TOBACCO SMOKE & CHILD HEALTH

THERE IS NO SAFE LEVEL OF EXPOSURE TO TOBACCO SMOKE

Among children aged 3 to 11 in the United States, nearly 60% are exposed to tobacco smoke, and almost 1 in 4 lives in a home with at least one smoker.[1] These children are at greater risk of:

- Sudden infant death syndrome (SIDS);
- More severe and frequent asthma attacks;
- Respiratory illness, like bronchitis and pneumonia;
- Middle ear infections; and
- Slowed lung growth.[1]

Tobacco dependence is a pediatric disease; nearly 90% of smokers start smoking before the age of 18. Children whose parents/caregivers smoke and who grow up in homes where smoking is allowed are also more likely to become smokers themselves.[1,2]

HEALTHCARE PROVIDERS HAVE A ROLE TO PLAY

Pediatric healthcare providers come into direct contact with approximately 25% of smokers in the U.S. during child health visits. Parents may see their child's pediatrician more often than their own healthcare provider, especially during the first two years of their child's life.[3] You are in a unique position to motivate parents and caregivers to stop smoking by taking these three simple steps:

- **ASK about tobacco smoke exposure at every visit.** The majority of parents and caregivers, even those who smoke, expect providers to ask about secondhand smoke exposure and provide advice or information during a pediatric health visit.[4]
- **ADVISE all tobacco users to quit.** By talking to parents/caregivers about quitting smoking, you can have a positive influence on their decision to quit – even if the discussion only lasts 3 minutes or less.[1] Also, did you know you can bill for cessation counseling? See the billing codes guide enclosed in this toolkit for more information.
- **REFER tobacco users to the Texas Tobacco Quit Line: 1-877-YES-QUIT.** If the parent/caregiver is ready and willing to make a quit attempt in the next 30 days, refer the patient to the Texas Tobacco Quit Line. **Why?** When a clinician submits a referral to the Quit Line, adult patients become eligible for up to five telephone-based cessation counseling sessions and two weeks of nicotine replacement therapy at no cost to the individual.

To find out more information and access toolkit materials, visit **www.YesQuit.org/healthcare-providers**

TEXAS Department of State Health Services

1. U.S. Department of Health and Human Services. *Children and Secondhand Smoke Exposure. Excerpts from The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, 2007.
2. Centers for Disease Control and Prevention. (2016). *Health effects of secondhand smoke*. Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/
3. American Academy of Pediatrics Julius B. Richmond Center of Excellence. (n.d.). *Counseling about smoking cessation*. Available at www2.aap.org/richmondcenter/CounselingAboutSmokingCessation.html
4. American Academy of Pediatrics Julius B. Richmond Center of Excellence. (n.d.). *Speakers' kit*. Available at http://www2.aap.org/richmondcenter/PowerpointPresentations.html

CLINICAL TOOLKIT FOR TREATING TOBACCO DEPENDENCE

INTRODUCTION

The influence your role as a healthcare practitioner carries in helping smokers quit cannot be overstated. Evidence produced by the U.S. Public Health Service in 2000 shows that a clinician's advice to quit improves a patient's success in maintaining abstinence. With the addition of a few minutes of counseling, this success rate **doubles**.

One-third of the 3,367,000 adults in Texas who smoke will try to quit this year. Regrettably, only one in 20 will be able to stay tobacco-free. Tobacco claims the lives of approximately 24,100 Texans every year, and every year, about 56,900 young Texans under the age of 18 become new, daily smokers. Of all Texas youth alive now, nearly 486,000 will ultimately die from tobacco-related diseases.

Adding to this challenge is the $726 million spent annually on tobacco marketing in Texas. Research has found that children are three times more sensitive to tobacco industry marketing efforts than adults, and that cigarette marketing carries more influence than peer pressure in underage experimentation with smoking.

As daunting as the task for smoking intervention may seem, current data underscore this fact:

The coordinated efforts of healthcare administrators, insurers, purchasers, and practitioners can boost cessation success.

The tools in this kit are designed to support your clinic's own tobacco intervention efforts. They offer flexibility to meet the needs of different office practices and different patients, and their focus on brevity, as with the "Quick Guides" available at www.YesQuit.org, seeks to accommodate the busiest practitioner.

Use only those tools that fit the specific needs of your office, and enlist the support of clinic staff in implementing a system that ensures that, for every patient at every clinic visit, tobacco use is queried and documented. Most important is your consistent support of your patients' efforts to stay tobacco-free.

> **"As clinicians, you are in a frontline position to help your patients by asking two key questions: 'Do you smoke?' and 'Do you want to quit?'"**
>
> *– David Satcher, MD, PhD*
> *U.S. Surgeon General*

TEXAS Department of State Health Services

CLINICAL TOOLKIT FOR TREATING TOBACCO DEPENDENCE

for teens, pregnant women, and adult populations

Access these materials at **www.YesQuit.org/healthcare-providers**

Clinician Resources

- Electronic referral form
- Training video series
- e-Tobacco Protocol interactive tool
- Toolkit materials:

Guides

- Introductory Guide
- 5As & 5Rs Guide
- e-Tobacco Protocol Brochure
- Pharmacotherapy Quick Guide
- Resources & Further Reading List
- Helping Smokers Quit Guidebook Treating
- Quick Reference Guide

Office Displays and Forms

- Fax referral form
- Patient encounter checklist
- Identification & vital signs stickers
- Business card holder
- Brochure holder display
- Table tent visual aid

Patient Brochures (English/Spanish)*

- Yes! I am ready to quit.
- Maybe. I'm thinking about quitting.
- No. I'm not ready to quit.
- Never Too Young to Get Addicted
- Smoking and My Baby

Patient Handouts

- Information for Expectant Fathers
- Information for Expectant Mothers
- Information for Vietnamese Men
- Quit Line bookmark
- Quit Line wallet cards

Patient Brochures (English/Spanish)

The following three patient take-home brochures address three distinct stages in the quitting process, allowing you to deliver appropriate materials for your patients' smoking status.

- **Yes! I'm ready to quit.** This brochure contains, among other relevant suggestions and techniques, a personalized quit plan sheet that acts as a "contract" for your patient to set a quit date and write a quit plan.
- **Maybe. I'm thinking about quitting.** This brochure acknowledges the difficulties in quitting an addiction and presents the many benefits and rewards of not smoking. A short worksheet helps your patients identify their personal reasons for quitting.
- **No, I'm not ready to quit.** This brochure acknowledges how a smoker feels and lists reasons why some people smoke. Risks and rewards are listed, including a "Healing Time Line" that charts the body's healing from 20 minutes after the last cigarette to 10 years of smoke-free life.

