Implementing Tobacco Control Into the Primary Healthcare Setting

Opportunities *for* Reimbursement

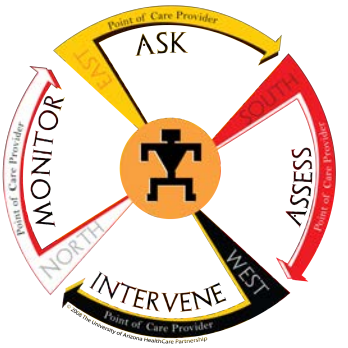
Indian Health Service Tobacco Control Task Force 2010

Indian Health Service
Division of Epidemiology
Albuquerque, New Mexico
www.ihs.gov/medicalprograms/epi/

National I.H.S. Tobacco Control Task Force

The University of Arizona

Indian Health Service · PHS · 1955



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FOREWORD

For many years, patients and healthcare providers have experienced the adverse effects of commercial tobacco use. Despite the health consequences of smoking, physicians and other healthcare clinicians often fail to assess and treat commercial tobacco use consistently and effectively. Effective tobacco cessation services preserve health, reduce illness, and improve quality of life. The scientific literature also provides strong and convincing evidence that people benefit from tobacco dependence treatment services. The **Clinical Practice Guideline** (2000) states that "tobacco use presents a rare confluence of circumstances":

> (1) A highly significant health threat; (2) a disinclination among clinicians to intervene consistently; and (3) the presence of effective interventions. This last point is buttressed by evidence that smoking cessation interventions, if delivered in a timely and effective manner, significantly reduce the smoker's risk of suffering from smoking-related disease. Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, despite effective and readily available interventions (Fiore *et al.*, 2000, p. 7).

Commercial tobacco dependence treatment offers advantages to the Indian healthcare system by lowering the long-term costly effects of commercial tobacco use. Successful cessation systems impact our organization by saving money and providing a potential source of revenue through CMS reimbursement. Implemented correctly, tobacco cessation services will become fiscally sustainable and support public health efforts on a national level. This timely tobacco dependence reimbursement guide provides primary care providers, Tobacco Treatment Specialists (TTS), and healthcare professionals with the information they need to obtain Medicare reimbursement for tobacco cessation counseling services. The advice in this guide will help you enhance your facility's ability to obtain reimbursement for cessation services. This will help increase access to tobacco dependence services throughout the Indian healthcare system.

This guide also reveals how a multidisciplinary team of healthcare providers, administrators, data entry and billing personnel make a difference—not only to the health of patients, but also to a clinic's financial bottom line.

This is an exciting time in Indian healthcare. We are increasingly focusing our efforts on health promotion, disease prevention, and chronic care management. Many of us know that tobacco cessation is integral to these efforts and to improving the overall health of American Indians and Alaska Natives. By increasing reimbursement for cessation services, we hope to improve access to cessation services so that all American Indians and Alaska Natives who need or desire this service can obtain it in a timely manner.

Nathaniel Cobb, MD
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2010 (revised)

INTRODUCTION

There is increasing evidence that the success of any tobacco dependence treatment strategy or effort cannot be divorced from the healthcare system in which it is embedded. Data strongly indicate that effective tobacco interventions require coordinated interventions. Just as the clinician must intervene with his or her patient, so must the healthcare administrator, insurer, and purchaser foster and support tobacco dependence treatment interventions as an integral element of healthcare delivery. Healthcare administrators and insurers should ensure that clinicians and medical billing professionals have the training and support, and receive the reimbursement necessary to achieve consistent, effective intervention with tobacco users (Fiore, *et al*.).

This guide is designed for **you**. It was also designed to encourage delivery of tobacco dependence treatment in Indian Health Service and to assure that providers receive reimbursement for providing treatment services. The guide details: **who** is eligible to receive reimbursement for providing tobacco dependence treatment; **how** to register with Medicare in order to bill for services rendered; **how** to start providing tobacco dependence treatment services; **what** nicotine replacement (NRT) and pharmacotherapy is covered; **what** codes to use for billing; **how** to document services; and several resources to help you get started.

Tobacco dependence treatment services have just recently been introduced into the Indian Health Service (IHS) organization. The Government Performance Results Act provided an initial push in providing cessation services throughout the IHS system. Let's examine how this snapshot of tobacco cessation services has changed over time.

The 1980s

- Health costs began to soar in the United States.
- The IHS received minimal budget increases to provide or expand services.

The 1990s

- Healthcare costs continued their upward trend.
- Despite the growing demand for health services—including public health services—
  - IHS received few budget increases from Congress. As a result, no line item budget for

Tobacco Cessation Services in the Indian health system was approved.

- Tribal contracting and compacting for IHS services redirected reduced funds from the IHS to Tribes.
- The IHS decentralized services from Headquarters and Areas to service units, Tribes, and urban Indian health programs.
- Managed care companies took over the operation of more and more hospitals. Staff reductions included public health programs and "non-billable" services were released to contractors.

Today

- Healthcare costs are enormous!
- Obesity, diabetes, and other chronic conditions are at an all time high. The U.S. Public Health Service Guideline provided a clear message that tobacco dependence treatment services incorporated into routine healthcare settings are effective and support the improvement of long-term health outcomes.
- Now, more than ever, every dollar counts.

The Future

For some of us, the future is now. The Electronic Health Record and Clinical Reporting Systems are now certified for Indian Health facilities and available in over one-third of clinics. Other applications to assist with case-management and GPRA are also available, such as iCare. Although these advances serve to make systems easier and user-friendlier, you have to dedicate time in planning how to implement these tools locally and to evaluate their use in your healthcare setting.

REIMBURSEMENT FOR TOBACCO DEPENDENCE TREATMENT: AN OVERVIEW

Medicare Tobacco Dependence Treatment Reimbursement

The Centers for Medicare and Medicaid Services (CMS) determined the evidence was adequate to conclude that smoking and tobacco-use cessation counseling, based on the current U.S. Public Health Service Guideline, is reasonable and necessary for certain individuals and should be covered by Medicare. Effective for services performed on or after March 22, 2005, Medicare provides coverage of two levels of counseling for smoking cessation, intermediate and intensive, as well as physician prescribed pharmacotherapy.

Medicare Coverage

Medicare provides coverage for smoking and tobacco-use counseling for beneficiaries who meet one of the following criteria:

- use tobacco and have a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use; or
- are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration-approved information.

Medicare will cover **two cessation attempts per year.** Each attempt may include **a maximum of four intermediate or intensive counseling sessions**. The total annual benefit covers up to eight smoking and tobacco-use cessation counseling sessions in a 12-month period. The practitioner and patient have flexibility to choose between intermediate or intensive cessation strategies for each attempt. Tobacco cessation pharmacotherapy is covered with a prescription issued from a qualified and CMS eligible prescriber.

Intermediate and intensive smoking cessation counseling services will be covered for outpatient and hospitalized beneficiaries who smoke and meet all coverage requirements, as long as those services are furnished by qualified physicians and other Medicare-recognized practitioners. Beneficiaries must be competent and alert at the time services are provided. Both the coinsurance and deductible apply.

REFLECTIONS

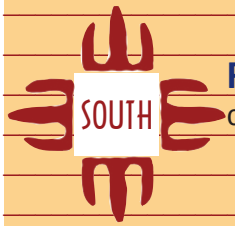
In addition to Medicare's smoking cessation counseling benefit, the Department of Health and Human Services launched a national telephone counseling quitline for all smokers in the United States. The toll free number **1-800-QUITNOW (1-800-784-8669, TTY 1-800-332-8615**) is a single access point to the National Network of Tobacco Cessation Quitlines. Callers are routed to a state-run quitline for assistance. If there is no state-run quitline, they are routed to the National Cancer Institute's quitline.

The Indian Health Service (IHS) **All-Inclusive Rate** is the rate negotiated by the IHS for services provided under Medicare Part A. The Medicare Part A IHS 2009 **All-Inclusive Rate** is $215.00 per provider visit. The IHS renegotiates this rate with the CMS each year; therefore, the rate may vary from year to year. The Medicare Part B payment will be 80% (because a 20% co-pay applies) of the lesser of either the actual charge or 85% of the physician's fee schedule amount. To obtain tobacco cessation reimbursement for outpatient services the patient must be a Medicare Part B beneficiary.

ACTION

REFLECTION

THINKING — What opportunities are available for tobacco dependence treatment reimbursement in my setting?



PLANNING — How will I proceed to explore the opportunities for reimbursement?

INITIATING A PLAN — Who will I contact to identify the steps required to explore the opportunity for tobacco dependence treatment reimbursement in my setting? Who could partner with me to create a Task Force to explore opportunities and create a plan of action?

EVALUATING AND MAINTAINING — How will I know that my efforts have resulted in system-wide opportunities for tobacco dependence treatment reimbursement?

CAN MY ORGANIZATION OBTAIN REIMBURSEMENT FOR THE TREATMENT OF TOBACCO DEPENDENCE? WHO? HOW?

WHO is Eligible to Receive Medicare Reimbursement for Providing Tobacco Dependence Treatment?

The first step in obtaining reimbursement for tobacco dependence treatment is to become a recognized Medicare provider. A Medicare National Provider Identifier (NPI) is needed to bill for reimbursement and identifies the individual as a recognized, qualified Medicare provider.

The Centers for Medicare and Medicaid Services (CMS) requires each provider to obtain a national provider identifier (NPI) which replaces the Medicare UPIN#. The transition to the NPI was completed in May 2007. All providers need to have current NPI numbers in order for the business office to bill for their services.

Community health centers, physicians, and acute outpatient hospital departments can bill Medicare for providing tobacco cessation counseling services. Included within the category of physician are MDs (or DOs), such as primary care physicians, psychiatrists, and specialty physicians.

