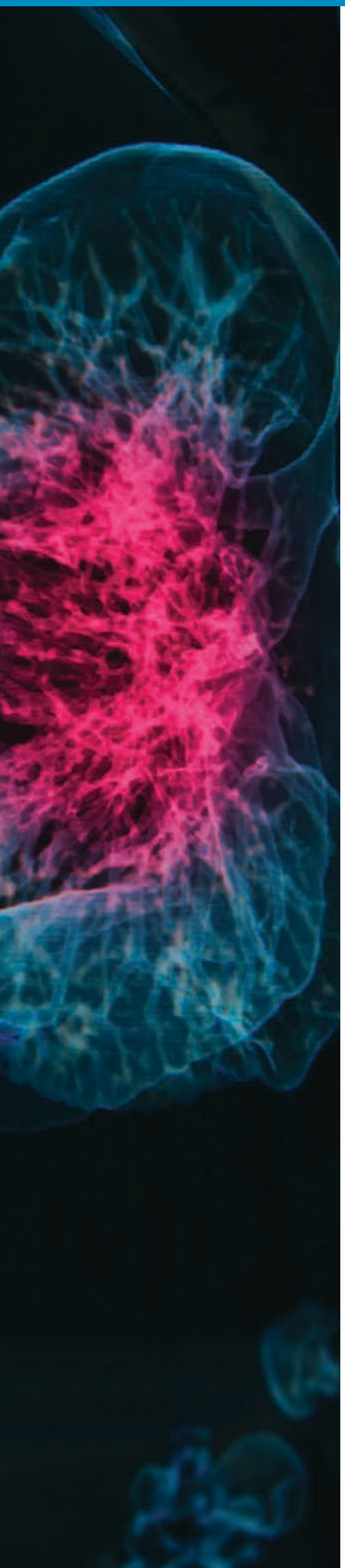
healthfirst

Spectrum of Health



Dear Colleague:

The impact of smoking, especially for those with chronic illness, is known and staggering. Currently, there are 46.6 million smokers in the U.S., where **tobacco use is still the leading preventable cause of death.**

The prevalence of tobacco use among adult Medicaid members is about 30%, and as high as 40% among some blue-collar groups. 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.

- 70% of smokers want to quit
- 40% try to quit each year
- Only 2% call state or national quit lines

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 Affordable Care 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—New York among them—reimburse some forms of counseling.[i]

Physicians may only consider those stating that they are "ready to quit" as best candidates for tobacco dependence treatment. However, a minority of tobacco users at any time will state that they are indeed ready to cease using tobacco products. Nor has selection for treatment candidates based on other health conditions been effective in promoting smoking cessation treatment for the millions of people who will benefit.[ii]

The National Lung Screening Trial (NLST) reviewed clinician-reported delivery of the 5As (ask, advise, assess, assist, and arrange [follow-up]) after lung screening to determine if there was an association with smoking behavior changes among patients. In this matched case-control study of more than 3,000 smokers (in the first year after the participants' initial screens), the 5A rates were as follows:

- Ask 77.2%
- Advise 75.6%
- Assess 63.4%
- Assist 56.4%
- Arrange (follow-up) 10.4%

The authors found that providers were less likely to deliver assistance with quitting, and much less likely to arrange for follow-up, yet those smokers receiving the delivery of "assist (with quitting)" or "arrange (follow-up)" were significantly more likely to quit.[iii]

This study affirms and confirms the value of primary care intervention for patients who smoke, but it raises the concern that the proven intervention is offered only to a limited number of patients, and in a manner that is often inconsistent and incomplete.

Smoking Cessation in Persons with Chronic Mental Illness

In addition, it is well documented that people with chronic mental illness have a high prevalence of tobacco use and related complications and mortality.

- In a seminal study in 1986, patients receiving services in psychiatric outpatient units were found to have a significantly higher smoking rate than local or national populations (52% v. 30 or 33%). Among those with schizophrenia, the rate of smoking was 88%; for those with mania, it was 70%.[iv]
- Standard cessation approaches may require longer maintenance on pharmacotherapy to reduce relapse rates.
- Based on a systematic review of the literature by Tidey and Miller (2015):
  - Bupropion increases threefold the cessation rate in smokers with schizophrenia; Varenicline yields an almost five-fold increase in cessation.
  - Varenicline is effective in those with unipolar and bipolar depression.[v]

Your patients living with schizophrenia, depression, anxiety, and post-traumatic stress are important candidates for standard cessation approaches described in this bulletin.[vi]

Many Healthfirst members in your care face socioeconomic challenges that can impact optimal health outcomes; yet this need not be true for tobacco-dependence treatment.[vii] But for ALL Healthfirst members who use tobacco, smoking cessation is vital to longevity, quality of life, and improved health outcomes.

