NATIONAL COUNCIL for Mental Wellbeing

Financing the Future of Integrated Care Billing: 2024 Updates

Thursday, July 18, 2024
12:00pm – 1:00pm E.T.

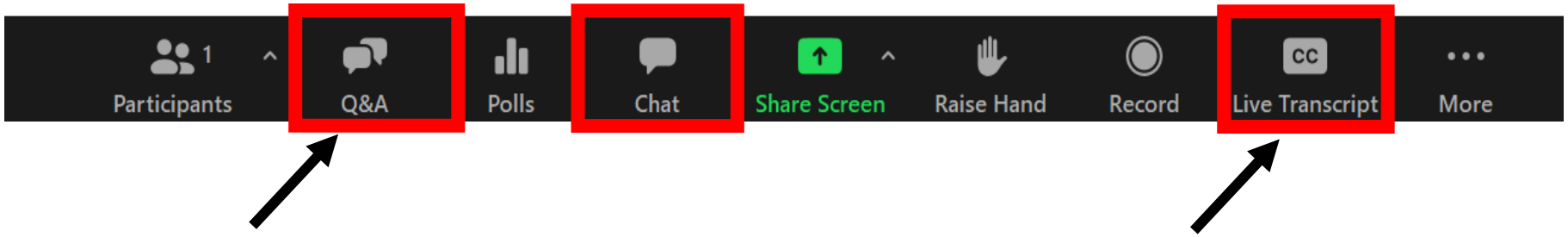
CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

BBS strategy + heart

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**



Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

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Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Speakers

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Co-Founder and COO,
Concert Health

Learning Objectives

After this webinar, participants will be able to:

- Explain the rationale for focusing on billing and financing as part of an integrated care strategy
- Describe new billing tools available to promote implementation of different integrated care services
- Understand how to use the updated *Decision Support Tool* to project revenues for providing tobacco cessation services
- Describe new staff regulations outlined in Medicare's 2024 Physician Fee Schedule Final Rule related to provision of integrated care
- Describe new Medicare billing codes, services, and staff types eligible to help address health-related social needs

Today's Agenda

The Need for Sophisticated Financial Tools → Drill Down on Health-Related Social Needs → Decision Support Tool Overview

Drill Down on Tobacco Cessation → Feedback and Q&A → Integration in Action Session (7/25, 12-1pm ET)

→ END GOAL: Provide timely, accurate, and localized financial insight that accelerates adoption of integrated care services.

Rationale – Why Focus on Financing as Part of an Integrated Care Strategy?

BILL FOR NON-DIRECT SERVICES

ADDRESS HEALTH-RELATED SOCIAL NEEDS

UNDERSTAND SPECIFIC INTEGRATED CARE MODELS

MAXIMIZE BILLABLE SERVICES BY STAFF TYPE

SELECT AND IMPLEMENT SUSTAINABLE INTEGRATED CARE PROGRAMS

Understanding & leveraging available financing strategies is key to ensuring that evidence-based integrated care approaches are sustainable, widespread and accessible to all consumers.

Medicare Physician Fee Schedule Final Rule: CY 2024 Changes Related to Integrated Care

Medicare coverage of services provided by marriage and family therapists (MFTs) and mental health counselors (MHCs), including addiction counselors, starting January 1, 2024.

Updated changes to behavioral health integration codes allow MFTs and MHCs to provide integrated behavioral health care as part of primary care settings.

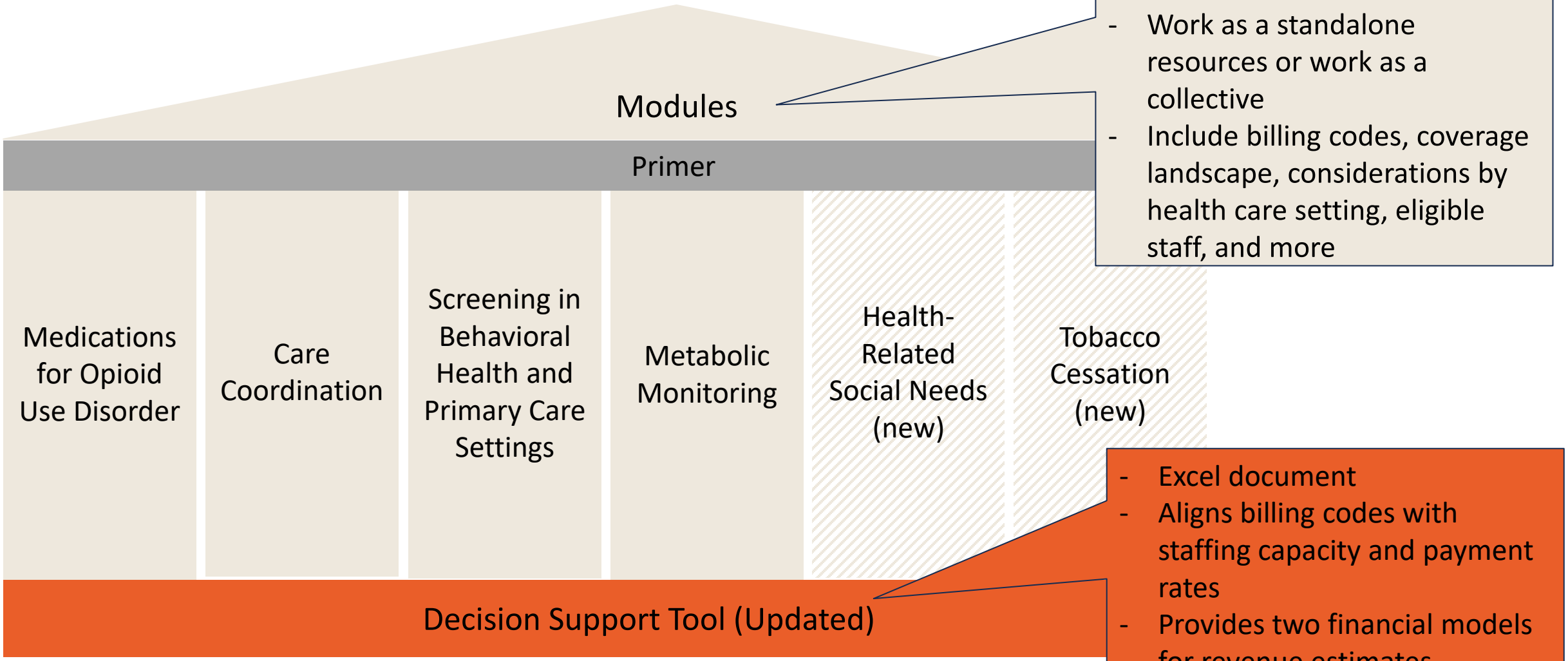
Health behavior and assessment codes may now be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.

