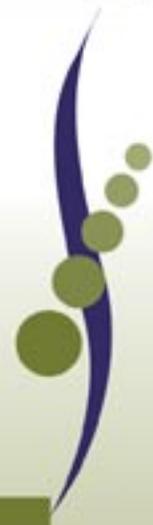


Reimbursement for Smoking Cessation Therapy

A Healthcare Practitioner's Guide

Third Edition



Professional
Assisted
Cessation
Therapy™

Developed by PACT (Professional Assisted Cessation Therapy), an independent consortium of leaders in the treatment of tobacco dependence, whose mission is to lower barriers to broader utilization of cessation therapy through education and advocacy

Reimbursement for Smoking Cessation Therapy

A Healthcare Practitioner's Guide

PACT gratefully acknowledges the contributions of the following individuals who have graciously shared their time and expertise for the creation of this publication.

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About PACT

Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide was developed by PACT (Professional Assisted Cessation Therapy), whose members collaborate in the creation and dissemination of educational materials with the aim of motivating healthcare professionals in all disciplinary areas to promote smoking cessation and empower patients to quit. This guide addresses one of PACT's critical long-term objectives, which is to make tobacco counseling and treatment fully reimbursable.

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INTRODUCTION AND PREVIEW

Introduction

Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide provides information to healthcare providers and their administrative staffs on how to obtain reimbursement for smoking cessation treatment and counseling. It contains advice for providers who wish to maximize benefits for smoking cessation, find their way around coverage deficiencies, and advocate effectively for adequate coverage.

The guide focuses on reimbursement, and is neither a review of the efficacy of various treatment types nor a compendium of all the ways to integrate smoking cessation treatment into a medical practice.

The Status of Smoking Cessation Treatment Reimbursement in the United States

In its June, 2000 report, *Clinical Practice Guidelines: Treating Tobacco Use and Dependence*, the U.S. Public Health Service urged healthcare insurers and group purchasers to provide benefit coverage for effective counseling and pharmacotherapy. The report also urged insurers and purchasers to pay clinicians for providing tobacco dependence treatment, just as they do for treating other chronic conditions. Advances in pharmacological and behavioral treatment for tobacco dependence, combined with evidence of the economic impact of successful smoking cessation treatment, offer more hope than ever that we will continue to reduce our nation's greatest preventable public health problem. New tools such as the Internet and telephone quitlines now provide low-cost and barrier-free access to information and counseling, adding to optimism that this health problem can be solved.

This optimism is tempered, however, by missed opportunities to involve healthcare providers fully in smoking cessation treatment. Patients look to their healthcare providers for smoking cessation advice, and those attempting to quit cigarette smoking are most successful when their doctors and other healthcare providers support them. Yet, only half of smokers who see a doctor have even been urged to quit. Doctors report time pressures, paperwork, lack of training, and lack of incentives as obstacles to providing counseling. Medical assistants are busy, forget to mention it, and are frustrated by the lack of provider interest.

Adequate health insurance coverage, including reimbursement for both patients and providers, increases quit rates and is thus one of the key pieces in an effective, comprehensive smoking cessation strategy. However, this piece has not yet fallen into place. Smoking cessation counseling and pharmacotherapy are not consistently provided as paid services for health insurance subscribers. Only 36 states provide coverage to Medicaid patients for smoking cessation treatment; only 10 of these cover counseling. Medicare does not provide coverage, and a minority of states mandate coverage by private health insurers and managed care organizations (MCOs). While most MCOs cover services for smoking cessation treatment, this often consists of self-help materials, which have been shown to be less effective than counseling and drug therapies. Even when there is adequate coverage, consumers may not know that benefits exist. Providers and MCOs can do more to inform consumers of existing benefits.

The smoking cessation reimbursement scenario is changing rapidly, however, and there is a trend toward reimbursing smoking cessation efforts. Growing numbers of states are providing or planning to provide Medicaid coverage, and Medicare has started a pilot program in 7 states to explore the expansion of smoking cessation benefits to the elderly, the group that is hardest hit by the negative health effects of smoking. Health plans, some in public/private partnerships, are developing innovative smoking cessation strategies that include counseling and drug benefits. Tobacco settlement money is providing another alternative for funding improved services and covered benefits. As smoking becomes "the sixth vital sign," and as the majority of healthcare providers advise and help smokers to quit during office visits—and are reimbursed for providing these services—patients and providers are sure to see greater success in smoking cessation efforts.

We hope this guide helps in accomplishing these important goals by giving providers a useful roadmap for smoking cessation therapy reimbursement. We welcome your feedback for future editions of this guide.

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THE LEXICON OF SMOKING CESSATION TREATMENT AND HEALTH BENEFIT COVERAGE OPTIONS

Healthcare providers interested in receiving reimbursement for smoking cessation counseling should first acquaint themselves with available options for smoking cessation treatment and health insurance reimbursement.

Simply stated, providers cannot expect reimbursement for treating unless they have a solid understanding of the services for which they can seek reimbursement.

An understanding of available therapeutic and health benefit coverage options and resources will help providers and their administrative staffs to:

1. Know what questions to ask regarding available coverage and the limits of coverage in order to maximize both their reimbursement and their patients' current benefits
2. Increase their awareness of referral resources
3. Effectively advocate for enhanced insurance coverage

Treatment Options and the Role of Primary Providers

Effective treatment for smoking cessation can consist of over-the-counter (OTC) and prescription pharmacotherapies, as well as counseling/behavioral interventions:

- Pharmacotherapies. *First-line* drugs include bupropion (Zyban®), nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch. Two *second-line* therapies are clonidine and nortriptyline.
- Counseling/behavioral interventions. These generally consist of problem-solving, social support, and helping "quitters" obtain social support.

Primary providers can help their patients who wish to quit smoking by using both drugs and counseling, though a provider's efforts will vary according to his or her specific practice situation. Counseling/behavioral interventions can be minimal (less than 3 minutes), low intensity (3 to 10 minutes), or more intensive (longer than 10 minutes). As counseling intensity (i.e., session length and the number of sessions) increases, so does the quit rate. More intensive interventions, typically provided by smoking cessation specialists, are most effective at 4 or more sessions.

Smoking cessation specialists are not defined by their professional affiliation nor by the field in which they are trained. Rather, the specialist views smoking cessation as a critical professional role, has the requisite smoking cessation skills, and is often affiliated with programs offering intensive cessation interventions or services.¹ Many different types of providers—physicians, nurses, dentists, hygienists, psychologists, pharmacists, and others—are effective in helping patients to quit. Involving multiple types of providers in delivering antismoking messages appears to enhance cessation rates, according to newly updated *Clinical Practice Guidelines* published by the U.S. Public Health Service (developed by the Agency for Healthcare Research and Quality [AHRQ]).²

Self-help, as opposed to help that is provider-assisted, is also an option, though a less effective one on its own. Table 1 contains a summary of the types/variables of smoking cessation counseling.

