CHEST

Integrating Tobacco Use Treatment Into Practice

Billing and Documentation

Frank T. Leone, MD, FCCP; Sarah Evers-Casey, MPH, MTTS; Mary A. Mulholland, MHA, RN, CPC; and David P. L. Sachs, MD

Balancing population-based efforts to modify the social and environmental factors that promote tobacco dependence with efforts to improve the delivery of case-based treatments is necessary for realizing maximum reductions in the cost and consequences of the disease. Public health antismoking campaigns following the 1964 Surgeon General's report on the health risks of smoking have changed social norms, prevented initiation among youth, and promoted abstinence among the addicted. However, the rate of progress enjoyed to date is unlikely to continue into the coming decades, given that current annual unassisted cessation rates among prevalent smokers remains fairly low. With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem. Clinicians report a perceived lack of reimbursement as a significant barrier to full integration of tobacco dependence into health care. A more complete understanding of the coding and documentation requirements for successful practice in this critically important area is a prerequisite to increasing engagement. This paper presents several case-based scenarios illustrating important practice management issues related to the treatment of tobacco dependence in health care.

CHEST 2016; 149(2):568-575

KEY WORDS: addiction; reimbursement; smoking; tobacco

Given that tobacco smoking remains responsible for a major portion of preventable death and disability, who, if not health-care providers, should be responsible for preventing that portion of preventable death and disability?

Tobacco control is clearly one of the greatest public health achievements of the 20th century, preventing millions of smoking-related deaths.[1,2] Consequently, the current "end-game" strategy relies heavily on extending gains made by policy initiatives and environmental modifications.[3-6] Relative to the emphasis placed on population-based controls, efforts to increase the ability of health-care systems to provide effective case

ABBREVIATIONS: CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9

AFFILIATIONS: From the Perelman School of Medicine (Dr Leone, Mss Evers-Casey and Mulholland), University of Pennsylvania, Philadelphia, PA; Comprehensive Smoking Treatment Program (Dr Leone, Ms Evers-Casey), University of Pennsylvania, Philadelphia, PA; Leonard Davis Institute of Health Economics (Dr Leone), Philadelphia, PA; and Palo Alto Center for Pulmonary Disease Prevention (Dr Sachs), Palo Alto, CA.

FUNDING/SUPPORT: This work was supported in part by grants derived from the Pennsylvania Master Settlement Agreement through the Philadelphia Department of Public Health, and the National Institutes of Health (grants# R01-CA165001 and R01-DA033681).

CORRESPONDENCE TO: Frank T. Leone, MD, FCCP, Comprehensive Smoking Treatment Program, Penn Lung Center, Suite 251 Wright-Saunders Bldg, 51 N 39th St, Philadelphia, PA 19104; e-mail: frank.tleone@uphs.upenn.edu

DOI: http://dx.doi.org/10.1378/chest.15-0441

treatment have been comparatively pedestrian, and places low on expert lists of tobacco control priorities.[7,8] With more than 1 billion patient interactions annually, there is an enormous unrealized capacity for health-care systems to have an effect on this problem.

Though physicians clearly understand their unique role in promoting abstinence,[9] they do not generally recognize their role in achieving tobacco control goals.[10] Even when high rates of brief intervention behaviors are confirmed, physicians do not generally engage in the "next steps" consistent with sophisticated interventions of chronic illness.[11] This observation has prompted various regulatory agencies to introduce evolutionary pressures, designed to encourage behavior change.[12-14] The US Preventive Services Task Force lists tobacco dependence counseling as a "grade A" recommendation for all adults using tobacco.[15] System readiness to adopt these changes appears low, but is improving.[16,17]

The growing interest in harnessing health care's potential and the increasing demand for professional services will require addressing the issues that have stunted its impact on the tobacco epidemic to date. Several efforts have focused on improving physicians' familiarity with practical evidence-based treatment strategies and time management techniques. However, reported barriers have also included the perceived lack of reimbursement—a topic not routinely addressed in the literature.[18,19] If this is indeed a significant barrier, then fully integrating tobacco dependence into health care will require a more complete understanding of the coding and documentation requirements for successful practice in this critically important area.