New billing options for care coordination and addressing health-related social needs.

New codes on the list of Medicare telehealth services, including SDOH risk assessment.

Source: *Medicare Learning Network. (2023). Medicare Physician Fee Schedule Final Rule Summary: CY 2024*

Module and Decision Support Tool (DST) Overview



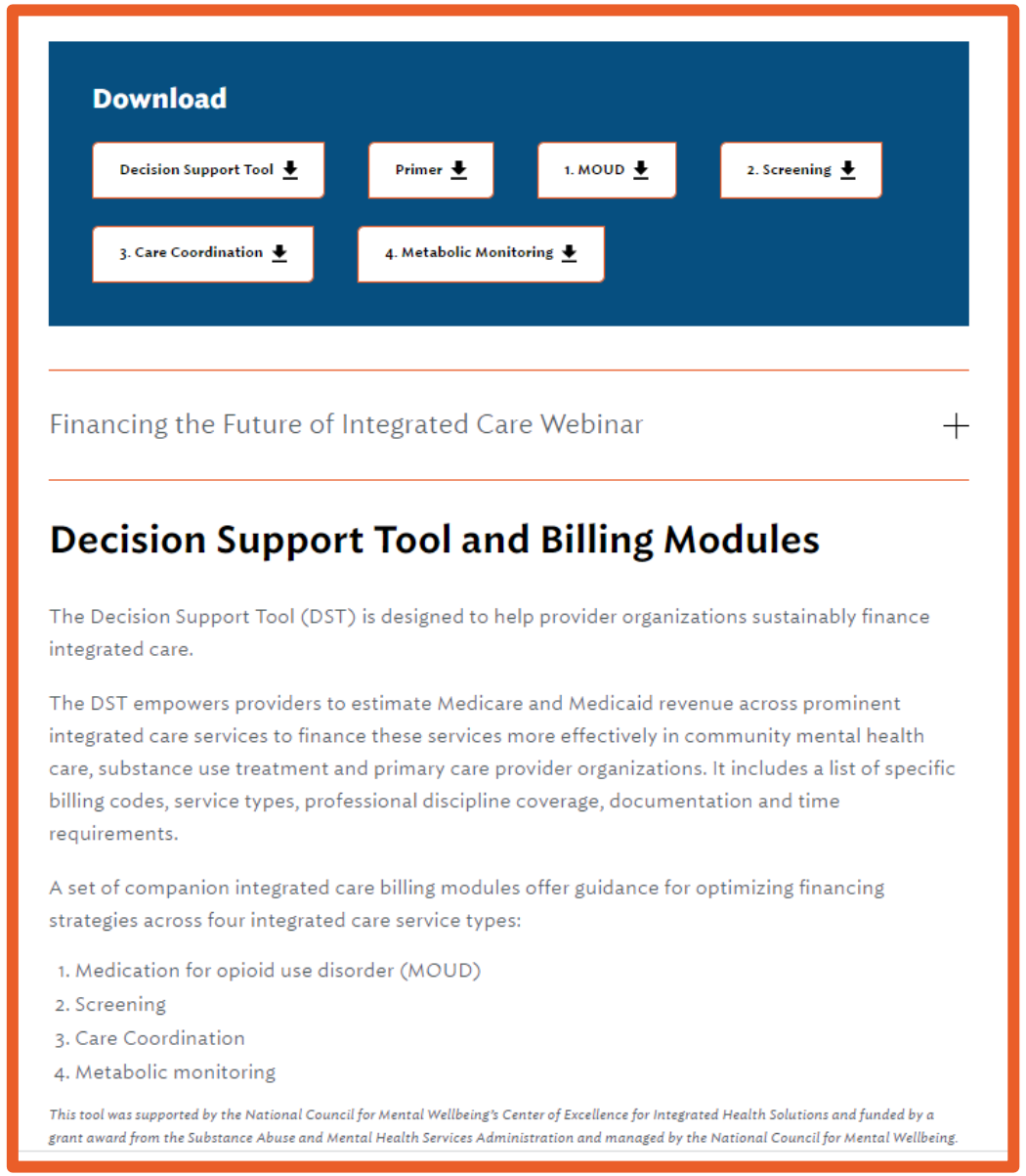
Contextualize the DST

- Work as a standalone resources or work as a collective
- Include billing codes, coverage landscape, considerations by health care setting, eligible staff, and more

- Excel document
- Aligns billing codes with staffing capacity and payment rates
- Provides two financial models for revenue estimates
- Updates include new service codes, staff, & rates for CY2024

Module and Decision Support Tool (DST)

[View and Download the Decision Support Tool and Billing Modules]



Download

Decision Support Tool | Primer | 1. MOUD | 2. Screening | 3. Care Coordination | 4. Metabolic Monitoring

Financing the Future of Integrated Care Webinar +

Decision Support Tool and Billing Modules

The Decision Support Tool (DST) is designed to help provider organizations sustainably finance integrated care.

The DST empowers providers to estimate Medicare and Medicaid revenue across prominent integrated care services to finance these services more effectively in community mental health care, substance use treatment and primary care provider organizations. It includes a list of specific billing codes, service types, professional discipline coverage, documentation and time requirements.

A set of companion integrated care billing modules offer guidance for optimizing financing strategies across four integrated care service types:

1. Medication for opioid use disorder (MOUD)
2. Screening
3. Care Coordination
4. Metabolic monitoring

This tool was supported by the National Council for Mental Wellbeing's Center of Excellence for Integrated Health Solutions and funded by a grant award from the Substance Abuse and Mental Health Services Administration and managed by the National Council for Mental Wellbeing.

Drill Down on Select Integrated Care Topic: Billing for Health-Related Social Needs

Billing for Health-Related Social Needs (HRSN)

Services to address HRSN can be provided in multiple health care settings

HRSN services can be provided by a wide range of staff types

There are new Medicare covered HRSN services

Socio-economic factors drive 50-80% of all health outcomes, with only 20% of outcomes attribute to clinical care.[1]

Individuals with identified behavioral health needs are more likely to have unmet or adverse HRSN. [2,3]

[1] Hood, C.M. et al. (2016). County Health Rankings: Relationships Between Determinant Factors and Health Outcomes.
[2] Whitman A. et al. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts.
[3] Omolola, A. E. et al. (2022). Assessment of Unmet Health-Related Social Needs Among Patients With Mental Illness Enrolled in Medicare Advantage.