Brochures for Special Patient Audiences (English/Spanish)

- **Smoking and My Baby:** Quitting at any point in pregnancy can yield benefits. This brochure outlines the numerous risks to both the woman and the fetus, and builds on the increased motivation to quit during pregnancy.
- **You're Never Too Young to Get Addicted:** This brochure finds ways to appeal to the fastest growing population of new smokers: teens. Every day, more than 3,000 young people under the age of 18 try their first cigarette. Designed to appeal to the special concerns and interests of teens, this brochure provides background information, tips for quitting, and referral to the Texas Tobacco Quit Line at **1-877-YES-QUIT**.

TEXAS Department of State Health Services

Talking to Teens About Tobacco Use

Clinical interventions to prevent initiation of tobacco use among youth can protect patients' lives, especially when they occur with other initiatives such as mass media campaigns, smoke-free communities, higher tobacco prices, school programs, and family involvement.

The five As of smoking cessation (*ASK* about tobacco use every visit, *ADVISE* smokers to quit, *ASSESS* the patient's readiness to quit, *ASSIST* in creating a quit plan, *ARRANGE* follow-up care) are great conversation starters. Here are some other points you can make to your adolescent patients.

ADVICE ON TALKING WITH YOUR TEEN PATIENTS

- **Ask** what your patients know about smoking and health, and help them fill in the gaps. Tell them they are more susceptible to nicotine addiction than adults. Smoking does make you sick and can do so even if you're not a heavy smoker or a longtime smoker. Most teen smokers already have early cardiovascular damage, and smoking can have immediate effects on athletic performance, activity level, and endurance.
- **Tell them** fewer than one out of five high school students smoke, but nearly four out of five of them end up smoking into adulthood, even if they plan to quit in a few years.
- **Remind them** that all tobacco products—even the smokeless ones—contain nicotine and can cause addiction.
- **Share** some of the tobacco industry's marketing myths—that smoking is cool, popular, or can make you thin, for example—then share the truth:
  - Most teens don't like smoking. Fewer than a third say it's OK to be around smokers.
  - Teens don't want to date smokers. Most high school seniors prefer to date nonsmokers.
  - As a group, teen smokers are no thinner than their nonsmoking peers.
- **Remind them** it's much easier to say no in the first place than to quit later.

In addition to clinical cessation treatment and advice, www.teen.smokefree.gov can help teens quit smoking. For stories of real people living with the consequences of smoking, tell your patients to go to www.cdc.gov/tips.

Talking to Parents About Tobacco Use

Parents can be powerful allies in your efforts to prevent your patients from using tobacco and to protect them from secondhand smoke (SHS) exposure. The following information can help you persuade parents to be actively engaged in keeping their children safe from the health effects of smoking:

- Infants and children are especially vulnerable to serious health consequences from SHS exposure. Infants whose parents smoke in the home or family vehicles are more likely to die from SIDS. Children regularly exposed to SHS have more ear infections, asthma attacks, and upper respiratory infections than children who are not exposed. Parents should not allow anyone to smoke around their children.*
- Nicotine is a highly addictive drug, and youth are particularly susceptible to nicotine addiction. The younger they are when they start smoking, the greater their risk for addiction and the more strongly addicted they will become.*
- Teens tend to underestimate the powerful addictive effect of nicotine. Nearly four out of five high school smokers will become adult smokers, even if they intend to quit after a few years.*
- Smoking has immediate health effects, even for young people. As an example, smoking can decrease athletic performance, activity level, and endurance. Even adolescent smokers exhibit cardiovascular damage, including early signs of abdominal aortic atherosclerosis; those most sensitive die very young.*
- One of the most important examples parents can set for their children is to stop smoking.* Parents can call 1-800-QUIT-NOW or go to www.smokefree.gov for free help with quitting.
- Even very young children can understand that smoking makes people sick.
- Teens don't like to be preached to, but studies show they're less likely to smoke if their parents are clear that they disapprove of tobacco use.* They also respond when parents share their own struggles with tobacco use and their own regrets over having smoked in the first place.

*Source: *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, 2012.*

For more information and resources, go to http://www.cdc.gov/tobacco/, http://www.surgeongeneral.gov/, or the American Academy of Pediatrics Julius B. Richmond Center resources for clinicians and clinical practice at http://www2.aap.org/richmondcenter/Clinicians_ClinicalPractice.html.

For information to help patients quit smoking, go to http://www.cdc.gov/tobacco/campaign/tips/groups/health-care-providers.html.

Thirdhand smoke: A Threat to Child Health

Thirdhand smoke is a danger to children. People with breathing problems, pregnant women, the elderly, and animals are also vulnerable to thirdhand smoke. The American Academy of Pediatrics (AAP) recommends that all children be protected from tobacco smoke. This fact sheet offers information and suggestions to prevent exposure to thirdhand smoke.

What is Thirdhand Smoke?

- The left-over pollution after a cigarette is put out
- The smoke residue can stick to dust, furniture, carpeting, car seats, hair, or clothes
- Secondhand smoke particles are released into the air, combine with particles normally in the atmosphere (ie, nitrous acid or ozone) and forms a new compound called nitrosamines, which are released into the air as cancer-causing chemicals

Facts about Thirdhand Smoke

- 43% of smokers (65% of nonsmokers) believe thirdhand smoke can hurt children
- There is **no** safe level of exposure to tobacco smoke
- Thirdhand smoke contains more than 250 chemicals
- Homes and cars where people have smoked can smell of cigarettes for a long time
- Decontaminating a home or car that was used by a smoker may require expensive professional cleaning as it can stain walls, floors, and the smell can remain in dry wall, insulation, and other building materials
- Smoking in a different rooms using fans, or smoking in front of an open window does not prevent thirdhand smoke
- Babies and children can be harmed because they breathe in toxic chemicals when they crawl on floors, sit in cars, or are held by adults- thirdhand smoke can settle on all of these surfaces
- Pets are also at risk because the chemicals from smoke stay in their fur or feathers

How to Protect against Thirdhand Smoke

- Do not allow smoking inside your home or car
- Do not allow smoking near you, your children, or your pets
- Ask anyone who cares for your child or pet to follow these rules- and tell them why
- E-cigarette vapor or aerosol also contains chemicals. Do not let anyone use e-cigarettes in your home, car, or near your child or pet
- The only way to completely protect against thirdhand smoke is to quit. The AAP recommends talking to your child's pediatrician about ways to keep your child healthy

E-Cigarettes and Electronic Nicotine Delivery Systems: What Parents Need to Know

E-cigarettes have become very popular. Also called electronic nicotine delivery systems (ENDS), e-cigarettes, vape pens, personal vaping devices, e-hookah, and e-cigars are not a safe alternative to cigarette smoking. The American Academy of Pediatrics (AAP) supports actions to help prevent children and youth from using or being exposed to the vapor from ENDS. This fact sheet offers facts and tips for parents to help address ENDS use and exposure.