What does this mean for you?

- Healthfirst recommends that you implement an "opt-out" approach to smoking cessation.
- Ask every adolescent and adult patient about tobacco use and dependence.
- If your patient is using tobacco, initiate the "5As" for all.
- Focus on key areas of impact:
  - ASSIST your patients by talking about quitting, recommending use of stop-smoking medications, and/or recommending stop-smoking counseling;
  - ARRANGE follow-up for counseling and support, either in your office or by use of the New York State (NYS) Smokers' Quitline (1-866-697-8487 or www.nysmokefree.com); and
  - REMEMBER to follow up at every visit to show your support for the tough journey that your patient who smokes must follow until they successfully cease tobacco use.

Making tobacco-dependence treatment a cornerstone of your prevention and management care plan for your patients is of proven benefit to the improvement of outcomes, including longevity.

I appreciate your partnership in caring for our members.

Warm regards,

Susan J. Beane, M.D.
VP, Medical Director
Healthfirst
1-212-823-2437
sbeane@healthfirst.org

Healthfirst Reimbursement for Smoking-Cessation Counseling (SCC)

Coverage Guidelines

Eight smoking-cessation counseling sessions to a Medicaid beneficiary within any 12 continuous months.

SCC must be provided:

- face-to-face by a physician, registered physician assistant, registered nurse practitioner (RNP), or licensed midwife (LM), either with or without an Evaluation and Management procedure code.
- face-to-face by either a dentist or by a dental hygienist under a dentist's supervision. Dental practitioners can only provide individual SCC services, which must exceed three minutes in duration.

Smoking cessation counseling complements existing Medicaid-covered benefits for prescription and nonprescription smoking-cessation products, including nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), and over-the-counter nicotine patches and gum. For more information about our formulary, please visit www.healthfirst.org/formulary.

For you to receive reimbursement for SCC services, the following information must be documented in the patient's record:

- At least four of the 5As; smoking status; and, if yes, willingness to quit;
- If willing to quit, offer medication as needed, target date for quitting, and follow-up date (with documentation in the record that the follow-up occurred);
- If unwilling to quit, the patient's expressed roadblocks;
- Referrals to the New York State Smokers' Quitline and/or community services to address roadblocks and for additional cessation resources and counseling, if needed.

Clinical Guidelines:[viii]

Ask	Ask the patient about tobacco use at every visit, and document the response.
Advise	Advise the patient to quit in a clear and personalized manner.
Assess	Assess the patient's willingness to make a quit attempt at this time.
Assist	Assist the patient to set a quit date and make a quit plan; offer medication as needed.
Arrange	Arrange to follow up with the patient within the first week, either in person or by phone, and take appropriate action to assist them.

For patients not ready to make a quit attempt:

Clinicians should use a brief intervention designed to promote the motivation to quit. Content areas that should be addressed can be captured by the "5Rs." Research suggests that the "5Rs" enhance future quit attempts.

Relevance	Encourage the patient to be as specific as possible about why quitting is relevant to them.
Risks	Ask the patient to identify potential negative consequences of their tobacco use, including acute, environmental, and long-term risks.
Rewards	Ask the patient to identify potential benefits, such as improved health, saving money, setting a good example for children, and better physical performance.
Roadblocks	Ask the patient to identify barriers (e.g., fear of withdrawal, weight gain, etc.), and provide treatment and resources to address them.
Repetition	The motivational intervention should be repeated every time the patient is seen.

