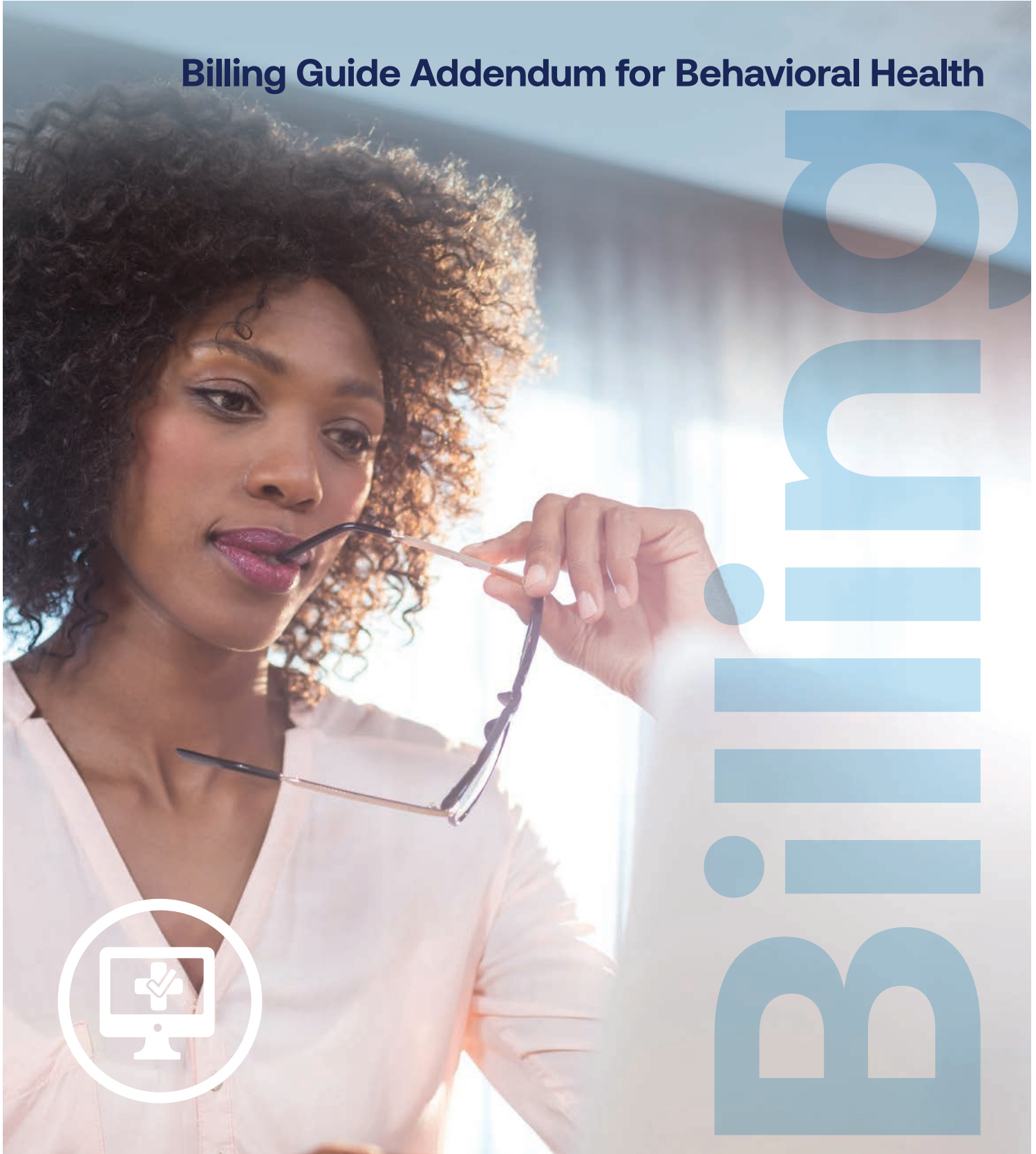


## Billing Guide Addendum for Behavioral Health



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In 2017, 14 percent of US adults aged 18 years or older currently smoked cigarettes. Although the rate of tobacco use declined significantly over the last 50 years, the reduction in cigarette use has not been consistent across the population. Approximately 50 percent of people with behavioral health conditions (including mental health and substance use disorders), still smoke. While this group smokes half of all cigarettes produced, they are only half as likely as other smokers to quit.<sup>1</sup> Research has shown that smoking can worsen symptoms and behavioral health outcomes, and quitting can improve mental health and substance use disorder treatment outcomes.<sup>2</sup>