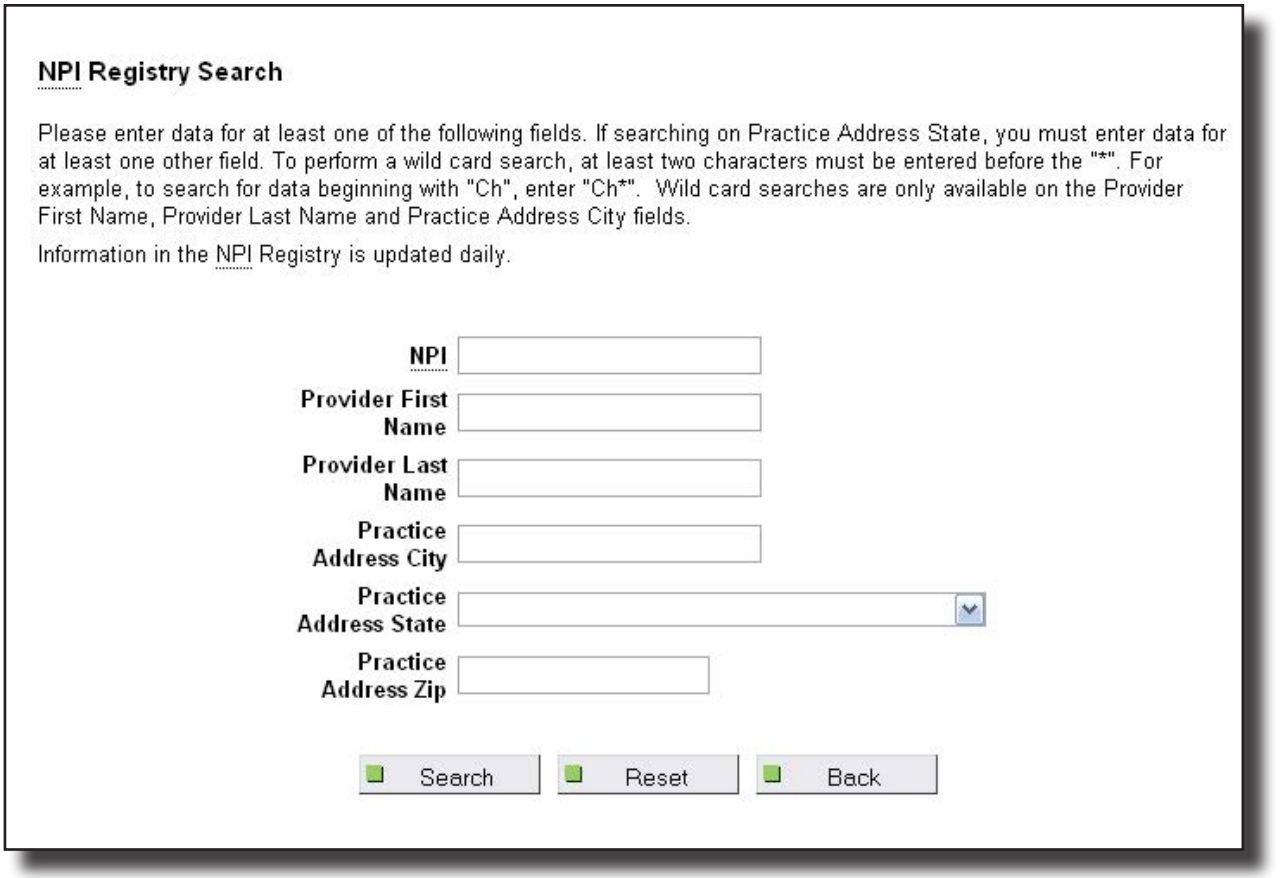
Specific clinical providers eligible to provide the counseling service are physicians, nurse practitioners, nurse midwives, registered nurses, and physicians' assistants; all non-physician providers must be under the supervision of a physician, except independent nurse practitioners and independent nurse midwives providing the tobacco cessation counseling services directly.

At this time (May 2010), healthcare providers, who are not recognized providers as identified in the "all-inclusive" CMS-recognized practitioner agreement for IHS do not qualify for cessation services for CMS reimbursement.

HOW to Register with Medicare In Order to Bill for Services Rendered

In order to bill for tobacco dependence treatment services, you must register with Medicare by applying for a National Provider Identifier (NPI) online at https://nppes.cms.hhs.gov. The NPI form can also be downloaded at http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf. Health care providers needing assistance with applying for an NPI or updating their data in the National Plan and Provider Enumeration System (NPPES) may contact the NPI Enumerator at **1-800-465-3203** or email the request to the NPI Enumerator at CustomerService@NPIEnumerator.com.

If you are not certain you have already obtained an NPI or cannot remember your NPI, you can visit the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do to search for the information. The NPI Registry enables you to search for a provider's NPPES information, which includes the NPI. All information displayed in the NPI Registry is done so in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Name/Legal Business Name. There is no charge to use the NPI Registry. An example of the NPI Registry Search screen is provided below.



Provider Transaction Access Number (PTAN)

As of May 1, 2008, when you use the National Government Services Interactive Voice Response (IVR) system, you are prompted to enter your Provider Transaction Access Number (PTAN). Your PTAN is your existing six-digit Medicare provider identification number (PIN). When you use the IVR, you are now prompted to enter **both** your NPI **and** your PTAN.

Make sure that you have both numbers available to you before you contact National Government Services so they can promptly respond to your questions using the IVR. The representatives will not be able to provide you with these identification numbers. In addition, as of May 23, 2008, a UPIN will no longer be accepted.

Steps To Obtain a Provider Transaction Access Number (PTAN)

Step 1

Obtain the necessary application forms to apply for a Provider Transaction Access Number (PTAN). PTAN application forms can be obtained by directly contacting the National Plan & Provider Enumeration System (NPPES) at 1-800- 465-3203.

Applications can also be completed and submitted online through the NPPES website at https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

Step 2

Gather all information required to complete your PTAN application prior to completing the online application process. Once the application has been started you are unable to quit from the form or save any information entered on the application until you have completed the required forms.

Step 3

Determine your health provider taxonomy code number. The taxonomy code is used to identify precisely what type of health care provider category that you are applying for. These codes are specialized according to group or individual provider, type of practitioner and subspecialty.

Step 4

Create a National Provider Information (NPI) user ID. This ID will permanently be connected with your PTAN information and cannot be changed once it has been entered. The ID cannot contain more than four digits.

Step 5

Determine a password for your NPI account. The password should consist of 8 to 12 characters that contain at least one character and one number. The user ID and password cannot be the same. The system will not accept any special characters in the user ID or password.

Step 6

Submit five secret questions and answers to be entered into the NPI system. This information will be used to retrieve necessary log-on information in case it has been forgotten. Choose questions you are likely to remember for a long period of time, these questions and answers will be permanently tied to your NPI user ID.

Step 7

Complete the necessary medical provider application forms to obtain a PTAN Medicare number. The NPI system and PTAN number is only for the use of health care providers. Use the information on your prepared lists to fill in details on the application. This application is relatively straightforward and should only take approximately 20 minutes to complete.

Step 8

Double check the information you entered on your PTAN application for accuracy. Inaccurate information will lead to delays in receiving your PTAN number.

Step 9

Wait for Medicare to review the credentials and information that you have submitted. PTAN numbers will not be issued until all credentials are correct and currently up to date.

Step 10

Receive your new PTAN identifier from Medicare and start a billing relationship with Medicare insurance and Medicare patients.

HOW to Become a Recognized Medicare Provider for Professional Part B Services

To become a recognized Medicare provider, you will need to complete CMS Form 8551, "Medicare for Physicians and non-Physicians Practitioners Enrollment Application". This form covers the professional charges for the providers' level of care. Along with the form, you will need to submit supporting documentation, such as your registration number and a copy of your state license or certification. You will generally be enrolled as a Medicare provider within 90 days of the Medicare carrier's receipt of your application. This may take longer if your application is incomplete. You can contact the Medicare carrier to check the status of your enrollment if more than two months have passed since you submitted your application and you have not yet received your Medicare PIN#.

You may need to complete other forms depending on your practice setting and employment relationship. For example, you may need to complete CMS Form 855R Medicare enrollment application for providers for Reassignment of Medicare benefits (This form covers the facility charges for the providers). In addition, this form reassigns Medicare payment back to the healthcare facility. This form is needed when you are employed or contracted by a facility that will submit the service claims on your behalf and collect payment for your services.

Your billing department or Credential Officer will have these forms on hand, but they should be completed prior to your effective date of employment.

Note: **IHS loses money if the forms cannot be processed quickly**.

Make Friends with Your Business Office

Just as you have a working relationship with your healthcare team, you will need to foster a cooperative relationship with your business office team, including the billing department, compliance officer, finance staff, and medical records coding department.

REFLECTIONS

Forming a Relationship with the Business Office

The following steps can help ensure that you form a good working relationship with your business office:

- Introduce yourself to the business office team and meet the billing and coding staff. This should take place during your employee orientation period.
- Work closely with your providers, nursing staff, and medical records staff on how to properly document the information using Electronic Health Records (EHR).
- Work with your billing and information systems staff to develop a method of tracking claims and reimbursements. Depending on your business office's procedures, the business office will file an 837 (Inst) (UB) form or an 837 (Prot) (HCFA) form electronically depending on services rendered.

ACTION

REFLECTION

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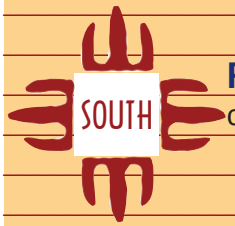

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CODING FOR TOBACCO DEPENDENCE TREATMENT

ICD and CPT Codes

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code is based on an international classification system originally developed and maintained by the World Health Organization (WHO). The system is used throughout the healthcare industry to describe diseases, injuries, symptoms and conditions. *Current Procedural Terminology* (CPT) codes are used to describe medical and surgical services performed by healthcare providers. ICD-9-CM codes and CPT codes are inherently related, as the diagnosis (ICD-9-CM code) must support the procedure (CPT code). All Medicare claims require a valid ICD-9-CM diagnosis code and a CPT procedure code in order to be reimbursed.

CPT codes were developed and copyrighted by the American Medical Association (AMA) in 1966 and an update is published annually in January. CPT is a listing of five-digit codes that identify services and procedures performed by physicians in any setting and by facilities for services and procedures performed in any outpatient setting. CPT is divided into three categories of codes.

- *Category I*: Procedures that are consistent with contemporary medical practice and are widely performed.
- *Category II*: Supplementary tracking codes that can be used for performance measures.
- *Category III*: Temporary codes for emerging technology, services and procedures.

ICD-9-CM codes as related to Purpose of Visit (POV)

When working with a patient who has become dependent on commercial tobacco utilize ICD-9-CM code **305.1, Tobacco Use Disorder**.

- Other tobacco-caused health problems may be coded, i.e., 162 for lung cancer, 410-414 for coronary heart disease, etc...
- Psychological problems are catalogued in the Diagnostic and Statistical Manual for Mental Disorders volume IV Text Revision (DSM IV TR). These codes are a subset of the ICD-9-CM codes and should be coded if applicable.
- Other Tobacco Use Disorder codes: 305.13 (Quit smoking).

When working with a patient who is not dependent on commercial tobacco, utilize code **V15.82, History of Tobacco Use**, which excludes Tobacco Dependence (305.1).