Are They Safe?

- The solution in ENDS devices and exhaled vapor contains chemicals, some of which can cause cancer
- These products are also used to smoke or "vape" marijuana, herbs, waxes, and oils
- The long-term health effects to the user and bystanders are still unknown
- There is no national regulation of the ingredients or amounts used in ENDS solution
- ENDS have exploded and caused fires while charging
- ENDS have not been approved by the government as a proven way to quit smoking
- The best way to protect your children is to never smoke or vape near them. Always go outside, away from children, or talk to your doctor about quitting.

Appeal to Youth

- Children, who are impressionable and model the behavior of adults, see ENDS ads everywhere- in television, radio, magazines, billboards, and social media
- The solution in ENDS devices is usually flavored. These flavors appeal to children, and are often things like peach schnapps, java jolt, piña colada, peppermint, bubble gum, or chocolate
- It is easy for children to illegally order ENDS online, and many retailers offer price discounts to make ENDS easier for children to purchase.

Risk of Poisoning

- ENDS solutions can poison children and adults through ingestion or skin contact
- A child can be killed by very small amounts of nicotine- less than half a teaspoon
- Calls to poison control centers have risen due to ENDS- there were 3,073 calls in 2015
- Symptoms of nicotine poisoning include sweating, dizziness, vomiting, increased heart rate and blood pressure, seizures, and slowed breathing

Recommendations for ENDS Users *(Courtesy of the American Association of Poison Control Centers)*

- Protect your skin when handling the products
- Always keep e-cigarettes and liquid nicotine locked up and out of the reach of children
- Follow the specific disposal instructions on the label
- If exposure to e-cigarettes and liquid nicotine occurs, call the local poison center at 1-800-222-1222

For more information about ENDS, including statistics and citations, please visit http://www2.aap.org/richmondcenter/ENDS.html

Electronic nicotine delivery systems

What physicians should know about ENDS

- Electronic nicotine delivery systems (ENDS), also called e-cigarettes, vaping devices or vape pens, are battery-powered devices used to smoke or "vape" a flavored solution.
- ENDS solution often contains nicotine, an addictive chemical also found in cigarettes.
- ENDS use is popular—the rate of adults trying an e-cigarette at least once more than doubled from 2010 to 2013,[1] and more youth are current users of e-cigarettes than combustible cigarettes.[2]
- There are no federal regulations addressing ENDS. Therefore, ingredients listed on packaging may not be accurate, may differ in quantities between devices, and product quality control is conducted by the manufacturer alone, if at all.
- Exhaled ENDS vapor is not harmless water vapor—it has been shown to contain chemicals that cause cancer,[3] can cause harm to unborn babies,[4] and is a source of indoor air pollution.[5] ENDS are promoted as a way to smoke where smoking is prohibited. However, state and local officials are incorporating ENDS use into existing smoke-free air regulations to protect health.
- Some people use ENDS as a way to quit smoking combustible cigarettes, but this has not been proven effective,[6] and some people use both devices due to the addictive nature of nicotine.

ENDS are a health hazard

- Lack of federal regulation means ENDS companies can legally promote these products by using techniques that cigarette companies have not been able to use since the 1998 Master Settlement Agreement. The agreement covered television and radio ads, billboards, outdoor signage, and sponsorships.
- ENDS and ENDS solutions are available in many flavors (bubble gum, chocolate, peppermint, etc.) that appeal to youth. Flavors, design, and marketing renormalize and glamorize smoking.
- There are no packaging safety standards for ENDS or the containers that hold ENDS solution. There is no mandate for safety warnings, child-resistant packaging, or flow restrictors that could make these products safer. As a result, U.S. poison control centers have reported skyrocketing adverse exposures from e-cigarettes and liquid nicotine since 2011.[7]

What physicians should tell patients and families about ENDS

- ENDS emissions are not harmless water vapor. Both the user and those around them are exposed to chemicals, some of which cause cancer.
- The U.S. Preventive Services Task Force guidelines show there is not enough evidence to recommend ENDS for smoking cessation.[6] Patients may ask about ENDS because they are interested in quitting smoking. Be ready to counsel as appropriate.
- Ask the right questions: "Do you smoke?" is not the same as, and is a less effective way to get patients talking than, "Do you vape or use electronic cigarettes?"
- Recommend FDA-approved cessation products and refer patients to the state quitline (1-800-QUIT NOW), a text-based program (text QUIT to 47848), or an in-person cessation program.
- Insurance covers some medications and programs, and grants may be available to offer free cessation help. Do not let cost be a barrier to quitting.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS
AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA
AMA
AMERICAN MEDICAL ASSOCIATION

References

1) King BA, Patel R, Nguyen KH, Dube SR. Trends in awareness and use of electronic cigarettes among U.S. adults, 2010-2013. *Nicotine Tob Res*. 2015;17(2):219-27
2) Johnston LD, et al. Monitoring the future. National survey results on drug use. 1975-2014. Overview. Key findings on adolescent drug use. National Institutes of Health. National Institute on Drug Abuse. The University of Michigan. Institute for Social Research. Ann Arbor, MI. 2015. http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2014.pdf. Accessed October 2, 2015.
3) Grana R, Benowitz N, Glantz SA. E-cigarettes: a scientific review. *Circulation*. 2014;129(19):1972-86.
4) Bahl V, Lin S, Xu N, Davis B, Wang YH, Talbot P. Comparison of electronic cigarette refill fluid cytotoxicity using embryonic and adult models. *Reprod Toxicol*. 2012;34(4):529-37.
5) Schober W, Szendrei K, Matzen W, et al. Use of electronic cigarettes (e-cigarettes) impairs indoor air quality and increases FeNO levels of e-cigarette consumers. *Int J Hyg Environ Health*. 2014;217(6):628-37.
6) Siu AL. Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med*. doi:10.7326/M15-2023. [Epub ahead of print 22 September 2015].
7) American Association of Poison Control Centers. Electronic Cigarettes and Liquid Nicotine Data. August 31, 2015. https://aapcc.s3.amazonaws.com/files/library/E-cig__Nicotine_Web_Data_through_8.2015_BjzqUYv.pdf. Accessed Oct. 1, 2015.