**Like other smokers, smokers with mental illness are interested in quitting, are able to quit, and have a better chance of quitting successfully when they have access to proven stop-smoking treatments.**

— CDC Vital Signs, February 2013

Smoking-related diseases are a leading cause of death among individuals with substance use disorders. Contrary to popular opinion, tobacco dependence treatment does not interfere with patients' recovery from the abuse of other substances.<sup>3</sup> In fact, individuals who treat their addiction to tobacco and other substances at the same time are 25 percent more likely to sustain their recovery, compared to the individuals who do not address tobacco while in recovery from alcohol and other drugs.<sup>4,5</sup>

An important component of integrating tobacco use treatment into services provided to people with behavioral health conditions is ensuring that the provider is compensated, which is uniquely challenging for many behavioral health providers.



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## Billing Overview for Behavioral Health

**Tobacco Use Disorder** can be effectively treated in a behavioral health setting and is considered a billable service by Medicare, Medicaid, and many commercial insurance carriers, depending on the licensure and scope of practice of the provider (for example, a psychologist vs a peer mentor). For the most part, the universe of diagnosis codes and procedures/service codes are the same for behavioral health providers as other providers offering tobacco use treatment (TUT). Likewise, the documentation requirements are the same for all types of providers. However, there are some important distinctions and nuances that behavioral health providers should consider to optimize the chance of successful billing. This addendum to [The American Lung Association Billing Guide for Tobacco Screening and Cessation](#), strives to clarify those distinctions. It should be noted however, that there is no one approach that is universally accepted and followed by all healthcare systems and payers. If a bill is not paid, try again using different codes and document what works with your health system's contracted payers.

There are three fundamental consideration to make when billing for TUT:

1. Who is qualified to bill?
2. What kind of diagnosis code to use?
3. What kind of service code to use?

## Eligible Providers

Medicare indicates that tobacco cessation services provided by qualified physicians and other Medicare-recognized practitioners are eligible for reimbursement. In addition to MDs and DOs, this includes physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, physical therapists, occupational therapists, speech language pathologists and clinical psychologists.

Other payers are subject to state licensing and scope of practice requirements. For behavioral health providers who do not fit into any of the Medicare categories, we advise pursuing three avenues of clarification:

1. Determine if the licensing and scope of practice laws in your practice area permit the provision of tobacco cessation.
2. Determine if your state Medicaid plan has any restrictions with respect to who may provide tobacco cessation services.
3. Contact the insurance carriers with whom you contract regarding any restrictions on providing cessation services. If you are a credentialed provider, it is unlikely that a commercial insurance carrier will prohibit you from providing cessation services. However, payment is by no means guaranteed.



## Billing Guide Addendum for Behavioral Health

### Diagnosis Codes

The first decision a behavioral health provider must make when diagnosing tobacco use is whether to use an ICD-10 F17 or Z code or a DSM-5 code. The F and Z codes are from the Mental and Behavioral Disorder category of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). The F17 codes are used if the patient is dependent on tobacco. The Z codes are used if there is NOT dependence on tobacco. The Z codes cannot be combined with an F17 code.

DSM-5 codes are from the Diagnostic and Statistical Manual of Mental Disorders, Edition 5. Tobacco Use Disorder is coded in the DSM-5 as 305.1 and is defined as cases in which tobacco is used to the detriment of the person's health or social functioning, or in which there is tobacco dependence. DSM-5 292.0 is the code for Tobacco Withdrawal.

Behavioral health providers are qualified to use either the DSM-5 codes or ICD-10 behavioral or mental health diagnoses such as F17 codes as the primary rationale for their services. Medical providers may not and so must select a diagnosis code that accurately reflects the biological impact of tobacco use.

### Service Codes

A fundamental decision that influences how a provider codes is whether the tobacco services constitute counseling that merits a separate code or will be included in a time-based Evaluation and Management (E/M) service code (a typical doctor's visit). An additional decision is whether the tobacco service should be considered an "incident to" service (these are services that are important for achieving a desired outcome but "incidental" to the services initially provided by the doctor). Each of these three decisions (counseling, E/M, incident to) are addressed below.

