CPT® Code 99406 Details

Code Symbols

MIPS : Merit Based Incentive Payment System

Code Descriptor

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

CPT® Advice

No data Available

Illustration

No data Available.

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2020 National Physician Fee Schedule Relative Value File, GPCI20, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2020, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	January 01, 2020
Medicare Carrier/Locality:	NATIONAL
Conversion Factor:	36.0896

Note 1: Fee data is from the national MPFS files, which do not reflect the recent extension of the work geographic index floor to a minimum of 1.00. Check your MAC's site for more specific fee information. This tool will be updated once national Medicare updates its files.
Note 2: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status A
A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

Medicare Fees

	National	Adjusted	26	TC	53
Facility	$12.63	$12.63	$0.00	$0.00	$0.00
Non Facility	$15.52	$15.52	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	Adjusted	26	TC	53
Work RVU:	0.24	0.24	0.00	0.00	0.00
PE RVU:	0.17	0.17	0.00	0.00	0.00
Malpractice RVU:	0.02	0.02	0.00	0.00	0.00
Total RVU:	0.43	0.43	0.00	0.00	0.00

RVU - Facility					
	National	Adjusted	26	TC	53
Work RVU:	0.24	0.24	0.00	0.00	0.00
PE RVU:	0.09	0.09	0.00	0.00	0.00
Malpractice RVU:	0.02	0.02	0.00	0.00	0.00
Total RVU:	0.35	0.35	0.00	0.00	0.00

Global & Other Info		
	Global Split	
Preoperative %:	0	
Intraoperative %:	0	
Postoperative %:	0	
Total RVU:	0	
Global Period (days):	XXX	

XXX = The global concept does not apply to the code.

Radiology Diagnostic Tests : 99

99 = Concept does not apply

PC/TC Indicator : 0

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

Endoscopic Base Code : None

Modifier Guidelines

	Modifier	Rules(Click on rules for Details)
MULT PROC	51	No multiple procedure payment adjustment
51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes		
0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.		
BILAT SURG	50	No 150% bilateral payment boost
50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.		
0 = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.		
ASST SURG	80	Assistant payment allowed when supported
80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
CO-SURG	62	Co-surgeons not permitted
62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.		
0 = Co-surgeons not permitted for this procedure.		
TEAM SURG	66	Team surgeons not permitted
66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.		
0 = Team surgeons not permitted for this procedure.		

MINIMUM ASST SURG	81	Assistant payment allowed when supported.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment allowed when supported.
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2020 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: January 01, 2020

Services	MUE	MAI	MUE Rationale
Practitioner Services	1	2	Code Descriptor / CPT Instruction
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	2	Code Descriptor / CPT Instruction

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy
MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

ICD-10 Crossref

F06.31, F06.32, F17.220, F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, F25.1, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, I10, I11.0, I11.9, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, I20.0, I20.1, I20.8, I20.9, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I44.30, I44.39, I44.4, I44.5, I44.60, I44.69, I44.7, I45.0, I45.10, I45.19, O99.330, O99.331, O99.332, O99.333, O99.334, O99.335, P04.2, P96.81, R00.0, R00.1, R00.2, R00.8, R00.9, R01.0, R01.1, R01.2, R03.0, R03.1, R04.0, R04.1, R04.2, R04.81, R04.89, R04.9, R05, R06.00, R06.01, R06.02, R06.09, R06.1, R06.2, R06.3, R06.4, R06.5, R06.6, R06.7, R06.81, R06.82, R06.83, R06.89, R06.9, R07.0, R07.1, R07.2, R07.81, R07.82, R07.89, R07.9, R09.01, R09.02, R09.1, R09.2, R09.3, R09.81, R09.82, R12, R13.0, R13.10, R13.11, R13.12, R13.13, R13.14, R13.19, T65.211A, T65.211D, T65.211S, T65.212A, T65.212D, T65.212S, T65.213A, T65.213D, T65.213S, T65.214A, T65.214D, T65.214S, T65.221A, T65.221D, T65.221S, T65.222A, T65.222D, T65.222S, T65.223A, T65.223D, T65.223S, T65.224A, T65.224D, T65.224S, T65.291A, T65.291D, T65.291S, T65.292A, T65.292D, T65.292S, T65.293A, T65.293D, T65.293S, T65.294A, T65.294D, T65.294S, Z57.31, Z71.6, Z72.0, Z77.22, Z81.2,

CPT® Lay Terms

The provider counsels the patient on how to stop tobacco use. The counseling lasts 3 to 10 minutes.

Clinical Responsibility

The provider counsels the patient on steps to stop use of tobacco products. The provider uses the discussion to discover the specific barriers to cessation the patient faces and possible relapse triggers. The provider and patient then discuss practical methods for coping with those issues. The provider may write a prescription for a pharmacologic intervention. The provider also may refer the patient to a support group that matches the patient's needs. The provider documents the discussion as well as the amount of time. Use this code when the provider documents 3 to 10 minutes of smoking and tobacco use cessation counseling.

Tips

See 99407 for counseling lasting more than 10 minutes.

CPT® Guidelines

Section Specific Guideline

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents, and adults.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the

same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. (Refer to 99401, 99402, 99403, 99404, 99411, and 99412 for reporting those counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

(For behavior change intervention, see 99406, 99407, 99408, 99409)

Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT® code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90460, 90461, 90471-90474. For vaccine/toxoid products, see 90476-90749.

These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.

Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

For counseling groups of patients with symptoms or established illness, use 99078.

Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) should not be reported on the same day as codes 99401-99412.

Upcoming and Historical Information

01-01-2008	Code Added