Billing Guidelines

Claims must include the following ICD-10 diagnosis codes:

Diagnosis Code	Description
F17.2	Nicotine Dependence – F17.2
099.33	Smoking Complicating Pregnancy, Childbirth, and the Puerperium
T65.212 T65.214 T65.222 T65.224 T65.292 T65.294	Toxic Effect of Tobacco and Nicotine
Z71.6	Tobacco Use Counseling, Not Elsewhere Classified
Z72.0	Tobacco Use Not Otherwise Specified (NOS)

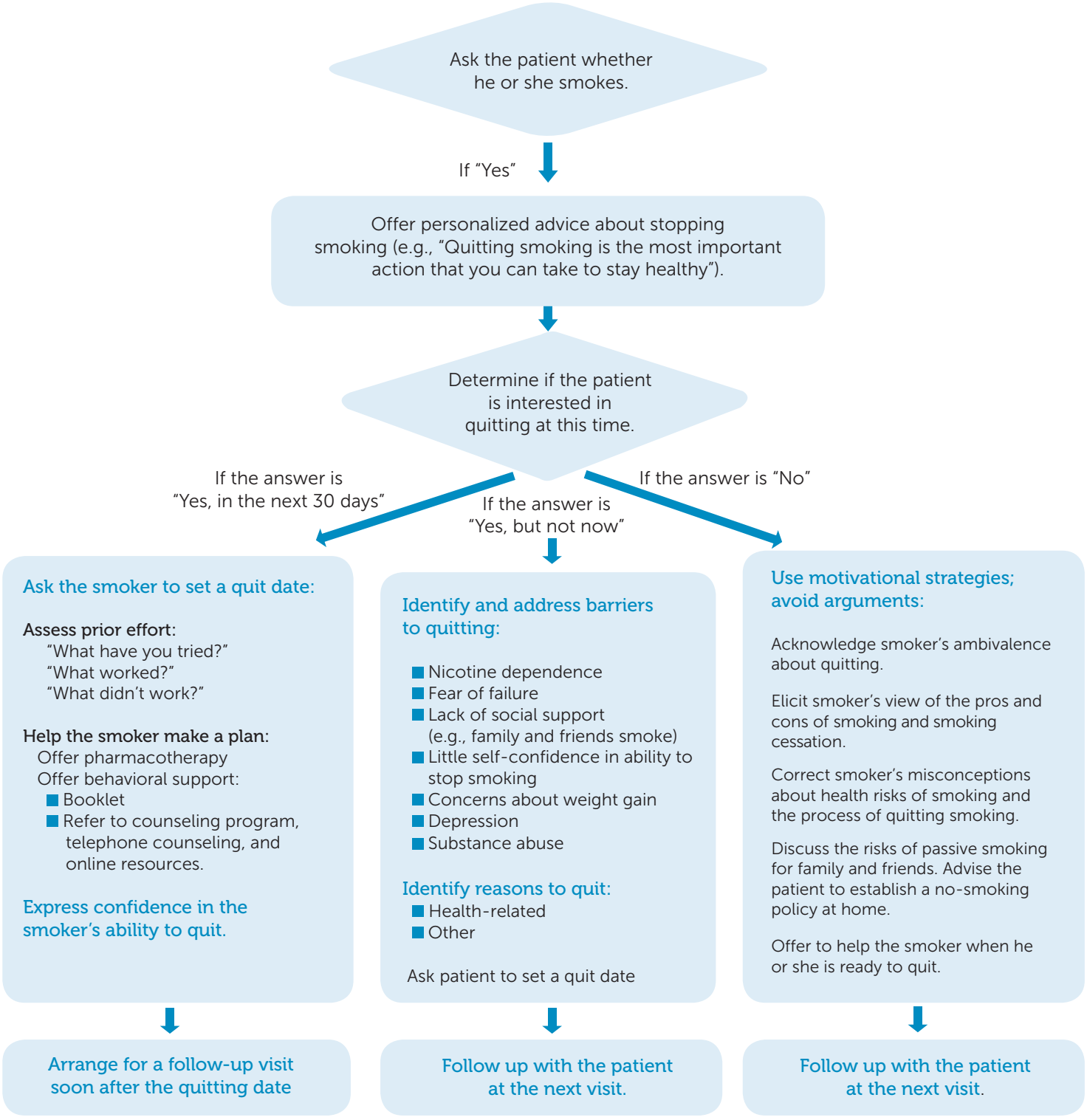
Procedure Code	Description	Note
99406	Intermediate SCC – 3 to 10 minutes	Billable ONLY as an individual session
99407	Intensive SCC – greater than 10 minutes	Billable as an individual or group session; using the 'HQ' modifier to indicate a group SCC session, up to eight patients in a group
D1320	Tobacco counseling for the control and prevention of oral disease	• Billable by dental practice only as an individual session under 3 minutes. SCC must be billed by either an office-based dental practitioner or by an Article 28 clinic that employs a dentist • SCC should take place only during a dental visit, as an adjunct when providing a dental service, and should NOT be billed as a stand-alone service

Summary of CAHPS Requirements for Smoking Cessation

CAHPS Measure: The three components of this measure assess different facets of providing medical assistance with smoking and tobacco-use cessation.