A Few Words of Caveat

Imprecise language has led to several unfortunate misimpressions over the years. The prevailing notion that "smoking cessation is not paid for" is, strictly speaking, true. Cessation is something the patient accomplishes, whereas tobacco-dependence treatment is a service provided by the clinician. This distinction is not merely semantic. Payers do not currently reimburse for cessation assistance, such as community-based counseling or quit line support. In contradistinction, cognitive services provided by eligible providers are reimbursable, irrespective of the problem to which they are applied. This paper does not discuss cessation services, but instead addresses several important practice management issues related to the treatment of tobacco dependence.

Although the specifics of tobacco treatment reimbursement vary by both insurer and contract, as a general rule, clinicians should expect to be fairly compensated for tobacco use treatment services, in a manner similar to compensation for services delivered for other problems.[20] Because tobacco use treatment represents a special circumstance with overlapping behavioral and biological dimensions, it is important to understand prevailing requirements and definitions that govern reimbursement. Though accurate in a general sense, the examples presented here are intended only as a guide and should not be interpreted as a guarantee of payment. When discrepancies exist, contact payer representatives for specific plan details and definitive guidance. Readers are referred to *Coding for Chest Medicine 2013*, published by the American College of Chest Physicians for specific coding details and definitions.[21]

All case vignettes are fictional. Any similarity to actual cases or events is purely coincidental.

The Established Outpatient Visit

Mr Jackson is a 49-year-old patient with a long history of asthma. His asthma has been well-controlled on inhaled corticosteroids and bronchodilators for some time, and he presents for routine follow-up monitoring. After identifying diffuse mild end-expiratory wheeze on examination, your discussion with him suggests control over his asthma is loosening. You engage Mr Jackson in conversation about the relevance of his continued smoking to his asthma and suggest that he take steps toward discontinuation.

At this point, the exact nature of your service depends on the type of cognitive services that you provide during the rest of the encounter. The first distinction to be made is whether your service meets the definition of counseling or of evaluation and management (E/M) (Fig 1). Because good clinical practice requires a therapeutic relationship and effective communication, regardless of which problem is being addressed, there can be considerable confusion over the distinction between the two services. It is important to remember that the distinction depends neither on the diagnosis nor on the presence of a physical examination, but on the nature of the cognitive interaction.

Evaluation refers to the cognitive processes applied while determining the significance or status of a problem or condition. This is typically accomplished through careful appraisal of the patient's problem through history-