Tribal System codes for tobacco use found in **Resource and Patient Management System (RPMS)** are as follows:

Tobacco Use Assessment/Screening ICD-9 Coding Equivalents

Code Type	Code	Screening Tool Option	Detailed Meaning
Diagnosis	305.1	Smoke, Chew or Quitting Now	Uses tobacco daily – Current user
Diagnosis	V15.82	Already quit	Has not used tobacco for > 6 months (Maintenance – current behavioral definition of stopped is > 6 months)
Diagnosis	V65.49	Counseling delivered	Counseling general delivered (must be used w/clinic 94)

When reviewing exam and lab results with a patient you have the **opportunity** to provide tobacco dependence treatment services. Below are medical procedures, CPT Codes, and ICD-9 Codes related to smoking diseases and co-morbidities:

Medical Procedures

- Electrocardiography
- Total leukocyte counts
- Blood pressure measurements
- Hematocrit
- Auscultation of heart and lungs
- Blood lipid studies
- Blood coagulation studies
- Serum alpha antiprotease measurements
- Pregnancy tests
- Carboxyhemoglobin determinations

Quick Glance of CPT Codes Related to Tobacco

Procedure	Code
Chest X-ray (PA & LL)	71020
Lipid Profile	80061
Total cholesterol	82465
HDL	83718
VLDL	83719
LDL	83721
Hemoglobin	85018
Electrocardiogram	93000
Spirometry (pre/post with bronchodilators)	94060
Carboxyhemoglobin	94250
Respiratory flow volume loop	94375
Aerosol inhalation	94664
Carbon monoxide diffusion capacity (DLCO)	94720
Pulse oximetry	94760
End tidal carbon dioxide	94770
Consultation	99244

Tobacco Use - Screening

99420 Administration/interpretation health risk assessment instrument

Tobacco Use - Pregnancy and/or Childbirth

649.0_ Tobacco use complicating pregnancy, childbirth or puerperium plus the complication (5th digit must be utilized here for specifics—consult with local Coder)

Tobacco Use - Toxic Effect

989.84 Tobacco as a toxic effect of other substance, chiefly non-medicinal (side-effects, overdose, etc.)

Tobacco Use - Risk Factor Reduction Counseling with an individual

99401 Preventive medicine counseling/risk factor reduction, individual, 15 mins
99402 Preventive medicine counseling/risk factor reduction, individual, 30 mins
99403 Preventive medicine counseling/risk factor reduction, individual, 45 mins
99404 Preventive medicine counseling/risk factor reduction, individual, 60 mins

Tobacco Use - Behavior Change with an individual

99406 Behavior change, smoking 3-10 minutes
99407 Behavior change, smoking >10 minutes
99408 Behavior change, alcohol &/or substance abuse structured screening and brief intervention 15-30 minutes
99409 Behavior change, alcohol &/or substance abuse structured screening and greater intervention 30 minutes+

Tobacco Use - Group Counseling

99411 Preventive counseling, group, ~30 minutes
99412 Preventive counseling, group, ~60 minutes
99420 Administrative health risk assessment – add modifier of 25 to indicate tobacco cessation counseling
99078 Physician education in a group setting – add modifier of 25 to indicate tobacco cessation counseling

Tobacco Use - Interventions

4000F Tobacco use cessation intervention, counseling and/or
4001F Tobacco use cessation intervention, pharmacologic therapy

Tobacco Use - Dental Setting

D1320 Counseling for the control and prevention of oral disease

Secondhand Tobacco Smoke

E869.4 Secondhand tobacco smoke (must have the illness condition code)

Tobacco Use - Related to Healthcare Procedural Coding System (HCPCS)

G8453 Tobacco use cessation intervention, counseling
G8454 Tobacco use cessation intervention, not counseled
G8455 Current tobacco smoker
G8456 Current smokeless tobacco user
G8457 Current tobacco nonuser

Smoking Cessation Treatment

S9075* Smoking cessation treatment
S9453* Smoking cessation class

*S codes are National Permanent Level II HCPCS codes. These codes provide a standardized coding system that is managed jointly by public and private insurers, thus providing a stable system for claims processing. These codes can be used by all private and public insurers.

Evaluation and Management (E&M) Codes

99201- 99215 + modifier 25

Used when individual cessation visit occurs in association with another medical condition. Add modifier 25 to indicate tobacco cessation counseling.

ICD-9 Codes Related to Tobacco Cessation Counseling *

231.2	Carcinoma, in situ, bronchus and lung
250.0	Diabetes mellitus
272.0	Hypercholesterolemia
412.0	Old myocardial infarction
413.x	Angina pectoris
414.0x	Coronary atherosclerosis
415.0	Acute cor pulmonale
415.1x	Pulmonary embolism and infarction
416.x	Chronic pulmonary heart disease
420.xx	Acute pericarditis
421.x	Acute and subacute endocarditis
422.xx	Acute myocarditis
423.x	Other diseases of the pericardium
424.xx	Other diseases of the endocardium
425.x	Cardiomyopathy
426.xx	Conduction disorders
427.xx	Cardiac dysrhythmias
428.xx	Heart failure
429.xx	Other ill-defined heart disease
430.0	Subarachnoid hemorrhage
431.0	Intracerebral hemorrhage
432.x	Other and unspecified intracranial bleeding
433.xx	Occlusion and stenosis of precerebral arteries
434.xx	Occlusion of cerebral arteries
435.x	Transient cerebral ischemia
436.0	Acute, but ill-defined, cerebrovascular disease
437.x	Other and ill-defined cerebrovascular disease
438.xx	Late effects of cerebrovascular disease

* This list is not all-inclusive and may be subject to different interpretation. Always refer to the latest version of the International Statistical Classification of Diseases and Health Problems. All codes with .x or .xx require fourth and fifth digits.

ICD ICD 9 Codes Related to Tobacco Cessation Counseling (cont.)*

440.xx	Atherosclerosis
441.xx	Aortic aneurysm and dissection
442.xx	Other aneurysm
443.xx	Other peripheral vascular disease
444.xx	Arterial embolism and thrombosis
445.xx	Atheroembolism
461.X	Acute sinusitis
462.0	Acute pharyngitis
463.0	Acute tonsillitis
464.xx	Acute laryngitis and tracheitis
465.x	Acute upper respiratory infections of multiple or unspecified sites
466.xx	Acute bronchitis and bronchiolitis
472.x	Chronic pharyngitis and nasopharyngitis
473.x	Chronic sinusitis
474.xx	Chronic disease of tonsils and adenoids
476.x	Chronic laryngitis and laryngotracheitis
477.x	Allergic rhinitis
478.xx	Other diseases of upper respiratory tract
480.x	Viral pneumonia
481.0	Pneumococcal pneumonia
482.xx	Other bacterial pneumonia
483.x	Pneumonia due to other specified organism
484.x	Pneumonia in infectious diseases classified elsewhere
485.0	Bronchopneumonia, organism unspecified
486.0	Pneumonia, organism unspecified
487.0	Influenza with pneumonia
413.x	Angina pectoris
487.0	Influenza with pneumonia
490.0	Bronchitis, not specified as acute or chronic
491.xx	Chronic bronchitis
491.2	Chronic obstructive pulmonary disease
492.x	Emphysema
492.8	Emphysema, obstructive
493.xx	Asthma
496.0	Chronic airway obstruction, not elsewhere classified

ICD ICD 9 Codes Related to Tobacco Cessation Counseling (cont.)*

519.1	Metaplasia, tracheobronchial tree
523.3x	Aggressive and acute periodontitis
523.4x	Chronic periodontitis
531.xx	Gastric ulcer
532.xx	Duodenal ulcer
533.xx	Peptic ulcer
733.xx	Osteoporosis
786.0	Dyspnea
786.2	Cough
786.4	Abnormal sputum
786.50	Chest pain
989.84	Toxic effect of tobacco

* This list is not all-inclusive and may be subject to different interpretation. Always refer to the latest version of the International Statistical Classification of Diseases and Health Problems. All codes with .x or .xx require fourth and fifth digits.

For additional information on tobacco related billing codes go to: http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/askact/coding.Par.0001.File.tmp/Coding-list.pdf, sponsored by the American Academy of Family Physicians.

Non-Reimbursable Indications

Inpatient hospital stays with the principal diagnosis of Tobacco Use Disorder are not reasonable and necessary for the effective delivery of tobacco cessation counseling services. Therefore, Center for Medicare and Medicaid Services (CMS) will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.

At the time of this guide (May 2010), healthcare providers, who are not recognized providers as identified in the "all-inclusive" CMS-recognized practitioner's agreement for IHS do not qualify for cessation services for CMS reimbursement.

If you have any questions regarding Indian Health Service CMS billing, refer to the link below: http://www.trailblazerhealth.com/Publication/training%20Manual/2003IHSManual.pdf

The Most Common Billing Errors

Your business office may need to submit a claim many times before it is fully paid. To maximize collections and minimize the number of resubmitted claims, you should avoid the following common documentation errors:

1. Misspelled beneficiary name, error in entry of identification number, and gender missing

- Name misspelled, which may result in an inability to match the eligible file.
- Identification number (i.e., social security number) missing, incomplete, or incorrect.
- Gender missing or incorrect.

Solution: Provide the correct and complete name, identification number, and gender of the beneficiary.

2. Billing provider information incorrect

- Assigned group number and PIN of billing provider missing or incorrect.

Solution: Provide the correct group and PIN number.

3. Diagnosis error

- ICD-9 codes missing or invalid.

Solution: Provide the ICD-9 code to the highest level of specificity (i.e., include all five digits).

4. Late filing

Solution: File claim form before the deadline. Check with your billing office staff to determine required filing deadlines.

5. Modifier error

- Modifiers inappropriate, invalid, or missing.

Solution: Provide correct modifiers.

6. Performing provider number error

- PIN missing, incorrect, or does not match group practice PIN number.

Solution: Provide the PIN of performing provider.

7. Place of service error

» Place of service missing or invalid.

Solution: Provide the place of service.

8. Procedure code error

» CPT missing or invalid.

Solution: Provide the correct CPT.

9. Quantity billed error

» Units of service out of the billable range.

» Incorrect unit format.

Solution: Units of service must be equal to or greater than 1 unit of service, but less than 99 units of service. Units of service must follow the following format: 1 unit = 0010 (the fourth digit is the tenths place for decimals).

10. Payment Name and Address error

» Incorrect payment name and address.

Solution: Provide the correct name and current address.

REFLECTIONS

ACTION

REFLECTION

THINKING — What opportunities are available for tobacco dependence treatment reimbursement in my setting?

PLANNING — How will I proceed to explore the opportunities for reimbursement?

INITIATING A PLAN — Who will I contact to identify the steps required to explore the opportunity for tobacco dependence treatment reimbursement in my setting? Who could partner with me to create a Task Force to explore opportunities and create a plan of action?

EVALUATING AND MAINTAINING — How will I know that my efforts have resulted in system-wide opportunities for tobacco dependence treatment reimbursement?

Reimbursement for Tobacco Dependence Treatment Available Through Alternate Venues: State Medicaid Programs Private Insurance Plans

The Payer Mix

Although this document emphasizes Medicare services, you can seek reimbursement for tobacco cessation services from other payers. For example, your state Medicaid Program may cover tobacco dependence treatment services. Also, many private insurance plans will match or pay even higher rates than the Medicare rate for these services. See Table 1 and Exhibit 2 that follow state Medicaid program coverage of tobacco dependence treatment.

