

# Medical Billing and Coding for Tobacco Dependence Treatment Services

## RESOURCE LIST

In response to Cancer Centers Cessation Initiative (C3I) Grantee interest and requests during and after the October 30, 2017 C3I Meeting, we have compiled a set of resources related to Coding and Billing for tobacco dependence treatment services. As you know, billing is a complicated topic. We offer these resources as a guide, but always contact payers for definitive guidance.

These materials include the following:

1. Integrating Tobacco Use Treatment into Practice – Billing and Documentation.  
Frank Leone, et. al. *Chest*, 149, #2, pages 568-575, February 2016.
2. A newly created document from C3I Grantee, James Davis, MD, based on his work at Duke University
3. A coding resource from the American College of Chest Physicians, with some adaptations
4. Current Procedural Terminology (CPT) Codes for Tobacco Use and Treatment
5. International Classification of Diseases (ICD) – 10 Codes for Tobacco/Nicotine Dependence

# Integrating Tobacco Use Treatment Into Practice

## Billing and Documentation



Frank T. Leone, MD, FCCP; Sarah Evers-Casey, MPH, MTTS; Mary A. Mulholland, MHA, RN, CPC; and David P. L. Sachs, MD

Balancing population-based efforts to modify the social and environmental factors that promote tobacco dependence with efforts to improve the delivery of case-based treatments is necessary for realizing maximum reductions in the cost and consequences of the disease. Public health antismoking campaigns following the 1964 Surgeon General's report on the health risks of smoking have changed social norms, prevented initiation among youth, and promoted abstinence among the addicted. However, the rate of progress enjoyed to date is unlikely to continue into the coming decades, given that current annual unassisted cessation rates among prevalent smokers remains fairly low. With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem. Clinicians report a perceived lack of reimbursement as a significant barrier to full integration of tobacco dependence into health care. A more complete understanding of the coding and documentation requirements for successful practice in this critically important area is a prerequisite to increasing engagement. This paper presents several case-based scenarios illustrating important practice management issues related to the treatment of tobacco dependence in health care.

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**KEY WORDS:** addiction; reimbursement; smoking; tobacco

Given that tobacco smoking remains responsible for a major portion of preventable death and disability, who, if not health-care providers, should be responsible for preventing that portion of preventable death and disability?

Tobacco control is clearly one of the greatest public health achievements of the 20th

century, preventing millions of smoking-related deaths.<sup>1,2</sup> Consequently, the current “end-game” strategy relies heavily on extending gains made by policy initiatives and environmental modifications.<sup>3-6</sup> Relative to the emphasis placed on population-based controls, efforts to increase the ability of health-care systems to provide effective case

**ABBREVIATIONS:** CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9

**AFFILIATIONS:** From the Perelman School of Medicine (Dr Leone, Mss Evers-Casey and Mulholland), University of Pennsylvania, Philadelphia, PA; Comprehensive Smoking Treatment Program (Dr Leone, Ms Evers-Casey), University of Pennsylvania, Philadelphia, PA; Leonard Davis Institute of Health Economics (Dr Leone), Philadelphia, PA; and Palo Alto Center for Pulmonary Disease Prevention (Dr Sachs), Palo Alto, CA.

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**CORRESPONDENCE TO:** Frank T. Leone, MD, FCCP, Comprehensive Smoking Treatment Program, Penn Lung Center, Suite 251 Wright-Saunders Bldg, 51 N 39th St, Philadelphia, PA 19104; e-mail: [frank.tleone@uphs.upenn.edu](mailto:frank.tleone@uphs.upenn.edu)

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treatment have been comparatively pedestrian, and places low on expert lists of tobacco control priorities.<sup>7,8</sup> With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem.

Though physicians clearly understand their unique role in promoting abstinence,<sup>9</sup> they do not generally recognize their role in achieving tobacco control goals.<sup>10</sup> Even when high rates of brief intervention behaviors are confirmed, physicians do not generally engage in the “next steps” consistent with sophisticated interventions of chronic illness.<sup>11</sup> This observation has prompted various regulatory agencies to introduce evolutionary pressures, designed to encourage behavior change.<sup>12-14</sup> The US Preventive Services Task Force lists tobacco dependence counseling as a “grade A” recommendation for all adults using tobacco.<sup>15</sup> System readiness to adopt these changes appears low, but is improving.<sup>16,17</sup>

The growing interest in harnessing health care’s potential and the increasing demand for professional services will require addressing the issues that have stunted its impact on the tobacco epidemic to date. Several efforts have focused on improving physicians’ familiarity with practical evidence-based treatment strategies and time management techniques. However, reported barriers have also included the perceived lack of reimbursement—a topic not routinely addressed in the literature.<sup>18,19</sup> If this is indeed a significant barrier, then fully integrating tobacco dependence into health care will require a more complete understanding of the coding and documentation requirements for successful practice in this critically important area.

### A Few Words of Caveat

Imprecise language has led to several unfortunate misimpressions over the years. The prevailing notion that “smoking cessation is not paid for” is, strictly speaking, true. Cessation is something the patient accomplishes, whereas tobacco-dependence treatment is a service provided by the clinician. This distinction is not merely semantic. Payers do not currently reimburse for cessation assistance, such as community-based counseling or quit line support. In contradistinction, cognitive services provided by eligible providers are reimbursable, irrespective of the problem to which they are applied. This paper does not discuss cessation services, but instead addresses several important practice management issues related to the treatment of tobacco dependence.

Although the specifics of tobacco treatment reimbursement vary by both insurer and contract, as a general rule, clinicians should expect to be fairly compensated for tobacco use treatment services, in a manner similar to compensation for services delivered for other problems.<sup>20</sup> Because tobacco use treatment represents a special circumstance with overlapping behavioral and biological dimensions, it is important to understand prevailing requirements and definitions that govern reimbursement. Though accurate in a general sense, the examples presented here are intended only as a guide and should not be interpreted as a guarantee of payment. When discrepancies exist, contact payer representatives for specific plan details and definitive guidance. Readers are referred to *Coding for Chest Medicine 2013*, published by the American College of Chest Physicians for specific coding details and definitions.<sup>21</sup>

All case vignettes are fictional. Any similarity to actual cases or events is purely coincidental.