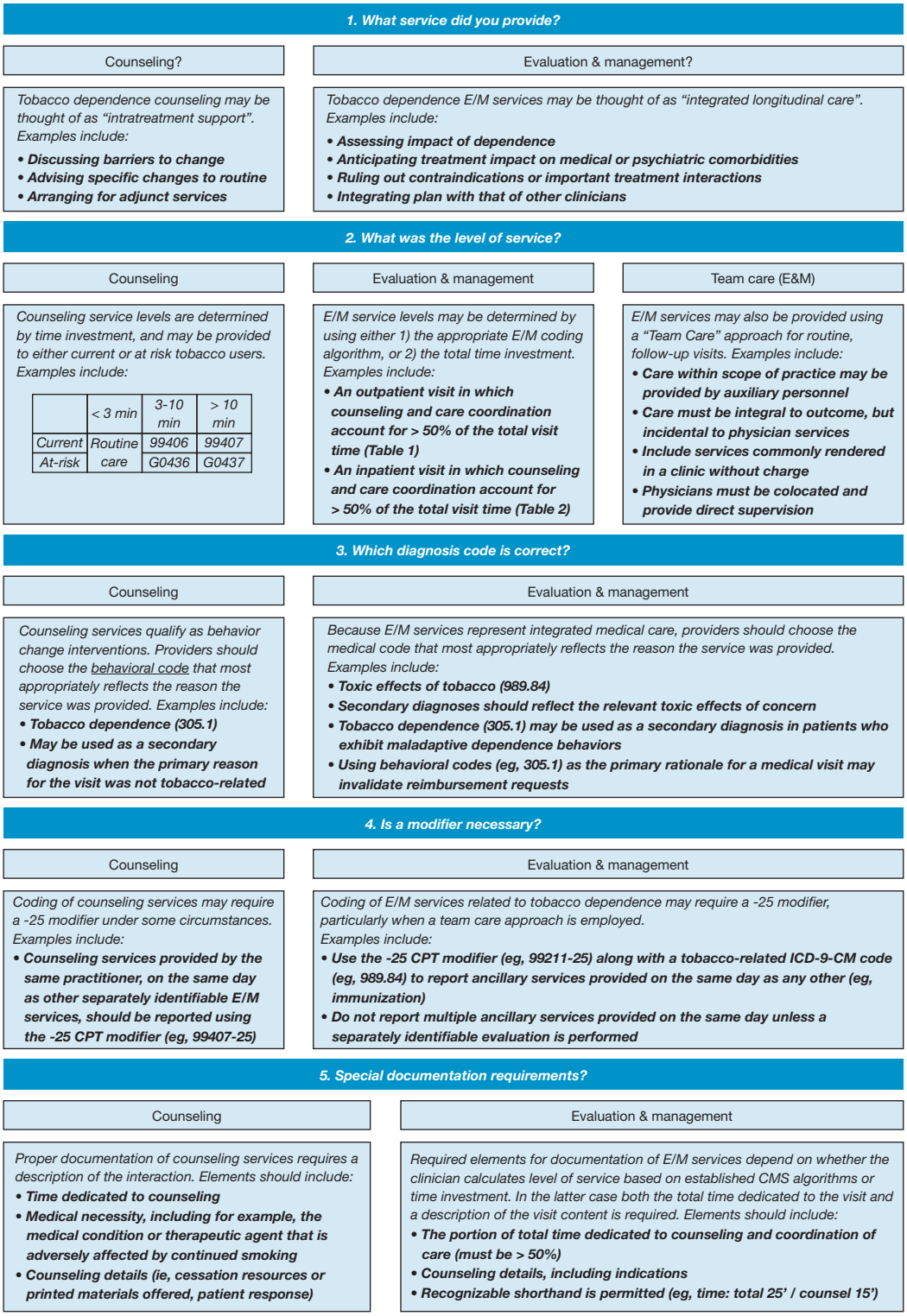

Figure 1 – *Essentials of tobacco dependence billing and coding. CMS = Centers for Medicare and Medicaid Services; CPT = current procedural terminology; E/M = evaluation and management; ICD-9-CM = International Classification of Diseases, Clinical Modification 9.*

taking and diagnostic testing. Management refers to the conduct or supervision of clinical activities in pursuit of a therapeutic goal and implies that the plan is based on the results of the preceding evaluation. Management decisions might include adjusting the medication plan, recommending a procedure, or referring for assistance

with environmental modification. An important feature of E/M services is their fundamentally iterative nature; the evaluation leads to a management plan, the response to which becomes part of the subsequent evaluation, and so on. Within medical practice, counseling refers to the guidance or education provided to an individual patient. As such, counseling may be conceived of as a subset of management activities. That is to say that good medical management will often include counseling services, but not all counseling interactions can be considered management. Counseling services related to tobacco dependence might include activities such as discussing barriers to change, advising specific changes to behavioral routines, or arranging for services and follow-up. E/M services are more likely to include activities such as estimating the impact of dependence, assessing the nature and severity of important behavioral or medical comorbidities, ruling out contraindications to specific pharmacotherapy, or assessing the potential for important drug-drug interactions.

Example 1: Tobacco Dependence Counseling as an Adjunct to Follow-up Care

During Mr Jackson's visit, you discuss the relevance of his continued smoking to his asthma and suggest that he consider stopping. The 5-min conversation included information regarding the interaction between cigarette smoke exposure and airway inflammation, a discussion of the potential impact of smoking on asthma medication effectiveness, and advice to engage available services within the system. Written after-visit instructions include a phone number to call for quit line registration.