Table 1. Types of Smoking Cessation Counseling Services²

| Service or Service Variable | Options – From Least to Most Service Provided |
|---|---|
| Screening for tobacco use | <ul style="list-style-type: none"> • No screening provided and no screening system in place • Sporadic (i.e., individual providers may screen, but no formal system in place) • Screening system in place and screening occurs |
| Advice to quit | <ul style="list-style-type: none"> • No advice to quit • Sporadic (i.e., individual providers may advise, but no formal system in place) • Provider advises quitting |
| Intensity of person-to-person counseling by provider | <ul style="list-style-type: none"> • No intervention • Minimal intervention (sessions of ≤ 3 minutes) • Low intensity (sessions of >3 but ≤ 10 minutes) • Higher intensity (sessions of >10 minutes; multiple sessions) |
| Type of provider contact | <ul style="list-style-type: none"> • No clinician/intervention • Self-help materials only • Non-physician healthcare clinician • Physician |
| Counseling/psychosocial intervention formats | <ul style="list-style-type: none"> • No contact • Self-help/self-administered (e.g., pamphlet, audiotape, videotape, mailing, computer program, Internet/intranet, automated telephone line) • Individual counseling (face-to-face, proactive quitline/telephone counseling, Internet/intranet counseling) • Group counseling |
| Self-help interventions | <ul style="list-style-type: none"> • Individual (e.g., books, computer programs) • Group support (in person, online) |

The *Clinical Practice Guidelines* suggest that all healthcare providers give brief interventions at every visit, minimally to determine whether each patient they encounter smokes, and to provide encouragement, information, and resources necessary for quitting for those who do smoke. This is summarized as the Five A's (Table 2).

Table 2. The Five A's²

| | |
|--|--|
| Ask about tobacco use | Identify and document tobacco use status for every patient at every visit |
| Advise to quit | In a clear, strong, and personalized manner, urge every tobacco user to quit |
| Assess willingness to make a quit attempt | Determine if the tobacco user is willing to make a quit attempt at this time |
| Assist in quit attempt | For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit |
| Arrange follow-up | Schedule follow-up contact, preferably within the first week after the quit date |

Consistently asking about and charting tobacco use allows providers to ensure that smoking status (perhaps determined by history or physical signs) becomes "the sixth vital sign." When advising to quit, providers can give personal motivational information based on the patient's medical feedback tests,³ in order to capitalize on a "teachable moment." Sources include:

- Smoking history and symptomatology (cough, wheeze, dyspnea, hemoptysis);
- Specialized assessments/medical feedback: pulmonary function testing (viewed increasingly as "the sixth vital sign"), arterial blood gases, quantitative pulmonary sputum cytology, in-office nicotine metabolite assays.

The Pacific Business Group on Health (PBGH) breaks this process into more specific steps, recommending that doctors help patients quit by:

- Asking patients at every visit whether they smoke
- Asking how much they want to quit
- Motivating reluctant patients to try to quit
- Helping motivated smokers set a quit date
- Prescribing pharmacotherapies, such as nicotine gum and nicotine patch
- Helping patients resolve problems that result from smoking
- Counseling patients, which increases their chances of success
- Encouraging relapsed smokers to try to quit again
- Letting patients know about smoking cessation programs that may be offered by health plans, community organizations, or Web sites (See Appendices A and B to find resources for both providers and patients)

Available Resources

While some healthcare providers develop smoking cessation expertise and provide intensive counseling/behavioral interventions in their practices, most depend upon community and other referral resources for which patients receive financial coverage to varying degrees. These services generally include self-help materials, telephone counseling (i.e., quitlines), group or individual counseling, or some combination of these, which is usually more effective. The Internet is fast becoming a source for information, individual counseling, and group support. The growth in telephone quitlines and Internet counseling is rapidly increasing access to low-cost smoking cessation services, providing an incentive to providers and patients to actively engage in smoking cessation. (See Appendices A and B)

Community-based classes and social support may be available through managed care plans, growing numbers of which now reimburse for classes. Staff model health maintenance organizations are most likely to offer classes, though other plans increasingly provide them as well. A variety of other community organizations such as the American Cancer Society and the American Lung Association also provide classes and counseling. Materials can also be obtained from the National Cancer Institute and AHRQ. In addition, some pharmaceutical companies offer counseling, targeted information, and follow-up monitoring plus other support.

Health Insurance Reimbursement and Other Financial Incentive Options

Healthcare providers who wish to obtain reimbursement for smoking cessation counseling in their practices have several options. These range from no reimbursement for tobacco dependency as a discrete, chronic condition to full reimbursement (and associated coding) for tobacco dependency as a chronic condition on a par with other chronic conditions (Table 3).

Table 3. The Smoking Cessation Reimbursement Spectrum

Part of job description

Counseling is part of the basic job requirements

Providers do not receive reimbursement for tobacco dependency as a discrete condition

Reimbursement for related conditions

Providers counsel patients on quitting smoking within the content of an office visit for related conditions (e.g., chronic obstructive pulmonary disease)

Office visit not coded separately for smoking

Represents a more proactive stance by physicians working within benefit constraints

Reimbursement for smoking cessation counseling

Providers code for and receive reimbursement for smoking cessation/tobacco dependency counseling, even in the absence of a related condition; sources include:

- Health plans (e.g., Blue Cross Blue Shield of Minnesota, Group Health Cooperative of Puget Sound)
 - Tobacco settlement funding grants
-

Growing numbers of health plans award financial incentives or bonuses to providers who give their patients smoking cessation counseling. While providers do not receive specific reimbursement for smoking cessation counseling, they may receive a quality bonus for providing such counseling.⁴ However, there is currently no consensus as to whether primary providers should be reimbursed for providing low-intensity counseling or whether they should receive incentives for so doing.

Depending upon their health insurance coverage, patients may or may not be reimbursed for prescription or OTC drugs. While this does not pertain to provider reimbursement, it does influence providers' willingness to counsel smokers to quit. Providers are more willing to view counseling as part of their jobs if the appropriate drug therapies are available to their patients.

WHO IS DOING WHAT: PUBLIC AND PRIVATE SECTOR INITIATIVES

Many smokers who wish to quit do not have insurance coverage for appropriate drugs and counseling. This problem is diminishing rapidly for growing numbers of Americans in a variety of public and private sector health insurance plans. This section contains a synopsis of these plans and other treatment funding sources, including:

- Medicaid coverage
- State-mandated coverage
- Employers and employer purchasing coalitions
- Managed care organizations
- Medicare
- Tobacco settlement initiatives
- Pharmaceutical company programs

It is not possible to cover all initiatives within the context of this document. Appendices A and B list online resources. The hard copy version of this guide will be updated periodically, and the online version will be updated at frequent intervals.