TABLE 1. State Medicaid fee-for-service program coverage of tobacco-dependence treatments,* by type of coverage and year coverage began --- United States, 2007†

		Medication coverage							Counseling coverage		
State/Area	Year any coverage began	Gum	Patch	Nasal spray	Inhaler	Lozenge	Varenicline (Chantix)	Bupropion hydrochloride Zyban§)	Group	Individual	Phone
Alaska	2006	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No
Arizona	Unknown (P¶)	No	No	No	No	No	No	No	No	Yes (P)	No
Arkansas	1999	Yes	Yes	No	No	No	Yes**	Yes	No	Yes	No
California	1996	Yes	Yes	Yes	Yes	Yes	Yes**	Yes	No††	No	No
Colorado	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	No
Delaware	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
District of Columbia	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Florida	1998	Yes	Yes	No	No	No	Yes	Yes	No	No	No
Hawaii	1999	Yes§§	Yes§§	Yes§§	Yes§§	Yes§§	Yes§§	Yes§§	No	No	No
Idaho¶¶	2007	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	No	No	No
Illinois	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Indiana	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Iowa	2007	Yes**	Yes**	No	No	No	No	Yes**	No	Yes (P)	No
Kansas	1999	No	Yes	No	No	No	Yes	Yes	No	No	No
Kentucky	2007	No	No	No	No	No	No	No	Yes (P)	Yes (P)	Yes**
Louisiana	1990	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No
Maine	1996	Yes	Yes	Yes	Yes	Yes	Yes**	No***	No	Yes	No
Maryland	1996	No	Yes†††	Yes	Yes	No	Yes	Yes	No	Yes**	No
Massachusetts	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Michigan	1997	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes§§§	No
Minnesota	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Mississippi	2001	Yes	Yes	Yes	Yes	Yes	Yes**	Yes	Yes (P)	Yes (P)	No
Montana	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Nevada	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
New Hampshire	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	No
New Jersey	1996	Yes**	Yes**	Yes**	Yes**	Yes**	Yes	Yes	No	No	No
New Mexico	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes¶¶¶	Yes¶¶¶	No
New York	1999	Yes	Yes	Yes	Yes	No	Yes	Yes	No****	No††	No
North Carolina	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
North Dakota	1996	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No
Ohio	1998	Yes	Yes	Yes**	Yes	Yes	Yes	Yes	No	No	No
Oklahoma	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No

Table continued on next page.

Oregon	1998	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pennsylvania	2002	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Rhode Island	1994	No****	No****	No****	No****	No****	No	No	Yes	Yes	No
South Carolina	2004††	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No††	No††	No
South Dakota	2001	No	No	No	No	No	Yes	Yes	No	No	No
Texas	1996	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No
Utah††††	2001	Yes	Yes	Yes††	Yes††	Yes	Yes	Yes	Yes (P)	Yes (P)	Yes
Vermont	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Virginia	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (P)	No	No
Washington	2002 (P)	No	No	No	No	No	No	Yes (P)	No	Yes (P)	No
West Virginia	2000	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Wisconsin	1996	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No
Wyoming	2007	Yes**	Yes**	No	No	Yes**	Yes**	Yes**	Yes**	Yes**	No
Total states/areas	**45**	**37**	**40**	**33**	**32**	**30**	**38**	**41**	**15**	**25**	**4**
All Medicaid enrollees	43	37	40	33	32	30	38	40	9	17	4§§§§
Pregnant women only	2	0	0	0	0	0	0	1	6	8	0
Added in 2007	4¶¶¶¶	4	4	3	2	3	6	3	1	2	1

Source: http://www.cdc.gove/mmm/preview/mmwrhtml/mm5843a1.htm

TABLE 1. State Medicaid fee-for-service program coverage of tobacco-dependence treatments,* by type of coverage and year coverage began --- United States, 2007†
SOURCE: 2007 State Medicaid Tobacco-Dependence Treatment Survey, Center for Health and Public Policy Studies, University of California, Berkeley.
* Based on response to the following survey item: "Please indicate if your Medicaid program covered any of the following tobacco-dependence treatments in 2007: nicotine gum, nicotine patch, nicotine nasal spray, nicotine inhaler, nicotine lozenge, Chantix, Zyban, bupropion, individual face-to-face counseling, group counseling, proactive telephone counseling." Each state also was asked to provide documentation of coverage.
† N = 45. In 2007, four states with Medicaid programs (Alabama, Connecticut, Missouri, and Tennessee) covered none of the tobacco-dependence treatments recommended in the 2000 Public Health Service Clinical Practice Guideline. Two states (Georgia and Nebraska) covered bupropion without prior authorization; therefore, it could have been used for smoking cessation, although this was not the intention of the coverage policy.
§ Covered specifically for smoking cessation.
¶ P = Medicaid coverage exclusively for pregnant women.
** Treatment added in 2007.
†† Response differs from previous year's survey because of a previous reporting error. In most cases, this was a result of the state reporting on managed-care organization coverage policies and not Medicaid fee-for-service.
§§ Covered only after the gum or patch was used in conjunction with quitline support for 2 weeks.
¶¶ In 2007, Idaho provided a $200 per enrollee per year allowance for personal health benefits that could be applied to smoking cessation benefits.
*** Maine covered bupropion, but not specifically for smoking cessation.
††† Coverage for nicotine patches differs from the 2006 report because of a different interpretation of Maryland's coverage policy. Generally, Maryland does not cover any pharmaceuticals that are available over-the-counter; however, some prescription-only (legend) patches are still available and therefore were covered.
§§§ Covered since 2006. This was erroneously reported as "not covered" in the previous report.
¶¶¶ Fee-for-service covers when a valid behavioral health diagnosis other than tobacco dependence exists.
**** Fee-for-service Medicaid did not cover, but Medicaid managed-care organizations were required to cover.
†††† Utah's coverage will continue until Tobacco Settlement funds expire.
§§§§ Telephone counseling is available for free to the entire population in every state and the District of Columbia through quitlines (available by dialing 1-800-QUITNOW [784-8669]). Four states use some of their Medicaid funds to support quitline operations.
¶¶¶¶ Since 2006, two states (Kentucky and Iowa) expanded coverage beyond exclusively pregnant women to the general Medicaid population, and two states (Idaho and Wyoming) began new coverage for tobacco-dependence treatments.

EXHIBIT 2
Tobacco-Dependence Treatments For Special Medicaid Populations And Program Coordination

	Special populations		Coordination		
States	Exclusive treatment for pregnant women	Treatment covered through EPSDT	Medicaid works with tobacco control division	Medicaid works with maternal and child health division	State operates a smoking quitline
AK					●
AZ	●	●	●	●	●
AR		●			●
CA		●	●	●	●[a]
CO	●	●			●
CT				●	●[a]
DE		●		●	●
FL		●			●
GA				●	●
HI		●			
IL		●		●	●[a]
IN		●		●	
IA	●		●		●
KS			●	●	●
KY	●	●		●	
LA					●
ME		●	●	●	●
MD	●			●	
MA	●	●	●	●	●
MI		●		●	●
MN	●			●	●
MS	●	●	●	●	●
MO				●	
MT		●		●	
NE		●	●	●	●
NV	●	●	●		●
NH	●	●		●	●
NJ	●	●	●	●	●
NM		●		●	●
NY	●		●	●	●
NC				●	
ND		●		●	●[b]
OH		●		●	●
OK		●	●	●	●
OR	●		●	●	●
PA	●	●			●
RI	●	●			●
SC				●	●[b]
SD		●		●	●
TX				●	●
UT	●	●	●	●	●
VT		●			●
VA	●	●		●	
WA	●	●		●	●
WV	●		●	●	●
WI	●	●	●	●	●
WY		●	●	●	●[a]
DC				●	
States	20 (39%)	32 (63%)	17 (33%)	37 (73%)	39 (76%)

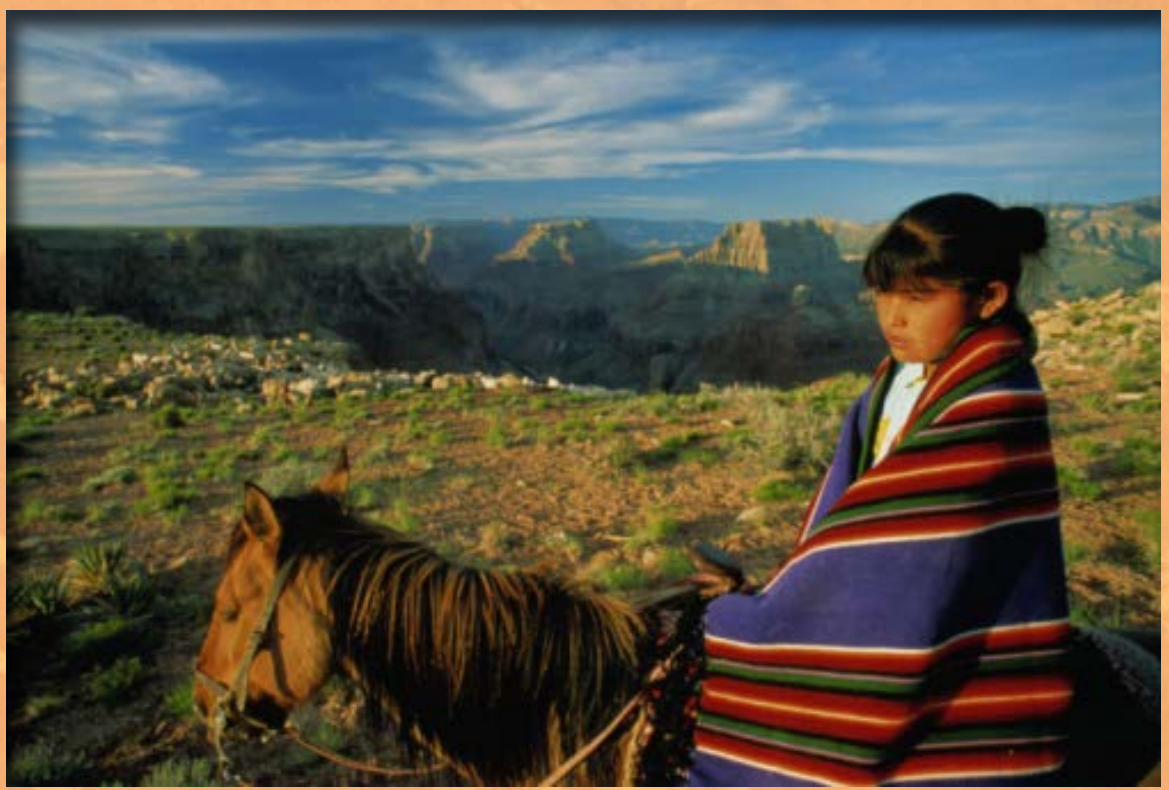
SOURCE: Center for Health and Public Policy Studies, State Medicaid Tobacco Dependence Treatment Survey, University of California, Berkeley, 2003.

NOTES: State Medicaid agencies were asked (1) if they offer any tobacco dependence treatment exclusively for pregnant women; (2) if the state operates a telephone quitline for smokers; (3) if they cover any tobacco dependence treatments under their Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; (4) if they work with their state's tobacco control division; and (5) if they work with their state's maternal and child health division. The quitline information provided in the survey was verified by the Center for Tobacco Cessation survey of states through September 2003.

[a] Identified as a state with a quitline by the Center for Tobacco Cessation survey.

[b] Although North Dakota and South Carolina did not report having a quitline in 2003, they were identified as states with quitlines through press releases announcing the launch of the quitlines in 2004.

EVIDENCE-BASED TOBACCO DEPENDENCE TREATMENT INTERVENTIONS AND STRATEGIES



Tobacco Dependence Treatment Services: Beginning to Build Systems of Change

Tobacco dependence treatment systems will occur with administrative support, education & treatment, and reimbursement. Clinician involvement is vital in offering individuals evidence-based tobacco dependence treatment on the importance of counseling to quit (Houston, Miller, 2006).