In this scenario, the patient has been well-counseled to quit smoking. Counseling services, also referred to as Behavior Change Interventions, are reimbursable services provided by qualified health-care personnel (ie, physician and nonphysician billing providers) for the purpose of promoting health or preventing injury, and there is good evidence supporting the effectiveness of brief counseling interventions of this type.[22] The level of Behavior Change Intervention depends on the amount of time dedicated to the endeavor. Clinicians should first report the established patient visit code (99211-99215) reflecting the level of service provided for the underlying condition (in this case, asthma: International Classification of Diseases, Clinical Modification 9 [ICD-9-CM] code 493.90), and consider the time spent in counseling separately. Cessation counseling that lasts less than 3 min is considered to be part of the standard E/M service. For patients who require additional counseling time, the clinician may also report current procedural terminology code 99406 for intermediate (3-10 min), or 99407 for intensive (> 10 min) of service. Primarily use the ICD-9-CM code 305.1 (Tobacco Dependence) to report the smoking cessation counseling service, along with the appropriate code for the underlying condition.[23] For patients who do not currently smoke but who are at risk for initiation or relapse, Centers for Medicare and Medicaid Services has created two G codes that reflect counseling services aimed at preventing tobacco use. Clinicians may report G0436 for intermediate (3-10 min) and G0437 for intensive (> 10 min) of service. Counseling services provided by the same practitioner, on the same day as other, separately identifiable E/M services, should be reported using the -25 current procedural terminology code modifier (eg, 99407-25).

In addition to recording the time dedicated to counseling, Medicare requires documentation of medical necessity, including for example, the medical condition or therapeutic agent that is adversely affected by continued smoking. Comments about the counseling delivered should include details of the discussion, such as the cessation resources discussed, printed materials offered, and an indication of the patient's response. Medicare will cover two attempts at cessation during a 12-month period, with each attempt consisting of four visits (intermediate and/or intensive). Other payers may have variable reimbursement policies, and financial responsibility for unpaid charges could fall to the patient under some circumstances (eg, https://www.bcbsal.org/providers/hcReform/HCRpreventivecoding.pdf).

Example 2: Tobacco Dependence E/M Services in the Longitudinal Care of the Patient

In the process of identifying case-specific strategies for addressing Mr Jackson's tobacco dependence, you assess several clinically relevant variables such as the severity of his nicotine dependence, the potential interactions with his other comorbid conditions and preexisting therapies, his specific risk of downstream toxic effects of prolonged exposure, his insight into the problem and confidence in his ability to stop, his previous experience with tobacco dependence treatment, and his prior response to pharmacologic interventions, among other items. You identify Mr Jackson's medical conditions, signs/symptoms of disease progression, and current

prescriptions that may be affected by the treatment of tobacco dependence or by abstinence from smoking. The discussion leads you to a set of recommendations that include a tailored pharmacotherapy prescription, advice to engage hospital-based counseling resources, and a planned return visit in 1 month for reevaluation and continued management.

It is apparent that the tobacco dependence service provided is no longer of a limited nature, but instead characterized by the integration of complex data into specific recommendations. Here, the clinical interaction is more consistent with the provision of E/M services, with counseling and education being a subset of the total cognitive services provided. When counseling time exceeds 50% of the total time dedicated to the visit, the level of E/M service may be calculated using established time parameters (Table 1). Documentation must include the total visit time, the portion of that time dedicated to counseling and coordination of care (eg, Time: total 25 min/counsel 15 min), and should reference indications for counseling such as prognosis, risks/benefits of treatment, adherence instructions, or need for discussion with another health-care provider. It is permissible to use recognizable shorthand to create this documentation.