Last updated: December 2015

QUITTING TAKES HARD WORK AND A LOT OF EFFORT, BUT—

You Can Quit Smoking

SUPPORT AND ADVICE FROM YOUR CLINICIAN

A PERSONALIZED QUIT PLAN FOR: _____

WANT TO QUIT?

- Nicotine is a powerful addiction.
- Quitting is hard, but don't give up. **You can do it**.
- Many people try 2 or 3 times before they quit for good.
- Each time you try to quit, the more likely you will be to succeed.

GOOD REASONS FOR QUITTING:

- You will live longer and live healthier.
- The people you live with, especially your children, will be healthier.
- You will have more energy and breathe easier.
- You will lower your risk of heart attack, stroke, or cancer.

TIPS TO HELP YOU QUIT:

- Get rid of ALL cigarettes and ashtrays in your home, car, or workplace.
- Ask your family, friends, and coworkers for support.
- Stay in nonsmoking areas.
- Breathe in deeply when you feel the urge to smoke.
- Keep yourself busy.
- Reward yourself often.

QUIT AND SAVE YOURSELF MONEY:

- At over $5.00 per pack, if you smoke 1 pack per day, you will save more than $1,800 each year and more than $18,000 in 10 years.
- What else could you do with this money?

U.S. Department of Health and Human Services
Public Health Service

ISSN 1530-6402
Revised September 2008

(over)

Five Keys for Quitting

1. GET READY.

- Set a quit date and stick to it—not even a single puff!
- Think about past quit attempts. What worked and what did not?

2. GET SUPPORT AND ENCOURAGEMENT.

- Tell your family, friends, and coworkers you are quitting.
- Talk to your doctor or other health care provider.
- Get group or individual counseling.
- For free help, call 1-800-QUIT NOW (784-8669) to be connected to the quitline in your State.

3. LEARN NEW SKILLS AND BEHAVIORS.

- When you first try to quit, change your routine.
- Reduce stress.
- Distract yourself from urges to smoke.
- Plan something enjoyable to do every day.
- Drink a lot of water and other fluids.
- Replace smoking with low-calorie food such as carrots.

4. GET MEDICATION AND USE IT CORRECTLY.

- Talk with your health care provider about which medication will work best for you:
- Bupropion SR—available by prescription.
- Nicotine gum—available over the counter.
- Nicotine inhaler—available by prescription.
- Nicotine nasal spray—available by prescription.
- Nicotine patch—available over the counter.
- Nicotine lozenge—available over the counter.
- Varenicline—available by prescription.

5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.

- Avoid alcohol.
- Be careful around other smokers.
- Improve your mood in ways other than smoking.
- Eat a healthy diet, and stay active.

Your Quit Plan

1. YOUR QUIT DATE:

2. WHO CAN HELP YOU:

3. SKILLS AND BEHAVIORS YOU CAN USE:

4. YOUR MEDICATION PLAN:

Medications:

Instructions:

5. HOW WILL YOU PREPARE?

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Followup plan: _____

Other information: _____

Referral: _____

_____

Clinician Date

MAKE IT EASIER TO HELP YOUR PATIENTS QUIT TOBACCO

Incorporate Ask, Advise, Refer into your electronic health records system

ELECTRONIC HEALTH RECORDS (EHRs) MAKE THINGS EASIER FOR EVERYONE.

It's no secret that EHRs can save time and paperwork, reduce errors, and streamline the billing process. But did you know they can also make it easier to help patients kick the tobacco habit?

THE E-TOBACCO PROTOCOL IS SIMPLE TO IMPLEMENT AND USE.

The e-Tobacco Protocol incorporates the successful **Ask, Advise, Refer** method into your EHR system. It makes recording tobacco use at every patient visit a simple, routine step during the checking and recording of vital signs.

The protocol not only prompts the doctor or appropriate staff member to ask the patient about tobacco use, but it also helps him or her assess the patient's interest in quitting and, if the patient is interested, connects the patient with an effective tobacco cessation service.

By incorporating the e-Tobacco Protocol into an EHR system, connecting the patient with a cessation service no longer requires filling out paperwork and faxing forms after the patient has left. Instead, the connection is made automatically while the patient is still in the clinic.

THE BENEFITS ARE HUGE.

As part of an EHR system, the e-Tobacco Protocol can help meet the required Meaningful Use guidelines by documenting patients' tobacco status while saving more lives more quickly. It can streamline patient data collection and dissemination and enhance the effectiveness of tobacco cessation services.

In addition, health care practitioners following the **Ask, Advise, Refer** steps have found that although some patients do not want to discuss quitting tobacco during their first appointment, they will ask about the process during return visits.

Smoking is a leading cause of hospitalizations and re-hospitalizations; therefore, effective tobacco cessation interventions may also increase bed availability and reduce wait times.

READY FOR A GUIDE? USE OUR INTERACTIVE TOOL.

Visit **YesQuit.org** to use an interactive tool that covers important steps you can take toward implementing an EHR system that includes the e-Tobacco Protocol.

TEXAS Department of State Health Services

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Tobacco Coding Fact Sheet for Primary Care Pediatrics

Current Procedural Terminology (CPT®) Codes

Physician Evaluation & Management Services

Outpatient

99201	Office or other outpatient visit, *new* patient; self limited or minor problem, 10 min.
99202	low to moderate severity problem, 20 min.
99203	moderate severity problem, 30 min.
99204	moderate to high severity problem, 45 min.
99205	high severity problem, 60 min.

A *new patient* is one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211	Office or other outpatient visit, *established* patient; minimal problem, 5 min.
99212	self limited or minor problem, 10 min.
99213	low to moderate severity problem, 15 min.
99214	moderate severity problem, 25 min.
99215	moderate to high severity problem, 40 min.