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Recent Changes Focused on HRSN

Medicare

- Changes to expand Place of Service options
- New covered services that address HRSN under Medicare Part B

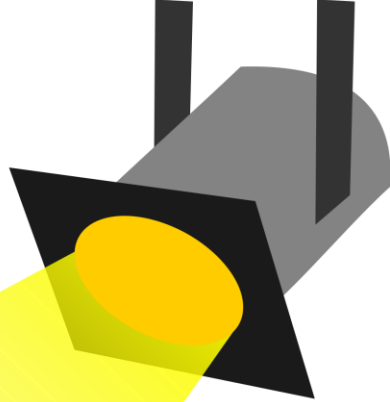
Medicaid

- Expansions and standardization of State Waiver options to cover services that address HRSN

HEDIS

- New Social Need Screening and Intervention HEDIS measure

Spotlight on Medicare



- New Place of Service
- New Codes
- Rates
- Eligible Providers

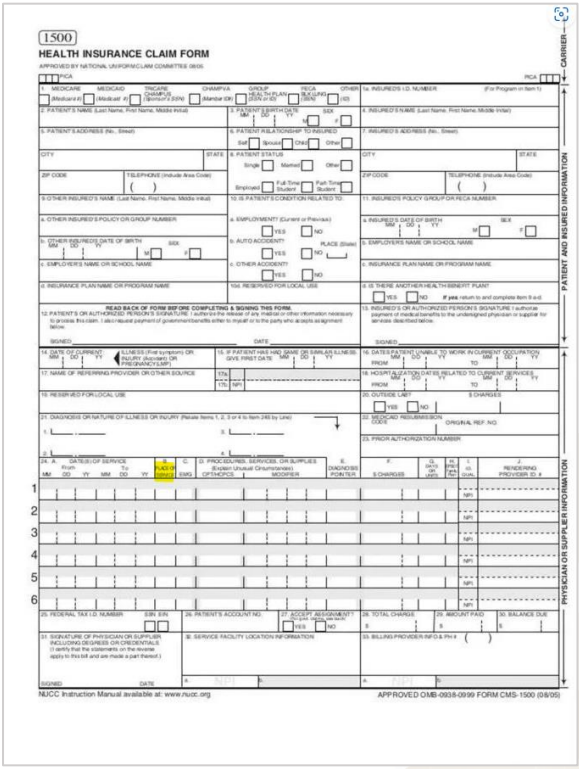
Spotlight on Medicare

- New Place of Service
- New Codes
- Rates
- Eligible Providers

(POS) 27 - Outreach Site/Street.

Effective Date: October 2023

Used on a claim to show when a service is provided in a “non-permanent location on the street or found environment, not described by any other POS code, where preventive, screening, diagnostic, or treatment services are provided to unsheltered, homeless patients.”


1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
PICA
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Note: Individual payers will have different reimbursement policies. Local outreach is recommended.

Place of Service Change Transmittal:
Centers for Medicare & Medicaid Services. (2021). CMS Manual System: New Place of Service (POS) Code 27 - "Outreach Site/Street."
Place of Service Code Set:
Centers for Medicare & Medicaid Services. (2024). Place of Service Code Set.

Spotlight on Medicare

New Place of Service

New Codes

Rates

Eligible Providers

SDOH needs assessment and 3 related services

New Covered Codes – In January of 2024, Medicare finalized new rules under Medicare Part B that expand service options to support both health-related social needs assessments and services to mitigate and/or address identified needs.

- SDOH Risk Assessment (G0136)
- Community Health Integration (G0019, G0022)
- Principal Illness Navigation (G0023, G0024)
- Principal Illness Navigation – Peer Support (G0140, G0146)

Federal Register

Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

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Spotlight on Medicare

- New Place of Service
- New Codes
- Rates
- Eligible Providers

Medicare Rates	Facility	Non-Facility
SDOH Risk Assessment (G0136)	$8.99	$18.97
Community Health Integration (G0019, G0022)	$49.60 $34.62	$80.56 $50.26
Principal Illness Navigation (G0023, G0024)	$49.60 $34.62	$80.56 $50.26
Principal Illness Navigation – Peer Support (G0140, G0146)	$49.60 $34.62	$80.56 $50.26

Rate Note: *These are the published National Rates. There will be some variation in the rate depending on the MAC and local market where services are being rendered.*

Facility vs. Non-facility Note: *The facility rate is less because the facility receives a separate "facility fee" in addition to the services rendered.*

Search the Physician Fee Schedule | CMS

Federal Register

Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

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Spotlight on Medicare

New Place of Service

New Codes

Rates

Eligible Providers

Provider Type	SDOH Risk Assessment (G0136)	Community Health Integration (G0019, G0022)	Principal Illness Navigation (G0023, G0024)	Principal Illness Navigation – Peer Support (G0140, G0146)
Physicians	Yes	Yes	Yes	Yes
Practitioners	Yes	Yes, *not Clinical Psychologists	Yes	Yes
Auxiliary Personnel	No	Yes, under the supervision of a Physician or other Qualified Practitioner	Yes, under the supervision of a Physician or other Qualified Practitioner	Yes, under the supervision of a Physician or other Qualified Practitioner

Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

Federal Register

Spotlight on Medicare

New Place of Service

New Codes

Rates

Eligible Providers

Provider Type	Medicare Descriptions
Physicians	Doctor of medicine; Doctor of osteopathy; Doctor of dental surgery or dental medicine; Doctor of podiatric medicine; Doctor of optometry; Doctor of chiropractic medicine (with respect to certain specified treatment and as legally authorized to practice by a State in which he/she performs this function).
Practitioners	Physician assistant, Nurse practitioner, Clinical nurse specialist, Certified registered nurse anesthetist, Certified nurse midwife, **Clinical psychologist, Clinical social worker, Marriage and family therapist, Mental health counselor***, Registered dietitian or nutrition professional, who is currently legally authorized to practice in that capacity by each State in which he or she furnishes services to patients or clients.
Auxiliary Personnel	Community Health Workers, Certified Peers, Social Worker, Mental Health Navigator, Primary Care Navigator, General Patient Advocate Navigators

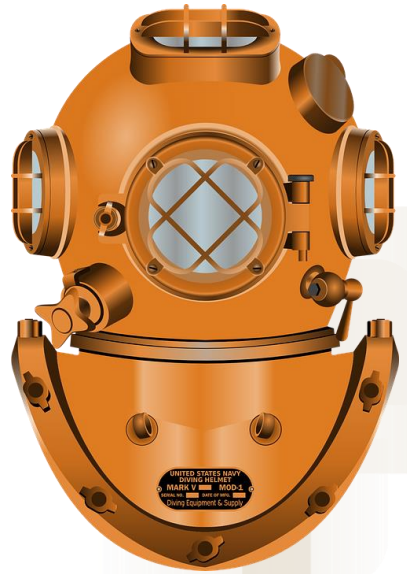
*subject to any limitations imposed by the State on the scope of practice.

