



## Smoking Cessation Counseling\*

### A Practice Management Perspective

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**Individuals continue to smoke despite its numerous proven adverse health effects. Now viewed as a chronic medical condition, health-care professionals are more involved in cessation efforts. Physicians are often the first line of defense, providing intervention through prescription management and counseling. Some insurers recognize these efforts as health promoting and cost saving, revising policies to include reimbursement. This article addresses the most recent smoking cessation policy revision implemented by the Centers for Medicare and Medicaid Services.**  
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**Key words:** cessation; counseling; G0375; G0376; smoking; tobacco use; practice management; reimbursement

**Abbreviation:** ACCP = American College of Chest Physicians

Cigarette smoking is associated with many health conditions that develop throughout the life span. Smoking during pregnancy may increase the risk of asthma in childhood.<sup>1</sup> The duration of smoking can limit airflow in individuals  $\geq 40$  years old.<sup>2</sup> The majority of COPD and lung cancer cases are attributable to cigarette smoking, and smokers are more likely to die from lung cancer than nonsmokers.<sup>3,4</sup> Cause and effect is well established, justifying the need for smoking cessation and disease prevention.

Several studies<sup>5,6</sup> demonstrate the positive impact smoking cessation has on reducing the risk of certain

pulmonary diseases. Cessation is most successful for those who recognize the cause-and-effect relationship and are motivated toward health. An increase in motivation occurs when people understand the risks of smoking, the benefits of cessation, and the impact each of these has on their own lives.<sup>7</sup> Physicians have the greatest contact with the community, and are charged with the responsibility of educating their patients with this needed information. Since "tobacco use is the single most preventable risk to human health in developed countries,"<sup>8</sup> many organizations, such as the American College of Chest Physicians (ACCP), strongly support the role of physicians as the first line of intervention in reducing tobacco use. Intervention is provided to individuals both willing and unwilling to quit.<sup>8</sup> For those identified as "willing" to quit smoking, the ACCP recommends the physician performs the five As:

- Ask about tobacco use at every visit
- Advise tobacco users to quit
- Assess the willingness to attempt quitting
- Assist the patient with methods for quitting
- Arrange for follow-up contact via phone or face-to-face

For individuals who are not willing to quit, the ACCP suggests the physician and patient jointly identify the five Rs:

- Relevance of quitting for the patient

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- Risks of illness related to continued tobacco use
- Rewards/benefits of smoking cessation
- Roadblocks for quitting, internal and external
- Repetition of the motivation intervention at each encounter

There are two basic strategies for smoking cessation: pharmacologic and behavioral. Pharmacologic measures are limited to nicotine replacement therapy and bupropion, while behavioral measures vary from brief counseling interventions to structured programs. “A series of meta-analyses suggest that quit rates increase within an increasing intensity of the intervention and that several sessions of  $\geq 10$  min will optimize benefits.”<sup>9,10</sup> Physicians determine which approach is best for each patient, and how long each intervention should last. Individualizing pharmacologic doses and counseling sessions offer successful outcomes.<sup>11</sup>

Costs associated with disease management can significantly outweigh those associated with prevention. Insurers recognize physician efforts in smoking cessation counseling and support the cause by revising policy to include reimbursement for these efforts. The most recent change came in 2005 when the Centers for Medicare and Medicaid Services published their reimbursement guidelines for smoking and tobacco use cessation counseling (<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3834.pdf> or <http://www.cms.hhs.gov/Transmittals/downloads/R36NCD.pdf>). Two new Healthcare Common Procedural Coding System codes were created and became effective in July 2005, capturing intermediate and intensive services:

- G0375: Smoking and tobacco use cessation counseling visit; intermediate, > 3 min up to 10 min
- G0376: Smoking and tobacco use cessation counseling visit; intensive, > 10 min

The Centers for Medicare and Medicaid Services reimburses physicians for reasonable and necessary smoking cessation services provided in compliance with national and local coverage determinations. Covered indications require the patient to have a disease or adverse health effect that is caused or complicated by tobacco use. The “adverse affect” may be a condition for which the patient is being treated with a medication whose metabolism or dosage is impacted by tobacco use. Each physician counseling session, up to four, is covered during a single attempt. Two physician attempts, totaling eight counseling sessions, are covered in a 12-month period. In order to receive reimbursement, the physician or a qualified nonphysician provider (*eg*, nurse practitioner, physician assistant, clinical nurse specialist, clinical social worker) must personally

provide a service lasting at least 3 min and report the counseling session(s) under the corresponding provider number, depending on the location of the services (refer to chapter 15, sections 170 and 190–210 of the Medicare Benefit Policy Manual for independent billing rules: <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>). Payment varies by region but averages approximately \$13 for G0375 and \$25 for G0376. Counseling < 3 min is included in the standard physician visit and is not separately reportable with the G-codes listed above.

Nuances within the billing policy exist, placing restrictions on services provided by certain individuals in specific areas. For example, physicians cannot seek reimbursement for smoking cessation counseling performed by clinical nurse specialists “incident-to” physician services in a rural health clinic or federally qualified health center, as these individuals are often facility employees. If reported, these incident-to services are not reimbursable. More information on incident-to services can be obtained from chapter 15, section 60 of the Medicare Benefit Policy Manual (<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>). Additionally, cessation services provided during an inpatient stay are not reimbursed if the primary reason for the stay is smoking cessation.

Documentation must support any services billed. It must include the indication for services as well as the length and details of the counseling session. Additional payment may be received for an evaluation and management service performed on the same day and separately identifiable from the smoking cessation counseling. As an example, the physician who evaluates an emphysema patient’s shortness of breath during the encounter in which a 7-min smoking cessation counseling session occurs reports G0375 and the appropriate category and level of evaluation and management (99201–99215). Assign the International Classification of Diseases, Ninth Edition, Clinical Modification code that corresponds with the documented indication to each service: report G0375 with 492.8 (emphysema, lung or pulmonary, not otherwise specified) and 305.1 (tobacco-use disorder); report 99213 with 786.05 (shortness of breath) and append modifier 25 to the evaluation and management visit (*ie*, 99213–25). Covered indications are not limited to emphysema but include a wide range of respiratory and cardiovascular conditions, such as COPD (496) or chronic obstructive asthma (493.20).

Although non-Medicare insurers may not recognize the new G-codes for smoking cessation counseling, some may have existing policies that offer separate reimbursement to physicians for such efforts using alternative Healthcare Common Proce-

dural Coding System codes such as S9075 (smoking cessation treatment). Payment methodologies range from capitation, in which eligible physicians may receive monies above their standard capitated rate, to fee-for-service models. Projects reviewing both of these methodologies as implemented by various insurers have not proven one physician incentive program more effective or efficient than the other.<sup>12</sup>

Documentation of these services remains a key factor and should accurately describe the interaction that occurred. It is prudent to check with each insurer regarding coverage as well as specific documentation rules and regulations. Communication between providers and billing staff is also critical. Educating the staff regarding insurer billing requirements and requesting providers include smoking intervention information on the encounter forms (*ie*, billing slips) are the best mechanisms to ensure charge capture.

Tobacco use and its associated health risks have given rise to more focused and frequent physician-conducted cessation intervention. Recognizing this as a separate and unique service, insurers are also responding, ensuring its continuation. With support from both sides, tobacco users can be more easily identified and offered an option for assistance in obtaining a healthier lifestyle.

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