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**Revised**

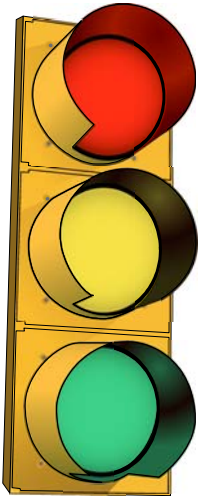
## Smoking and Tobacco Use Cessation Counseling

**Note:** This article was revised on June 6, 2005, to correct a grammatical error in the "STOP – Impact to You" section, but no substantive changes were made.

### Provider Types Affected

Physicians, other Medicare-recognized practitioners, and providers billing Medicare Fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and carriers for smoking and tobacco use cessation counseling

### Provider Action Needed



#### STOP – Impact to You

Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on Food and Drug Administration (FDA)-approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year and each attempt may include a maximum of four intermediate or intensive sessions. A maximum of 8 sessions in a 12-month period are covered.

#### CAUTION – What You Need to Know

The Centers for Medicaid & Medicare Services (CMS) has established two new "G" codes for billing for the new levels of smoking and tobacco use cessation counseling, effective for dates of service on or after March 22, 2005. **Note:** For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco use cessation counseling, use the unlisted code 99199. On July 5, 2005 and thereafter, when billing for this counseling, use the appropriate new "G" codes. Include one unit per session in the unit's field of the claim.

#### GO – What You Need to Do

Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco use cessation counseling services you provide on or after March 22, 2005.

#### Disclaimer

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## Background

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco use cessation counseling, based on current Public Health Service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco use. Patients must be competent and alert at the time that services are provided.

### *What is Covered*

When certain coverage conditions, frequency and other limitations are met, smoking and tobacco cessation counseling is covered under Medicare Part B. Medicare Part B coverage includes 2 attempts each year. Each attempt may include a maximum of 4 intermediate or intensive sessions. A total of 8 sessions are covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

### *Billing Codes*

The following two new Health Common Procedure Coding System (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

- **G0375** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. **Short Descriptor:** Smoke/Tobacco counseling 3-10.
- **G0376** - Smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. **Short Descriptor:** Smoke/Tobacco counseling greater than 10.

Because these new "G" codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco use cessation counseling. Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

**Note:** code 99199 is carrier priced. Also, providers whose claims are subject to payment under the Outpatient Prospective Payment System (OPPS) should use the G codes instead of 99199. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) bundled into the normal Evaluation and Management (E/M) visit.

Smoking and tobacco use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

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**Note:** Providers are reminded that they should keep on file appropriate documentation in the patient's medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E&M services on the same day as smoking cessation services are billed should use the appropriate HCPCS code in the 99201-99215 range AND modifier 25 to show that the E&M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, meaning charges to the beneficiary may be no more than 115% of the allowed amount.

Smoking and tobacco use cessation counseling services may be billed to FIs and RHHs on types of bills (TOB) 12X, 13X, 14X, 22X, 23X, 34X, 71X, 73X, 74X, 75X, 83X, and 85X. On TOBs 71X and 73X (Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)), FIs will pay for claims with revenue code 052X. For TOB 13X (Indian Health Service (HIS)), FIs shall accept revenue code 0510. For other TOBs, on claims received on or after July 5, 2005, FIs and RHHs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/training).

Payment by FIs/RHHs is as follows:

Type of Facility	Method of Payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/Tribally owned or operated hospitals and hospital based facilities	AIR
IHS/Tribally owned or operated non-hospital based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated Critical Access Hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled Nursing Facilities (SNFs) <b>Note:</b> Included in Part A PPS for skilled patients.	Medicare Physician Fee Schedule (MPFS)
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	MPFS
Home Health Agencies (HHAs)	MPFS
CAHs	<b>Method I:</b> Technical services are paid at 101% of reasonable cost; <b>Method II:</b> Professional services are paid at 115% of the MPFS Data Base
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

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## Additional Information

**Note:** When these services are provided by a clinical nurse specialist in the RHC/FOHC setting, the services are considered "incident to" and do not constitute a billable visit. In addition, Medicare will **not** cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change, which may be found by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

From that web page, look for CR 3834 in the CR NUM column on the right, and then click on the files for that CR. You will note two documents with CR 3834 in that column. The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

If you have questions regarding this issue, contact your carrier/FI/RHHI on their toll free number which is available at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

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