Particularly in instances in which the underlying condition is stable, the value of tobacco dependence treatment is reflected in the higher levels of service reported. For example, although Mr Jackson's follow-up visit for asthma, requiring only modest medication adjustment without need for complicated testing or complex medical decision-making, would be classified as a level 3 established office visit (99213), accurately accounting for the counseling and coordination time during a 25-min visit raises the service provided to level 4 (99214). In this case, clinicians would use the appropriate ICD-9-CM code for the underlying condition as the primary diagnosis, with 305.1 (Tobacco Dependence) as one of the relevant secondary diagnoses.

Example 3: The Tobacco Dependence Follow-up Visit

Mr Jackson returns for an established office visit 1 month later, specifically to follow-up on his progress regarding smoking. He reports reasonable adherence with the dependence medication regimen, but complains of minor side effects, particularly when taking the medications close to bedtime. He has several questions regarding advice he received from the hospital's cessation assistance program 2 weeks earlier. Although he has been able to reduce his tobacco use substantially, he has been unable to stop smoking completely. During your evaluation, you recognize the compulsion to smoke is incompletely controlled and consider adjusting his dosage or adding a second agent to his regimen.

The primary purpose of this visit is to address the patient's tobacco dependence. The context of asthma is of value, but may not be directly relevant to today's clinical activities. The visit clearly retains the elements of an E/M visit of moderate complexity because the treatment has resulted in possible side effects and an incomplete response, requiring prescription drug management. Here again, the appropriate level of service is decided by the applicable E/M coding algorithm or by total time if counseling dominates the visit (> 50%).

Though the E/M nature of the visit is not a function of the diagnosis or symptom that prompts the visit, it is important that clinicians accurately reflect the rationale for the tobacco dependence treatment visit in the primary diagnosis. Although behavioral health providers are qualified to use behavioral or mental health diagnoses such as Tobacco Dependence (305.1) as the *primary* rationale for their services, medical health providers are not. Medical health providers should instead be careful to select an ICD-9-CM code that accurately reflects their focus on the biological impact of tobacco use. For instance, it may be appropriate to use the code for Toxic Effects of Tobacco (989.84) as a primary diagnosis, followed by the relevant secondary

TABLE 1] Time Thresholds (in Minutes) That Define Levels of Service by Visit Type

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Outpatient consultation[a]	99241-99245	15	30	40	60	80
New patient	99201-99205	10	20	30	45	60
Established patient	99211-99215	5	10	15	25	40

[a]Medicare instituted a change in reporting structure in 2010 and no longer recognizes consultative services per se. Patients who have never been evaluated by the practice before should be coded as new patient visits, whereas those evaluated previously, even if by another provider in the practice, should be coded using the appropriate established patient time threshold values.[29]

diagnosis codes reflecting the toxic effects of concern. Remember that the term addiction refers to the disturbances in brain biology that manifest as dependence behaviors; therefore, it is legitimate to list Nicotine Addiction (305.1) as one of the secondary toxic effects of tobacco smoke exposure if signs of addiction are present. If reporting an E/M service with a primary diagnosis code of tobacco dependence (305.1), clinicians should be aware that some payers may consider this to be a behavioral health service, and not covered by the patient's medical insurance. Code 305.1 should not be used to simply indicate a history of tobacco use, however, which is instead indicated by V15.82.

Example 4: Use of "Team Care" Models in Tobacco Dependence Follow-up Visits

Mr Jackson returns to your clinic 2 weeks later to meet with your office tobacco treatment specialist for a review of his progress. Planned elements of the return visit include an assessment of medication adherence, identification of knowledge gaps, development of a practical behavioral action plan, and assistance with engaging extra-treatment cessation support (eg, quit line). Mr Jackson is found to be doing well on his regimen, and is progressing toward abstinence with good insight into his plan. The tobacco treatment specialist updates you on the patient's progress and arranges for a return visit with you in another 4 weeks for evaluation of treatment outcomes and medication management.