### The Established Outpatient Visit

Mr Jackson is a 49-year-old patient with a long history of asthma. His asthma has been well-controlled on inhaled corticosteroids and bronchodilators for some time, and he presents for routine follow-up monitoring. After identifying diffuse mild end-expiratory wheeze on examination, your discussion with him suggests control over his asthma is loosening. You engage Mr Jackson in conversation about the relevance of his continued smoking to his asthma and suggest that he take steps toward discontinuation.

At this point, the exact nature of your service depends on the type of cognitive services that you provide during the rest of the encounter. The first distinction to be made is whether your service meets the definition of counseling or of evaluation and management (E/M) (Fig 1). Because good clinical practice requires a therapeutic relationship and effective communication, regardless of which problem is being addressed, there can be considerable confusion over the distinction between the two services. It is important to remember that the distinction depends neither on the diagnosis nor on the presence of a physical examination, but on the nature of the cognitive interaction.

Evaluation refers to the cognitive processes applied while determining the significance or status of a problem or condition. This is typically accomplished through careful appraisal of the patient’s problem through history-

1. What service did you provide?		
Counseling?	Evaluation & management?	
<p>Tobacco dependence counseling may be thought of as "intratreatment support". Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Discussing barriers to change</b></li> <li>• <b>Advising specific changes to routine</b></li> <li>• <b>Arranging for adjunct services</b></li> </ul>	<p>Tobacco dependence E/M services may be thought of as "integrated longitudinal care". Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Assessing impact of dependence</b></li> <li>• <b>Anticipating treatment impact on medical or psychiatric comorbidities</b></li> <li>• <b>Ruling out contraindications or important treatment interactions</b></li> <li>• <b>Integrating plan with that of other clinicians</b></li> </ul>	

  

2. What was the level of service?														
Counseling	Evaluation & management	Team care (E&M)												
<p>Counseling service levels are determined by time investment, and may be provided to either current or at risk tobacco users. Examples include:</p> <table border="1"> <thead> <tr> <th></th> <th>&lt; 3 min</th> <th>3-10 min</th> <th>&gt; 10 min</th> </tr> </thead> <tbody> <tr> <td>Current</td> <td>Routine</td> <td>99406</td> <td>99407</td> </tr> <tr> <td>At-risk</td> <td>care</td> <td>G0436</td> <td>G0437</td> </tr> </tbody> </table>		< 3 min	3-10 min	> 10 min	Current	Routine	99406	99407	At-risk	care	G0436	G0437	<p>E/M service levels may be determined by using either 1) the appropriate E/M coding algorithm, or 2) the total time investment. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>An outpatient visit in which counseling and care coordination account for &gt; 50% of the total visit time (Table 1)</b></li> <li>• <b>An inpatient visit in which counseling and care coordination account for &gt; 50% of the total visit time (Table 2)</b></li> </ul>	<p>E/M services may also be provided using a "Team Care" approach for routine, follow-up visits. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Care within scope of practice may be provided by auxiliary personnel</b></li> <li>• <b>Care must be integral to outcome, but incidental to physician services</b></li> <li>• <b>Include services commonly rendered in a clinic without charge</b></li> <li>• <b>Physicians must be colocated and provide direct supervision</b></li> </ul>
	< 3 min	3-10 min	> 10 min											
Current	Routine	99406	99407											
At-risk	care	G0436	G0437											

  

3. Which diagnosis code is correct?	
Counseling	Evaluation & management
<p>Counseling services qualify as behavior change interventions. Providers should choose the <u>behavioral code</u> that most appropriately reflects the reason the service was provided. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Tobacco dependence (305.1)</b></li> <li>• <b>May be used as a secondary diagnosis when the primary reason for the visit was not tobacco-related</b></li> </ul>	<p>Because E/M services represent integrated medical care, providers should choose the medical code that most appropriately reflects the reason the service was provided. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Toxic effects of tobacco (989.84)</b></li> <li>• <b>Secondary diagnoses should reflect the relevant toxic effects of concern</b></li> <li>• <b>Tobacco dependence (305.1) may be used as a secondary diagnosis in patients who exhibit maladaptive dependence behaviors</b></li> <li>• <b>Using behavioral codes (eg, 305.1) as the primary rationale for a medical visit may invalidate reimbursement requests</b></li> </ul>

  

4. Is a modifier necessary?	
Counseling	Evaluation & management
<p>Coding of counseling services may require a -25 modifier under some circumstances. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Counseling services provided by the same practitioner, on the same day as other separately identifiable E/M services, should be reported using the -25 CPT modifier (eg, 99407-25)</b></li> </ul>	<p>Coding of E/M services related to tobacco dependence may require a -25 modifier, particularly when a team care approach is employed. Examples include:</p> <ul style="list-style-type: none"> <li>• <b>Use the -25 CPT modifier (eg, 99211-25) along with a tobacco-related ICD-9-CM code (eg, 989.84) to report ancillary services provided on the same day as any other (eg, immunization)</b></li> <li>• <b>Do not report multiple ancillary services provided on the same day unless a separately identifiable evaluation is performed</b></li> </ul>

  