Clinical opportunities to address smoking-related diseases present themselves during formal and informal settings. Providers should be looking for teachable moments in either setting when interacting with a person who uses commercial tobacco. Additionally, reimbursement for the provision of tobacco dependence treatment services must be provided in the clinical setting, be well documented, and be accurately coded for reimbursement.

Levels of Intensity in Tobacco Dependence Treatment Interventions

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use And Dependence* (2008) defines minimal, low-intensity (brief/intermediate), and high-intensity (intensive) interventions in tobacco dependence treatment.

Minimal Interventions

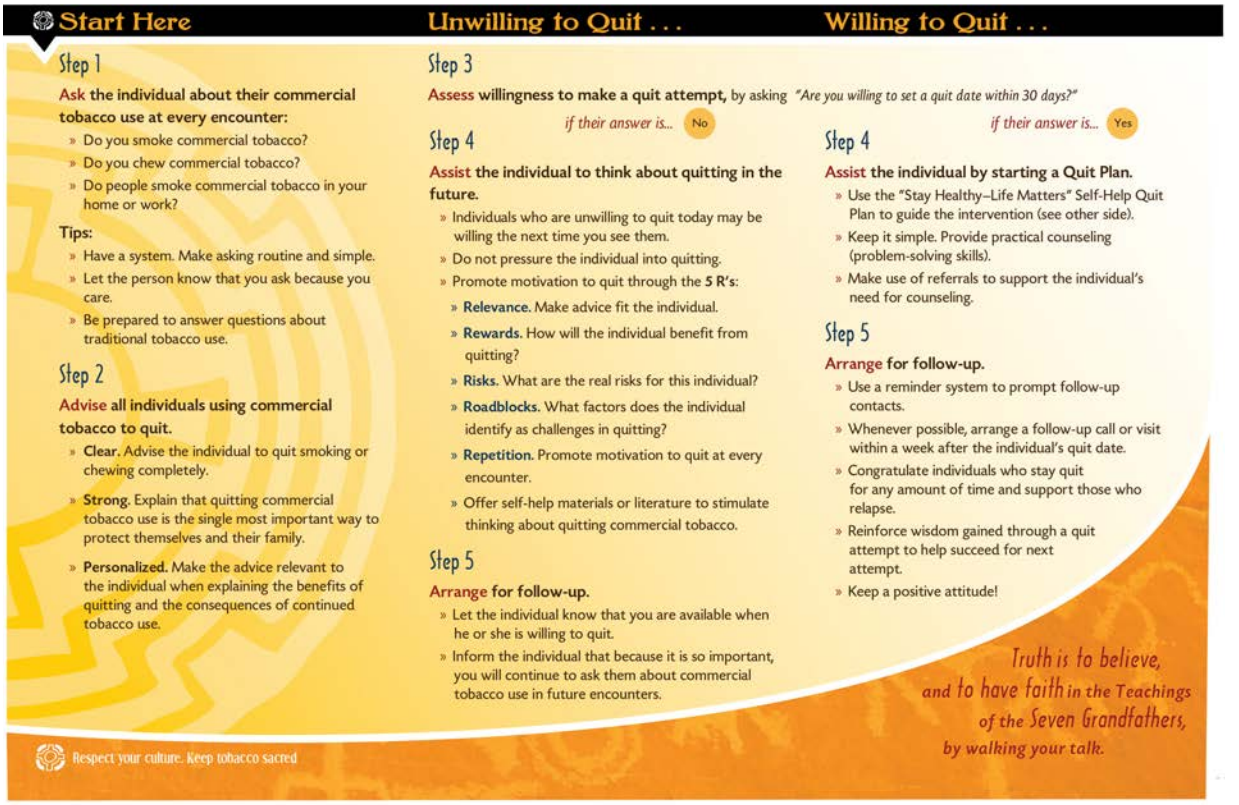
Minimal tobacco dependence interventions are defined as being less than three minutes long with little to no significant personal interaction (e.g., handing out informational brochures at a health fair). Minimal interventions may not have a significant effect upon clients/patients, but they are a low-cost method of reaching many people.

Low-Intensity Counseling (Brief/Intermediate Interventions)

The brief/intermediate interventions practiced in low-intensity counseling are 3 to 10 minutes in length and require personal interaction with the ultimate goal of assisting an individual in quitting commercial tobacco products. There are two types of brief interventions, individual and group:

» **Individual Brief Interventions** are based on the Five A Model

The Five A Model (Ask, Advise, Assess, Assist, and Arrange), was first developed by the National Cancer Institute and later expanded upon in the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use And Dependence* (2008). The Five A Model for brief interventions has been shown to be an effective model to intervene with patients dependent on commercial tobacco.



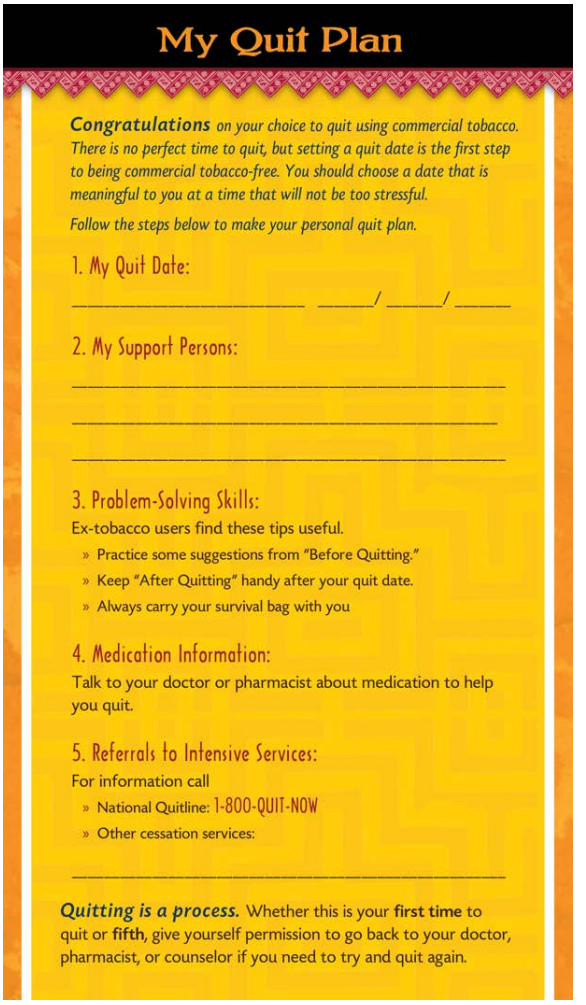
Learn more about the Five A Model from:

The IHS FlowChart (pictured above): *Basic Tobacco Intervention Skills for Native American Health Provider Clinical Flow Chart*. Available at Native Circle, http://www.nativeamericanprograms.org/index.html and The University of Arizona HealthCare Partnership, www.healthcarepartnership.org.

The *IHS Fieldbook: Implementing Tobacco Control into the Primary Healthcare Setting*, Pages 25-29. Available at Native Circle, http://www.nativeamericanprograms.org/index.html and The University of Arizona HealthCare Partnership, www.healthcarepartnership.org

Quick Reference Guide for Clinicians: *Treating Tobacco Use and Dependence*. Available at, http://www.surgeongeneral.gov/tobacco/tobaqrg.htm.

» Group Brief Interventions are short presentations used to raise awareness of the health consequences of tobacco dependence and present the core components of a simple evidence-based Quit Plan.



My Quit Plan

Congratulations *on your choice to quit using commercial tobacco. There is no perfect time to quit, but setting a quit date is the first step to being commercial tobacco-free. You should choose a date that is meaningful to you at a time that will not be too stressful.*

Follow the steps below to make your personal quit plan.

1. My Quit Date:

_____ _____/ _____/ _____

2. My Support Persons:

_____

_____

_____

3. Problem-Solving Skills:

Ex-tobacco users find these tips useful.

» Practice some suggestions from "Before Quitting."
» Keep "After Quitting" handy after your quit date.
» Always carry your survival bag with you

4. Medication Information:

Talk to your doctor or pharmacist about medication to help you quit.

5. Referrals to Intensive Services:

For information call

» National Quitline: 1-800-QUIT-NOW
» Other cessation services:

_____

Quitting is a process. Whether this is your **first time** to quit or **fifth**, give yourself permission to go back to your doctor, pharmacist, or counselor if you need to try and quit again.

Learn more about the evidence related to making a Quit Plan:

The Quit Plan can be used to assist a patient who is willing to quit commercial tobacco use. It should take no more than 10 minutes to complete.

The IHS Quit Plan (pictured on previous page): *Basic Tobacco Intervention Skills for Native American Health Provider Quit Plan*. Available at Native Circle, http://www.nativeamericanprograms.org/index.html and The University of Arizona HealthCare Partnership, www.healthcarepartnership.org

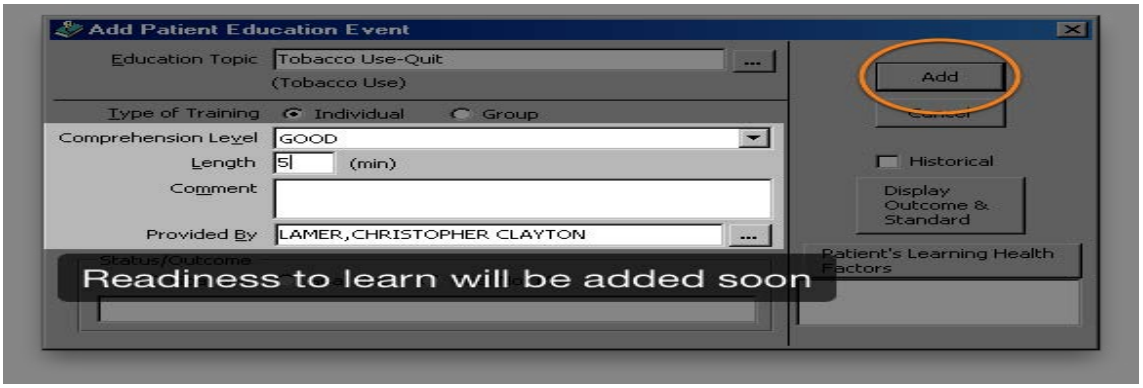
The IHS Fieldbook: *Implementing Tobacco Control into the Primary Healthcare Setting,* Page 31. Available at Native Circle, http://www.nativeamericanprograms.org/index.html and The University of Arizona HealthCare Partnership, www.healthcarepartnership.org

Quick Reference Guide for Clinicians: *Treating Tobacco Use and Dependence.* Available at http://www.surgeongeneral.gov/tobacco/tobaqrg.htm.