Medicaid Coverage

Approximately 36% (11.5 million) of the 32 million persons covered by Federal/State Medicaid programs in 2000 were smokers.⁵ While state Medicaid programs are not required to provide coverage for smoking cessation treatment, they are required to provide such therapy to Medicaid recipients under the age of 21, as well as to provide services for the health and well-being of pregnant women and their fetuses. Further, they are required to screen for tobacco use and provide counseling for smoking cessation in the case of children and adolescents.

In 1998, researchers associated with and funded by the Robert Wood Johnson Foundation conducted a survey that assessed the extent of Medicaid tobacco-cessation coverage.⁶ The survey was mailed to 51 Medicaid program directors by the staff of the Health Policy Tracking Service of the National Conference of State Legislatures. Results showed 24 states and the District of Columbia covered some type of tobacco-dependence treatments in 1998 (Table 4). Moreover, fully half of all Medicaid recipients at that time were not covered for any smoking cessation interventions.

A subsequent survey conducted by the Center for Health and Public Policy Studies at University of California at Berkeley during 1999-2000 showed that by 2000, 31 states covered some pharmacotherapy (a 35% increase from 1998) and 13 states offered special cessation programs for pregnant women.⁵

When the states and District of Columbia were again surveyed in 2001,⁷ this upward trend had leveled off: only 36 states provided some counseling or medication, prompting researchers to conclude that "if the 2010 National Health Objective is to be achieved, Medicaid coverage for treatment of tobacco cessation should be increased dramatically." (See Table 4 and Appendix J.)

**Table 4. States' * Medicaid Smoking Cessation Coverage
Results of Two Surveys: 1998⁶ and 1994-2001⁷**

| Coverage | 1998 | | 2001 | |
|--|--------|----|-----------------|----|
| | Number | % | Number | % |
| Some type of cessation services | 25 | 49 | 36 | 71 |
| Selected pharmacotherapies | | | | |
| Bupropion/Zyban® | 23 | 45 | 35 | 69 |
| Nicotine patch | 22 | 43 | 25 | 49 |
| Gum | 20 | 39 | 24 | 47 |
| Nasal spray | 17 | 33 | 26 | 51 |
| All FDA-approved pharmacotherapy | 10 | 20 | 19 [†] | 37 |
| Counseling services | 10 | 20 | 10 [†] | 20 |
| Comprehensive (all forms of NRT, bupropion, group & individual counseling) | 6 | 12 | 2 [†] | 4 |

* Including the District of Columbia.

† Includes Utah, which provides this service for pregnant women only.

In January 2001, the Health Care Financing Administration (now, the Center for Medicare and Medicaid Service [CMS]) sent a letter to state Medicaid directors urging them to heed the evidence about effective smoking cessation documented in the Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence (June 27, 2000).⁸ They strongly recommended that Medicaid programs provide coverage for smoking cessation drug therapy and counseling.

State-Mandated Coverage

The 1998 Survey of State Policy on Nicotine Addiction Treatment also assessed the extent to which states mandated private health insurers or managed care providers to provide a smoking cessation benefit. Only 4 states—California, Colorado, New Jersey and North Dakota—reported any mandate for health insurers to cover smoking cessation treatment (Table 5).

Table 5. Smoking Cessation Treatment Mandates for Health Insurers

| | |
|---------------------|---|
| California | <ul style="list-style-type: none"> Group disability policies covering hospital, medical, or surgical expenses must offer substance abuse treatment, including nicotine use; policies allowed to require separate deductibles, co-payments, and overall cost limitations for this benefit California residents may also apply for health insurance coverage for perinatal and infant care through the Access for Infants and Mothers Program, whose primary care services include health education for tobacco use |
| Colorado | <ul style="list-style-type: none"> All members of large health plans are entitled to one smoking cessation benefit Basic plan pays for one smoking cessation program under a physician's supervision or one authorized by the plan, limited to one treatment per lifetime and a \$150 patient payment limit |
| New Jersey | <ul style="list-style-type: none"> Small groups are required to cover smoking cessation treatment under a preventive healthcare benefit \$300 per member per year maximum If the annual preventive benefit is exhausted, annual medical check-ups are not reimbursed |
| North Dakota | <ul style="list-style-type: none"> Guaranteed issue statute—small and large employers are required to include smoking cessation as a benefit \$150 per member per lifetime Must be supervised by a physician If certified by physician, \$150 of cost will be reimbursed to member |

Employers'- and Employer-Purchasing Coalitions

The majority of employers are not required to provide health insurance benefits for smoking cessation drugs or therapy. As noted, only 4 states mandate private health insurers or MCOs to provide a smoking cessation benefit (Table 5) and, even in those states, employers who are self-insured are not required to provide coverage. In general, employers advocate against coverage mandates that they believe do not meet the particular health and business needs of their organizations.

That being said, employers—whose health benefits currently cover 62.6% of Americans⁹ and who have a stake in keeping employees healthy and on the job—have been a driving force in institutionalizing smoking cessation counseling into the national healthcare delivery system by:

- Selecting health plans based on quality indices such as National Committee on Quality Assurance (NCQA) accreditation and Health Employer Data Information Set 3.0 (HEDIS 3.0), a quality scorecard developed by NCQA (both NCQA accreditation and HEDIS 3.0 address smoking cessation programs and benefits in their rating systems; employees in many of these organizations [e.g., GTE Corporation] receive higher benefit contributions from their employers when they elect health plans with higher quality scores);
- Instituting provisions in benefit plans through "insurance risk rating" that reward nonsmokers and providing flexible benefit credits that smokers can use for smoking cessation classes;
- Enacting other internal initiatives that seek to reduce the incidence and negative cost impact of smoking, including: health promotion/wellness initiatives and health risk appraisals; on-site medical departments/primary care clinics; integrated disability management programs; smoking policies; and employee assistance and managed behavioral healthcare programs.

Providers have little opportunity to interact with employers and to advocate directly for smoking cessation treatment (unless they form their own MCOs). Nonetheless, they can still benefit from understanding the role of employers and the resources employers provide to help employees and their families (and sometimes retirees) to quit smoking. It is very important to involve group purchasers in the discussion of smoking cessation health benefit coverage.