### Counseling Services

Examples of counseling, or behavior change modifications, related to tobacco include advising specific changes to behavioral routines, arranging for services and follow-up, or addressing barriers to change. Counseling service levels are determined by time investment. A behavioral health provider may choose to use general CPT counseling codes or CPT psychotherapy codes. If a provider bills using a counseling code rather than an E/M code, he/she is required to document "counseling" activities (advising about specific changes to routines, arranging for services or follow up) and not just "evaluation" (determining severity of dependence, comorbidities and prior cessation attempts) and "management" (medication selection based on evaluation).



## Billing Guide Addendum for Behavioral Health

### CPT Counseling Codes

< 3 min.	3-10 min.	> 10 min.	Group counseling
Routine care, no cessation specific billing code can be used	99406	99407	99078

Codes 99406 and 99407 are specific to tobacco cessation and individual counseling proffered by a provider to a patient: 99406 is considered an intermediate counseling session, while 99407 is an intensive counseling session. As noted in the table above, the difference is tied to the amount of time spent with the patient. These are excellent codes to use in conjunction with other services provided during a visit.

Group counseling code 99078 is NOT specific to tobacco cessation. It can be used for any group education provided by qualified health professionals to patients (e.g. prenatal, obesity or diabetic self-management). There is high variability among payers regarding payment for group counseling. Although counterintuitive, some payers recommend that instead the provider bill as though the service was provided to an individual with observers present (there is no prohibition on group members observing while a physician provides a service to another beneficiary). We recommend contacting the payer to verify that coverage using this code is a payable benefit. This note of caution holds regardless of the type of group counseling or education being provided; it is not unique to tobacco cessation counseling.

### CPT Psychotherapy Codes

Evaluation	30 min.	45 min.	60 min.	Group Therapy
90791	90832	90834	90837	90853

None of the psychotherapy codes identified above are specific to tobacco. They do, however, provide a mechanism for billing for more time than the tobacco-specific 10+ minute intensive counseling session provided by CPT 99407. The use of psychotherapy service codes in conjunction with tobacco diagnoses may also provide higher reimbursement but there is a great deal of variation in payment policies with respect to these codes. They are endorsed by the Public Health Clinical Practice Guideline and several practitioners report success using these codes. However, other experts note that these codes are rarely recognized for tobacco. Jill Williams et al. state that “Tobacco Use is probably the only diagnosis... (in the DSM 5) that is exempted from use of behavioral health codes.”<sup>6</sup>

If an insurance company rejects a claim for psychotherapy visits with a primary diagnosis of tobacco use disorder (DSM-5), consider resubmitting using an ICD-10 diagnosis code. Remember that only behavioral health providers are allowed to use both DMS-5 and ICD-10 diagnosis codes.



## Billing Guide Addendum for Behavioral Health

### Evaluation and Management Services

Evaluation refers to the cognitive processes applied while determining the significance or status of a problem or condition. Management refers to the conduct or supervision of clinical activities in pursuit of a therapeutic goal and implies that the plan is based on the results of the preceding evaluation. An important feature of E/M services is their fundamentally iterative nature; the evaluation leads to a management plan, the response to which becomes part of the subsequent evaluation, and so on.<sup>7</sup>

The CPT codes for E/M services each have five levels, based on the minutes expended.

### CPT Evaluation and Management Codes

Outpatient Consultation	New Patient	Established Patient
99241 – 15 minutes	*99201 – 10 minutes	99211 – 5 minutes
99242 – 30 minutes	99202 – 20 minutes	99212 – 10 minutes
99243 – 40 minutes	99203 – 30 minutes	99213 – 15 minutes
99244 – 60 minutes	99204 – 45 minutes	99214 – 25 minutes
99245 – 80 minutes	99205 – 60 minutes	99215 – 40 minutes

\*The American Medical Association (AMA) has recently announced that this code will be eliminated after 2020.<sup>8</sup>

Examples of evaluation requirements for tobacco include evaluation of variables such as severity of dependence, co-morbidities and prior cessation attempts. Examples of management decisions in tobacco include ruling out contraindications to specific pharmacotherapy (medications) or assessing the potential for drug-drug interactions. These management decisions are typically based on the evaluation information.