**New in 2024 - Pg. 2069. Department of Health and Human Services and Centers for Medicare & Medicaid Services. (2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).

Deep Dive into Principal Illness Navigation

Health Equity

- Principal Illness Navigation has important implications for health equity.
- Members of historically disadvantaged communities and communities of color often receive lower rates of patient navigation, are often diagnosed with serious, high-risk illnesses like cancer at later stages, and have longer times between suspicion and definitive diagnosis for conditions like cancer.
- PIN services are hoped to fill a critical gap in navigation services, noting that many navigation programs are currently grant funded and unable to serve all patients that might benefit.



Federal Register

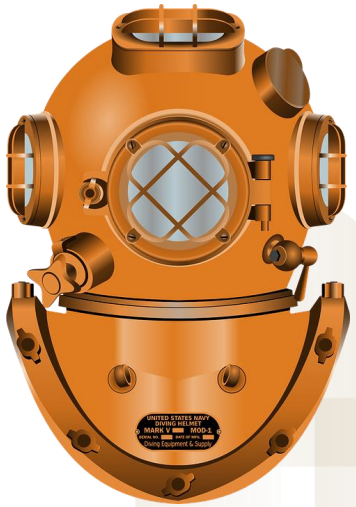
Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

Deep Dive into Principal Illness Navigation

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024)

G0023 – Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
- Practitioner, home- and community-based care communication
- Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition



Federal Register

Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

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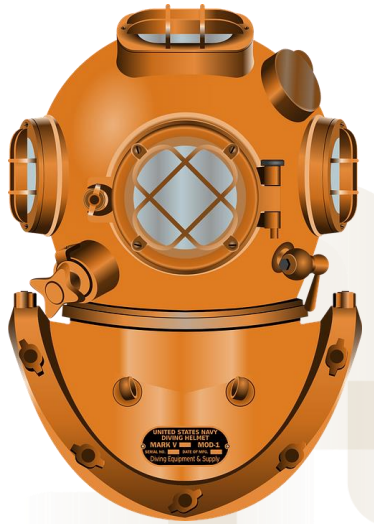
Deep Dive into Principal Illness Navigation

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024) *Continued*

- Health care access/health system navigation
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
- Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

G0024 – Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023) No frequency limitation.



Federal Register

Source: *Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).*

Deep Dive into Principal Illness Navigation

Qualified Practitioners	Auxiliary Personnel	Supervision	Contracting Considerations
Practitioners are physicians or other qualified healthcare professionals including clinical psychologists	Certified or trained auxiliary personnel under the direction of a billing practitioner who are involved in the patient's health care navigation. Auxiliary personnel may include a care navigator or certified peer specialist.	PIN services are considered care management services that may be furnished under general supervision. General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.	Auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

Principal Illness Navigation Workflow

Initiating visits

The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness, or disease.

Initiating visits include:

CPT code 90791 (Psychiatric diagnostic evaluation) or Health Behavior Assessment and Intervention (HBAI) services: 96156, 96158, 96159, 96164, 96165, 96167, and 96168

An E/M visit, (not a low-level E/M visit done by clinical staff)

A Medicare Annual Wellness Visit provided by the billing practitioner for subsequent PIN services

An E/M visit done as part of a Transitional Care Management (TCM) services

Subsequent PIN Visits

The same practitioner bills for the subsequent PIN services that auxiliary personnel provide.

Auxiliary personnel provide navigation in the treatment of a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition.

PIN services

- Health system navigation
- Person-centered planning
- Identifying or referring to supportive services
- Practitioner, home, and community-based care coordination or communication
- Patient self-advocacy promotion
- Facilitating access to community-based resources

Medicare Coverage Implementation Timeline

January 2024 – Final Physician Fee Schedule published with new codes

By September 30th, 2024 – Medicare Advantage & Special Needs Plan coverage and fee schedule updates include new codes

January 1, 2025 – new codes are effective under Medicare Advantage and Special Needs Plans for eligible providers

Other payers may also be considering the addition of these codes, including Medicaid, Commercial and Qualified Health Plans.

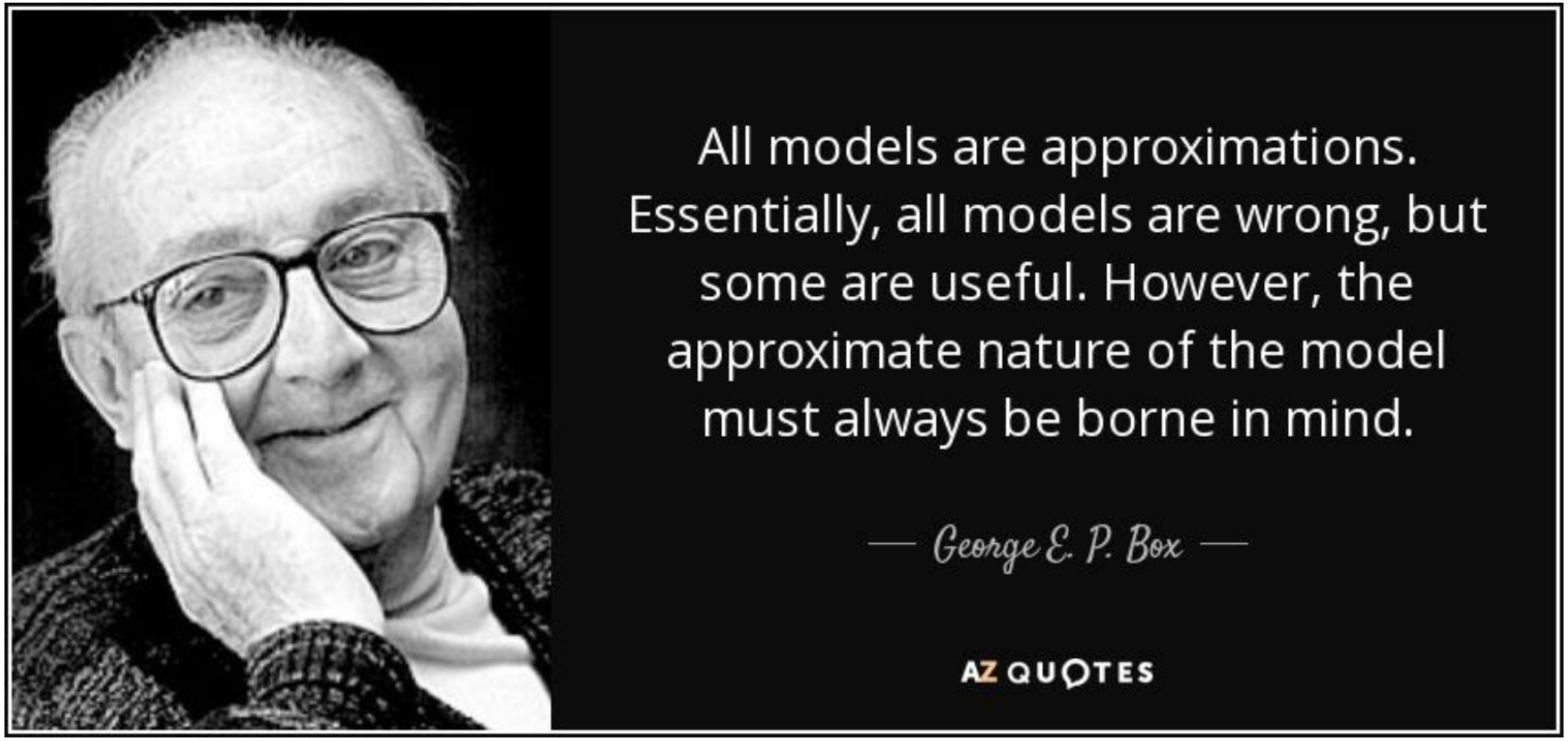
Resources – So Much More in the HRSN Module!