A 1988 unpublished study by the Maine Medical Assessment Foundation on employer tobacco policy surveyed the 30 members of the Maine Health Management Coalition (MHMC)¹⁰ found:

- All MHMC employers have a work site smoking policy
- The majority of employers offer designated outdoor smoking areas; only 10% have an entirely smoke-free work site
- 10% require smokers to pay higher insurance premiums
- Among 30 employers and a total of 44 insurance "products"
 - 33% provide cessation counseling at the work site
 - 47% provide counseling through health plans

- Only 18% have full access to plan-level counseling resources
- Of managed care products, 68% offer counseling compared to 40% of indemnity products
- 77% of insurance products provide some coverage for the nicotine patch and bupropion (82% for managed care and 70% for indemnity plans)
- Fully covered access to antismoking medications occurs in 50% of employer plans

Employer purchasing coalitions have also been drivers of growth in quality-based "value" purchasing and quality scorecards, which usually include counseling smokers on quitting. These organizations magnify the purchasing power of employers in their communities and play an important role in extending benefits coverage for smoking cessation. In a 2000 National Business Coalition on Health survey, approximately 60% of the responding coalitions reported that they use the HEDIS scorecard (up from 50% in 1998)¹¹. Several purchasing coalitions, including the Pacific Business Group on Health in the Greater San Francisco area, the Buyers Healthcare Action Group in Minneapolis, and the Gateway Purchasers for Health in St. Louis have provided smoking cessation benefits coverage or incentives. Some have required participating HMOs to rebate a percentage of premiums if performance for each of 5 clinical measures—including smoking cessation—is unsatisfactory.

Managed Care Organizations

MCOs have a history of covering preventive services and thus have the opportunity to effect healthy lifestyle changes in their member populations. Their influence is growing, as 90% of insured Americans now receive their health benefits through some type of MCO.¹² According to the Kaiser Family Foundation and Health Research and Educational Trust, fully 96% of those covered by employer health insurance were MCOs in 2002.¹³ Since MCOs comprise the nation's major healthcare delivery mechanism, healthcare providers who wish to ensure coverage for their patients and reimbursement for themselves should educate themselves regarding MCOs' smoking cessation reimbursement policies.

While few states mandate that MCOs cover smoking cessation services, growing numbers of health insurers and MCOs are offering some level of treatment for smoking cessation. The Robert Wood Johnson Foundation, in partnership with the AHRQ, the Centers for Disease Control and Prevention, and the National Cancer Institute, conducted surveys of all managed healthcare plans each year from 1997 to 2000 as part of their "Addressing Tobacco in Managed Care" initiative.¹⁴ These surveys had the overall objective of assessing the degree to which MCOs addressed smoking cessation through application and awareness of the *Clinical Practice Guidelines*, and whether they had integrated smoking cessation into their routine care policies, their governmental advocacy efforts, and their attempts to overcome barriers to addressing smoking cessation. Tables 6 through 8 summarize results from the 2000 survey.

Table 6. Addressing Tobacco in Managed Care 2000 Survey: MCOs* Offering Full Coverage for Smoking Cessation Interventions¹⁴

| <i>Benefit</i> | <i>MCOs (%)</i> |
|--|-----------------|
| Pharmacotherapy | |
| Some type of smoking cessation pharmacotherapy available | 59.2 |
| NRT (prescription + OTC) | 13.3 |
| NRT (OTC) | 14.9 |
| NRT (prescription) | 20.0 |
| NRT only with program | 26.0 |
| Zyban® | 37.2 |
| Wellbutrin® | 44.0 |
| Zyban and Wellbutrin | 25.3 |
| Behavioral intervention | |
| Some type of antismoking behavioral intervention available | 86.2 |
| Allow self-referral to programs | 69.4 |
| Self-help materials | 56.6 |
| Counseling during pregnancy | 46.6 |
| Groups/classes | 37.0 |
| Telephone counseling | 36.8 |
| Face-to-face counseling | 23.6 |

Table 7. Addressing Tobacco in Managed Care 2000 Survey: MCOs* Requiring Providers to Assess/Intervene for Tobacco Use¹⁴

| <i>Requirement</i> | <i>MCOs (%)</i> |
|--|-----------------|
| Document smoking status in medical record | 81.2 |
| Ask new patients about smoking status | 74.1 |
| Strongly advise all patients who smoke to quit | 68.8 |
| Include smoking status as a vital sign | 43.5 |
| Encourage patients who smoke to maintain smoke-free environment at home and in daycare settings | 41.3 |
| Arrange follow-up with patients trying to quit smoking | 36.5 |
| Refer smokers to intensive treatment when appropriate | 24.7 |
| Have literature about smoking cessation and the risks of smoking in waiting rooms and exam rooms | 23.8 |
| Ensure support staff are trained to counsel patients about quitting | 13.8 |

Table 8. Addressing Tobacco in Managed Care: Comparison of Full Coverage of Key Antismoking Benefits, 1997 vs. 2000¹⁴

| <i>Benefit</i> | <i>MCOs Offering Full Coverage (%)</i> | <i>1997¹⁵</i> | <i>2000*¹⁴</i> |
|-------------------------|--|--------------------------|---------------------------|
| NRT (OTC) | | 6.6 | 14.9 |
| NRT (prescription) | | 25.0 | 20.0 |
| NRT only with program | | 25.0 | 26.0 |
| Zyban | | 17.6 | 37.2 |
| Telephone counseling | | 32.8 | 36.8 |
| Face-to-face counseling | | 26.6 | 23.6 |
| Groups/classes | | 35.7 | 37.0 |
| Self-help materials | | 54.1 | 56.6 |

* A total of 85 out of 136 health plans (62.5%) completed and returned the survey, representing service to more than 26 million people.

A growing number of health plans have assumed proactive roles in developing tobacco treatment systems at the patient level, the practice level, and the health plan/MCO level (Table 9). Humana Inc.—one of the nation's largest providers of health insurance—launched “RxAllowance” in July of 2003, a prescription drug benefit that provides reimbursement for preventive medicines, including smoking cessation therapy. This is the industry's first such prescription drug coverage plan in which drugs are grouped according to their ability to prevent a serious medical episode or the need for further medical care. Smoking cessation therapies fall into the plan's Group D, “drugs that meet cosmetic and other lifestyle needs.” Humana pays an allowance to a participating pharmacy for each prescription or refill and the consumer pays the balance, if any.

