Priority Health	BILLING POLICY No. 128

SMOKING CESSATION

Date of origin: Aug. 2025	Review dates: 06/2026

This policy outlines how the company reimburses for tobacco use cessation counseling visits, aligning with Medicare guidelines.

DEFINITION

Priority Health will reimburse fee for service for tobacco cessation counseling codes. Reimbursement is available to primary care and specialty physicians.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

- Document the exact time spent with the patient involving smoking cessation counseling.
- Document what was discussed during this counseling session (plans to decrease smoking and/or steps to quit smoking)
- Documentation must support the code being billed

Examples of inadequate documentation. These examples lack a) the exact time and b) what was discussed.:

- “Spent greater than 3 minutes counseling the patient on smoking."
- "Spent between 3 to 10 minutes counseling the patient on smoking."
- "Spent over 10 minutes counseling the patient on smoking.

Reimbursement specifics

Codes should be billed with the appropriate ICD10 code identifying tobacco use.

Code	Description	Reimbursement
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Payable as a preventative benefit; no member copayment or deductible
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Payable as a preventative benefit; no member copayment or deductible
4000F	Tobacco use cessation intervention, counseling (COPD, CAP, CAD, Asthma) (DM) (PV)	CMS CPTIII report only code, no reimbursement
4001F	Tobacco use cessation intervention, pharmacologic	CMS CPTIII report only code, no reimbursement

	therapy (COPD, CAP, CAD, Asthma) (DM) (PV)	
4004F	Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both, if identified as a tobacco user. (PV, CAD)	CMS CPTIII report only code, no reimbursement

Frequency
Individuals are allowed up to two tobacco cessation counseling attempts annually. Each attempt may include up to four intermediate or intensive sessions, permitting a maximum of eight billable sessions per year using CPT codes 99406 or 99407.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Modifier 93 or 95 should be reported on lines when POS is 02 or 10 for telehealth services
Modifier 33 may be added when these codes are reported as a preventative service.
Modifier 25 should be appended to the E/M code when billed on the same day as E/ M services

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES
https://pmc.ncbi.nlm.nih.gov/articles/PMC2793720/#:~:text=Physicians%20and%20qualified%20nonphysician%20practitioners,four%20intermediate%20or%20intensive%20sessions.

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
06/2026	Reviewed, added table but no new information