CHEST

Integrating Tobacco Use Treatment Into Practice

Billing and Documentation

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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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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.[1,2] Consequently, the current "end-game" strategy relies heavily on extending gains made by policy initiatives and environmental modifications.[3-6] 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

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treatment have been comparatively pedestrian, and places low on expert lists of tobacco control priorities.[7,8] 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,[9] they do not generally recognize their role in achieving tobacco control goals.[10] 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.[11] This observation has prompted various regulatory agencies to introduce evolutionary pressures, designed to encourage behavior change.[12-14] The US Preventive Services Task Force lists tobacco dependence counseling as a "grade A" recommendation for all adults using tobacco.[15] System readiness to adopt these changes appears low, but is improving.[16,17]

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.[18,19] 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.[20] 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.[21]

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-