Table 9. Notable Public and Private Sector Antismoking Initiatives

| Managed Care Organization | Smoking Cessation Benefits or Provider Incentives |
|--|--|
| Allina Health | Performance expectations/incentives with central tobacco user registry and telephone counseling |
| Blue Cross and Blue Shield of Minnesota | NRT benefits; counseling, chronic disease office visit |
| Blue Cross Blue Shield of Maine (South Portland, Maine) | Follows <i>Clinical Practice Guidelines</i> ² (Appendix E); covering tobacco control as a chronic disease office visit |
| Group Health Cooperative of Puget Sound | One individual or group program per calendar year; educational materials; one course of NRT per calendar year, provided individual is participating in the Group Health “Free and Clear” program |
| Health Alliance Plan | Counseling by HAP-affiliated primary care physicians, telephone counseling, and smoking control classes; nicotine replacement therapy (prescription and OTC) with a prescription drug rider |
| HealthPartners (Minnesota) | NRT benefits; counseling |
| Humana Inc. | “RXAllowance” prescription plan for preventive medicines, including antismoking medications |
| Network Health Plan (Menasha, Wisconsin) | 24-hour health advice line offers members a multifaceted smoking cessation program; the “Call It Quits” program |
| Oregon Statewide Tobacco Cessation Project | 16 health and 9 dental plans implemented an adapted version of the 1996 AHCPR (now AHRQ), especially for the Medicaid population; led to the statewide integration of the Oregon Quitline |
| Tufts Health Plan (Waltham, Massachusetts) | Smoking cessation program for pregnant women using telephone counseling |

Medicare

Medicare does not require coverage for smoking cessation counseling and does not reimburse for either OTC nicotine replacement therapy or prescription drugs. Under government guidelines, Medicare managed care programs are supposed to encourage patients to quit smoking. The lack of coverage represents a missed opportunity, since Medicare recipients are more likely than other smokers to visit a physician or healthcare provider, thus allowing for greater opportunities for intervention. Thirteen percent of Medicare recipients are current smokers.¹⁶ Seventy-one percent of smokers in Medicare managed care plans received advice to quit smoking in the year 2000. Among those not receiving advice, some may have already quit prior to visiting their physicians, and others may have had emergency visits where a counseling session might not have been appropriate. While the prevalence of smoking is lower in the Medicare population, older smokers are more likely to suffer from smoking-related illness since they have smoked longer and tend to be heavier smokers. In fact, smoking is one of the leading causes of death in Medicare beneficiaries.

The Centers for Medicare and Medicaid Services (CMS; formerly HCFA) announced on July 12, 2000, that the agency will test ways to help older Americans stop smoking¹⁷ as part of its Healthy Aging Project, a new initiative aimed at identifying the best ways to keep seniors healthy. The demonstration cessation project will test specific strategies for helping older people quit smoking in states selected because of the prevalence of smokers age 65 and older. The participating states include Alabama, Florida, Missouri, Nebraska, Oklahoma, Ohio and Wyoming.

Peer Review Organizations (PROs), Medicare's quality assurance contractors, will run the program in each state. The PROs will publicize the project through newspaper and radio advertisements, in doctors' offices, and through community outreach programs. Eligible beneficiaries can register via a toll-free telephone number. Counseling, either by healthcare providers or trained telephone counselors, and FDA-approved antismoking medications will be used in a variety of combinations. These include counseling by healthcare providers only, provider counseling in conjunction with medication, and telephone counseling with medication.

The demonstration will last approximately 3 years. Individual participants will be offered smoking cessation assistance for 12 months, and healthcare professionals will follow their progress to evaluate success rates. Participants will be recruited on a rolling basis over the life of the program. The CMS anticipates publishing results in 2004–2005. If the demonstration identifies effective ways to help seniors stop smoking, this could prompt Congress to consider a Medicare benefit to cover smoking cessation.

Smoking cessation is a special concern for Medicare because more smokers will be entering the program in coming years. The prevalence of smoking in the Medicare population is currently declining slowly, but the actual number of smokers will increase with the aging of baby boomers.

Tobacco Settlement Initiatives

Legislatures across the country are deciding how to spend the hundreds of billions of tobacco settlement dollars that will flow into states for the next 25 years. Experts give states mixed reviews as to their stewardship of these resources. According to *Show Us the Money: A Report on the States' Allocation of the Tobacco Settlement Dollars* published in January 2003 by The Campaign for Tobacco-Free Kids (in association with the American Lung Association, American Cancer Society, American Heart Association, and SmokeLess States National Tobacco Policy Initiative), the states will receive \$8.7 billion in tobacco-settlement money in Fiscal Year (FY) 2003.¹⁸ Unfortunately, despite collecting more money than ever before between tobacco-settlement and cigarette tax revenues, funding for the same period declined by 11.2% (\$86.2 million). The deepest cuts occurred in states that had made great headway in cessation and prevention, including California (with a cut of 34.3%) and Massachusetts (with a 90% cut and complete elimination of a successful program; Table 10).

There were some positive developments in utilization of these funds for FY 2003, as 20 states increased funding for tobacco prevention, while 13 cut funding during this period. Indiana, Maine, Maryland, Minnesota, Mississippi, and New Jersey have become leaders in tobacco prevention and cessation. There was also strong public support in Arizona, Montana, and Oregon for initiatives that restored or increased funding for tobacco prevention and cessation initiatives.

Table 10. Show Us the Money: A Report on the States' Allocation of the Tobacco Settlement Dollars — Key Findings¹⁸

Only 4 states—Maine, Maryland, Minnesota, and Mississippi—are funding tobacco prevention and cessation programs at the minimum levels recommended by the CDC. This is down from 5 years ago, with Maryland being added and Arizona and Massachusetts dropping from the list (in FY 2004, Arizona and Montana will fund tobacco prevention programs at the CDC minimum if their elected leaders abide by ballot initiatives approved by voters in November 2002).

Only 19 states (including the 4 above) have committed even 50% of the minimum funding level recommended by the CDC. This is the same number as in 2002.

Sixteen states have committed only modest amounts to tobacco prevention and cessation (25 to 50% of the CDC minimum).

Twelve states have committed minimal amounts to tobacco prevention and cessation (less than 25% of the CDC minimum).

Three states—Michigan, Missouri, and Tennessee—and the District of Columbia currently spend none of their tobacco settlement tax revenue on tobacco prevention. This is the same number as in 2002, with Missouri joining the zero list and North Carolina, which now funds tobacco prevention at \$6.2 million a year, leaving the list.

In FY 2003, the states will spend \$682.3 million on tobacco prevention and cessation, a cut of 11.2% from FY 2002. This is the first budget year since the 1998 tobacco settlement in which states cumulatively cut such funding.

This \$682.3 million amounts to only 3.4% of state revenues from tobacco settlement and tobacco taxes, and only 42.6% of the minimum recommended by the CDC.

At least 18 states and the District of Columbia have sold the rights to, or securitized, all or part of their future tobacco settlement payments to investors for a much smaller up-front payment, or have passed laws authorizing such action.