Health-Related Social Needs Module Content Areas

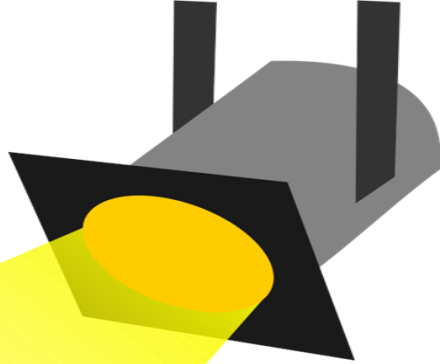
- Coverage Landscape
- Screening & Assessment for HRSN
- Service Delivery Adjustments and Interventions
- Data Management
- New Medicaid Service Types and Definitions
- New Medicare Codes
- Billing Medicare for New HRSN Codes in Different Health Care Settings
- New Medicare Code Specifications

The Decision Support Tool (DST)

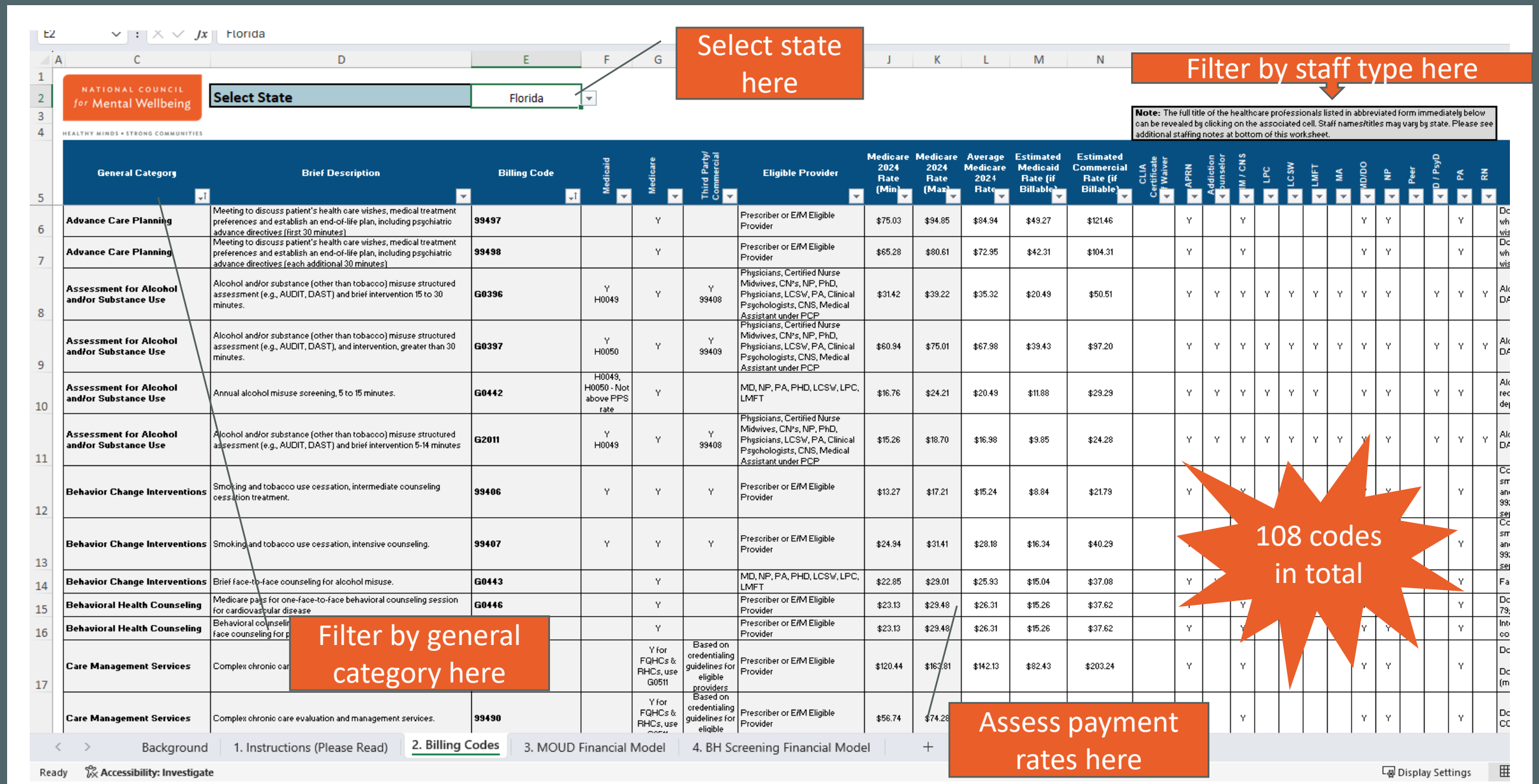
"All models are wrong, but some are useful."



Spotlight on Select DST Worksheets



- Background
- Instructions
- Billing Codes
- Medications for Opioid Use Disorder Financial Model
- Behavioral Health Screening Financial Model



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HEALTHY MINDS • STRONG COMMUNITIES

Select State: Florida

Note: The full title of the healthcare professionals listed in abbreviated form immediately below can be revealed by clicking on the associated cell. Staff names/titles may vary by state. Please see additional staffing notes at bottom of this worksheet.