5. Special documentation requirements?	
Counseling	Evaluation & management
<p>Proper documentation of counseling services requires a description of the interaction. Elements should include:</p> <ul style="list-style-type: none"> <li>• <b>Time dedicated to counseling</b></li> <li>• <b>Medical necessity, including for example, the medical condition or therapeutic agent that is adversely affected by continued smoking</b></li> <li>• <b>Counseling details (ie, cessation resources or printed materials offered, patient response)</b></li> </ul>	<p>Required elements for documentation of E/M services depend on whether the clinician calculates level of service based on established CMS algorithms or time investment. In the latter case both the total time dedicated to the visit and a description of the visit content is required. Elements should include:</p> <ul style="list-style-type: none"> <li>• <b>The portion of total time dedicated to counseling and coordination of care (must be &gt; 50%)</b></li> <li>• <b>Counseling details, including indications</b></li> <li>• <b>Recognizable shorthand is permitted (eg, time: total 25' / counsel 15')</b></li> </ul>

Figure 1 – Essentials of tobacco dependence billing and coding. CMS = Centers for Medicare and Medicaid Services; CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9.

taking and diagnostic testing. 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. Management decisions might include adjusting the medication plan, recommending a procedure, or referring for assistance

with environmental modification. 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. Within medical practice, counseling refers to the guidance or education provided to an individual patient. As such, counseling may be conceived of as a subset of management activities. That is to say that good medical management will often include counseling services, but not all counseling interactions can be considered management. Counseling services related to tobacco dependence might include activities such as discussing barriers to change, advising specific changes to behavioral routines, or arranging for services and follow-up. E/M services are more likely to include activities such as estimating the impact of dependence, assessing the nature and severity of important behavioral or medical comorbidities, ruling out contraindications to specific pharmacotherapy, or assessing the potential for important drug-drug interactions.

#### *Example 1: Tobacco Dependence Counseling as an Adjunct to Follow-up Care*

During Mr Jackson's visit, you discuss the relevance of his continued smoking to his asthma and suggest that he consider stopping. The 5-min conversation included information regarding the interaction between cigarette smoke exposure and airway inflammation, a discussion of the potential impact of smoking on asthma medication effectiveness, and advice to engage available services within the system. Written after-visit instructions include a phone number to call for quit line registration.

In this scenario, the patient has been well-counseled to quit smoking. Counseling services, also referred to as Behavior Change Interventions, are reimbursable services provided by qualified health-care personnel (ie, physician and nonphysician billing providers) for the purpose of promoting health or preventing injury, and there is good evidence supporting the effectiveness of brief counseling interventions of this type.<sup>22</sup> The level of Behavior Change Intervention depends on the amount of time dedicated to the endeavor. Clinicians should first report the established patient visit code (99211-99215) reflecting the level of service provided for the underlying condition (in this case, asthma: International Classification of Diseases, Clinical Modification 9 [ICD-9-CM] code 493.90), and consider the time spent in counseling separately. Cessation

counseling that lasts less than 3 min is considered to be part of the standard E/M service. For patients who require additional counseling time, the clinician may also report current procedural terminology code 99406 for intermediate (3-10 min), or 99407 for intensive (> 10 min) of service. Primarily use the ICD-9-CM code 305.1 (Tobacco Dependence) to report the smoking cessation counseling service, along with the appropriate code for the underlying condition.<sup>23</sup> For patients who do not currently smoke but who are at risk for initiation or relapse, Centers for Medicare and Medicaid Services has created two G codes that reflect counseling services aimed at preventing tobacco use. Clinicians may report G0436 for intermediate (3-10 min) and G0437 for intensive (> 10 min) of service. Counseling services provided by the same practitioner, on the same day as other, separately identifiable E/M services, should be reported using the -25 current procedural terminology code modifier (eg, 99407-25).

In addition to recording the time dedicated to counseling, Medicare requires documentation of medical necessity, including for example, the medical condition or therapeutic agent that is adversely affected by continued smoking. Comments about the counseling delivered should include details of the discussion, such as the cessation resources discussed, printed materials offered, and an indication of the patient's response. Medicare will cover two attempts at cessation during a 12-month period, with each attempt consisting of four visits (intermediate and/or intensive). Other payers may have variable reimbursement policies, and financial responsibility for unpaid charges could fall to the patient under some circumstances (eg, <https://www.bcbsal.org/providers/hcReform/HCRpreventivecoding.pdf>).

#### *Example 2: Tobacco Dependence E/M Services in the Longitudinal Care of the Patient*

In the process of identifying case-specific strategies for addressing Mr Jackson's tobacco dependence, you assess several clinically relevant variables such as the severity of his nicotine dependence, the potential interactions with his other comorbid conditions and preexisting therapies, his specific risk of downstream toxic effects of prolonged exposure, his insight into the problem and confidence in his ability to stop, his previous experience with tobacco dependence treatment, and his prior response to pharmacologic interventions, among other items. You identify Mr Jackson's medical conditions, signs/symptoms of disease progression, and current

prescriptions that may be affected by the treatment of tobacco dependence or by abstinence from smoking. The discussion leads you to a set of recommendations that include a tailored pharmacotherapy prescription, advice to engage hospital-based counseling resources, and a planned return visit in 1 month for reevaluation and continued management.

It is apparent that the tobacco dependence service provided is no longer of a limited nature, but instead characterized by the integration of complex data into specific recommendations. Here, the clinical interaction is more consistent with the provision of E/M services, with counseling and education being a subset of the total cognitive services provided. When counseling time exceeds 50% of the total time dedicated to the visit, the level of E/M service may be calculated using established time parameters (Table 1). Documentation must include the total visit time, the portion of that time dedicated to counseling and coordination of care (eg, Time: total 25 min/counsel 15 min), and should reference indications for counseling such as prognosis, risks/benefits of treatment, adherence instructions, or need for discussion with another health-care provider. It is permissible to use recognizable shorthand to create this documentation.

Particularly in instances in which the underlying condition is stable, the value of tobacco dependence treatment is reflected in the higher levels of service reported. For example, although Mr Jackson's follow-up visit for asthma, requiring only modest medication adjustment without need for complicated testing or complex medical decision-making, would be classified as a level 3 established office visit (99213), accurately accounting for the counseling and coordination time during a 25-min visit raises the service provided to level 4 (99214). In this case, clinicians would use the appropriate ICD-9-CM code for the underlying condition as the primary diagnosis, with 305.1 (Tobacco Dependence) as one of the relevant secondary diagnoses.