+99354	Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with time-based codes 99201-99215, 99241-99245, 99301-99350*)
+99355	each additional 30 min. (*use in conjunction with 99354*)

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	intensive, greater than 10 minutes

Codes 99406-99407 can only be reported under the person being counseled. The codes cannot be reported under the pediatric patient if a parent or guardian is counseled on smoking cessation. Time spent counseling the parent or guardian falls under the E/M service time unless billing under the parent or guardian's name and ID.

99420	Administration and interpretation of health risk assessment instruments

Inpatient

99238	Hospital discharge day management; 30 min.
99239	more than 30 min

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

99221 Initial hospital care, per day: admitting problem of low severity, 30 min.
99222 admitting problem of moderate severity, 50 min.
99223 admitting problem of high severity, 70 min.

99231 Subsequent hospital care, per day, also used for follow-up inpatient consultation services; patient is stable, recovering or improving, 15 min.

99232 patient is responding inadequately to therapy or has developed minor complication, 25 min.
99233 patient is unstable or has developed a significant complication or new problem, 35 min.

99218 Initial observation care, per day: admitting problem of low severity, 30 min,
99219 admitting problem of moderate severity, 50 min,
99220 admitting problem of high severity, 70 min.

99224 Subsequent observation care, per day: patient is stable, recovering or improving, 15 min.
99225 patient is responding inadequately to therapy or has developed a minor complication, 25 min.
99226 patient is unstable or has developed a significant new problem, 35 min.

99460 Normal newborn care; Initial Day
99462 Subsequent day, per day
99463 Same Day Admit and Discharge

+99356 Prolonged services in the inpatient/observation setting; first hour (use in conjunction with time-based codes 99221-99233, 99218-99220, 99224-99226)
+99357 each additional 30 min. (use in conjunction with 99356)

Reporting E/M services using "Time"

- Only pertains to E/M codes with a typical time. For purposes of this fact sheet, this refers only to codes 99201-99215, 99218-99220, 99221-99226, 99231-99233).

- When counseling or coordination of care dominates (more than 50%) the physician/patient or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services.

- This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

- For coding purposes, face-to-face time for **outpatient** services (eg, office) is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient. For reporting purposes, intraservice time for **inpatient** (eg, hospital care) services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family. In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

- When codes are ranked in sequential typical times (such as for the office-based E/M services or consultation codes) and the actual time is between 2 typical times, the code with the typical time closest to the actual time is used.
- Prolonged services can only be added to codes with listed typical times such as the ones listed above. In order to report physician or other qualified health care professional prolonged services the reporting provider must spend a minimum of 30 minutes beyond the typical time listed in the code level being reported. When reporting outpatient prolonged services only

  count face-to-face time with the reporting provider. When reporting inpatient or observation prolonged services you can count face-to-face time, as well as unit/floor time spent on the patient's care. However, if the reporting provider is reporting their service based on time (ie, counseling/coordinating care dominate) and not key components, then prolonged services cannot be reported unless the provider reaches 30 minutes beyond the listed typical time in the highest code in the set (eg, 99205, 99226, 99223). It is important that time is clearly noted in the patient's chart. For clinical staff prolonged services refer to CPT codes 99415-99416 in the CPT manual.

Physician Non-Face-to-Face Services

99339 Care Plan Oversight Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 30 minutes or more

99358 Prolonged physician services without direct patient contact; first hour Note: This code is no longer an "add-on" service and can be reported alone.

+99359 each additional 30 min. (*use in conjunction with 99358*)

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

99441 Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

99444 Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

Care Management and Transition Care Management Services:

Care management and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional.

Care Management codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99487 Complex chronic care management services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

99488 first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Complex chronic care management services are is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
3. commonly require the coordination of a number of specialties and services.

99495 Transitional care management (TCM) services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including

acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and .requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately.

Refer to the *CPT* manual for complete details on reporting chronic care management and TCM services.

Non-Physician Provider (NPP) Services

99366 Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional

99368 Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional

96150 Health and behavior assessment performed by nonphysician provider (health-focused clinical interviews, behavior observations) to identify psychological, behavioral, emotional, cognitive or social factors important to management of physical health problems, 15 min., initial assessment
96151 re-assessment

96152 Health and behavior intervention performed by nonphysician provider to improve patient's health and well-being using cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems), individual, 15 min.
96153 group (2 or more patients) 96154
family (with the patient present)

96155 family (without the patient present)

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

Non-Face-to-Face Services: NPP

98966 Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 11-20 minutes of medical discussion

98968 21-20 minutes of medical discussion

98969 Online assessment and management service provided by a qualified nonphysician healthcare professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous seven days nor using the internet or similar electronic communications network

Miscellaneous Services

99071 Educational supplies, such as books, tapes or pamphlets, provided by the physician for the patient's education at cost to the physician

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Codes

- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.
- ***ICD-10-CM codes are only valid on or after October 1, 2015.*** Respiratory Conditions

J06.9 Acute upper respiratory infection, unspecified

For **J44** codes

Code also type of asthma, if applicable (**J45**.-)

For **J44** and **J45** codes use additional code to identify: exposure to environmental tobacco smoke (**Z77.22**) history of tobacco use (**Z87.891**) occupational exposure to environmental tobacco smoke (**Z57.31**) tobacco dependence (**F17**.-) tobacco use (**Z72.0**)

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection (use additional code to identify the infection)
J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9 Chronic obstructive pulmonary disease, unspecified (Chronic obstructive airway disease NOS)
J45.20 Mild intermittent asthma, uncomplicated (NOS)
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated (NOS)
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated (NOS)
J45.41 Moderate persistent asthma with (acute) exacerbation

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated (NOS)
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus
J45.909 Unspecified asthma, uncomplicated (NOS)
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma
R06.02 Shortness of breath
R06.2 Wheezing

Substance-Related and Addictive Disorders:
If a provider documents multiple patterns of use, only one should be reported. Use the following hierarchy: use–abuse–dependence (eg, if use and dependence are documented, only code for dependence).