It is permissible for physicians to use the services of auxiliary personnel in the care of an established patient, particularly when collaboration with a professional of another discipline helps to reduce fragmentation of care and improve target outcomes.[24] The care provided within this team model must be integral to the outcome, but incidental to the services initially provided by the physician. "Incident to" services are not restricted to any particular type of nonphysician provider, as in shared/split billing. Auxiliary personnel should function under a formal agreement that outlines the specific care functions to be performed within their scope of practice, should provide only services that are commonly rendered in a clinic without charge, and must function only under the physician's colocated, direct supervision. Under these circumstances, the "incident to" service may be billed under the supervising physician's name, using the level 1 E/M service code (99211). Though this service does not require a personal evaluation by the physician, it does require the physician's presence in the suite during provision. Documentation should clearly reflect the collaborative nature of the discussion between the two professionals, alongside the resulting recommendations. Do not report 99211 on the same day as any other ancillary service (eg, immunization) or physician evaluation is performed.

The Outpatient New or Consultation Visit

Ms Dorsey is a 24-year-old woman, without significant medical history, referred to you by her primary care physician for consultation regarding her tobacco dependence. Your evaluation includes a review of her medical records, an assessment of her personal tobacco use and treatment history, a screening evaluation for other substance abuse or the possibility of depression, a directed physical examination, and a review of her concurrent medication use, among other relevant data. You discuss her personal history of oral contraceptive use and the impact smoking has on her future risk for thromboembolic events. Together, you settle on a strategy that includes medication and counseling. You ask that she return to your office for follow-up in 4 weeks and you dictate a letter back to the referring physician outlining your shared management plan.

In this scenario, the patient again visits specifically for assistance with tobacco dependence. The principal difference, however, is the consultative nature of the visit. Not all initial visits with specialists constitute a consultation. For a new patient visit to be considered a consultative service, it must be provided by a physician whose opinion or advice regarding the management of a specific problem is requested by another physician or other appropriate source. Documentation should therefore include evidence of *both* the request for advice and the communication of impressions and recommendations back to the requesting physician. Evidence of special training or expertise in the problem area is useful for authenticating the rationale for seeking the opinion of the consultant in the first place, but is not a necessary component of the visit documentation. When these conditions are met, it is appropriate to bill using the consultative E/M service codes (99241-99245), with level of service decisions made using the applicable E/M coding algorithm, or determined by the total time investment, as appropriate (Table 1). Choice of primary and secondary diagnosis codes remains consistent with the previous discussion. Services that fail to meet the criteria for consultative services should be billed using the codes for new patient evaluations (99201-99205).

TABLE 2] Time Thresholds (in Minutes) That Define Levels of Service for Inpatient Initial Care and Consultative Services

Visit Category	Code Range	Level 1	Level 2	Level 3	Level 4	Level 5
Inpatient initial care visits	99221-99223	30	50	70	…	…
Inpatient consultation visits	99251-99255	20	40	55	80	110

The Hospital Consult

Mr Trujillo is a 57-year-old man with several significant medical comorbidities, admitted to the hospital 1 week ago for acute myocardial infarction. He underwent emergency coronary artery bypass surgery on hospital day 1 and is recovering nicely except for minor memory/cognitive difficulties following circulatory bypass and a postoperative DVT. His adherence with prescribed hypercholesterolemia and diabetes regimens in the past has been spotty, resulting in poor outcomes. Control of his tobacco dependence is a key part of managing his future risk, but the primary care team has several questions regarding treatment. You are called to see the patient to comment on whether his recent cardiac event constitutes a contraindication to nicotine replacement, the potential for drug interactions between nicotine replacement and his planned warfarin therapy, the best way to maximize adherence with his tobacco dependence regimen, and the availability of postdischarge follow-up.

Questions regarding the management of tobacco dependence, especially in the face of complex comorbidities, are not uncommon. Consultants may be asked to help with patients who have expressed a reluctance to stop smoking, patients who have recently begun to abstain, or even to help manage a patient at high risk of relapse. In this scenario, you are asked to see the patient during his inpatient stay to provide advice on important acute management decisions as well as to assist with arrangements for postdischarge follow-up. Consultants should document the question being asked or problem being addressed and should indicate whether verbal communication accompanied the written advice. The note should reflect key details of the tobacco use history, relevant medical/psychiatric history, and any prior experience with dependence medications, among other important variables.[25] Level-of-service decisions are again made using the applicable E/M coding algorithm or are determined by the total time investment if counseling and care coordination dominate (> 50%) the visit (Table 2).