### Example 3: The Tobacco Dependence Follow-up Visit

Mr Jackson returns for an established office visit 1 month later, specifically to follow-up on his progress regarding smoking. He reports reasonable adherence with the dependence medication regimen, but complains of minor side effects, particularly when taking the medications close to bedtime. He has several questions regarding advice he received from the hospital's cessation assistance program 2 weeks earlier. Although he has been able to reduce his tobacco use substantially, he has been unable to stop smoking completely. During your evaluation, you recognize the compulsion to smoke is incompletely controlled and consider adjusting his dosage or adding a second agent to his regimen.

The primary purpose of this visit is to address the patient's tobacco dependence. The context of asthma is of value, but may not be directly relevant to today's clinical activities. The visit clearly retains the elements of an E/M visit of moderate complexity because the treatment has resulted in possible side effects and an incomplete response, requiring prescription drug management. Here again, the appropriate level of service is decided by the applicable E/M coding algorithm or by total time if counseling dominates the visit (> 50%).

Though the E/M nature of the visit is not a function of the diagnosis or symptom that prompts the visit, it is important that clinicians accurately reflect the rationale for the tobacco dependence treatment visit in the primary diagnosis. Although behavioral health providers are qualified to use behavioral or mental health diagnoses such as Tobacco Dependence (305.1) as the *primary* rationale for their services, medical health providers are not. Medical health providers should instead be careful to select an ICD-9-CM code that accurately reflects their focus on the biological impact of tobacco use. For instance, it may be appropriate to use the code for Toxic Effects of Tobacco (989.84) as a primary diagnosis, followed by the relevant secondary

**TABLE 1 ] Time Thresholds (in Minutes) That Define Levels of Service by Visit Type**

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Outpatient consultation <sup>a</sup>	99241-99245	15	30	40	60	80
New patient	99201-99205	10	20	30	45	60
Established patient	99211-99215	5	10	15	25	40

<sup>a</sup>Medicare instituted a change in reporting structure in 2010 and no longer recognizes consultative services per se. Patients who have never been evaluated by the practice before should be coded as new patient visits, whereas those evaluated previously, even if by another provider in the practice, should be coded using the appropriate established patient time threshold values.<sup>29</sup>



diagnosis codes reflecting the toxic effects of concern. Remember that the term addiction refers to the disturbances in brain biology that manifest as dependence behaviors; therefore, it is legitimate to list Nicotine Addiction (305.1) as one of the secondary toxic effects of tobacco smoke exposure if signs of addiction are present. If reporting an E/M service with a primary diagnosis code of tobacco dependence (305.1), clinicians should be aware that some payers may consider this to be a behavioral health service, and not covered by the patient's medical insurance. Code 305.1 should not be used to simply indicate a history of tobacco use, however, which is instead indicated by V15.82.

#### *Example 4: Use of "Team Care" Models in Tobacco Dependence Follow-up Visits*

Mr Jackson returns to your clinic 2 weeks later to meet with your office tobacco treatment specialist for a review of his progress. Planned elements of the return visit include an assessment of medication adherence, identification of knowledge gaps, development of a practical behavioral action plan, and assistance with engaging extra-treatment cessation support (eg, quit line). Mr Jackson is found to be doing well on his regimen, and is progressing toward abstinence with good insight into his plan. The tobacco treatment specialist updates you on the patient's progress and arranges for a return visit with you in another 4 weeks for evaluation of treatment outcomes and medication management.

It is permissible for physicians to use the services of auxiliary personnel in the care of an established patient, particularly when collaboration with a professional of another discipline helps to reduce fragmentation of care and improve target outcomes.<sup>24</sup> The care provided within this team model must be integral to the outcome, but incidental to the services initially provided by the physician. "Incident to" services are not restricted to any particular type of nonphysician provider, as in shared/split billing. Auxiliary personnel should function under a formal agreement that outlines the specific care functions to be performed within their scope of practice, should provide only services that are commonly rendered in a clinic without charge, and must function only under the physician's colocated, direct supervision. Under these circumstances, the "incident to" service may be billed under the supervising physician's name, using the level 1 E/M service code (99211). Though this service does not require a personal evaluation by the physician, it does require the physician's presence in the

suite during provision. Documentation should clearly reflect the collaborative nature of the discussion between the two professionals, alongside the resulting recommendations. Do not report 99211 on the same day as any other ancillary service (eg, immunization) or physician evaluation is performed.

#### *The Outpatient New or Consultation Visit*

Ms Dorsey is a 24-year-old woman, without significant medical history, referred to you by her primary care physician for consultation regarding her tobacco dependence. Your evaluation includes a review of her medical records, an assessment of her personal tobacco use and treatment history, a screening evaluation for other substance abuse or the possibility of depression, a directed physical examination, and a review of her concurrent medication use, among other relevant data. You discuss her personal history of oral contraceptive use and the impact smoking has on her future risk for thromboembolic events. Together, you settle on a strategy that includes medication and counseling. You ask that she return to your office for follow-up in 4 weeks and you dictate a letter back to the referring physician outlining your shared management plan.

In this scenario, the patient again visits specifically for assistance with tobacco dependence. The principal difference, however, is the consultative nature of the visit. Not all initial visits with specialists constitute a consultation. For a new patient visit to be considered a consultative service, it must be provided by a physician whose opinion or advice regarding the management of a specific problem is requested by another physician or other appropriate source. Documentation should therefore include evidence of *both* the request for advice and the communication of impressions and recommendations back to the requesting physician. Evidence of special training or expertise in the problem area is useful for authenticating the rationale for seeking the opinion of the consultant in the first place, but is not a necessary component of the visit documentation. When these conditions are met, it is appropriate to bill using the consultative E/M service codes (99241-99245), with level of service decisions made using the applicable E/M coding algorithm, or determined by the total time investment, as appropriate (Table 1). Choice of primary and secondary diagnosis codes remains consistent with the previous discussion. Services that fail to meet the criteria for consultative services should be billed using the codes for new patient evaluations (99201-99205).