When a minus symbol (-) is included in codes **F10–F17,** a last digit is required. Be sure to include the last digit from the following list:
0 anxiety disorder **2** sleep disorder **8** other disorder **9** unspecified disorder

[C]Alcohol
F10.10 Alcohol abuse, uncomplicated
F10.14 Alcohol abuse with alcohol-induced mood disorder
F10.159 Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.18- Alcohol abuse with alcohol-induced
F10.19 Alcohol abuse with unspecified alcohol-induced disorder
F10.20 Alcohol dependence, uncomplicated
F10.21 Alcohol dependence, in remission
F10.24 Alcohol dependence with alcohol-induced mood disorder
F10.259 Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.28- Alcohol dependence with alcohol-induced
F10.29 Alcohol dependence with unspecified alcohol-induced disorder
F10.94 Alcohol use, unspecified with alcohol-induced mood disorder
F10.959 Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.98- Alcohol use, unspecified with alcohol-induced
F10.99 Alcohol use, unspecified with unspecified alcohol-induced disorder

[C]Cannabis
F12.10 Cannabis abuse, uncomplicated
F12.18- Cannabis abuse with cannabis-induced
F12.19 Cannabis abuse with unspecified cannabis-induced disorder
F12.20 Cannabis dependence, uncomplicated
F12.21 Cannabis dependence, in remission
F12.28- Cannabis dependence with cannabis-induced
F12.29 Cannabis dependence with unspecified cannabis-induced disorder
F12.90 Cannabis use, unspecified, uncomplicated
F12.98- Cannabis use, unspecified with
F12.99 Cannabis use, unspecified with unspecified cannabis-induced disorder

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

[C]Sedatives

F13.10 Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.14 Sedative, hypnotic or anxiolytic abuse w sedative, hypnotic or anxiolytic-induced mood disorder
F13.18- Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced
F13.21 Sedative, hypnotic or anxiolytic dependence, in remission
F13.90 Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.94 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.98- Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced
F13.99 Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic- induced disorder

[C]Stimulants (eg, Caffeine, Amphetamines)

F15.10 Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated
F15.14 Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced mood disorder
F15.18- Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced
F15.19 Other stimulant (amphetamine-related disorders or caffeine) abuse with unspecified stimulant- induced disorder
F15.20 Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated
F15.21 Other stimulant (amphetamine-related disorders or caffeine) dependence, in remission
F15.24 Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced mood disorder
F15.28- Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced
F15.29 Other stimulant (amphetamine-related disorders or caffeine) dependence with unspecified stimulant-induced disorder
F15.90 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified, uncomplicated
F15.94 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant- induced mood disorder
F15.98- Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant- induced
F15.99 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with unspecified stimulant-induced disorder

[C]Nicotine (eg, Cigarettes)

F17.200 Nicotine dependence, unspecified, uncomplicated
F17.201 Nicotine dependence, unspecified, in remission
F17.203 Nicotine dependence unspecified, with withdrawal
F17.20- Nicotine dependence, unspecified, with
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

Depressive Disorders

F30- Report for bipolar disorder, single manic episode
F30.10 Manic episode without psychotic symptoms, unspecified

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

F30.11 Manic episode without psychotic symptoms, mild
F30.12 Manic episode without psychotic symptoms, moderate
F30.13 Manic episode, severe, without psychotic symptoms
F30.2 Manic episode, severe with psychotic symptoms
F30.3 Manic episode in partial remission
F30.4 Manic episode in full remission
F30.8 Other manic episodes
F30.9 Manic episode, unspecified
F31.0 Bipolar disorder, current episode hypomanic
F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11 Bipolar disorder, current episode manic without psychotic features, mild
F31.12 Bipolar disorder, current episode manic without psychotic features, moderate
F31.13 Bipolar disorder, current episode manic without psychotic features, severe
F31.2 Bipolar disorder, current episode manic severe with psychotic features
F31.30 Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31 Bipolar disorder, current episode depressed, mild
F31.32 Bipolar disorder, current episode depressed, moderate
F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60 Bipolar disorder, current episode mixed, unspecified
F31.61 Bipolar disorder, current episode mixed, mild
F31.62 Bipolar disorder, current episode mixed, moderate
F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70 Bipolar disorder, currently in remission, most recent episode unspecified
F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72 Bipolar disorder, in full remission, most recent episode hypomanic
F31.73 Bipolar disorder, in partial remission, most recent episode manic
F31.74 Bipolar disorder, in full remission, most recent episode manic
F31.75 Bipolar disorder, in partial remission, most recent episode depressed
F31.76 Bipolar disorder, in full remission, most recent episode depressed
F31.77 Bipolar disorder, in partial remission, most recent episode mixed
F31.78 Bipolar disorder, in full remission, most recent episode mixed
F31.81 Bipolar II disorder
F31.89 Other bipolar disorder (Recurrent manic episodes NOS)
F31.9 Bipolar disorder, unspecified
F34.1 Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)

Anxiety Disorders

F40.10 Social phobia, unspecified
F40.11 Social phobia, generalized
F40.8 Phobic anxiety disorders, other (phobic anxiety disorder of childhood)
F40.9 Phobic anxiety disorder, unspecified
F41.1 Generalized anxiety disorder

Behavioral/Emotional Disorders

F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.8 Attention-deficit hyperactivity disorder, other type
F90.9 Attention-deficit hyperactivity disorder, unspecified type

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

F91.1 Conduct disorder, childhood-onset type
F91.2 Conduct disorder, adolescent-onset type
F91.3 Oppositional defiant disorder
F91.9 Conduct disorder, unspecified

Neurodevelopmental/Other Developmental Disorders

F81.0 Specific reading disorder
F81.2 Mathematics disorder
F81.89 Other developmental disorders of scholastic skills
F81.9 Developmental disorder of scholastic skills, unspecified

Other

R45.851 Suicidal ideations
R48.0 Alexia/dyslexia, NOS

Poisoning and Adverse Effects

For codes **T40 – T65** use the following as the 5th or 6th digit to define the poisoning or adverse effect
Accidental (unintentional)Intentional self-harmAssaultUndeterminedAdverse effect

Codes **T40 – T65** require a 7th digit to define the encounter.