General Category	Brief Description	Billing Code	Medicaid	Medicare	Third Party/ Commercial	Eligible Provider	Medicare 2024 Rate (Min)	Medicare 2024 Rate (Max)	Average Medicare 2024 Rate	Estimated Medicaid Rate (if Billable)	Estimated Commercial Rate (if Billable)	CLIA Certificate of Waiver	APRN	Addiction Counselor	IM / CNS	LPC	LCSW	LMFT	MA	MD/DO	NP	Peer	PsyD / PsyD	PA	RN	
Advance Care Planning	Meeting to discuss patient's health care wishes, medical treatment preferences and establish an end-of-life plan, including psychiatric advance directives (first 30 minutes)	**99497**		Y		Prescriber or E/M Eligible Provider	$75.03	$94.85	$84.94	$49.27	$121.46		Y		Y					Y	Y			Y		Dc wh wis
Advance Care Planning	Meeting to discuss patient's health care wishes, medical treatment preferences and establish an end-of-life plan, including psychiatric advance directives (each additional 30 minutes)	**99498**		Y		Prescriber or E/M Eligible Provider	$65.28	$80.61	$72.95	$42.31	$104.31		Y		Y					Y	Y			Y		Dc wh wis
Assessment for Alcohol and/or Substance Use	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST) and brief intervention 15 to 30 minutes.	**G0396**	Y H0049	Y	Y 99408	Physicians, Certified Nurse Midwives, CNPs, NP, PhD, Physicians, LCSW, PA, Clinical Psychologists, CNS, Medical Assistant under PCP	$31.42	$39.22	$35.32	$20.49	$50.51		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Alc DA
Assessment for Alcohol and/or Substance Use	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes.	**G0397**	Y H0050	Y	Y 99409	Physicians, Certified Nurse Midwives, CNPs, NP, PhD, Physicians, LCSW, PA, Clinical Psychologists, CNS, Medical Assistant under PCP	$60.94	$75.01	$67.98	$39.43	$97.20		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Alc DA
Assessment for Alcohol and/or Substance Use	Annual alcohol misuse screening, 5 to 15 minutes.	**G0442**	H0049, H0050 - Not above PPS rate	Y		MD, NP, PA, PHD, LCSW, LPC, LMFT	$16.76	$24.21	$20.49	$11.88	$29.29		Y	Y	Y	Y	Y	Y		Y	Y		Y	Y		Alc rec dep
Assessment for Alcohol and/or Substance Use	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST) and brief intervention 5-14 minutes	**G2011**	Y H0049	Y	Y 99408	Physicians, Certified Nurse Midwives, CNPs, NP, PhD, Physicians, LCSW, PA, Clinical Psychologists, CNS, Medical Assistant under PCP	$15.26	$18.70	$16.98	$9.85	$24.28		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Alc DA
Behavior Change Interventions	Smoking and tobacco use cessation, intermediate counseling cessation treatment.	**99406**	Y	Y	Y	Prescriber or E/M Eligible Provider	$13.27	$17.21	$15.24	$8.84	$21.79		Y											Y		Co sm an 99 se
Behavior Change Interventions	Smoking and tobacco use cessation, intensive counseling.	**99407**	Y	Y	Y	Prescriber or E/M Eligible Provider	$24.94	$31.41	$28.18	$16.34	$40.29													Y		Co sm an 99 se
Behavior Change Interventions	Brief face-to-face counseling for alcohol misuse.	**G0443**		Y		MD, NP, PA, PHD, LCSW, LPC, LMFT	$22.85	$29.01	$25.93	$15.04	$37.08		Y											Y		Fa
Behavioral Health Counseling	Medicare pays for one-face-to-face behavioral counseling session for cardiovascular disease	**G0446**		Y		Prescriber or E/M Eligible Provider	$23.13	$29.48	$26.31	$15.26	$37.62				Y									Y		Dc 79
Behavioral Health Counseling	Behavioral counseli face counseling for p			Y		Prescriber or E/M Eligible Provider	$23.13	$29.48	$26.31	$15.26	$37.62		Y		Y					Y	Y			Y		Int co
Care Management Services	Complex chronic car			Y for FQHCs & RHCs, use G0511	Based on credentialing guidelines for eligible providers	Prescriber or E/M Eligible Provider	$120.44	$163.81	$142.13	$82.43	$203.24		Y		Y					Y	Y			Y		Dc Dc (m
Care Management Services	Complex chronic care evaluation and management services.	**99490**		Y for FQHCs & RHCs, use	Based on credentialing guidelines for eligible	Prescriber or E/M Eligible Provider	$56.74	$74.28							Y					Y	Y			Y		Dc CC

Background | 1. Instructions (Please Read) | 2. Billing Codes | 3. MOUD Financial Model | 4. BH Screening Financial Model

Ready | Accessibility: Investigate | Display Settings

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HEALTHY MINDS ▪ STRONG COMMUNITIES

Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

Integrated Billing Financial Model: Medications for Opioid Use Disorder (MOUD)

Insert anticipated clients and no-show rate here

Annual Number of Patients Receiving Medications for Opioid Treatment (e.g., Buprenorphine)	# of Clients	Annual No Show Rate	Adjusted # of Clients
Medicaid	70	15%	59.5
Medicare	10	15%	8.5
Commercial	20	15%	17
Annual treatment retention rate	60%		

Note: The annual completion rate refers to the average percentage of patients receiving buprenorphine that are expected to be retained in treatment for the entire 12-month period.

Visit type	Code	Annual Visits*	Revenue Medicare	Revenue Medicaid	Revenue Commercial	Revenue Total
Initial medical evaluation	99204	1	$ 174	$ 101	$ 249	$ 11,714
Follow-up medication evaluation, Level 3	99213	15	$ 96	$ 55	$ 137	$ 96,582
Follow-up medication evaluation, Level 4	99214	1	$ 135	$ 78	$ 193	$ 9,063
Behavioral health intake assessment	90791	1	$ 179	$ 104	$ 256	$ 12,033
Individual psychotherapy	90837	12	$ 158	$ 91	$ 226	$ 127,417
Group psychotherapy	90853	19	$ 29	$ 17	$ 41	$ 36,582
Urine drug screen	80305	19	$ 13	$ 7	$ 18	$ 16,116

Review revenue estimates

Estimated Total Annual Gross Revenue	**$ 309,500**
Adjusted Annual Gross Revenue	**$ 185,700**

Note: This accounts for annual retention rate in cells C15.