**TABLE 2 ] Time Thresholds (in Minutes) That Define Levels of Service for Inpatient Initial Care and Consultative Services**

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Inpatient initial care visits	99221-99223	30	50	70	...	...
Inpatient consultation visits	99251-99255	20	40	55	80	110

## The Hospital Consult

Mr Trujillo is a 57-year-old man with several significant medical comorbidities, admitted to the hospital 1 week ago for acute myocardial infarction. He underwent emergency coronary artery bypass surgery on hospital day 1 and is recovering nicely except for minor memory/cognitive difficulties following circulatory bypass and a postoperative DVT. His adherence with prescribed hypercholesterolemia and diabetes regimens in the past has been spotty, resulting in poor outcomes. Control of his tobacco dependence is a key part of managing his future risk, but the primary care team has several questions regarding treatment. You are called to see the patient to comment on whether his recent cardiac event constitutes a contraindication to nicotine replacement, the potential for drug interactions between nicotine replacement and his planned warfarin therapy, the best way to maximize adherence with his tobacco dependence regimen, and the availability of postdischarge follow-up.

Questions regarding the management of tobacco dependence, especially in the face of complex comorbidities, are not uncommon. Consultants may be asked to help with patients who have expressed a reluctance to stop smoking, patients who have recently begun to abstain, or even to help manage a patient at high risk of relapse. In this scenario, you are asked to see the patient during his inpatient stay to provide advice on important acute management decisions as well as to assist with arrangements for postdischarge follow-up. Consultants should document the question being asked or problem being addressed and should indicate whether verbal communication accompanied the written advice. The note should reflect key details of the tobacco use history, relevant medical/psychiatric history, and any prior experience with dependence medications, among other important variables.<sup>25</sup> Level-of-service decisions are again made using the applicable E/M coding algorithm or are determined by the total time investment if counseling and care coordination dominate (> 50%) the visit (Table 2).

In addition to complex pharmacotherapy decisions, the consultant is also in a position to help arrange a specific follow-up plan after discharge. For example, arrangements

might be made for the patient to come to your office for an established patient visit as described previously. It is clear that the most important predictor of continued nonsmoking posthospitalization is the effective transition of care to the outpatient environment, for follow-up treatment of tobacco dependence within 4 weeks of discharge.<sup>26</sup>

## Conclusion

Though control of tobacco use within populations has traditionally relied heavily on public policy and educational approaches, an increasing emphasis on the health-care system's potential to treat prevalent cases has led to significant changes in regulatory and payment models meant to encourage these changes. The magnitude of impact might be expected to be quite high after providers fully integrate tobacco dependence into their personal, organizational, and institutional roles, but system pressures are likely to produce suboptimal change unless significant barriers to engagement have been removed.<sup>27,28</sup> Clarity regarding coding and documentation requirements relevant to the problem are a necessary prerequisite to full adoption. Several key points are important to recognize—primary among them is the distinction between counseling and E/M services. The treatment of tobacco dependence is not equivalent to smoking cessation. Team care models may represent an efficient way to improve care outcomes with minimal disruption in clinic workflow. When counseling and coordination of care make up the majority of the time spent in the patient visit, the level

**TABLE 3 ] Approximate Conversions Between ICD-9-CM Codes and ICD-10-CM Codes**

Category	ICD-9-CM Code	Converted ICD-10-CM Code
Asthma	493.90	J45.909
Nicotine dependence	305.1	F17.200
Toxic effects of tobacco	989.84	T65.221x

Note that actual code choice requires clinical interpretation to determine the most appropriate ICD-10 code(s) for any specific situation. The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. CPT = current procedural terminology; ICD-9-CM = International Classification of Diseases, Clinical Modification 9; ICD-10-CM = International Classification of Diseases, Clinical Modification 10.



of service is often more accurately documented using the appropriate time threshold definitions. Remember that medical care providers should not select behavioral codes as the primary diagnosis when providing E/M services. It is most appropriate for medical providers to instead select primary diagnosis codes that reflect their attention to the physical effects of smoke exposure, including for example, their general concern over the Toxic Effects of Tobacco (989.84) (Table 3).

Clinicians who have established a special expertise in the area may elect to provide consultative services in both out- and inpatient environments. Specialized training or certification is a good way to establish this expertise, but is not a necessary prerequisite to providing consultative service. Institutionalizing the care of the tobacco-dependent patient allows the health-care system to elevate its capacity for providing high-quality care and to successfully participate in several important quality initiatives and program certifications.

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## Use of Standard Medical Billing for Tobacco Use Treatment

James Davis, MD, Director, Duke University Smoking Cessation Program

It is possible to structure clinical smoking cessation care in such a way that physicians or advanced practice providers (APPs) evaluate and treat patients for tobacco dependence and bill for services through standard medical billing procedures. In this model, the initial medical visit typically includes a chart review, physical exam, and evaluation of smoking cessation medication use in the context of physical and psychiatric comorbidities, medications, assessment of renal or hepatic function. Follow up medical visits typically include assessment of response to medication treatment and side effects, co-morbidities, other medications and treatments. Carbon Monoxide breath testing may be performed to assess smoke exposure and pulmonary function testing may be performed in cases when undiagnosed COPD is a concern.

