "Psychiatry" Current Procedural Terminology codes that encompass treatment for mental, psychoneurotic and personality disorders: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=130&

6. Health care sharing ministries are organizations in the United States in which health care costs are shared among members who have common ethical or religious beliefs.

7. The American Lung Association (ALA) Billing Guide for Tobacco Screening and Cessation recommends the following questions to ask payers about coverage for tobacco counseling:

a. Are both individual and group counseling covered?
b. Are there limits on the number of counseling sessions (either individual or group)?
c. Are there any restrictions on what provider types may bill for counseling? (MD, NP, LCSW, etc.)
d. Are there any notes specific to this payer that must be included in the documentation?

For further larger-scope discussion of billing for tobacco treatment can be found in "Billing Guide for Tobacco Screening and Cessation". June, 2018, American Lung Association.
https://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco-1.pdf

Information on coverage of tobacco treatment medications in Maine can be found in "State Tobacco Cessation Coverage: Maine". 1/2019, American Lung Association
http://www.lungusa2.org/cessation2/statedetail.php?stateId=23 (see appendix B)

8. Stand-alone use of Psychotherapy codes: there is conflicting information at this time and it is not resolved.

Use of psychotherapy billing codes for tobacco treatment is endorsed in the U.S. Department of Health and Human Services Treating Tobacco Use and Dependence Clinical Practice Guideline 2008 Update.
It is also stated as an option in "Integrating Tobacco Use Treatment into Practice: Billing and Documentation" by Frank T. Leone, et al, Chest, February, 2016. It specifically notes that behavioral health codes for tobacco treatment can be used when the primary reason for the visit is not tobacco related. (p 570).
Bloom, EL et al. in "Billing Practices Among US Tobacco Use Treatment Providers", found through survey that a variety of billing codes were being utilized, though the tobacco treatment codes were the most frequently used.

There are some programs, nationally, that appear to be successfully using these billing codes.
On the other hand, Jill Williams et al. state in "An Argument for Change in Tobacco Treatment Options Guided by the ASAM Criteria for Patient Placement" (Addiction Medicine volume 10, number 5, September/October 2016) that "Tobacco Use is probably the only diagnosis …(in the DSM 5) that is exempted from use of behavioral health codes." They find this fact regrettable and would like to see this changed.

Use of psychotherapy billing codes is not mentioned in the ALA "Billing Guide for Tobacco Screening and Cessation. Discussion with some private insurers indicates that these psychotherapy codes would need to be specifically built into the plan benefit; otherwise the tobacco billing codes should be used.

Correspondence with staff of MaineHealth, Coding & Compliance MMP indicates that psychotherapy billing codes can be used in conjunction with tobacco diagnostic codes, only when tobacco and another behavioral health disorder is being treated in the same session. The psychotherapy billing codes should not be used for tobacco treatment as a stand-alone treatment.

9. The H&B codes may best be utilized by behavioral health clinicians who are embedded in physician practices and are being referred as a treatment extender for behavioral change (in this case tobacco use cessation) to address a physical health condition without the need for diagnosing tobacco use disorder. Conditions that should not be mentioned in notes are "withdrawal", "addiction", "craving" – any symptom commonly associated with dependence. The presence of those symptoms would indicate that the tobacco billing codes, not the H&B codes, should be used. See Appendix C

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Appendix A

DSM – 5 Diagnostic Criteria

American Psychiatric Association. (2013). Anxiety Disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.).

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 efforts 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, or a 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 (e.g., interference with work).
6. Continued tobacco use 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:
    1. A need for markedly increased amounts of tobacco to achieve the desired effect.
    2. A markedly diminished effect with continued use of the same amount of tobacco.
11. Withdrawal, as manifested by either of the following:
    1. The characteristic withdrawal syndrome for tobacco (refer to Criteria A and B of the criteria set for tobacco withdrawal).
    2. Tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms.

Mild = 2-3 criteria Moderate = 4-5 criteria Severe = 6-11 criteria

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Appendix B

Legend: ★ = Covered ▼ = Coverage Varies X = Not Covered

Medicaid Coverage

MaineCare Covers:

- ★ Nicotine Gum
- ★ Nicotine Patch
- ★ Nicotine Nasal Spray
- ★ Nicotine Lozenge
- ★ Nicotine Inhaler
- ★ Varenicline (Chantix)
- ★ Bupropion (Zyban)
- ★ Group Counseling
- ★ Individual Counseling
- ★ Quitline

All seven pharmacotherapy treatments are covered. Individual and group counseling are covered. Prior authorization is required for NRT nasal spray lozenge, and inhaler. There are stepped care therapy requirements: individuals must try preferred (gum, patch, Chantix, Zyban) before non-preferred.

For more information, please call the Office of MaineCare Services at 207-624-7539 or 800-321-5557, or visit their website at https://maine.gov/dhhs/oms/

Note: the Affordable Care Act requires all Medicaid programs cover all tobacco cessation medications beginning January 1, 2014. If a medication is market here as not being covered, there is not yet evidence that Medicaid has complied with this requirement. Patients should call their Medicaid program and ask how to receive these medications.

Health Insurance Marketplace Coverage

All plans in the Health Insurance Marketplace are required to cover tobacco cessation treatment. Specific coverage varies by plan. Check with your insurance plan to find out what is covered.

