Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Facing Denials For Same Session ''Tobacco Counseling'' and E/M? Check This

Question: I am billing '99407' with '99213' and getting denials. I have used the modifier '25' with '99213', but it seems to be asking for a modifier for the '99407'. Can anyone help me with this modifier? Also I am using TOS '9' for consultation, would this be correct or should I be using TOS of '1'?

New Jersey Subscriber

Answer: CMS provides coverage for smoking and any other tobacco-use cessation counseling. The coverage for counseling includes two attempts at cessation. In each attempt, only four counseling sessions will be covered. So, in one year, a total of eight sessions will be covered. Once a person receives a total of eight sessions in the period of one year (365 days), another round of counseling can be taken up only after a 12 month interim period has been completed.

For insurance payers who do not follow Medicare guidelines, you can report 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes).

Claims for smoking and tobacco use cessation counseling services shall be submitted with an appropriate diagnosis code. Diagnosis codes should reflect: the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

These codes may be reported in addition to other E/M services provided on the same day, but they do require face to face counseling by the physician personally to do so. In order for the emergency physician to personally report these codes, he or she must be the one providing the direct counseling rather than by another provider such as a nurse or social worker employed by the hospital. The two services should be distinct, but can be related to the same presenting problem. There are no CCI edits between 99407 and E/M codes, so there is no need to use a modifier when reporting both these codes together.

Your type of service (TOS) should be 1 (Medical care) and not 9 (Other medical service). It looks like this is the main cause for denial otherwise there should not be any issues with this claim. But, even if this is not accepted and paid then you need to call your insurance or consider this service as being part of E/M only.