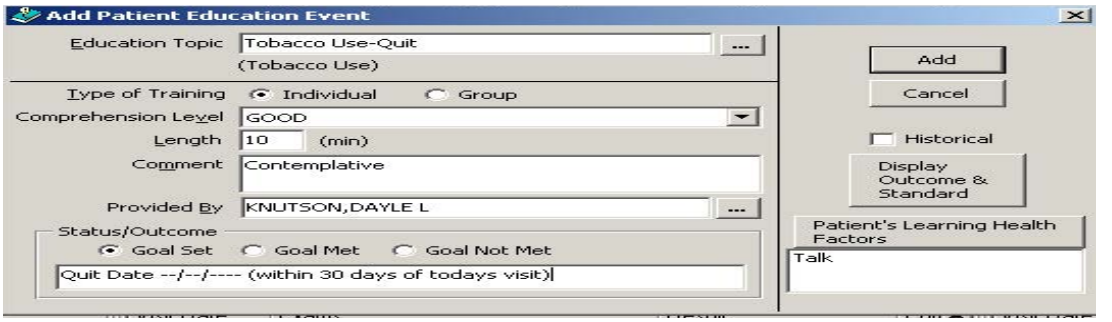
Sample Electronic Health Record FIVE A Model Documentation

ASK

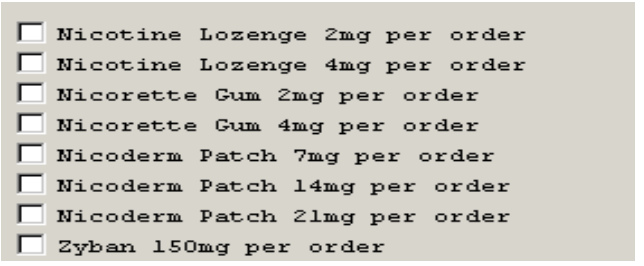
ADVISE



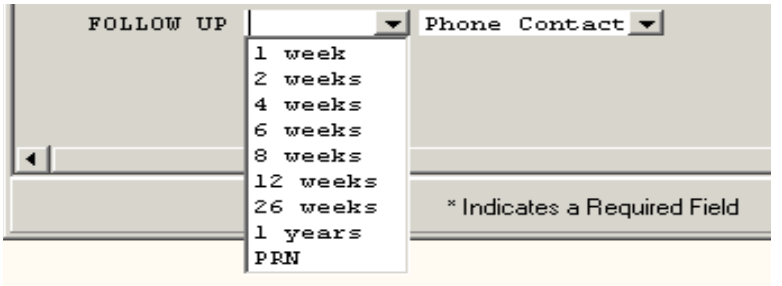
ASSESS



ASSIST



ARRANGE



Sample I.H.S. Electronic Health Record notes can be found at:

ftp://ftp.ihs.gov/pubs/EHR/Templates/TIU%20Note%20Templates/By%20Clinic/Tobacco%20Cessation/

High-Intensity Counseling (Intensive Interventions)

Intensive interventions are multi-session treatment programs that are aimed at helping people quit using commercial tobacco. The U.S. Public Health Service Clinical Practice Guideline stresses that intensive treatments must last at least two weeks, consist of sessions longer than 10 minutes, contain four or more sessions, have total contact time of more than 30 minutes, and be scientifically proven effective (Fiore *et al.*, 2008).

Intensive interventions are facilitated by certified providers who assess an individual's willingness to quit; teach about health risks, benefits, and pharmacotherapy; and emphasize the importance of practical counseling and social support.

- There is a strong dose-response relationship between treatment effectiveness and the number of sessions, the session length, and the total amount of contact time.
- Higher-intensity counseling produces significantly higher quit outcomes than minimal or low-intensity counseling.
- Any contact time produces significantly higher quit outcomes over no contact, with 31–90 minutes producing the highest abstinence rates (Fiore *et al.*, 2008).

There are two validated Intensive Tobacco Dependence Treatment Programs specific to American Indian/Alaska Native community members: *Puyallup Tribal Health Clinic (PTHA) Intensive Intervention System and Second Wind:* An Intensive Stop-Smoking Curriculum for American Indians/Alaska Natives. The American Lung Association offers a validated face-to-face Tobacco Dependence Treatment intensive program and an online program, *Freedom from Smoking:* www.lungusa.org. The American Cancer Society offers a face-to-face validated intensive program, *Freshstart:* www.cancer.org.

Assessing Nicotine Dependence

An individual who is more dependent on nicotine may have greater difficulty in quitting tobacco products (Fagerström & Schneider, 1989), and may benefit more from intensive tobacco dependence treatment (Niaura & Abrams, 2002).

Simply asking a person if s/he uses tobacco may not be enough information to determine their treatment needs. Several instruments used to assess a person's level of dependence are:

- Fagerström Test for Nicotine Dependence (Heatherton, Kozlowski, Frecker, & Fagerström, 1991).
- Wisconsin Inventory of Smoking Dependence Motives (WISDM-68). (Pidoplichko VI, DeBiasi M, Williams JT, Dani JA. 1997)

» CAGE Questionnaire Modified for Smoking Behavior (Lairson DR, Harrist R, Martin DW, Ramby R, Rustin TA, Swint JM, et al. 1992).

Biomarkers Validating Nicotine Use

Carbon Monoxide monitors can be used in the clinical and non-clinical setting to conduct a non-invasive but potentially motivational biomedical test. Carbon Monoxide monitors measure the parts per million of carbon monoxide present in the smokers exhaled breath.

Nicotine and cotinine, a metabolite of nicotine, can be measured in blood serum, urine, saliva, and hair. Clinicians can request lab tests to validate use and/or to provide a treatment intervention. However, none of the biomarker tests mentioned is reimbursable through Medicare or Medicaid as of April 2010.

REFLECTIONS

ACTION

REFLECTION

THINKING — What opportunities are available for tobacco dependence treatment reimbursement in my setting?

PLANNING — How will I proceed to explore the opportunities for reimbursement?

INITIATING A PLAN — Who will I contact to identify the steps required to explore the opportunity for tobacco dependence treatment reimbursement in my setting? Who could partner with me to create a Task Force to explore opportunities and create a plan of action?

EVALUATING AND MAINTAINING — How will I know that my efforts have resulted in system-wide opportunities for tobacco dependence treatment reimbursement?

IMPLEMENTING EVIDENCE-BASED TREATMENT WITH A PERSON DEPENDENT ON TOBACCO

Case Study

Mr. M is a 70 year old patient who recently suffered a stroke. Mr. M is in the preparation stage of quitting tobacco. He still has doubts, but he is ready to make a commitment. He is also being treated for hypertension and diabetes. Mr. M was referred by his Primary Care Physician (PCP) who recommended that Mr. M quit smoking due to his medical risks. Mr. M feels that he may have a hard time quitting because of his lifestyle. His significant other is also a smoker. Mr. M smokes a pack of cigarettes per day. He was prescribed Zyban® (bupropion-SR) and the 21 mg nicotine patch by his PCP to help him quit smoking. Mr. M maintains good eye contact; he is oriented x5. His attention and concentration are normal. His stroke affected his speech and movement, but did not affect his memory. He is using a cane to help him ambulate. Discussion focused on how Mr. M can change the behaviors that bind him to smoking. He says he is determined to quit smoking due to his health problems. He states that he will use the patches and Zyban® to help him quit smoking. He will work on staying away from smoke filled areas and businesses. He will not allow smoking in his home and has thrown away all ashtrays and lighters. His sister is his support person. She is supporting his efforts to quit. Mr. M has smoked for 50 years, so he realizes he may have a hard time quitting on his own. He is going to work on changing some of his old habits for new ones. He says he smokes more when he is stressed out. He will try deep breathing exercises to help him relax and deal with the stress. Mr. M has agreed to a treatment plan:

- Continue use of Zyban® and 21 mg nicotine patch
- Continue with counseling session weekly until he is smoke free
- Use deep breathing exercises to help him reduce his stress.
- Change his old habits for new ones.
- Deal with his triggers; stay away from smoke filled areas. Chew sugar free gum and suck on sugar free hard candies to reduce his risk of reaching for a cigarette.

Mr. M is a Medicare Part A and B recipient. His visit was submitted to the billing office for reimbursement of services. Mr. M has several conditions (s/p stroke, diabetes and hypertension) that are adversely affected by his smoking; therefore, his visit is eligible for payment of services.

Dec 02, 2008 Page 1

Chargemaster PCC Patient Detail Report

(Aug 19, 2008 - Aug 19, 2008)

Type Code	Description	CPT	Qty	Mod	Mod Pg	Charge
VISIT	LICENSED MEDICA CATEGORY: A					
CPT	PSYTX, OFFICE, 20-30 MIN	90804				
POV 305.1	TOBACCO USE DISORDER					
TC 26401450	SMOKING/TOBACCO CESS; +10M	99407		8A		66.00
TC 22000010	OP IND PSYCH; 20-30M	90804		8H		147.62

Details:
90804 - Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
90807 - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

Documenting Interventions

The term "SOAP notes" refers to a particular format of recording information regarding treatment procedures. Documentation of treatment is an extremely important part of the treatment process. In virtually all healthcare settings, some form of documentation is required and SOAP notes are the most popular format in medical settings. SOAP notes consist of information presented in the following order:

Subjective

Describes impressions of the client/patient. For example: "Mr. M maintains good eye contact; he is alert and oriented. His attention and concentration is normal" This section should be utilized to report subjective information of clinical significance.

Objective

Measurable and observable information gathered during clinic visit about a client. For example: “Mr. M is using a cane to help him ambulate.” Remember that this section can be used to report behaviors that are observed, not just the behaviors that are being targeted.

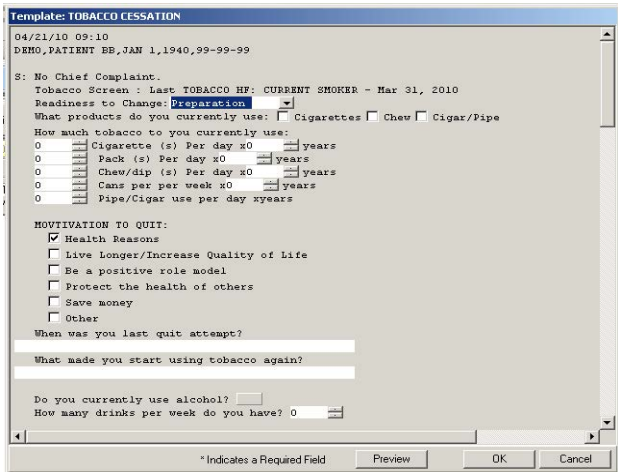
Assessment

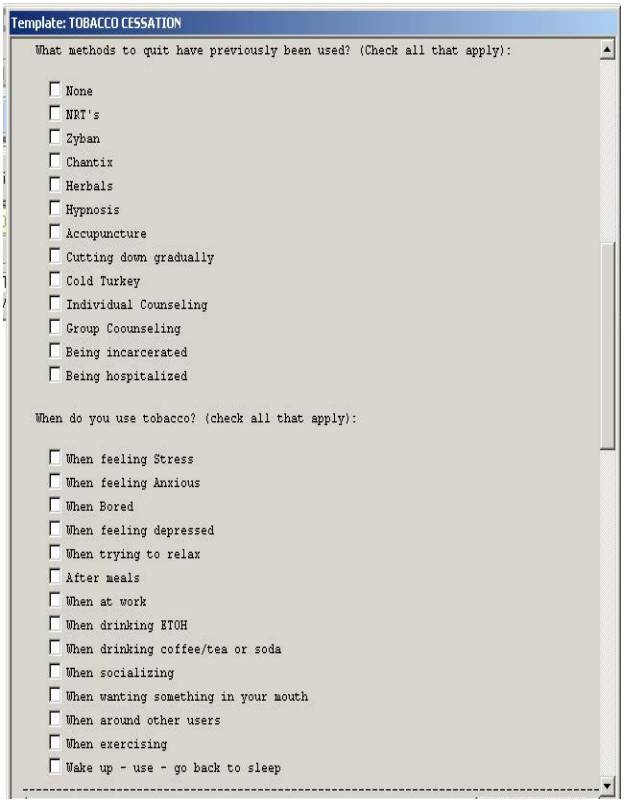
Client’s performance is assessed, in descriptive terms. For example: “Mr. M is in the preparation stage of tobacco dependence treatment.”