State Employee Health Plan Coverage

For state employees, Maine covers:

- ★ Nicotine Gum
- ★ Nicotine Patch
- [x] Nicotine Nasal Spray
- ★ Nicotine Lozenge
- [x] Nicotine Inhaler
- ★ Varenicline (Chantix)
- ★ Bupropion (Zyban)
- ★ Group Counseling
- ★ Individual Counseling
- [x] Phone Counseling
- ★ No Tobacco Surcharge

Anthem Blue Cross Blue Shield will pay for cessation medications up to $200 per year and $400 per lifetime. The plan covers individual follow-up visit with a member's physician for cessation counseling. It also covers enrollment in 2 group counseling classes per lifetime (provided through hospitals or physician's offices). Co-payments of $10-$30 are also required.
For more information, please call the Division of Employee Health Benefits at 207-284-6780 or 800-422-4503, or visit their website at http://www.state.me.us/beh/

Private Insurance Coverage

This state does not require private health insurance plans to cover cessation treatments. Cessation coverage in private health insurance plans varies by employer and/or plan. Smokers with this type of health insurance should contact their insurance plan for information on cessation benefits.

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Maine Tobacco Helpline

Hours: 8:00AM – 12:00 AM Monday-Sunday
Eligibility to receive counseling: All callers who are Maine residents eligible for 1-call. Eligibility for multiple-call includes: residents of Maine, and readiness to quit within 30 days. For medication: must be enrolled in multi-call program, age 18+ with no medical exclusions; no NRT for those with MaineCare (Maine Medicaid).

Medications provided:

★ Nicotine Gum	★ Nicotine Lozenge	[x] Bupropion (Zyban)
★ Nicotine Patch	[x] Nicotine Inhaler	
[x] Nicotine Nasal Spray	[x] Varenicline (Chantix)	

(Source: North American Quitline Consortium, www.naquitline.org)

American Lung Association Resources

The American Lung Association of Maine provides smoking cessation services statewide. Options include Freedom From Smoking ® Online, a program available 24/7 at http://www.ffsonline.org and the American Lung Association's Lung HelpLine (800-LUNG-USA). For further information, please call 207-622-6394 or visit us online at http://www.lung

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Appendix C

MaineHealth

March 2009

Health and Behavior Codes Guidelines for Use***		
Health and Behavior Assessment 96150	H&B Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment, or management of ***physical*** health problems. The focus is ***not on mental health*** but on the biopsychosocial factors important to physical health problems and treatments. ***Documentation*** for *Initial Assessment*: 1. Onset and history of initial diagnosis of physical illness 2. Clear rationale for H&B assessment 3. Assessment outcome including mental status and ability of patient to understand 4. Goals and expected duration of intervention 5. Length of time for assessment **Billing** • 15 minute units • ICD-9-CM medical diagnosis listed on claim • Limited to a maximum of (4 Units) one hour, regardless	For Patients: • With underlying physical illness or injury • Where a biopsychosocial factor may be affecting the medical treatment • Who has cognitive capacity for the approach • Where physician has documented the need for this intervention • Where assessment does not duplicate the other assessments
Health and Behavior Reassessment 96151	**Documentation** in *progress note*: 1. Date of change in status requiring reassessment 2. Clear rationale for reassessment 3. Clear indication of precipitating event 4. Length of time for reassessment **Billing** • 15 minute units • ICD-90CM medical diagnosis listed on claim • Limited to a maximum of (4 units) one hour, regardless	For Patients: • With underlying physical illness or injury • Where reassessment is not for diagnosis or treatment of mental illness • Where there is a question of the patient's capacity to understand or respond to the intervention • Where physician has documented need • Where assessment does not duplicate other assessments
Health and Behavior Interventions 96152 - 96153	H&B Intervention procedures are used to ***modify*** the psychological behavioral, emotional, cognitive and social factors identifies as important tool directly affecting the patient's physiological functioning, disease status, health and wellbeing utilizing cognitive, behavioral, social and/or psychological procedures designed to ameliorate specific disease-related problems.	For Patients: • With underlying physical illness or injury • Where you are not treating mental illness • Who have capacity to understand the intervention

	Documentation: 1. Evidence that patient has capacity to understand 2. Clearly defined psychological intervention 3. Goals of the intervention 4. Information that the intervention should help improve compliance 5. Response to intervention 6. Rationale for frequency and duration of services 7. Length of time for intervention **Billing:** • 15 minute units • ICD-9-CM medical diagnosis listed on claim • Limited to maximum of 12 hours (48 Unites) regardless	• Who require psychological intervention to address ○ Non-compliance with medical treatment ○ Biopsychosocial factors associated with a new diagnosis, and exacerbation of an existing illness when patient behaviors negatively impact medial self-management • For whom specific psychological interventions and outcome goals have been identified
Health and Behavior Intervention (with the family and patient present) 96154	Is considered reasonable and necessary for patient and family representative. Family representative is defined as: • Immediate family members – nuclear and extended, including domestic partners • Primary caregiver – voluntary, regular and uncompensated basis • Guardian or health care proxy	For patients and families: • When the family rep directly participates in the patient's care • Where family involvement is necessary to address the biopsychosocial factors that affect compliance with the medical plan of care
No allowable interventions	• T update family about patient's condition • To educate non-immediate family members or other members of the treatment team no considered family reps • For treatment planning with staff • To mediate or provide family therapy • To educate diabetic patients and their family members • To deliver medial nutrition therapy • To maintain health and overall well-being • To provide person, social, recreation and general support services (including case management)	

*****Notes Concerning Reimbursement with use of H&B codes:**

*****Medicare in New England Region only allows Psychologists to use these codes – not LCSW's, LCPC's etc.

*****MaineCare does reimburse for these codes for licensed master level social workers/counselors as well as psychologists

*****Commercial insurers in Maine are reimbursing licensed master level social workers/counselors, but may vary from insurer to insurer.

Information extracted from HHS Gov CMS- Article for Health and Behavioral Assessment/Intervention - Medical Policy Article (A48209)

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