Key service types listed here

Source: Fried, J., Basu, S., Phillips, R. S., & Landon, B. (2020, November). Financing Buprenorphine Treatment in Primary Care: A Microsimulation Model. The Annals of Family Medicine, 18(6) 535-544; DOI: https://doi.org/10.1370/afm.2587

Notes/Disclaimers:

Commercial payment rates are estimated at 143% of Medicare rates. See https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

Background | 1. Instructions (Please Read) | 2. Billing Codes | 3. MOUD Financial Model | 4. BH Screening Financial Model

Ready | Accessibility: Investigate

Drill Down on Select Integrated Care Topic: Billing for Tobacco Cessation Services

Rationale for Focusing on Tobacco Cessation as Part of an Integrated Care Program

Cigarette smoking is the leading cause of preventable death in the United States

Tobacco cessation services can be provided in multiple health care settings

Tobacco cessation services can be provided by a wide range of staff types

Tobacco cessation services widely viewed as underutilized and underdelivered

Most payers cover tobacco cessation treatment services

Disparities abound as it relates to tobacco use and treatment

Sources:
1. *U.S. Department of Health and Human Services. (2024). HHS Framework to Support and Accelerate Smoking Cessation 2024.*
2. *American Lung Association. (2021).Billing Guide Addendum for Behavioral Health.*

Average Smoking Rate by Population Type

Population	Average Smoking Rate	Source
Private Insurance	16.0%	Tobacco Product Use Among Adults — United States, 2020 | MMWR (cdc.gov)
Medicaid	29.0%	Tobacco Product Use Among Adults — United States, 2020 | MMWR (cdc.gov)
Medicare	12.5%	Tobacco Product Use Among Adults — United States, 2020 | MMWR (cdc.gov)
Serious Mental Illness	36.0%	Implementing Tobacco Cessation Treatment for Individuals with Serious Mental Illness: A Quick Guide for Program Directors and Clinicians (samhsa.gov)
Substance Use	70.0%	Tobacco use among substance use disorder (SUD) treatment staff is associated with tobacco-related services received by clients - ScienceDirect

Other disparities in tobacco use occur among those living in rural areas and/or in the U.S. South or Midwest, and among LGBT individuals, lower socioeconomic groups, American Indian and Alaska Native adults, and Black men.

Source: *U.S. Department of Health and Human Services. (2024). HHS Framework to Support and Accelerate Smoking Cessation 2024.*

More Work is Needed to Expand Delivery of Tobacco Cessation Services

The U.S. Preventive Services Task Force[1] recommends that clinicians:

- Ask all adults & pregnant people about tobacco use
- Advise them to stop using tobacco products
- Provide behavioral interventions and FDA–approved pharmacotherapy for cessation

American Lung Association estimated that for every dollar the U.S. spends on tobacco cessation treatments, there is an **average return on investment of $1.26.**[4]

Only 69% of substance use disorder treatment facilities and 55% of mental health facilities offer tobacco cessation services[2]

Nearly 85% of federally-qualified health center patients receive tobacco cessation services[3]

TheNationalCouncil.org/program/Center-of-Excellence

1. U.S. Preventative Services Task Force. (2021). Final Recommendation Statement: Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions.
2. Analysis of data at: FindTreatment.gov
3. National Health Center Program Uniform Data System (UDS) Awardee Data (hrsa.gov)
4. American Lung Association. (2024). Smoking Cessation - The Economic Benefits.

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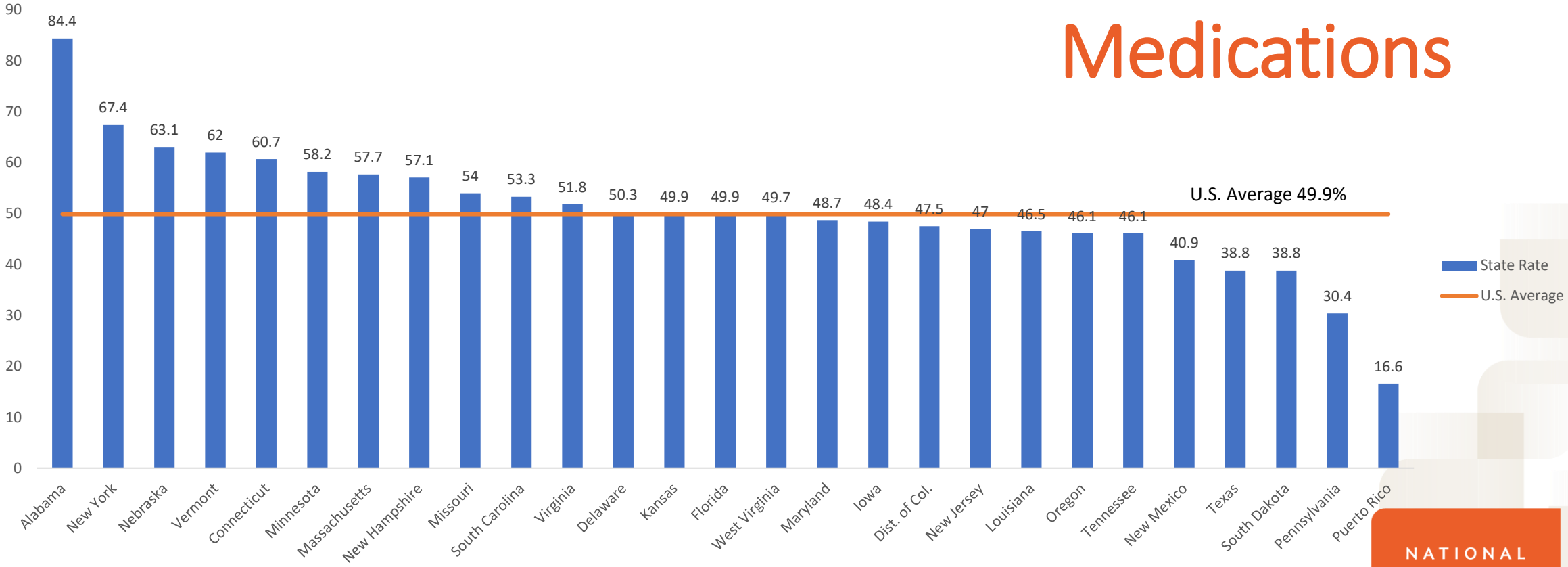
CMS Measure: Percentage of Adult Medicaid Tobacco Users Recommended Cessation Medications



Source: [Medicaid.gov. (2024). Adult Health Care Quality Measures.]