A Initial encounter
D Subsequent encounter
S Sequela

T40.0X- Opium
T40.1X- Heroin
T40.2X- Opoids (other)
T40.3X- Methadone
T40.5X- Cocaine
T40.60- Narcotics, unspecified
T40.7X- Cannabis (derivatives)
T40.8X- Lysergide (LSD)
T40.90- Hallucinogens, unspecified
T42.3X- Barbiturates
T42.7- Sedative-hypnotics, unspecified (need to add a 6th digit placeholder X)
T43.60- Psychostimulants, unspecified
T43.9- Psychotropic drugs, unspecified (need to add a 6th digit placeholder X)
T65.22- Toxic effect of tobacco cigarettes

Z Codes

Z codes represent reasons for encounters. Categories **Z00–Z99** are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories **A00–Y89** are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways:
(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.
(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

Z13.89 Encounter for screening for other disorder
Z57.31 Occupational exposure to environmental tobacco smoke
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
Z60.4 Social exclusion and rejection
Z60.8 Other problems related to social environment
Z60.9 Problem related to social environment, unspecified
Z62.0 Inadequate parental supervision and control
Z62.21 Foster care status (child welfare)
Z62.22 Institutional upbringing (child living in orphanage or group home)
Z62.29 Other upbringing away from parents
Z62.6 Inappropriate (excessive) parental pressure
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 Personal history of psychological abuse in childhood
Z62.812 Personal history of neglect in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member
Z63.5 Disruption of family by separation and divorce
Z63.8 Other specified problems related to primary support group
Z65.3 Problems related to legal circumstances
Z69.010 Encounter for mental health services for victim of parental child abuse
Z69.020 Encounter for mental health services for victim of non-parental child abuse
Z71.6 Tobacco abuse counseling
Z71.89 Counseling, other specified
Z72.0 Tobacco use
Z73,4 Inadequate social skills, not elsewhere classified
Z77.22 Exposure to environmental tobacco smoke
Z81.1 Family history of alcohol abuse and dependence (conditions classifiable to **F10.-)**
Z81.2 Family history of tobacco abuse and dependence (conditions classifiable to **F17.-)**
Z81.3 Family history of other psychoactive substance abuse and dependence (conditions classifiable to **F11–F16, F18–F19)**
Z81.8 Family history of other mental and behavioral disorders
Z86.69 Personal history of other diseases of the nervous system and sense organs
Z87.891 Personal history of nicotine dependence (tobacco)

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm
- Indicates that an additional character is required for the ICD-10-CM code

Vignettes

Vignette #1

A mother brings her two-year old child (established patient) in for a well-baby check. In social history, you ask the mother whether she smokes and she admits that she smokes 1 pack a day and has been doing so for the past 10 years. You explain to her that besides the fact that smoking can be detrimental to her health, her child is at increased risk for respiratory problems including asthma, colds, upper respiratory infections and ear infections. You spend 10 minutes face to face explaining to her the serious implications this can have on her child's health. When the parent shows interest in quitting, you discuss various options for smoking cessation, refer her to the state quitline using a fax referral form*, and give her literature on smoking cessation programs in your area.

How do you code this encounter?

CPT	ICD-10-CM
99392 Preventive medicine service; 1 -4 years	**Z00.129** Encounter for routine child health examination without abnormal findings **Z77.22** Exposure to environmental tobacco smoke **Z81.2** Family history of tobacco abuse and dependence **Z71.89** Counseling, other specified

Teaching Point: Since you are not counseling the patient, you cannot report the smoking cessation codes 99406-99407. Preventive medicine service codes take into account all preventive medicine counseling. Since the patient is healthy and the smoking cessation counseling is being done to preventive future illness you cannot report a "sick" E/M services based on time spent, in addition to the preventive medicine service.

Vignette #2

A mother brings her 5-year old son in for sudden onset of wheezing. You diagnose an acute exacerbation of his moderate persistent asthma and initiate nebulizer treatment. His mother admits to being a 1.5 pack per day smoker and has tried to quit smoking in the past without success. You explain to the mother that her smoking has contributed to the exacerbation of the asthma. You give her literature on the various options for smoking cessation and explain the various modalities available to her, including local options such as the state quitline*. You then spend 10 additional minutes face to face discussing the relative risks and benefits of each. Overall face-to-face time is 20 minutes. You are at a level 4 office visit given the key components.

How do you code this encounter?

CPT	ICD-10-CM
99214 (modifier **25**)	**J45.41** Moderate persistent asthma with (acute) exacerbation **Z77.22** Exposure to environmental tobacco smoke **Z81.2** Family history of tobacco abuse and dependence **Z71.89** Counseling, other specified
94640 Nebulizer treatment	**J45.41** Moderate persistent asthma with (acute) exacerbation

Teaching Point: Unless you are going to bill under the mother's name to the insurance for the time spent counseling, the time spent would be subsumed under the E/M service for the patient. Since counseling does take up 50% of the total face-to-face time, you can use it to report your E/M service, however, the 20 minutes would only lead you to a 99213. Since your key components support the higher level, report the 99214.

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

Vignette #3

You are evaluating a teenager (16 year-old) that has come for a sports physical examination and yearly check-up. On review of systems, she admits to some shortness of breath on exertion. Direct questioning reveals that she smokes 5-6 cigarettes a day and has also experimented with smokeless tobacco. She began smoking when her parents got divorced as it helped her cope with the depression she was feeling at that time. Since then, she has continued to smoke as she has heard that stopping smoking could cause her to gain weight. She is concerned, however, as she knows that smoking is bad for her health and could cause respiratory problems. You confirm that smoking has been shown to be detrimental to general health, and especially to the respiratory system. You briefly discuss options to assist her in stopping smoking. You then refer her to counseling for the depression as well as smoking cessation. Total time spent on smoking cessation counseling is 5 minutes.

How do you code this encounter?

CPT	ICD-10-CM
99394 Preventive Medicine Service; 12-17 years	**Z00.121** Encounter for routine child health examination with abnormal findings
99406 (modifier **25**) Smoking cessation counseling; 3-10 mins	**F17.210** Nicotine dependence, cigarettes, uncomplicated **Z71.6** Tobacco abuse counseling

Teaching Point: You will not report the sports physical separately in ICD-10-CM. The Z00.121 is all that is needed.

Vignette #4

You see a 15 year-old boy in the after-hours clinic for his third visit in two months for an upper respiratory tract infection. He is an otherwise healthy boy with no chronic medical problems. However, this time, he has developed a persistent cough and shortness of breath when he plays soccer. You ask his parents to leave the room and discover that he has been smoking a pack of cigarettes a day for the past two years. He started when he started a new high school, as he wanted to fit in with the popular boys. A spirometry is performed. You find that his tidal volume is decreased by 15% and he has some rhonchi. A chest X-ray is negative for pneumonia. You explain to the boy that his smoking is making him susceptible to repeated episodes of upper respiratory tract infection. In addition, he is developing reactive airway disease that could make him susceptible to asthma and other problems. You show him literature that describes the various complications of smoking. You also tell him about the various smoking cessation programs available in the county and answer his questions about options that he would be able to obtain without his parents' knowledge. You spend 40 minutes face to face total, with 20 minutes in counseling and 10 minutes strictly discussing smoking cessation options. He is diagnosed with exercise induced bronchospasms.