In addition to complex pharmacotherapy decisions, the consultant is also in a position to help arrange a specific follow-up plan after discharge. For example, arrangements might be made for the patient to come to your office for an established patient visit as described previously. It is clear that the most important predictor of continued nonsmoking posthospitalization is the effective transition of care to the outpatient environment, for follow-up treatment of tobacco dependence within 4 weeks of discharge.[26]

Conclusion

Though control of tobacco use within populations has traditionally relied heavily on public policy and educational approaches, an increasing emphasis on the health-care system's potential to treat prevalent cases has led to significant changes in regulatory and payment models meant to encourage these changes. The magnitude of impact might be expected to be quite high after providers fully integrate tobacco dependence into their personal, organizational, and institutional roles, but system pressures are likely to produce suboptimal change unless significant barriers to engagement have been removed.[27,28] Clarity regarding coding and documentation requirements relevant to the problem are a necessary prerequisite to full adoption. Several key points are important to recognize—primary among them is the distinction between counseling and E/M services. The treatment of tobacco dependence is not equivalent to smoking cessation. Team care models may represent an efficient way to improve care outcomes with minimal disruption in clinic workflow. When counseling and coordination of care make up the majority of the time spent in the patient visit, the level

TABLE 3] Approximate Conversions Between ICD-9-CM Codes and ICD-10-CM Codes

Category	ICD-9-CM Code	Converted ICD-10-CM Code
Asthma	493.90	J45.909
Nicotine dependence	305.1	F17.200
Toxic effects of tobacco	989.84	T65.221x

Note that actual code choice requires clinical interpretation to determine the most appropriate ICD-10 code(s) for any specific situation. The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. CPT = current procedural terminology; ICD-9-CM = International Classification of Diseases, Clinical Modification 9; ICD-10-CM = International Classification of Diseases, Clinical Modification 10.

of service is often more accurately documented using the appropriate time threshold definitions. Remember that medical care providers should not select behavioral codes as the primary diagnosis when providing E/M services. It is most appropriate for medical providers to instead select primary diagnosis codes that reflect their attention to the physical effects of smoke exposure, including for example, their general concern over the Toxic Effects of Tobacco (989.84) (Table 3).

Clinicians who have established a special expertise in the area may elect to provide consultative services in both out- and inpatient environments. Specialized training or certification is a good way to establish this expertise, but is not a necessary prerequisite to providing consultative service. Institutionalizing the care of the tobacco-dependent patient allows the health-care system to elevate its capacity for providing high-quality care and to successfully participate in several important quality initiatives and program certifications.

Acknowledgments

Financial/nonfinancial disclosures: None declared.

Role of sponsors: The sponsor had no role in the design of the study, the collection and analysis of the data, or the preparation of the manuscript.

Other contributions: The authors gratefully acknowledge the contributions of Dr Scott Manaker to this project. Without his vision and guidance, this group effort would have been impossible.