Billing Guidelines for Tobacco Cessation Services

- Available codes include **99406** (smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes, up to 10 minutes) and **99407** (intensive counseling, greater than 10 minutes)
- Claims for smoking and tobacco use cessation counseling services shall be submitted with an appropriate diagnosis code (e.g., **F17. 200**)
- Medicare allows up to 2 cessation attempts per year; each attempt includes 4 counseling sessions (for a maximum of 8 visits per year)
- CMS has included 99406 and 99407 on list of “approved” telehealth codes for CY 2024, including for audio-only service delivery
- Evaluation and management (E/M) and/or psychotherapy codes may be used with or instead of tobacco cessation counseling codes
- Screening for tobacco use is typically not separately reimbursable

Eligible Medicare providers typically include **physicians, physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, and clinical psychologists***

Medicaid programs may enable a wider variety of provider types, such as **dental providers, pharmacists, and/or peer specialists**

*Coverage may include staff types newly eligible for direct billing under Medicare, such as Marriage and Family Therapists and Mental Health Counselors (including addiction counselors).

Sources:

1. *American Lung Association. (2021).Billing Guide Addendum for Behavioral Health.*
2. *Centers for Medicare & Medicaid Services. (2024). List of Telehealth Services.*
3. *National Government Services. (2024). Tobacco Cessation.*

Factors Influencing Whether to Bill Tobacco Cessation Counseling Codes and/or E/M or Psychotherapy Codes

- The service components rendered (psychotherapy, medical decision making, and/or advice to quit)
- The amount of time spent on tobacco cessation counseling
- The specific type(s) of staff delivering services
- The extent to which an individual patient has exhausted available benefits (e.g., insurers may cover only eight counseling sessions per year)
- Nuances of the coverage landscape in your local area (e.g., payment rates, available codes, etc.)

Billing Code & Payment Rate Comparison for Tobacco Cessation Services

CPT Code	Description	Time Estimate	Average 2024 Medicare Rate	Average 2024 Medicaid Rate
99406	Smoking and tobacco use cessation, intermediate counseling cessation treatment.	3-10 minutes	$15.24	$10.97
99407	Smoking and tobacco use cessation, intensive counseling.	>10 minutes	$28.18	$20.29
99213	Established patient office or other outpatient services, low level of medical decision-making.	20-29 minutes	$95.65	$68.86
90832	Individual psychotherapy services rendered for 30 minutes by a licensed mental health provider.	16-37 minutes	$81.04	$58.35

Spotlight on Tobacco Treatment Specialists

Spotlight on Tobacco Treatment Specialists. A staffing model that can be integrated into different health care settings is one in which a tobacco treatment specialist (TTS) works under the supervision of a prescribing clinician to provide a comprehensive assessment, treatment plan, and behavioral counseling to patients who are being seen in the practice. A TTS is usually an allied health professional with specific training in treating tobacco use disorder. **Evidence suggests that a TTS can be more effective than a healthcare provider who fits tobacco into other provider duties.** Champions of tobacco use treatment programs can work with internal compliance and billing leaders to determine how, if at all, TTSs can bill for services depending on the setting, services rendered and license/credentials of the TTS.

BBS strategy + heart

Source: Burke, M. V. et al. (2015). Treatment Outcomes From a Specialist Model for Treating Tobacco Use Disorder in a Medical Center.

Case Study: Estimated Revenue for Tobacco Cessation Services

- Whole Health LLC, a provider based in West Virginia (the state with highest rate of tobacco use), would like to start a **tobacco cessation program**
- Whole Health serves roughly 10,000 clients per year:
  - 70% Medicaid insured
  - 20% Medicare insured
  - 10% commercially insured
- Whole Health plans to provide both intermediate and intensive tobacco cessation visits using **billing codes 99406** and **99407**
- Whole Health will aim for **2 cessation attempts per year** for clients actively using tobacco/nicotine
  - Each attempt includes a maximum of 4 counseling sessions per CMS guidelines.
- The DST indicates that annual revenue for this program would be approximately **$300,100**
  - **$105,344 for intermediate counseling [99406]**
  - **$194,756 for intensive counseling >10 minutes [99407])**

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Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

Enter total number of clients by payer and annual no-show rates here

Change % of clients requiring tobacco cessation if needed (research-based benchmarks provided)

Review revenue estimates

Integrated Billing Financial Model: Behavioral Health Screening and Referral

Projected Annual Clients by Payer	# of Clients	Annual No Show Rate	Adjusted # of Clients	% Requiring Brief Intervention	% Requiring Referral to Treatment	% Using Tobacco
Medicaid	7,000	10%	6,300	10%	4%	29%
Medicare	2,000	10%	1,800	10%	4%	13%
Commercial	1,000	10%	900	10%	4%	16%

Visit / screening type	Code	Annual Medicare Visits	Annual Medicaid Visits	Annual Commercial Visits	Revenue Medicare	Revenue Medicaid	Revenue Commercial	Revenue Total
Alcohol and/or substance use assessment and brief intervention	G0396	180	630	90	$ 35	$ 25	$ 51	$ 26,702
Annual alcohol screening	G0442	1,620	5,670	810	$ 20	$ 15	$ 29	$ 139,380
Annual depression screening	G0444	1,800	6,300	900	$ 20	$ 15	$ 29	$ 154,867
Interprofessional coordination for referral to treatment	99446	72	252	36	$ 18	$ 13	$ 26	$ 5,454
Tobacco cessation, intermediate counseling	99406	900	7,308	576	$ 15	$ 11	$ 22	$ 105,344
Tobacco cessation, intensive counseling	99407	900	7,308	576	$ 28	$ 20	$ 40	$ 194,756

Note: Revenue projections can be updated if payer/insurer does not pay for a particular service code by entering "0" as the number of visits in the appropriate service category. Tobacco cessation estimates assume eligible beneficiaries using tobacco receive the maximum number of cessation visits per year (8), with four at an intermediate level and four at an intensive level.

Change service count for billing codes as appropriate (99406 or 99407)

Estimated Annual Gross Revenue (without Tobacco Cessation)	$ 326,400
Tobacco Cessation Gross Revenue	$ 300,100
Total Annual Gross Revenue	$ 626,500

Resources

- Medicare Physician Fee Schedule (PFS) Final Rule CY2024
- CMS PFS Final Rule Fact Sheet
- CMS FAQ re: Health-Related Social Needs (HRSN)
- CMS Medicare Learning Network Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- HRSN Codes Implementation Resources
- American Lung Association Billing Addendum for Behavioral Health

References

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- ***Place of Service Change Transmittal:*** Centers for Medicare & Medicaid Services. (2021). CMS Manual System: New Place of Service (POS) Code 27 - "Outreach Site/Street."
- ***Place of Service Code Set:*** Centers for Medicare & Medicaid Services. (2024). Place of Service Code Set.
- Department of Health and Human Services and Centers for Medicare & Medicaid Services.(2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).
- *New in 2024 - Pg. 2069.* Department of Health and Human Services and Centers for Medicare & Medicaid Services. (2023). CY 2024 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1784)(Section 610 Review).
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Survey Link:

https://www.surveymonkey.com/r/MQR685L

Questions?

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