Call to Action

Tobacco use is still the leading preventable cause of death in the United States. The prevalence among adult Medicaid members is about 30% and among some blue collar groups as high as 40%. Effective treatments are available but not always utilized. For many health plans, including Medicare and Medicaid counseling patients to quit smoking is a reimbursable service.

- Currently: 46.6 million U.S. smokers
  - 70% of smokers want to quit
  - 40% try to quit each year
  - Only 2% call state or national quit lines

- The most recent survey of members of New York State managed care plans shows that not all patients are getting the message (CAHPS, 2009):

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Medicaid</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of smokers were advised to quit</td>
<td>74%</td>
<td>80%</td>
</tr>
<tr>
<td>Percent of smokers had discussion with their PCP regarding smoking cessation medications</td>
<td>52%</td>
<td>59%</td>
</tr>
<tr>
<td>Percent of smokers had discussion with their PCP regarding smoking cessation strategies</td>
<td>47%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Thus physicians are advising most but not all of their patients to quit smoking, but we are missing opportunities to provide discussion of smoking cessation strategies or medications. The barriers to better outcomes are well understood: Physicians don’t have the time, frequently lack the training, lack a supportive practice design, and fail to maximize their reimbursement. In the next two years reimbursement for smoking cessation will be improved as a result of the Affordable Care Act. The Act calls for health plan coverage for interventions rated “A” by the Preventive Services Task Force and smoking cessation counseling by physicians meets that standard. Medicare already pays for smoking cessation counseling and twenty two states including New York reimburse some form of counseling see appendix at [http://www.lungusa.org/stop-smoking/tobacco-control-advocacy/reports-resources/helping-smokers-quit-state.html](http://www.lungusa.org/stop-smoking/tobacco-control-advocacy/reports-resources/helping-smokers-quit-state.html).

Nine states require private insurance plans to cover tobacco cessation treatments: Colorado, Illinois, Maryland, New Jersey, New Mexico, North Dakota, Oregon, Rhode Island and Vermont. Thus, a large fraction of smokers the United States have coverage for smoking cessation counseling by physicians and the number will continue to increase.
This toolkit organizes existing resources to help maximize the efficiency and effectiveness of smoking cessation interventions in your practice. This document is intended to supplement training materials on smoking cessation in office practice and should not be used without a basic familiarity of the clinical practice guideline.

**Smoking Cessation Interventions for all smokers, at every visit**

The core document of the smoking cessation literature is the Clinical Practice Guidelines published in 2008. [http://www.ncbi.nlm.nih.gov/books/NBK63952/](http://www.ncbi.nlm.nih.gov/books/NBK63952/) The key recommendations of this guideline include:

1. Tobacco dependence is a chronic, relapsing disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.
3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in this Guideline.
4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

Thus smoking should be considered as a vital sign that is recorded and addressed at every visit. Historically, smoking cessation interventions have been focused on patients who are ready to make a quit attempt. A close reading of the guideline and the instructions for reimbursement shows that smoking cessation counseling can and should be included as part of routine visits for every smoker. Repeated encouragement and assistance helps patients not ready to make a change at this time. With the proper documentation, reimbursement for most of the office visits for smokers can be enhanced by $10-15 per visit.

This document is not intended as a substitute formal training in smoking cessation interventions (See appendix 4), but will allow clinicians to use staff time in a more optimal manner.

**Improving the Quality of Care in Your Practice-A Team-Based Approach**

The literature on smoking cessation interventions shows that anyone in a white coat can provide effective advice and counseling. Physicians have the greatest impact, but any clinician or even paraprofessionals can administer the elements of the interventions described below. Consider how each of the elements below can fit into the workflow of your office:

**Taking the smoking history and documenting the intervention.**

Appendix 1 lists a brief smoking cessation history than can be included in paper or electronic records. Office staff and/or nurses can request completion of the information and a can update
the records. Much of the information collected would be useful in any counseling that may follow. The basic smoking cessation intervention is structured around “the Five As”: Ask, Advise, Assess, Assist, and Arrange. Appendix 4 shows how to document this encounter for every smoker. For patients who state that they are not ready to change at this time, counseling based on the “Five Rs” is an effective intervention to help patients become more ready to change. Each verbal exchange in the visit should be documented.

If a patient is making a quit attempt, then scheduling of telephonic or in office follow-up is essential. Specific roles for each member of the staff should be clearly defined. Their effectiveness would be enhanced if they were provided instruction and access to the training materials listed in Appendix 4.

Patient Engagement and Self-Management Materials can support the smoking cessation intervention. A broad range of materials are available on line for use in office settings (Appendix 3).