When a physician or APP provides this type of medical service, he or she may follow standard medical billing procedures through Evaluation and Management “E+M” and procedure-based coding. Documentation of E+M services require a detailed description of the medical assessment including comorbidities, medications, metabolic function other considerations that might impact medication initiation and management. This is identical to evaluation and documentation required for assessment of medication use for treatment of hypertension, diabetes, alcohol dependence etc. Documentation requirements for E+M-based billing are fairly rigid and vary by US region. As such, billing in this way will likely require a discussion with a Billing Compliance Officer at your institution. Billing capture rates also vary widely and are based on Medical System contracts with 3<sup>rd</sup> party providers. Patients with psychiatric comorbidities may be seen by a behavioral provider (for example, an LCSW) who may bill through psychotherapy codes. Medicare reimbursement rates for MD/APP and LCSW are shown below, though APPs capture at 85% of physician levels. Levels of service using time-based billing is shown in the figure.

Tobacco Treatment Billing	CPT/HCPS Codes	Medicare Reimbursement†
<b><u>MD/APP Visit</u></b>		
E+M Established Level 3 (15 min)	99213	\$74/\$52
E+M Established Level 4 (25 min)	99214	\$109/\$80
E+M Established Level 5 (50 min)	99215	\$146/\$113
Carbon Monoxide Breath Testing	94250	\$23/\$23
Office Spirometry	94010	\$36/\$36
<b><u>LCSW Psychotherapy Visit</u></b>		
16-37 minutes	90832	\$39/\$31
†The two values are the national payment amounts for non-facility and facility payments for each procedure, rounded to the nearest dollar.		

Medical “evaluation and management” is distinct from “smoking cessation counseling.” Evaluation of prior history, medical comorbidities, renal and hepatic function, other medications, etc. to guide initiation and management of medications are standard components of medical evaluation and management. On the other hand, “smoking cessation counseling” most typically refers to activities such as assessment of motivation to quit, quit day planning, assessment of smoking triggers, discussion of urge management strategies, instruction in coping skills.

When E+M-based billing is used for medical

evaluation and management, an additional charge for smoking cessation counseling (99406-7) may or may not be used. If the E+M visit level is based on *time-based* billing, additional billing for smoking cessation counseling is not allowed. This is because time-based billing encompasses the notion of counseling.

A common criticism of billing for tobacco treatment services is that billing creates a barrier to care and does not provide equal opportunity for services to disadvantaged members of society who smoke at the highest rates. This is a valid criticism. It should be said however, that many who are disadvantaged are eligible for Medicaid or other charity care programs. Furthermore, this model is consistent with access to medical services for other disorders – diabetes, hypertension etc., and paid services can be supplemented with access to free services such as tobacco quitlines.

# Coding for Tobacco Dependence Treatment

*This resource was adapted from the American College of Chest Physicians  
Tobacco Dependence Treatment Toolkit*

## Introduction

While the specifics of reimbursement for tobacco dependence treatment vary by insurer and contract, generally, clinicians should expect to be compensated for tobacco use treatment services, similar to compensation for other services. Because tobacco use treatment involves behavioral and biological dimensions, it is important to understand the basic compensation and billing requirements and definitions.

This resource provides a general framework of coding and billing principles relevant to tobacco use treatment. Though accurate in a general sense, the content is intended only as a guide. When discrepancies exist, contact payers for plan details and definitive guidance.

## CPT codes vs. ICD codes

**Current Procedural Terminology (CPT)** is a medical code set that is used to report medical, surgical, and procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

**International Classification of Diseases (ICD)** is the code set all clinicians and providers, including physicians, use to report medical diagnoses and procedures in U.S. health care settings and hospital inpatient procedures on claims for services furnished.

Simply, CPT codes are related to procedures and ICD codes are related to diagnoses. CPT codes, or procedural codes, describe what kind of procedure a patient has received while ICD codes, or diagnostic codes, describe any diseases, illnesses, or injuries a patient may have.

## Evaluation, Counseling, and Management

**Evaluation** refers to the cognitive processes applied while determining the significance or status of a problem or condition. This is typically accomplished through careful appraisal and study. Evaluation requirements for tobacco use often include a careful evaluation of variables such as severity of nicotine dependence, the severity of confounding co-morbidities, the likelihood of downstream toxic effects of prolonged exposure, the patient's insight into the problem and his or her confidence in abstinence, prior experience with cessation, or response to your recently prescribed interventions.

**Management** refers to the conduct or supervision of activities in pursuit of a pre-specified end. This often implies that the plan be based on the results of the evaluation, and that it includes the judicious use of multiple means to that end. Management decisions in the tobacco dependent patient might include medication or environmental modification recommendations, and are typically based on historical, physical, or standardized evaluation information.

**Counseling** services (also referred to as Behavior Change Interventions) are services that are provided directly by a physician or other qualified healthcare professional for the purpose of

promoting health or preventing injury. These are distinct from the more typical evaluation and management (E/M) services, and may be reported separately when performed. Behavior change interventions are for persons who have a condition that may be considered a disease unto itself, including tobacco use.

## Level of Service

### Evaluation and Management (E/M) services

For most Evaluation and Management visits, clinicians will refer to the American Medical Association CPT Guidelines and Procedures Manual to identify the correct level of service using the algorithms that relate elements of history, physical exam, and complexity of clinical decision making.

### Time thresholds (in minutes) that define levels of service per visit category

Visit Category	Code Range	Level 1 (Minutes)	Level 2 (Minutes)	Level 3 (Minutes)	Level 4 (Minutes)	Level 5 (Minutes)
Outpatient Consultation	99241 - 99245	15	30	40	60	80
New Patient	99201 - 99205	10	20	30	45	60
Established Patient	99211 - 99215	5	10	15	25	40

### Counseling services - Behavior Change Interventions

Medicare and Medicaid deem smoking cessation counseling to be reasonable and necessary. Clinicians should consider using the counseling codes when tobacco use treatment can be viewed as a portion of, or adjunct to, the primary purpose of the visit. For example, in a patient who presents for evaluation and management of COPD, cessation counseling would be considered a core component of their care, but may not be the main focus of the interaction.