Pharmaceutical Company Programs

Several pharmaceutical companies who manufacture smoking cessation therapies sponsor online antismoking programs to be used in conjunction with their products. Such computer-tailored behavioral treatment modalities have proven quit rates higher than those seen with nicotine replacement therapy alone.¹⁹

GlaxoSmithKline offers the "Committed Quitters® Program" (www.committedquitters.com), an 8-to-12 week, personalized antismoking behavioral support plan offered free with the purchase of Nicorette® Starter Kit or a Step 1 or Step 2 box of NicoDerm® CQ®. Enrollees receive a newsletter addressing high-risk situations and social support, coping strategies and other motivational aids. Patients can enroll via the toll-free number found inside either the Nicorette or NicoDerm CQ packaging or at the above Web site. Online enrollees obtain individualized information instantaneously, 24-hours a day, 7 days a week; those who enroll by phone receive support materials in the mail. All continue to receive personal support over the entire course of therapy.

GlaxoSmithKline also offers the Zyban Advantage Plan (ZAP) pack for patients who purchase a 7-week full course of Zyban® (bupropion SR). The ZAP pack contains a quit diary to record daily progress during the treatment, a cassette on best kept secrets on quitting, a counseling booklet, a family guide to help smokers during the quitting process, stress reliever, screen saver, and a poster.

Novartis offers the Habitrol® Support Program (www.habitrol.com), a free, interactive, personalized, 6-step series of antismoking exercises delivered online, to be used in conjunction with the Habitrol transdermal nicotine patch. A toll-free support line staffed by registered nurses (1-888-227-5777) is also available free of charge to Canadian residents only. Novartis also has an antismoking Web site in French and German (www.nicotinell.ch).

Pfizer's Nicotrol® Web site (www.nicotrol.com) offers the Nicotrol® Helping Hand™ Program, a free, personalized, online support program that identifies an enrollee's smoking profile and tracks his/her progress towards quitting.

HOW TO OBTAIN REIMBURSEMENT

How to Code for Smoking Cessation Reimbursement

Healthcare providers interested in reimbursement for providing smoking cessation counseling must do so within the limitations of a system that does not yet universally reimburse for either brief or intensive interventions. Providers often work within less than ideal coverage. For example, drugs may be covered but counseling may not; patients may have to pay for their own OTC drugs while obtaining counseling from their healthcare providers. Where counseling is a covered benefit, providers can simply code for it using the ICD-9 code for tobacco dependence (305.1). In these cases, providers may deliver low-intensity counseling covering all or part of the "5 A's" (Ask, Advise, Assess, Assist, Arrange) within the context of office visits for other diseases or conditions (e.g., COPD or cough). They may also offer this counseling as part of medical assessments for related conditions or during routine physical examinations. For example, clinical opportunities to address smoking-related diseases present themselves when healthcare professionals review the results of the following tests with their patients:

- Electrocardiography
- Total leukocyte counts
- Blood pressure measurements
- Hematocrit
- Auscultation of heart and lungs
- Blood lipid studies
- Blood coagulation studies
- Serum alpha antiprotease measurements
- Pregnancy tests
- Carboxyhemoglobin determinations
- Biological markers of tobacco exposure, such as carbon monoxide and cotinine; pulmonary function tests; histopathological changes

Many smokers have smoking-related diagnoses (e.g., bronchitis) that permit third-party insurance reimbursement through the CPT or ICD-9 codes corresponding to these diagnoses (Tables 11 and 12).³ Table 13 offers suggestions on how to handle various antismoking reimbursement scenarios. (See also the coding section of the *Clinical Practice Guidelines*—Appendix C.)

Table 11. Medical Procedures and CPT Codes Related to Smoking Co-Morbidity³

| | |
|--|-------|
| Consultation | 99244 |
| Hemoglobin | 85018 |
| Spirometry (pre/post with bronchodilators) | 94060 |
| Spirometry | 94010 |
| Respiratory flow volume loop | 94375 |
| Aerosol inhalation | 94664 |
| Carbon monoxide diffusion capacity (DLCO) | 94720 |
| Pulse oximetry | 94760 |
| Carboxyhemoglobin | 94250 |
| End tidal carbon dioxide | 94770 |
| Chest x-ray (PA & LL) | 71020 |
| Electrocardiogram | 93000 |
| Lipid Profile | |
| Total cholesterol | 82465 |
| HDL | 83718 |
| LDL | 83721 |
| VLDL | 83719 |

Table 12. ICD-9 Codes of Smoking-Related Diseases³

| | |
|--|--------|
| Metaplasia, tracheobronchial tree | 519.1 |
| Carcinoma, in situ, bronchus and lung | 231.2 |
| Reduced vital capacity | 794.2 |
| Chronic obstructive pulmonary disease (COPD) | 491.2 |
| Emphysema, obstructive | 492.8 |
| Infection, upper airway | 465.9 |
| Dyspnea | 786.0 |
| Hypercholesterolemia | 272.0 |
| Cough | 786.2 |
| Abnormal sputum | 786.4 |
| Chest pain | 786.50 |
| Asthma | 493.00 |
| Chronic airway obstruction | 496.00 |
| Diabetes mellitus | 250.0 |
| Coronary atherosclerosis | 414.0 |
| Toxic effect of tobacco | 989.84 |

Table 13. Provider's Reimbursement Troubleshooting Guide

| Situation | Suggestion/Options |
|---|---|
| Drugs are covered, but counseling is not | <ul style="list-style-type: none"> • Counsel patient in conjunction with treatment for related conditions • Refer to low-cost community resources, telephone, or Internet counseling programs • In the case of employer plans, find out if an in-house wellness/health promotion program is available or if flexible benefit plans provide credits or dollars that can be used for smoking cessation • Look into online chat groups and pharmaceutical company programs online (e.g., www.quit.com) |
| Prescription drugs are covered, but preauthorization is required | <ul style="list-style-type: none"> • Ask the office manager or other staff member involved with counseling to learn about the MCO's specific requirements and develop a positive relationship with those individuals charged with preauthorization at the MCO |
| Brief counseling is covered, but intensive counseling (multiple sessions >10 minutes in length) is not | <ul style="list-style-type: none"> • Learn about low-cost community, telephone, or Internet counseling programs • Find out if the patient's employer provides on-site programs • Look into online chat groups and pharmaceutical company programs |
| Drug benefits are denied and the patient cannot afford to pay for medications | <ul style="list-style-type: none"> • Look into pharmaceutical company programs for low-income patients, as well as services provided by the state |
| An elderly patient smokes and suffers from COPD but does not have coverage for smoking cessation treatment since it is not covered by Medicare | <ul style="list-style-type: none"> • See the above advice regarding obtaining counseling • Medicare pilot program applies in Alabama, Florida, Missouri, Nebraska, Oklahoma, Ohio, and Wyoming • Look into pharmaceutical company programs |

In addition to understanding and maximizing existing coding systems, proactive providers can institute tracking and coding systems with which to monitor smoking and smoking cessation treatment in their practices. Refer to the section "Providers as Change Agents for Improved Reimbursement" (pages 27-28) for examples of tracking codes.