Plan

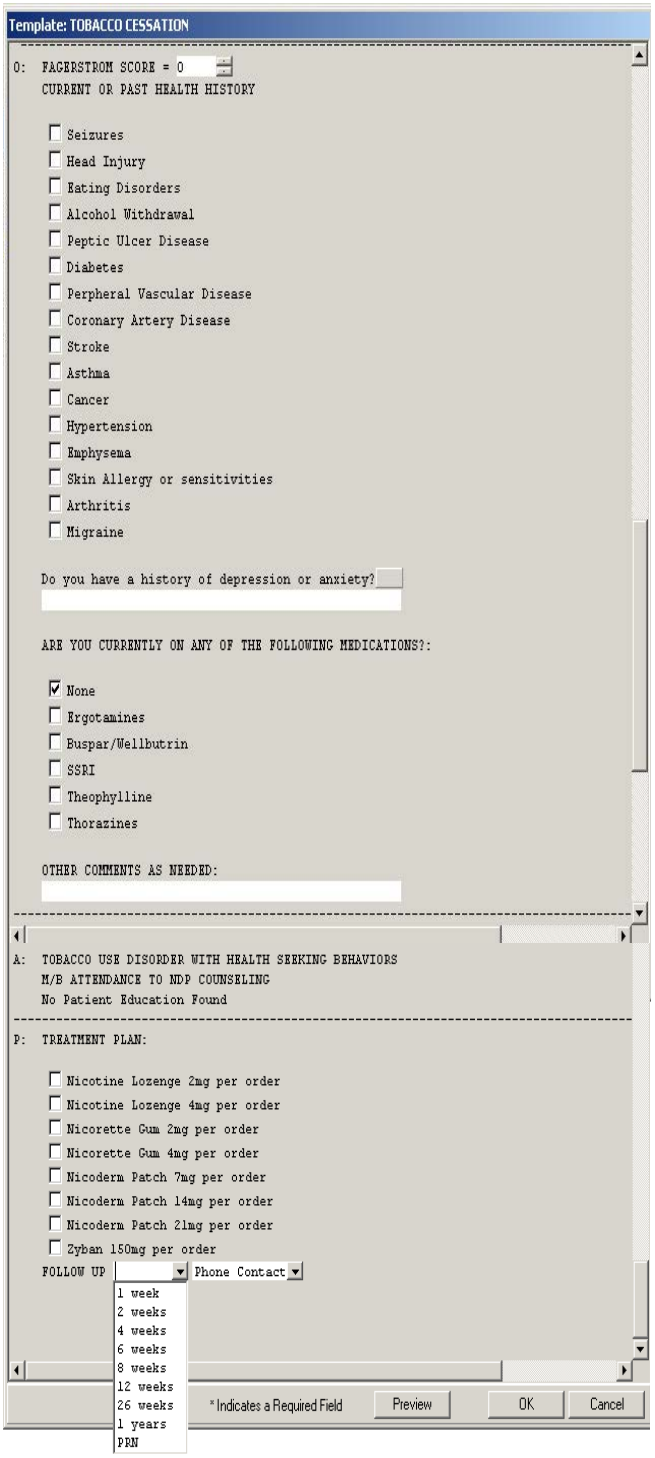
The final section of the SOAP notes is where the course of treatment is outlined, after considering the information gathered during the session. For example: “Mr. M has created a Quit Plan in which he states he will: 1) Continue to use Zyban and 21 mg nicotine patch; 2) Continue with weekly tobacco dependence counseling sessions; 3) Continue to use deep breathing exercise to reduce stress; and 4) Deal with triggers by staying away from smoke filled areas and avoid establishments that permit tobacco use.”

Sample Electronic Health Record SOAP Note





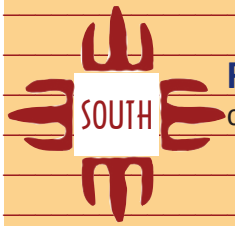
REFLECTIONS



ACTION

REFLECTION

THINKING — What opportunities are available for tobacco dependence treatment reimbursement in my setting?

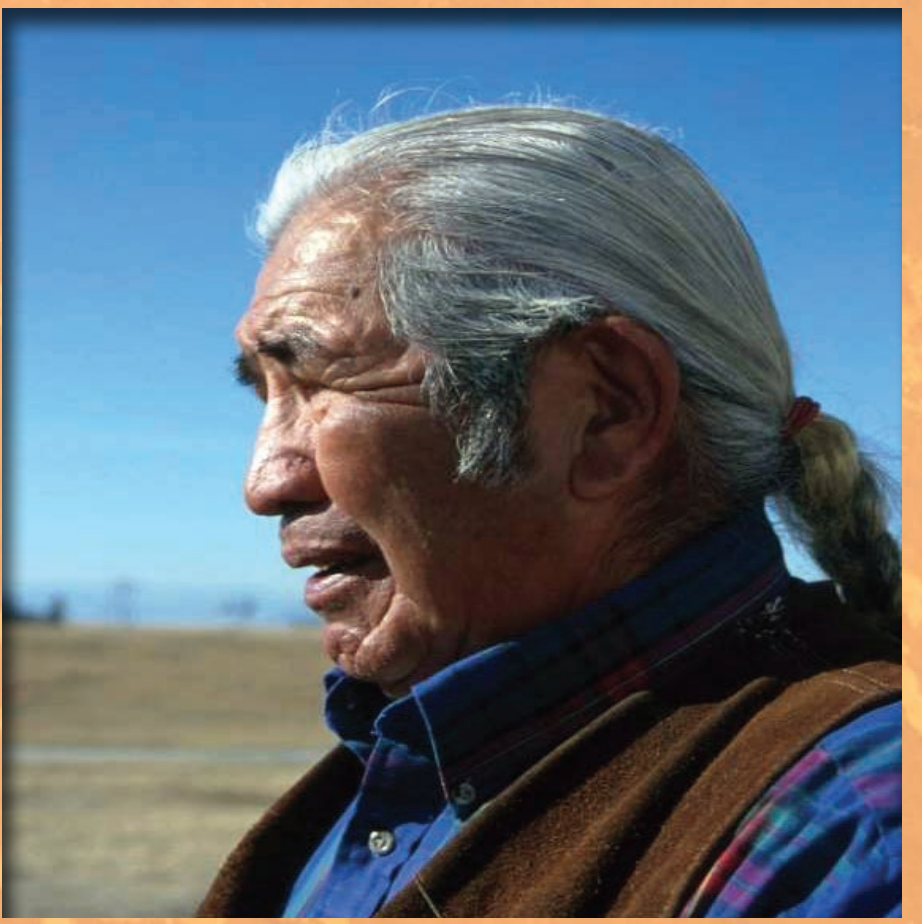


PLANNING — How will I proceed to explore the opportunities for reimbursement?

INITIATING A PLAN — Who will I contact to identify the steps required to explore the opportunity for tobacco dependence treatment reimbursement in my setting? Who could partner with me to create a Task Force to explore opportunities and create a plan of action?

EVALUATING AND MAINTAINING — How will I know that my efforts have resulted in system-wide opportunities for tobacco dependence treatment reimbursement?

INDIAN HEALTH SERVICE SYSTEMS TO SUPPORT THE TREATMENT OF TOBACCO DEPENDENCE —SUPERBILL EXAMPLES



Mental Health (P & F)

QUENTIN N. BURDICK
HEALTH CARE FACILITY

CAN/DEPT: J450461

If using the Mental Health package, enter only Trancodes. If not using the Mental Health package, enter Trancodes AND CPT codes.

Date of Service: _____

VISITS

(NOTE: For use by MD & CNS only.)

ESTABLISHED VISITS

	26100245	Office/OP, Level 1, 5-10 Min	**99211**
	26100250	Office/OP, Level 2, 10-20 Min	**99212**
	26100255	Office/OP, Level 3, 15-30 Min	**99213**
	26100260	Office/OP, Level 4, 20-40 Min	**99214**
	26100265	Office/OP, Level 5, 40-60 Min	**99215**
	22001345	Monitoring MH Drug Rx (M0064) TE	**22101345**

VISIT WITH PROCEDURE

	26101225	Office-OP W/Proc, Level 1, 5-10 Min	**99211**
	26101230	Office-OP W/Proc, Level 2, 10-20 Min	**99212**
	26101235	Office-OP W/Proc, Level 3, 15-30 Min	**99213**
	26101240	Office-OP W/Proc, Level 4, 20-40 Min	**99214**
	26101245	Office-OP W/Proc, Level 5, 40-60 Min	**99215**

DIAGNOSTIC INTERVIEW

(NOTE: For use by MD, CP, CNS & CSW only.)

	22000000	New and Reassess	**90801**
	22000005	With Communication Barrier	**90802**

PSYCHOLOGIST ONLY

(NOTE: For use by Clinical Psychologist only.)

HOURLY SERVICE - Please indicate # of hours
(Coders: Bill each hour as one unit.)

	22001365	PSYCH TEST BY PSYCH/PHYS	**96101**
	22001370	PSYCH TEST BY TECHNICIAN	**96102**
	22001375	PSYCH TEST ADMIN BY COMPUTER	**96103**
	22000150	Developmental Testing, Limited w/Inter & Report	**96110**
	22000155	Developmental Testing, Extended w/Inter & Report # Hours _____	**96111**
	22001380	NEUROBEHAVIORAL STATUS EXAM	**96116**
	22001385	NEUROPSYCH TST BY PSYCH/PHYS	**96118**
	22001390	NEUROPSYCH TESTING BY TECH	**96119**
	22001395	NEUROPSYCH TST ADMIN W/COMPUT	**96120**

ENTER ONLY TRANCODES FOR THE FOLLOWING SERVICES:

INJECTIONS

	26101485	Injection, SQ or IM	90772

MEDICATIONS

	80600351	Haloperidol Decan Per 50 mg	**J1631**
	80600350	Fluphenazine Decanoate (Prolixin) per 25 mg	**J2680**

GROUP PSYCHOTHERAPY

(NOTE: For use by MD, CP, CNS & CSW only.)

	22000090	Group Psychotherapy	**90853**
	22000095	With Communication Barrier	**90857**

OP INDIVIDUAL PSYCHOTHERAPY

(NOTE: For use by MD & CNS only.)

	22000015	20 to 30 minutes w/Medical E/M Services	**90805**
	22000025	45 to 50 minutes w/Medical E/M Services	**90807**
	22000035	75 to 80 minutes w/Medical E/M Services	**90809**

OP INDIVIDUAL PSYCHOTHERAPY

(NOTE: For use by MD, CP, CNS & CSW.)