### Diagnosis

Please refer to the [\*International Classification of Disease, Tenth Edition\*](#), (ICD-10) for complete descriptions of diagnostic codes relevant to tobacco use treatment.

#### Sources

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Current Procedural Terminology (CPT) Codes Tobacco Use and Treatment	
CPT Code	Description
<b>1000F</b>	Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
<b>1031F</b>	Smoking status and exposure to second hand smoke in the home assessed (Asthma)
<b>1032F</b>	Current tobacco smoker or currently exposed to secondhand smoke (Asthma)
<b>1033F</b>	Current tobacco non-smoker and not currently exposed to secondhand smoke (Asthma)
<b>1034F</b>	Current tobacco smoker (CAD, CAP, COPD, PV) (DM)
<b>1035F</b>	Current smokeless tobacco user (e.g., chew, snuff) (PV)
<b>1036F</b>	Current tobacco non-user (CAD, CAP, COPD, PV) (DM) (IBD)
<b>4000F</b>	Tobacco use cessation intervention, counseling (COPD, CAP, CAD, Asthma) (DM) (PV)
<b>4001F</b>	Tobacco use cessation intervention, pharmacologic therapy (COPD, CAD, CAP, PV, Asthma) (DM) (PV)
<b>4004F</b>	Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (PV, CAD)
<b>99406</b>	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
<b>99407</b>	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
<b>99408</b>	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
<b>99409</b>	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
<b>G0396</b>	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
<b>G0397</b>	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
<b>G0436</b>	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
<b>G0437</b>	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
<b>G6055</b>	Nicotine
<b>G9275</b>	Documentation that patient is a current non-tobacco user
<b>G9276</b>	Documentation that patient is a current tobacco user
<b>G9458</b>	Patient documented as tobacco user and received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user
<b>G9459</b>	Currently a tobacco non-user
<b>G9460</b>	Tobacco assessment or tobacco cessation intervention not performed, reason not otherwise specified
<b>S0106</b>	Bupropion HCl sustained release tablet, 150 mg, per bottle of 60 tablets
<b>S4990</b>	Nicotine patches, legend
<b>S4991</b>	Nicotine patches, non-legend
<b>S4995</b>	Smoking cessation gum
<b>S9453</b>	Smoking cessation classes, non-physician provider, per session

Source: <https://ocm.ama-assn.org/OCM/> (Keyword search – tobacco, smoking, nicotine)



# **International Classification of Diseases (ICD)-10 Codes Tobacco/Nicotine Dependence, and Secondhand Smoke Exposure Effective October 1, 2015**

## **Background and Context**

Through September 30, 2015, the **ICD-9** diagnostic code for identifying and documenting patients who use tobacco is **305.1**. Thus, there has been a single diagnostic code for tobacco use/dependence.

**Effective October 1, 2015**, healthcare will transition to **ICD-10 codes**. ICD-10 expands the breadth and depth healthcare documentation in general and for tobacco use and exposure in particular.

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). The change to ICD-10 does not affect Current Procedural Terminology (CPT) billing codes for outpatient procedures and physician services.

## **Purpose of this Document**

This document provides the new ICD-10 codes for patients who use, are dependent on, or are exposed to nicotine/tobacco. For example, ICD-10 includes specific codes/modifiers for cigarette use, chewing tobacco use, smoking during pregnancy, exposure to secondhand smoke, and many others.

Importantly, the former **ICD-9 code 305.1** (tobacco use and dependence) will transition to the new **ICD-10 codes**:

- **F17.2** (nicotine dependence),
- **099.33** (smoking complicating pregnancy, childbirth, and the puerperium),
- **P04.2** (newborn affected by maternal use of tobacco),
- **P96.81** (exposure to environmental tobacco smoke in the perinatal period),
- **T65.2** (toxic effect of tobacco and nicotine),
- **Z57.31** (occupational exposure to environmental tobacco smoke),
- **Z71.6** (tobacco use counseling, not elsewhere classified),
- **Z72** (tobacco use not otherwise specified (NOS),
- **Z77.2** (contact with and exposure to environmental tobacco smoke), and
- **Z87.8** (history of nicotine dependence).

Each of these codes are often used with modifier(s) to specifically define the type of tobacco use or exposure. See pages 2 – 4.

The *full* set of **nicotine, smoking, tobacco, and smoke exposure ICD-10 codes** are on the pages that follow.

## ICD-10 Diagnostic Codes for Nicotine Dependence, effective October 1, 2015

### **F17 Nicotine Dependence**

**Excludes1:** History of tobacco dependence (Z87.891); tobacco use not otherwise specified (NOS) (Z72.0)

**Excludes2:** Tobacco use (smoking) during pregnancy, childbirth and the puerperium (O99.33); toxic effect of tobacco and nicotine (T65.2) – see below

### **F17.2 Nicotine dependence**

#### F17.20 Nicotine dependence, unspecified

F17.200 Nicotine dependence, unspecified, uncomplicated

F17.201 Nicotine dependence, unspecified, in remission

F17.203 Nicotine dependence unspecified, with withdrawal

F17.208 Nicotine dependence, unspecified, with other nicotine-induced disorders

F17.209 Nicotine dependence, unspecified, with unspecified nicotine-induced disorders

#### F17.21 Nicotine dependence, cigarettes

F17.210 Nicotine dependence, cigarettes, uncomplicated

F17.211 Nicotine dependence, cigarettes, in remission

F17.213 Nicotine dependence, cigarettes, with withdrawal

F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders

F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

#### F17.22 Nicotine dependence, chewing tobacco

F17.220 Nicotine dependence, chewing tobacco, uncomplicated

F17.221 Nicotine dependence, chewing tobacco, in remission

F17.223 Nicotine dependence, chewing tobacco, with withdrawal

F17.228 Nicotine dependence, chewing tobacco, with other nicotine-induced disorders