Learning What Smoking Cessation Treatment Is Covered: The Proactive Office Manager

Healthcare providers can take a proactive stance through their office managers or other MCO liaison personnel and thereby equip themselves with cessation treatment coverage levels for drugs and counseling in the health plans in which they participate. This information will allow them to:

- Confidently communicate choices to their patients;
- Help their patients maximize their benefits and thus increase their chances of successfully quitting;
- Receive any allowable reimbursement for smoking cessation counseling;
- More effectively advocate for health plan changes that serve their patients' best interests and also result in provider reimbursement.

This research can also be part of the "tire-kicking" that providers should do when considering joining an MCO. Appendix D contains a worksheet that can be used for this purpose.

If this information is not readily available in the contract or in other materials the provider has received from the health plan, the office manager/MCO liaison can call the MCO's provider relations department to assess benefits, perhaps faxing or E-mailing the worksheet prior to the conversation. In the case of Medicaid subscribers, office managers can use the worksheet in their conversations with state insurance departments to determine allowable Medicaid coverage levels in their state.

PROVIDERS AS CHANGE AGENTS FOR IMPROVED REIMBURSEMENT

There are a number of proactive steps that providers and their staffs can take to advocate for adequate health insurance coverage for smoking cessation treatment.

- In the context of Strategies 4 and 5 of *Clinical Practice Guidelines* pertaining to provider and patient reimbursement (Appendix E):
 - Educate oneself about guidelines
 - Before joining the panel of an MCO, inquire to what extent guidelines are met
 - Advocate with existing MCO contracts
- Regarding the specific benefits that are covered:
 - Ask specific questions about coverage and quality bonuses before contracting with an MCO; then use Appendix D to study and track coverage
 - Advocate for expanded coverage (Appendix I); since smokers often try to quit smoking 4 or more times before being successful, benefits should support several quit attempts to reduce the incidence and costs of smoking
- Learn about the cost benefit associated with providing smoking cessation benefits and share this information with patients' MCOs; if providers are able to identify a champion within the HMO (perhaps an executive personally affected by a smoking-related tragedy or the Chief Financial Officer), they can provide this person with these financial tools (Appendix F)
- Develop or adopt a system (codes, procedures, a line on forms/medical charts) of tracking codes for preventive healthcare measures, including the incidence of smoking and counseling, or encourage health plans to do so:
 - At the point of encounter, providers can thus easily record whether the patient smokes and what services/advice were provided; otherwise, chart reviews are required to determine the extent to which preventive services have been provided
 - Such a system will facilitate providers' acceptance into the provider panel of MCOs with NCOA accreditation and/or HEDIS mechanisms and make a case for specific coverage decisions or for broader MCO coverage
 - A 2001 pilot study shows the feasibility of such systems, and notes that computerized charting systems are superior to paper-based systems.²⁰
 - The Providence Health System in Oregon has developed such a system based on HEDIS 3.0 quality measures and the organization's internal quality tracking program (Table 15).⁴

PROACTIVE STRATEGIES FOR IMPROVED REIMBURSEMENT

- **Educate** oneself about health plans' or MCOs' concerns regarding coverage of behavioral counseling and formulate possible responses to these concerns (Table 14).²¹

Table 14. Reasons Insurers Do Not Reimburse for Behavioral Counseling

| Concern | Response |
|--|---|
| Concerned that additional benefits will force increase in premiums | The cost-effectiveness of all evaluated smoking cessation interventions remains highly attractive; Group Health Cooperative has estimated their comprehensive program costs \$0.10 to \$0.40 per member per month |
| Not convinced that getting smokers to quit will reduce other healthcare costs | Studies have shown cost decreases after 4 years; employer costs will decrease more rapidly |
| Unconvinced that getting their insurees to quit will reduce their plan's costs due to turnover of membership | Synthesized models show that 50% of program costs will be recouped in 6.5 years, even accounting for turnover; the vast majority of other MCO services do not result in reduced costs |

Learn about tobacco settlement initiatives in your state and get involved in advocacy for enhanced treatment resources funded by settlement money.

Encourage health plans to participate in Robert Wood Johnson/American Association of Health Plan's "Addressing Tobacco in Managed Care" programs (awards program, grants, surveys, and annual conference) administered by the National Technical Assistance Office, which also provides day-to-day technical assistance for providers (Appendices A and B).

Adopt a coding system. One reason tobacco cessation is not systematically addressed in healthcare settings is the lack of a framework for measurement.²⁰ The Providence Health System in Oregon has developed such a system, similar to traditional CPT and ICD-9 codes, that facilitates measurement and reimbursement for delivery of preventive health services, including addressing tobacco use (Table 15).⁴

Table 15. Providence Health System Tobacco Tracking Codes⁴

| Concern | Response |
|--|-------------------------------------|
| TR001: Smoking | TR100: Smoking cessation counseling |
| TR002: Non-smoker/remote quitter (>6 months) | |
| TR003: Recent quitter (<6 months) | |

These codes are documented by the clinician when service is provided, recorded on fee slips, and submitted to MCOs for reimbursement. The system is based on HEDIS 3.0 quality measures and the 1999 Providence Health Plan quality bonus program. A project to refine and implement these codes, funded by the Robert Wood Johnson Foundation, is currently under way.

A. Resources for Healthcare Providers and Policymakers

www.aahp.org

American Association of Health Plans

www.aahp.org/atmc/mainindex.cfm

Main index of available resources from the National Technical Assistance Office

www.ahrq.gov

Agency for HealthCare Research and Quality site

www.ama-assn.org/ama/pub/category/6694.html

SmokeLess States National Tobacco Policy Initiative: 36 states and the District of Columbia, funded by the Robert Wood Johnson Foundation, American Cancer Society, American Heart Association, American Lung Association

www.atmc.wisc.edu

Addressing Tobacco in Managed Care National Program office—information on grant application

www.bluecrossmn.com/public/healthandwellness/tobacco.html

Blue Cross Blue Shield of Minnesota smoking cessation site for policymakers

www.ctcinfo.org

The Center for Tobacco Cessation: available science and partnering to expand tobacco dependence treatment; funded by the Robert Wood Johnson Foundation and the American Cancer Society

www.ctri.wisc.edu

University of Wisconsin Center for Tobacco Research and Intervention: nationally-recognized academic center for advancing the science of tobacco dependence/treatment, providing intervention/outreach, developing policy initiatives

www.endsmoking.org

Professional Assisted Cessation Therapy (PACT) Web site; consortium whose mission is to lower barriers to broader utilization of cessation therapy; includes useful related links

www.ncqa.org

National Committee on Quality Assurance (NCQA)

www.healthaffairs.org

Health Affairs journal

www.rwjf.org

Robert Wood Johnson Foundation

www.srnt.org

Society for Research on Nicotine and Tobacco

www.surgeongeneral.gov/tobacco

Office of the Surgeon General *Tobacco Cessation Guideline*

www.tepp.org/actev/index.html

Arizona's cessation training site

www.tobacco.org

Information for health professionals and policymakers

www.tobaccofreekids.org

Campaign for Tobacco-Free Kids

www.stopsmokingdoctors.com

Assists the medical community in developing nicotine dependence treatment; offers clinicians free listings on the site, so that smokers can access local antismoking services

cms.hhs.gov

Centers for Medicare & Medicaid Services (CMS); formerly Health Care Financing Administration (HCFA)

tc.bmjournals.com

Tobacco Control (online journal; requires subscription or payment per article)