Coding and Billing

If the documentation standards have been met, then you can be confident in coding and billing the visits for additional revenue. Although not all commercial plans cover smoking cessation counseling, several do. Ideally, office-based smoking cessation interventions should be set up to deliver services to all patients. All payors should be billed. For those that reject claims for reimbursement, the attached letter in Appendix 7 can be used to help make the case. Advocating for coverage through your specialty society may hasten the shift in coverage.

The basic codes are

99406 Smoking and tobacco use cessation counseling visit; intermediate, > 3 minutes up to 10 minutes

99407 Smoking and tobacco use cessation counseling visit; intensive, >10 minutes

There are some nuances to coding that should be studied by the office manager. These are detailed in appendix 5 and 6. Reimbursement varies from $10 to $19. In some settings group visits are also reimbursable.

Program evaluation and outcomes

It is important to evaluate the economic and clinical implications of this practice change. Increases to payment by payor should be tracked and payors who are denying claims should be given the appeals letter in the appendix.

It would be important to track the practice-specific prevalence of smoking over time and the impact of this practice transformation. Prevalence of smoking among adult patients can be tracked with an electronic medical record. If possible the data should be divided by line of
business and health plan coverage. New members to the panel should also be identified as their smoking prevalence may distort the evaluation.

Baseline quit rates of general populations tend to be low and the impact of practice based interventions are on the order of 3 percent per year. Smoking cessation programs when tested in general medical populations have a 5-10 percent reduction on the prevalence of smoking.

The core of the data that should be collected reflects the wording of the CAHPS questions which is ask of adult patients who currently smoke cigarettes or use tobacco every day or some days:

1. In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
2. In the last six months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?
3. In the last six months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?

Practices that adopt the practice transformation described herein should score very well.

Evaluation of how the individual staff apply each of the steps would be helpful in maintaining the and feedback on the behavioral and economic outcomes would be essential to maintaining an effective program.

**Reimbursement for smoking cessation**

Reimbursement varies with coverage, but the coding is similar. Practices can design a billing strategy that maximizes reimbursement across all lines of business.

At present there is no consistent benefit design and coverage for smoking cessation. Commercial Health Plans are waiting for the Institute of Medicine’s interpretation of the essential health benefit under the Affordable Care Act. Smoking cessation counseling will be included as one of the covered benefits, to be provided without copayment, as the strength of evidence, as documented in the guideline, is based on multiple well-designed randomized clinical trials, directly relevant to the recommendation, yielding a consistent pattern of findings.

**Medicare** has been providing reimbursement for smoking cessation since 2005. **Medicaid** varies from state to state: At present New York, Minnesota, Pennsylvania, Nebraska, Nevada, Indiana, Massachusetts, and Oregon provide reimbursement. **Commercial** plans vary widely in their approach. More than a few have claims systems to pay smoking cessation, but do not actively promote the benefit. It may be worthwhile to take a default position on billing based on the Medicare rules. An appeal letter template, for those carriers that reject claims, is included in the appendix.

Appendices
1. Smoking History form
2. Documentation standards for Smoking Cessation counseling
3. Patient resources
4. Training resources for clinicians
5. Medicaid billing and coding
6. Medicare billing and coding
7. Appeal letter for denied claims

Appendix 1. Smoking History

BASELINE SMOKING HISTORY (which can be helpful in counseling)

Age of initiation of regular tobacco use. ______

Present cigarettes per day ____________

Brand __________

Daily cost____________ Monthly cost________ Annual cost_________

What would you do with (annual cost) if you had it today?

Previous Quit Attempts:
Longest duration without smoking

    Reason for relapse

Second longest duration without smoking

    Reason for relapse

Prior Quit Methods (list date)
    Self-initiated
    Physician Advice
    Tobacco control quit line
    Medications (name them)
    Support group
    Other
Appendix 2 . Documentation standards for Smoking Cessation counseling

To be recorded at every visit, check all items discussed:

ASK. Current Smoking Status
  __Current Smoker
  __Recent Quitter Quit date

ADVISE
  __Patient advised to quit smoking

ASSESS
  __Do you believe that you can quit smoking in the next six months

If YES to initial ASSESS question
  __Do you believe that you can quit smoking in the next months
  __Do you believe that you can set a date to quit smoking

ASSIST WITH A FORMAL QUIT PLAN
  __discussion with office staff focused on developing a formal quit plan include use of materials
  selected from http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/index.htm
  __discussion of state quit line
  __Fax to quit referral
  __discussion of medications

ARRANGE FOR FOLLOW-UP
  ONE WEEK AFTER INTENDED QUIT DATE
  __Telephone call scheduled
  __Office visit scheduled

TIME ALLOCATION FOR BILLING 3-10 minutes greater than 10 minutes

Professional signatures

If NO to initial ASSESS question
Discuss one or more topic with patient

  __Relevance
Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient’s disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

  __Risks
The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:
  
  • Acute risks: Shortness of breath, exacerbation of asthma, increased risk of respiratory infections, harm to pregnancy, impotence, infertility.
• Long-term risks: Heart attacks and strokes, lung and other cancers (e.g., larynx, oral cavity, pharynx, esophagus, pancreas, stomach, kidney, bladder, cervix and acute myelocytic leukemia), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), osteoporosis, long-term disability and need for extended care.
• Environmental risks: Increased risk of lung cancer and heart disease in spouses; increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.