How do you code this encounter?

CPT	ICD-10-CM
99214 (modifier **25**)	**J45.990** Exercise induced bronchospasm
99406 (modifier **25**)	**F17.210** Nicotine dependence, cigarettes, uncomplicated **Z71.6** Tobacco abuse counseling
94010 Spirometry	**J45.990** Exercise induced bronchospasm

Teaching Point: While the overall time spent was 40 minutes, 10 minutes of that time will be separately reported under the smoking cessation code so it cannot be counted towards your overall E/M service.

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

Vignette #5

You are evaluating a male adolescent (15 year old) patient that has come for his yearly routine visit. When asking about substance use, he offers that he experimented with e-cigarettes within the past month. He denies traditional cigarette use, offering that he would never use such a product because he cares about his health. You congratulate that patient for caring about his health and avoiding cigarette use. You then spend 10 minutes informing him of the potential health hazards related to e-cigarettes, focusing on both the highly addictive and toxic nature of nicotine. You emphasize that nicotine addiction could lead to future cigarette use and encourage him to avoid any use of nicotine containing product.

How do you code this encounter?

CPT	ICD-10-CM
99394 Preventive Medicine Service; 12-17 years	**Z00.121** Encounter for routine child health examination with abnormal findings
99406 (modifier **25**) Smoking cessation counseling; 3-10 mins	**F17.210** Nicotine dependence, cigarettes, uncomplicated **Z71.6** Tobacco abuse counseling

Vignette #6

While covering the newborn nursery, you discharge a first-time mother who plans to breastfeed. As you routinely do, you ask her about smoking and she admits to smoking 1 pack or more a day for the past 10 years. She decreased this to half a pack while pregnant but could not decrease it any further due to cravings. Her husband is a smoker too and smokes 2 packs a day. You explain to the mother that smoking is very harmful, especially to the lungs of a newborn. You spend 15 minutes face to face explaining the various complications of smoking including asthma, recurrent upper respiratory infections, and ear infections. You explain to her that merely smoking outside the baby's room would not eliminate the risk as she would be exposed to nicotine through breast milk which could lead to irritability and decreased sleep. You explain the various options for smoking cessation and give her literature to share with her husband for the same. You offer to refer her to a smoking cessation program in the hospital, as well as the state quitline*. Overall the discharge service takes 35 minutes to complete.

How do you code this encounter?

CPT	ICD-10-CM
99239 Discharge Service over 30 mins	**Z38.00** Single liveborn infant, delivered vaginally **Z81.2** Family history of tobacco abuse and dependence **Z71.89** Counseling, other specified

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

Vignette #7

You see an infant admitted in the hospital for his second episode of wheezing in the last three months. He is the only child and does not attend day care. Both parents smoke in the house and in the car. He has had three ear infections in the last six months and is being considered for tube placements by his pediatrician. As part of the management of the infant you discuss the increased risk of ear infections and frequent respiratory symptoms, amongst others, as a consequence of their smoking. You assess their willingness to quit smoking and assist with arranging smoking cessation resources, both available in the hospital and through the state quitline*. This initial hospital encounter takes 80 minutes to complete, including unit/floor time. Of that time 45 minutes is spent in counseling and coordinating care.

How do you code this encounter?

CPT	ICD-10-CM
99223 Initial hospital care; 70 mins	**R06.2** Wheezing **Z86.69** Personal history of other diseases of the nervous system and sense organs **Z77.22** Exposure to environmental tobacco smoke **Z81.2** Family history of tobacco abuse and dependence **Z71.89** Counseling, other specified

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

*To find your state's quitline fax referral form, visit http://www2.massgeneral.org/ceasetobacco/states.htm

- Indicates that an additional character is required for the ICD-10-CM code

RESOURCES AND FURTHER READING FOR HEALTHCARE PRACTITIONERS

CME PROGRAMS

www.texmed.org/cme/tmaonlinecme.asp
Nicotine Dependence and Its Treatment was prepared for the Internet by the Texas Medical Association Committee on Physician Health and Rehabilitation. The course requires 45 to 60 minutes for study and evaluation to deliver one hour of AMA/PRA Category 1 CME.

www.cme.uwisc.org
A free Web-based program providing training in the treatment of tobacco dependence. Based on the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, this program offers one hour of CME/Pharmacy CE credit to clinicians (including pharmacists) completing the program.

RESOURCES

www.surgeongeneral.gov/tobacco/default.htm
Information on how to obtain a copy of the U.S. Public Health Service guideline

www.cdc.gov/tobacco
Centers for Disease Control and Prevention
Tobacco Information and Prevention Source (TIPS)

www.endsmoking.org
Professional Assisted Cessation Therapy (PACT)
Web site with publication on *Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide*

www.atmc.wisc.edu
Information from the Addressing Tobacco in Health Care Research Network

www.ahrq.gov
Agency for Healthcare Research and Quality

www.ahip.org
America's Health Insurance Plans

www.chestnet.org
American College of Chest Physicians

www.ama-assn.org
American Medical Association Web site with mostly legislative information on tobacco

www.who.int/tobacco/en
World Health Organization

www.alcase.org/
Alliance for Lung Cancer Advocacy, Support and Education

www.ncqa.org
National Committee on Quality Assurance

www.texas-step.org
Statistics and other information on the toll tobacco takes in Texas

www.rwjf.org
Robert Wood Johnson Foundation

www.mayoclinic.org/ndc-rst
Mayo Clinic Nicotine Dependence Center

www.tobaccofreekids.org
Campaign for Tobacco-Free Kids

www.tobacco.org
Information for health professionals and policymakers

www.srnt.org
Society for Research on Nicotine and Tobacco

www.cms.hhs.gov
Centers for Medicare and Medicaid Services

www.cancer.org
American Cancer Society

www.americanheart.org
American Heart Association

www.americanlegacy.org/greatstart
American Legacy Foundation, includes cessation program and quitline for pregnant women

www.lungusa.org
American Lung Association

www.tobaccofree.org
Foundation for a Smoke-Free America

www.aafp.org
ASK and ACT, a tobacco cessation program for physicians by the American Academy of Family Physicians