F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders

#### F17.29 Nicotine dependence, other tobacco product

F17.290 Nicotine dependence, other tobacco product, uncomplicated

F17.291 Nicotine dependence, other tobacco product, in remission

F17.293 Nicotine dependence, other tobacco product, with withdrawal

F17.298 Nicotine dependence, other tobacco product, with other nicotine-induced disorders

F17.299 Nicotine dependence, other tobacco product, unspecified nicotine-induced disorders

### **Maternal Tobacco Use and Exposure (099.3, P04.2, P96.8)**

**O99 Maternal diseases classified elsewhere but complicating pregnancy, childbirth, and the puerperium**

**O99.3 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium**

#### O99.33 Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium

Use additional code from F17 to identify type of tobacco

O99.330 Smoking (tobacco) complicating pregnancy, unspecified trimester

O99.331 Smoking (tobacco) complicating pregnancy, first trimester

O99.332 Smoking (tobacco) complicating pregnancy, second trimester  
O99.333 Smoking (tobacco) complicating pregnancy, third trimester  
O99.334 Smoking (tobacco) complicating childbirth  
O99.335 Smoking (tobacco) complicating the puerperium

**P04 Newborn (suspected to be) affected by noxious substances transmitted via placenta or breast milk**

**P04.2 Newborn (suspected to be) affected by maternal use of tobacco**

Newborn (suspected to be) affected by exposure in utero to tobacco smoke

**Excludes2:** Newborn exposure to environmental tobacco smoke (P96.81)

**P96 Other conditions originating in the perinatal period**

**P96.8 Other specified conditions originating in the perinatal period**

P96.81 Exposure to (parental) (environmental) tobacco smoke in the perinatal period

**Toxic Effect of Tobacco and Nicotine (T65.2)**

**T65 Toxic effect of other and unspecified substances**

**T65.2 Toxic effect of tobacco and nicotine**

**Excludes2:** Nicotine dependence (F17.2)

**T65.21 Toxic effect of chewing tobacco**

T65.211 Toxic effect of chewing tobacco, accidental (unintentional)  
Toxic effect of chewing tobacco not otherwise specified (NOS)  
T65.212 Toxic effect of chewing tobacco, intentional self-harm  
T65.213 Toxic effect of chewing tobacco, assault  
T65.214 Toxic effect of chewing tobacco, undetermined

**T65.22 Toxic effect of tobacco cigarettes**

Toxic effect of tobacco smoke  
Use additional code for exposure to second hand tobacco smoke (Z57.31, Z77.22)  
T65.221 Toxic effect of tobacco cigarettes, accidental (unintentional)  
Toxic effect of tobacco cigarettes not otherwise specified (NOS)  
T65.222 Toxic effect of tobacco cigarettes, intentional self-harm  
T65.223 Toxic effect of tobacco cigarettes, assault  
T65.224 Toxic effect of tobacco cigarettes, undetermined

**T65.29 Toxic effect of other tobacco and nicotine**

T65.291 Toxic effect of other tobacco and nicotine, accidental (unintentional)  
Toxic effect of other tobacco and nicotine not otherwise specified (NOS)  
T65.292 Toxic effect of other tobacco and nicotine, intentional self-harm  
T65.293 Toxic effect of other tobacco and nicotine, assault  
T65.294 Toxic effect of other tobacco and nicotine, undetermined

## **Environmental Tobacco Smoke Exposure (Z57.31, Z77.22)**

### **Z57 Occupational exposure to risk factors**

#### **Z57.3 Occupational exposure to other air contaminants**

Z57.31 Occupational exposure to environmental tobacco smoke (Z57.31)

**Excludes2:** Exposure to environmental tobacco smoke (Z77.22)

### **Z77 Other contact with and (suspected) exposures hazardous to health**

#### **Z77.2 Contact with and (suspected) exposure to other hazardous substances**

Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke

Exposure to second hand tobacco smoke (acute) (chronic)

Passive smoking (acute) (chronic)

**Excludes1:** Nicotine dependence (F17.2) tobacco use (Z72.0)

**Excludes2:** Occupational exposure to environmental tobacco smoke (Z57.31)

## **Counseling and Medical Advice Services, Not Elsewhere Classified (Z71.6, Z72.0)**

### **Z71 Persons encountering health services for counseling and medical advice, not elsewhere classified**

#### **Z71.6 Tobacco abuse counseling**

Use additional code for nicotine dependence (F17.2)

### **Z72 Problems related to lifestyle**

#### **Z72.0 Tobacco use**

Tobacco use not otherwise specified (NOS)

**Excludes1:** History of tobacco dependence (Z87.891); nicotine dependence (F17.2); tobacco dependence (F17.2); tobacco use during pregnancy (O99.33)

## **History of (noncurrent) Nicotine Dependence (Z87.891)**

### **Z87 Personal history of other diseases and conditions**

#### **Z87.8 Personal history of other specified conditions**

Z87.891 Personal history of nicotine dependence

**Excludes1:** Current nicotine dependence (F17.2)

#### **Excludes1**

A type 1 Excludes note is a pure excludes. It means 'NOT CODED HERE!' An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

#### **Excludes2**

A type 2 excludes note represents 'Not included here'. An excludes2 note indicates that the condition excluded is not part of the condition it is excluded from but a patient may have both conditions at the same time. When an Excludes2 note appears under a code it is acceptable to use both the code and the excluded code together.

#### **Source**

The National Center for Health Statistics (NCHS), the Federal agency responsible for use of the International Statistical Classification of Diseases and Related Health Problems in the United States, 10th revision (ICD-10), Fiscal Year 2015. <http://www.cdc.gov/nchs/icd/icd10cm.htm>

Centers for Medicare and Medicaid Services (CMS) - <http://cdn.roadto10.org/wp-uploads/2014/08/2015-ICD-10-CM-Tabular-List-of-Diseases-and-Injuries.pdf>