__Rewards__
The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:
- Improved health.
- Food will taste better.
- Improved sense of smell.
- Saving money. Identify specific items for purchase.
- Feeling better about yourself.
- Home, car, clothing, breath will smell better.
- Having healthier babies and children.
- Setting a good example for children and decrease the likelihood that they will smoke.
- Feeling better physically.
- Performing better in physical activities.
- Improved appearance including reduced wrinkling/aging of skin and whiter teeth.

__Roadblocks__
The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problem-solving counseling, medication) that could address barriers. Typical barriers might include:
- Withdrawal symptoms.
- Fear of failure.
- Weight gain.
- Lack of support.
- Depression.
- Enjoyment of tobacco.
- Being around other tobacco users.
- Limited knowledge of effective treatment options.

__Repetition__
The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting.
Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

**TIME ALLOCATION FOR BILLING**
- 3-10 minutes
- greater than 10 minutes

Professional signatures
Appendix 3. Patient Resources

http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/index.htm
http://www.nysmokefree.com/

Appendix 4. Training resources for clinicians

The Medical Society of the State of New York offers a 2-Hour CME Program for Physicians as a booklet or downloadable from the MSSNY.org website, or at http://mssny.org/mssnycfm/mssnyeditor/File/2011/Main_Page/100411_-_Tabacco_-_Eileen_Karen/BookletFINAL_FOR_WEB.pdf (2.3 MB)

Appendix 5. NYS Medicaid Reimbursement

Effective April 1, 2011:
Expansion of Smoking Cessation Counseling to ALL Medicaid Beneficiaries

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Medicaid Payment</th>
<th>To be used with one of these ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, &gt; 3 minutes up to 10 minutes</td>
<td>Office: $10 APG Statewide Average: $20</td>
<td>650-677, V22, V23, V2</td>
</tr>
<tr>
<td>99407</td>
<td>Smoking and tobacco use cessation counseling visit; intensive, &gt;10 minutes</td>
<td>Office: $10 APG Statewide Average: $20</td>
<td>650-677, V22, V23, V2</td>
</tr>
</tbody>
</table>
Appendix 6. Medicare Reimbursement

### Medicare Coverage

**Counseling:**
- Applicable to all Medicare beneficiaries
- Two quit attempts are covered per year.
- Each quit attempt may include a maximum of 4 intermediate or intensive counseling sessions, with the total annual benefit covering up to 8 sessions in a 12 month period.
- These visits must be ordered by a doctor and provided by a qualified doctor or other Medicare-recognized practitioner.

**Medication:**
- Medicare Part D will cover smoking cessation treatments prescribed by a physician. However, over-the-counter treatments, such as nicotine patches or gum, will not be covered.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Medicare Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406/ G0375</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, &gt; 3 minutes up to 10 minutes</td>
<td>** Facility: $12.94  *** Non-Facility: $13.93</td>
</tr>
<tr>
<td>99407/ G0376</td>
<td>Smoking and tobacco use cessation counseling visit; intensive, &gt;10 minutes</td>
<td>** Facility: $25.73  *** Non-Facility: $27.21</td>
</tr>
</tbody>
</table>

* Rates vary by geographic location 
** Facility: Includes hospitals (inpatient, outpatient, and emergency department), ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs) 
*** Non-Facility: Includes all other settings

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Appendix 7. Appeal letter for denied claims

To: Insurance Company Chief Medical Officer

Greetings,

Attached is a denial notice for claims related to smoking cessation counseling for my patient(s). Given the significance of smoking to health care costs and the efficacy of smoking cessation interventions, it is surprising that your organization would deny this type of claim. The medical literature shows that smoking cessation interventions are effective, cost-effective, and produce a positive return on investment with a short time frame. The codes I have submitted are covered by Medicare, New York State Medicaid, and numerous commercial health plans and I meet the documentation standards outlined in the clinical practice guideline.
I am copying a number of interested parties. Why should your health insurance company be granted a rate increase if you choose to deny services that save money for all New Yorkers.

Cordially,

CC:
Nirav Shah, MD, MPH
Commissioner of Health
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Thomas Farley, MD, MPH
New York City Health Commissioner
New York City Department of Health and Mental Hygiene
125 Worth Street, New York, NY 10013

Benjamin M. Lawsky
Superintendent of Financial Services
New York State Department of Financial Services
One State Street
New York, NY, 10004-1511

Your professional society executive director