	22000010	20 to 30 minutes	**90804**
	22000020	45 to 50 minutes	**90806**
	22000030	75 to 80 minutes	**90808**

OP INDIVIDUAL PSYCHOTHERAPY - INTERACTIVE

(NOTE: For use by MD & CNS only.)

	22000045	20 to 30 minutes w/Medical E/M Services	**90811**
	22000055	45 to 50 minutes w/Medical E/M Services	**90813**
	22000065	75 to 80 minutes w/Medical E/M Services	**90815**

OP INDIVIDUAL PSYCHOTHERAPY - INTERACTIVE

(NOTE: For use by MD, CP, CNS & CSW.)

	22000040	20 to 30 minutes	**90810**
	22000050	45 to 50 minutes	**90812**
	22000060	75 to 80 minutes	**90814**

FAMILY PSYCHOTHERAPY

(NOTE: For use by MD, CP, CNS & CSW.)

	22000080	w/Patient [R]	**90847**
	22000075	w/o Patient [R]	**90846**
	22000085	Multiple Family [R]	**90849**

OTHER PSYCHOTHERAPY / PROCEDURES

(NOTE: For use by MD only.)

	22000125	Unlisted Service or Procedure	**90899**

OTHER

(NOTE: For use by MD, CNS, & NP only.)

	22000120	Hypnotherapy	**90880**
	22000100	Medication Management w/Minimal Therapy	**90862**

KEY

R **Restricted Medicare Coverage**

TOBACCO CESSATION

	99406	Smoking/Tobacco Cess; 3-10min (MD only)	
	99407	Smoking/Tobacco Cess; +10min (MD only)	
	26101775	Smoking/Tobacco Cess; 3-10 min	
	26101780	Smoking/Tobacco Cess; +10 min	

FAMILY MEDICINE CLINIC-PROVIDER

QUENTIN BURDICK HEALTHCARE CENTER

BELCOURT, ND 58316

NOTE: For use by MD, DO, NP & PA only.

Date of Service: _____ Provider: _____

VISITS

NOTE: May need -25 modifier with procedure(s).

Established Patients

CC, HPI 1-3, ROS 0, PF Exam, Straight Forward - 10 minutes	99212
CC, HPI 1-3, ROS 1, EPF Exam, Low - 15 minutes	99213
CC, HPI - 4, ROS 2-9, PMFSH (1), D Exam, Moderate - 25 minutes	99214
CC, HPI - 4, ROS 10-14, PMFSH (2), C Exam, High - 40 minutes	99215
POST OP (1st) Surgical Pkg (eg. Suture Rmvl, F/U Fx Care)	99024

New Patients

CC, HPI 1-3, ROS 0, PF Exam, Straight Forward - 10 min	99201
CC, HPI 1-3, ROS 1, EPF Exam, Straight Forward - 20 minutes	99202
CC, HPI - 4, ROS 2-9, PMFSH (1), D Exam, Low - 30 minutes	99203
CC, HPI - 4, ROS 10-14, PMFSH (2), C Exam, Moderate - 45 minutes	99204
CC, HPI - 4, ROS 10-14, PMFSH (3), C Exam, High - 60 minutes	99205

PREVENTIVE/WELL EXAMS

	NEW	ESTAB
Under 1 Year	99381	99391
1 - 4 Years	99382	99392
5 - 11 Years	99383	99393
12 - 17 Years	99384	99394
18 - 39 Years	99385	99395
40 - 64 Years	99386	99396
65 & Older	99387	99397

Medicare Breast and Pelvic Exam Only (G0101) Mnemonic TE: 26400110

Medicare Distal Rectal Exam (Prostate) Only (G0102) Mnemonic TE: 26400115

Medicare Screening Pap Smear (G0091) Mnemonic TE: 26100145

INITIAL MEDICARE VISIT

INITIAL PREVENTIVE EXAM	G0344
EKG-12 LEADS; WITH INT& REPORT	G0366
EKG TRACING ONLY	G0367
INT& REPORT ONLY	G0368

WELLNESS COUNSELING - NO EXAM

15 Minutes	99401
30 Minutes	99402
45 Minutes	99403
Group - 30 Min	99411
Group - 60 Min	99412

PROLONGED SERVICES

Prolonged Face to Face, 1st hr	99354
ea. additional 30 minutes	99355

CONSULTATIONS

Requested By:

CC, HPI 1-3, PF Exam, Straight Forward - 15 minutes	99241
CC, HPI 1-3, ROS 1, EPF Exam, Straight Forward - 30 minutes	99242
CC, HPI 4+, ROS 2-9, PMFSH 1, D Exam, Low - 40 minutes	99243
CC, HPI 4+, ROS 10-14, PMFSH 3, C Exam, Moderate - 60 minutes	99244
CC, HPI 4+, ROS 10-14, PMFSH 3, C Exam, High - 80 minutes	99245

SMOKING CESSATION

SMOKING/TOBACCO CESS 3-10 MIN	99406
SMOKING/TOBACCO CESS >10 MIN	99407

BURNS, LOCAL TREATMENT

Code facility procedure at this level with same CPT:

Initial Treatment, 1st degree	16000	1
Drsg/Debride Initial/Subs w/o Anes., Small	16020	1
Medium (eg, whole face/whole extremity)	16025	2
Large (more than one extremity)	16030	2

GYN

Diaphragm Fitting	57170	
IUD Insertion	58300	
IUD Removal	58301	1
Noplant Placement	11975	
Noplant Removal	11976	3
Noplant Removal w/Reinsert	11977	

DELIVERY/ANTE/POSTPARTUM

Code both physician and facility components after delivery

Antepartum Care 4-6 Visits	59425	
Antepartum Care 7/More Visits	59426	
Postpartum Care Only	59430	
Vaginal-Delivery Only	59409	
Vaginal-Total Package	59400	
Vaginal w/PP Care	59410	

ORTHO PROCEDURES

Aspirate/Inject Small Joint (eg, finger, toes	20600	2
Medium Joint (eg, ankle, wrist)	20605	2
Large Joint (eg, shoulder, hip)	20610	2
Dislocation, Finger	26700	2
Nerve Block; Digital	64450	3
Osteopath Manip, 1-2 body regions	98925	
Osteopath Manip, 3-4 body regions	98926	
Osteopath Manip, 5-6 body regions	98927	
Trigger Point Injection	20552	2
Ulna Boot	29580	1

PERIPHERAL NEUROPATHY in Diabetes Treatment

Use Tram Codes; Enter with Umbrella TE

Initial Foot Exam Pt LOPS - G0245	26401030
Follow-up Eval of Foot Pt LOPS - G0246	26401035
Routine Footcare of Pt w/ LOPS - G0247	26401040

FRACTURE CARE

NOTE: Global includes rechecks for 90 days.

BONE/JOINT: _____

Manipulation? ☐ Yes ☐ No

Wound Repair? ☐ Yes ☐ No

___ Initial Cast - no fx care management

___ Recasting - specify below

CPT:	Facility Charges:
	Level varies by procedure. Check Nar

LACERATION REPAIR

Location:

Size (cm):

___ Simple ___ Intermed ___ Complex

Tendon involvement? ___ No ___ Yes

CPT:	Facility Charges:	
	Less 430 sm	2
	Less simple 430 sm	2
	Less layered 430 sm	4

LESION: ☐ Excision ☐ Destruction

Location:

#	Simple	Extensive

Size (cm):

Pathology? ___ Benign ___ Malignant

CPT:	Facility Charges:
	Level varies by procedure. Check Nar

INITIAL OR RE - APP CAST/SPLINT

Code facility procedure at this level with same CPT:

Short Arm Splint	29125	1
Long Arm Splint	29105	1
Short Leg Splint	29515	1
Long Leg Splint	29505	1
Finger Splint	29130	1
Long Leg Cast	29345	2
Long Leg Walker Cast	29355	2
Cylinder Cast (Thigh to Ankle)	29365	2
Short Leg Cast	29405	2
Short Leg Walker Cast	29425	2
Long Arm Cast	29065	2
Short Arm Cast	29075	2
Removal/Window; Cast Applied Elsewhere	29700	1

PROCEDURES

Benign/Premalignant First Lesion	17000	1
2nd-14th, Ea Add'l. Lesion #	17003	
15 or more lesions	17004	2
Biopsy, Skin	11100	1
Cerumen Impaction Removal	69210	
Chem cauterization tissue	17250	1
Debride infected skin	11000	1
Debridement, Partial Thickness	11040	1
Evacuate Subungual Hematoma	11740	
Flex Sig	45330	3
FB Removal; Ear	69200	
Nose	30300	
Conjunctiva Superficial	65205	1
Conjunctiva Embedded/Irrigation	65210	1
Corneal w/o Slit Lamp	65220	1
Corneal w/Slit Lamp	65222	1
I & D Abscess, Simple or Single	10060	1
Complicated / Multiple	10061	1
I&D abscess, perirectal	42700	2
I&D Hematoma, Seroma, Fluid	10140	5
Lumbar puncture	62270	3
Nail Plate Avulsion, Single	11730	1
each additional nail plate	11732	1
Pinch Aspiration abscess	10160	1
Skin Tag Removal; up to 15 Lesions	11200	1
each additional 10 lesions	11201	1
Wart Destruction, up to 14	17110	1
15 or more	17111	1

URGENT PROCEDURES

Control Nasal Hemor, Anterior, Simple	30901	1
Control Nasal Hemor, Posterior, Initial	30905	1
Subsequent	30906	1

OTHER

CIRCUMCISION	54150	8

Modifiers

-24	Unrelated Exam During Post OP
-25	Separate Exam - Same Day of Procedure
-52	Reduced Services
-79	Different Procedure During Post Op

Definitions

CC - Chief Complaint

History - Location, Quality, Severity, Duration, Time, Context, Mod. Factors, Assoc. Signs/Symptoms

ROS - Review of Systems

PMFSH - Past Medical, Family, Social History

EXAM - PF-(Problem Focused) 1 Body Area/Organ System

EPF (Expanded Problem Focused) Limited Exam 2-9 Body Areas/Organ Systems

D-(Detailed) Extended Exam 2-9 Body Areas/Organ Systems

C-(Comprehensive) 8 Organ Systems

MDM - Straight Forward-Low, Moderate, or High

ADDITIONAL RESOURCES

- http://www.nativeamericanprograms.org/index-circle.html (Mayo Native CIRCLE)
- http://www.healthcarepartnership.org (The University of Arizona HealthCare Partnership)
- http://surgeongeneral.gov/tobacco/ (Office of the Surgeon General)
- http://www.smokefree.gov/ (National Website for Tobacco Dependence Treatment)
- http://www.fda.gov/TobaccoProducts/default.htm (Food and Drug Administration)
- http://www.cancer.org/docroot/home/index.asp (American Cancer Society)
- http://www.armericanheart.org/ (American Heart Association)
- http://www.lungusa.org/ (American Lung Association)
- http://www.becomeanex.org/ (Become An EX)
- http://endsmoking.org/ (Professional Assisted Cessation Therapy)
- http://srnt.org/ (Society for Research on Nicotine and Tobacco)
- http://www.tobacco.org/ (Tobacco News and Information)

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