Most E/M services inevitably include a counseling component. If a provider chooses to use E/M codes but the counseling component exceeds 50 percent of the total time dedicated to the visit, the level of E/M service may be calculated using the established time parameters noted in the table above.

- If the provider uses an E/M code that is based on time-based billing, tobacco cessation counseling codes 99406-08 may not also be added since time-based billing encompasses the likelihood of counseling.

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

### Incident to Services

Physicians may use other staff, such as a nurse or tobacco treatment specialist to care for an established patient. If the care provided is integral to the outcome, but incidental to the services initially provided by the physician it is considered an “incident to” service. These services are not restricted to any particular type of provider but the personnel providing these services must operate within scope of practice and under a formal agreement that identifies the services to be provided. Care must also be provided face-to-face and not in a hospital setting.



## Billing Guide Addendum for Behavioral Health

Medicare pays 100 percent of the Medicare fee schedule for incident to services. This is a way to seek reimbursement for some professionals and behavioral health staff who are not qualified to bill independently but are supervised by a physician in an outpatient setting. Claims are submitted as if the supervising physician personally performed the service.

Medicare regulations specify that services may be covered as incident to when they are:<sup>9</sup>

- An integral, although incidental, part of the physician’s professional service.
- Commonly rendered without charge or included in the physician’s bill.
- Of a type commonly furnished in physicians’ offices or clinics.
- Furnished by the physician or by auxiliary personnel (non-physician practitioners and non-physician employees) under the physician’s direct supervision (the physician must be on premises but not necessarily in the same room).

To qualify as an incident to service, the service must meet all of the above requirements. A few other considerations to keep in mind:

- An incident to service cannot be billed as part of the patient’s initial visit.
- An incident to service cannot be billed in association with a new problem brought up by a patient during a visit if the new problem is not related to the reason for the visit. That requires its own coding.
- The physician does not have to provide a personal service each time the patient is seen as part of an incident to claim, but he or she must remain directly involved in the patient’s care. For example, a physician cannot turn over a patient for tobacco cessation support and bill incident to unless the physician continues to care for the patient’s conditions relating to tobacco cessation.
- The service provided should be related to or a component of the physician’s treatment plan for the patient. Diagnostic testing cannot be billed as incident to services.
- For these “incident to” services, the person providing the service must bill under the supervising physician’s name, using the level 1 E/M service code 99211.

### Incident to examples

- A psychiatrist is treating a patient for TUT and the treatment plan includes step therapy medication – starting with NRT. Patient comes in because NRT is not working. A member of the staff changes the Rx to bupropion or changes the form of NRT. This could be an “incident to” service.
- An ancillary provider does a urine test to measure nicotine as part of ongoing cessation treatment plan.



<sup>1</sup>North American Quitline Consortium (2016). A Promising Practices Report. Quitlines and Priority Populations: An Update on Our Progress to Reach and Serve Those Most Impacted by Tobacco's Harm, 2016. (Thomas-Haase, T and Rudie M). Phoenix, Arizona.

<sup>2</sup>Centers for Disease Control. What We Know: Tobacco Use and Quitting Among Individuals With Behavioral Health Conditions.

<sup>3</sup>Lemon SC, Friedman PD, Stein MD. The impact of smoking cessation on drug abuse treatment outcome. Addictive Behaviors, 2003; 28(7):1323-31.

<sup>4</sup>Kohn, C.S.; Tsoh, J.Y.; and Weisner, C.M. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. Drug and Alcohol, 2003: 69:61-71.

<sup>5</sup>Smoking cessation and alcohol abstinence: What do the data tell us? Available from: [https://www.researchgate.net/publication/6434787\\_Smoking\\_cessation\\_and\\_alcohol\\_abstinence\\_What\\_do\\_the\\_data\\_tell\\_us?](https://www.researchgate.net/publication/6434787_Smoking_cessation_and_alcohol_abstinence_What_do_the_data_tell_us?)

<sup>6</sup>Jill Williams. 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.

<sup>7</sup>Frank T. Leone, MD, FCCP; Sarah Evers-Casey, MPH, MTTS; Mary A. Mulholland, MHA, RN, CPC; and David P. L. Sachs, MD. CHEST 2016; 149(2):568-575

<sup>8</sup>American Medical Association CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

<sup>9</sup>Medicare Benefit Policy Manual, Chapter 15, Section 60 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>. Accessed July 20, 2019.



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