References

1. Centers for Disease Control. Ten great public health achievements—United States, 1900-1999. *MMWR Morb Mortal Wkly Rep*. 1999;48(12):241-243.
2. National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA: Centers for Disease Control and Prevention (US), 2014. http://www.ncbi.nlm.nih.gov/books/NBK179276/. Accessed September 28, 2015.
3. Warner KE, Mendez D. Tobacco control policy in developed countries: yesterday, today, and tomorrow. *Nicotine Tob Res*. 2010;12(9):876-887.
4. Warner KE. Tobacco control policies and their impacts. Past, present, and future. *Ann Am Thorac Soc*. 2014;11(2):227-230.
5. Dubois G. Smoking cessation should have more emphasis within tobacco control? The case against. *Health Policy Amst Neth*. 2009;91(Suppl 1):S26-S30.
6. World Health Organization. Why tobacco is a public health priority. http://www.who.int/tobacco/health_priority/en/. Accessed September 28, 2015.
7. Bolliger CT. Smoking cessation should have more emphasis within tobacco control? The case for. *Health Policy Amst Neth*. 2009;91(Suppl 1):S31-S36.
8. Joossens L, Raw M. The Tobacco Control Scale: a new scale to measure country activity. *Tob Control*. 2006;15:247-253.
9. McIlvain HE, Backer EL, Crabtree BF, Lacy N. Physician attitudes and the use of office-based activities for tobacco control. *Fam Med*. 2002;34(2):114-119.
10. Ravara SB, Castelo-Branco M, Aguiar P, Calheiros JM. Are physicians aware of their role in tobacco control? A conference-based survey in Portugal. *BMC Public Health*. 2014;14:979.
11. Association of American Medical Colleges. Physician behavior and practice patterns related to smoking cessation,. 2007. https://www.aamc.org/download/55438/data/smokingcessationsummary.pdf. Accessed September 28, 2015.
12. Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Aff Proj Hope*. 2011;30(8):1402-1410.
13. The Joint Commission. Tobacco treatment. http://www.jointcommission.org/tobacco_treatment. Accessed September 28, 2015.
14. Colla CH, Fisher ES. Beyond PCMHs and accountable care organizations: payment reform that encourages customized care. *J Gen Intern Med*. 2014;29(10):1325-1327.
15. US Preventive Services Task Force. USPSTF A and B recommendations. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Accessed September 28, 2015.
16. Fiore MC, Goplerud E, Schroeder SA. The Joint Commission's new tobacco-cessation measures—will hospitals do the right thing? *N Engl J Med*. 2012;366(13):1172-1174.
17. Berkowitz SA, Pahira JJ. Accountable care organization readiness and academic medical centers. *Acad Med*. 2014;89(9):1210-1215.
18. Vogt F, Hall S, Marteau TM. General practitioners' and family physicians' negative beliefs and attitudes towards discussing smoking cessation with patients: a systematic review. *Addiction*. 2005;100(10):1423-1431.
19. Park E, Eaton CA, Goldstein MG, DePue J, Niaura R, Guadagnoli E, et al. The development of a decisional balance measure of physician smoking cessation interventions. *Prev Med*. 2001;33(4):261-267.
20. Sachs D, Leone F, Farber H, Bars M, Prezant D, Schane R, et al. ACCP Tobacco Dependence Treatment Toolkit. American College of Chest Physicians Tobacco-Dependence Treatment Tool Kit, 3rd ed. http://tobaccodependence.chestnet.org. Accessed September 28, 2015.
21. Manaker S, Krier-Morrow D, Pohlig C. *Coding for Chest Medicine 2013: Pulmonary, Critical Care, Sleep*. 16th ed. Northbrook, IL: American College of Chest Physicians; 2012.
22. Stead LF, Bergson G, Lancaster T. Physician advice for smoking cessation. *Cochrane Database Syst Rev*. 2008;(2):CD000165.
23. Medicare Learning Network, Centers for Medicare and Medicaid Services. Counseling to prevent tobacco use; 2010. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7133.pdf. Accessed September 28, 2015.
24. Centers for Medicare and Medicaid Services. Medicare claims processing manual; 2015. http://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf. Accessed September 28, 2015.
25. Peereboom D, Evers-Casey S, Leone FT. Are you equipped to treat tobacco dependence? *Consultant*. 2014;54(12):767-771.
26. Rigotti NA, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients. *Cochrane Database Syst Rev Online*. 2007;(3):CD001837.
27. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation; 2007. http://www.iom.edu/Reports/2007/Ending-the-Tobacco-Problem-A-Blueprint-for-the-Nation.aspx. Accessed September 28, 2015.
28. Leone FT, Evers-Casey S. Examining the role of the health care professional in controlling the tobacco epidemic: individual, organizational and institutional responsibilities. *Prog Respir Res*. 2015;42:219-228.
29. Hoffman SA, Manaker S. Consultations after elimination of payments for evaluation and management consultation codes. *Chest*. 2011;139(4):933-938.