- **Advising Smokers and Tobacco Users to Quit** *Percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.*
- **Discussing Cessation Medications** *Percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.*
- **Discussing Cessation Strategies** *Percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.*

5A Flow Chart



Smoking-Cessation Strategy for Physicians
The strategy uses the five steps (the Five As) recommended in the Public Health Services Guidelines: ask, advise, assess, assist, and arrange follow-up.

Source: www.nysmokefree.com/CME/CME1Docs/5AFlowChart.pdf. Accessed 7/22/2015.

Frequently Asked Questions Regarding Tobacco-Dependence Treatment

In the setting of value-based healthcare, what is the return on investment for investing in tobacco cessation efforts?

In a study of the Massachusetts Medicaid program's implementation of a comprehensive tobacco cessation program (which successfully decreased smoking prevalence), program costs included medication, counseling, and outreach. The majority of savings came from reductions in hospital admissions, especially cardiovascular inpatient stays, for those who received the benefit. The study estimated $3.12 of savings for every $1 of annual program cost.[ix]

I don't offer smoking cessation services within my practice. What are my options?

- NYS publishes a list of local and regional resources/stop smoking programs that can be obtained at **www.nysmokefree.com/SpecialPages/Showprog.aspx?p=20&p1=20330&r=Region1** or by calling **1-866-NY-QUITS.**
- You can also "prescribe" a visit to the NYS Smokers' Quitline or refer patients to the "Refer-to-Quit" program, which provides your patient the opportunity to receive a follow-up call from a Quit Coach who will conduct a stop-smoking or a stop-smokeless-tobacco coaching session and will mail to the patient a Stop-Smoking or a Stop-Smokeless-Tobacco packet containing information tailored to his or her situation, along with a list of local stop-smoking programs. You will receive a progress report from the Quitline team.

Patient Referral Forms and Quitline RX pads are available by calling **1-866-NY-QUITS** (1-866-697-8487).

What is the NYS Opt-to-Quit™ program?

The Opt-to-Quit™ program provides a systemwide solution for your hospital, clinic, or practice to ensure that all of your patients are offered stop-smoking support (perhaps at hospital discharge for those at high risk). The program also offers staff training and technology help. Patients continue to receive outreach for up to 12 months, or until they opt out of the program.

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[i] **www.nysmokefree.com/download/MedicaidMedicareHighlights.pdf.** Accessed 7/22/15.
[ii] Richter, Kimber P. and Edward F. Ellerbeck. "It's Time to Change the Default for Tobacco Treatment." Addiction 110.3 (2014): 381–386. Web.
[iii] Park, Elyse R. et al. "Primary Care Provider-Delivered Smoking Cessation Interventions and Smoking Cessation Among Participants in the National Lung Screening Trial." JAMA Internal Medicine JAMA Intern Med (2015): n. pag. Web.
[iv] Hughes JR, Hatsukami DK, Mitchell JE, et al. Prevalence of smoking among psychiatric patients. Am J Psychiatry 1986;143:993–7.
[v] Tidey, Jennifer W, and Mollie E Miller. "Smoking Cessation and Reduction in People with Chronic Mental Illness." The BMJ 351 (2015): h4065. PMC. Web. 5 May 2016.
[vi] Ibid.
[vii] Evans, S. and C.E. Sheffer. "The Process of Adapting the Evidence-Based Treatment for Tobacco Dependence for Smokers of Lower Socioeconomic Status." J Addict Res Ther Journal of Addiction Research & Therapy 06.01 (2015): n. pag. Web.
[viii] AHRQ's Treating Tobacco Use and Dependence Pathfinder: Resources for Clinicians and Consumers — This site provides the DHHS Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update and includes evidence-based treatment, provider, and patient educational materials. www.ahrq.gov/path/tobacco.htm.
[ix] Patrick Richard, Kristina West, and Leighton Ku. "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts." Ed. Jos H. Verbeek. PLoS ONE 7.1 (2012): e29665. PMC. Web. 22 July, 2015. Accessed 7/22/15.