B. Resources for Consumers

www.acog.org

Contacts/resources to help pregnant women stop smoking; sponsored by American College of Obstetricians and Gynecologists

www.americanheart.org

American Heart Association

www.ashline.org

Arizona smokers' helpline; active programs for Arizona residents only, but contains quitting tips and link for all Site visitors

www.cancer.org

American Cancer Society

www.cdc.gov/tobacco/cess.htm

Centers for Disease Control, National Cancer Institute.

The CDC's Tobacco Information and Prevention Source (TIPS), providing up-to-date news and research reports, magazine articles, tips for quitting, the Great American Smokeout, and US government publications

www.ctri.wisc.edu

University of Wisconsin Center for Tobacco Research and Intervention: direct services to individuals, including a clinic, group counseling sessions, and self-help materials (plus quit line for Wisconsin residents)

www.findhelp.com

A free resource to physicians, smokers, and anyone interested in current smoking cessation methods and medications provided by The Foundation for Innovations in Nicotine Dependence (FIND), a nonprofit corporation

www.health.org

National clearinghouse for alcohol and drug information—extensive tobacco-related resources provided by the US Department of Health and Human Services

www.lungusa.org/tobacco

American Lung Association

www.nci.nih.gov

National Cancer Institute

www.nicodermcq.com

Free smoking cessation resources and Nicoderm CQ product information sponsored by GlaxoSmithKline with link to their Committed Quitters Program

www.nicorette.com

Free smoking cessation resources and Nicorette product information sponsored by GlaxoSmithKline with link to their Committed Quitters Program

www.nicotine-anonymous.org

Quit site sponsored by Nicotine Anonymous®, an organization self-described as a "fellowship of men and women helping each other to live lives free of nicotine"

www.quit.com

Interactive resource center for smokers sponsored by GlaxoSmithKline

www.quitnet.com

The Web's original quit-site for consumers; operated in association with Boston University

www.quitnet.com/library/programs

National directory of local resources; search for regional/local resources by state or by ZIP code

www.quitsmoking.com

General and product information

www.quitsmokingsupport.com

Information and advice

www.quitsmokinguk.com

The UK's online community for quitting smokers by quitting smokers

www.quit tobacco.org

Information on the benefits of quitting, how to avoid a relapse, and everything in between. Includes a Tobacco Savings Calculator and a discussion group for support. Run by Group Health Cooperative of Seattle, WA

www.quit4life.com

Health Canada's site to support smoking cessation in young people, age 12-18 years

www.smokefreeair.org

News, resources, action alerts, and opportunities for individuals to get involved in smoking cessation

www.srnt.org/resources/other.html

Society for Research on Nicotine and Tobacco – more links for consumers and healthcare professionals

www.stop-tabac.ch

Created to motivate young people to quit smoking; personalized reports, questionnaires, facts, etc., conceived and prepared by the Institut of Social and Preventive Medicine, University of Geneva, Geneva, CH

www.surgeongeneral.gov/tobacco

The Surgeon General's Tobacco Cessation Guideline; the latest drugs and counseling techniques for treating tobacco use and dependence

www.tepp.org/quit/index.html

Arizona's quit support site

www.zyban.com

GlaxoSmithKline's Zyban Advantage Plan, a smoking cessation resource for consumers that is free of charge

cms.hhs.gov

Centers for Medicare & Medicaid Services (CMS); formerly Health Care Financing Administration (HCFA); information for consumers available

smokinghealthline.com

Offers a range of tools, tips, and strategies to help patients succeed in their struggle against nicotine addiction; modest membership fee required

C. Coding Information From *Clinical Practice Guidelines*²

Clinicians, clinic administrators, and healthcare delivery systems require appropriate diagnostic and billing codes for the documentation of reimbursement for tobacco dependence treatment. Information on such codes addresses a common concern of those treating tobacco-dependent patients: how to accurately document and obtain reimbursement for this treatment. Examples of such codes are provided on the following pages, although clinicians and billing coders may use other diagnostic and reimbursement codes to document and obtain payment for this medical treatment.

It is also incumbent on the clinician to ensure that appropriate billing guidelines are followed and to recognize that reimbursement of these codes may vary by payor or benefits package. For example, although psychiatric therapeutic codes appropriate for treating tobacco dependence exist, some payors or benefits packages have restrictions on mental health benefits. Similarly, reimbursement for preventive visits varies greatly among payors and benefits packages.

A systems-based approach will facilitate the understanding and use of such codes by clinicians. For example, various clinic or hospital meetings (e.g., business sessions, grand rounds, seminars, and coding in-service sessions) can explain and highlight the use of tobacco dependence codes for diagnosis and reimbursement.

Additionally, these diagnostic codes can be preprinted on the billing and diagnostic coding sheets and checked-off rather than expecting clinicians to recall and then manually document such treatment. Finally, clinicians can be reminded that counseling by itself is a reimbursable activity and can be billed for, based on the time spent.

- I. **Diagnostic Codes (ICD-9-CM)** – When clinicians provide treatment to tobacco-dependent patients, the ICD-9-CM diagnostic codes under the section on Mental Disorders (290-319) can be used. They can be found in the ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification) coding manual. The **code 305.1 (Tobacco Dependence)** can be used for cases in which tobacco is used to the detriment of a person's health or social functioning. Dependency is included here rather than under drug dependence because tobacco differs from other drugs of dependence in its psychotropic effect.
- II. **Billing Codes** – A number of billing codes may be used for reimbursement of tobacco dependence treatment. The examples provided fall under the general categories of preventive medicine treatments and psychiatric therapeutic procedures.
 - A. **Preventive Medicine Treatments/Codes for Billing** – Preventive medicine treatment codes allow for the billing of counseling and other activities related to risk factor reduction interventions. Given the recognition of tobacco use as a causal risk factor for cancer, coronary artery disease, chronic obstructive pulmonary diseases, and other diseases, these billing codes are appropriate when treating tobacco dependence. These codes can be billed on the basis of time spent counseling the tobacco dependent patient (measured in minutes). As with other counseling billing requirements, the clinicians must indicate the number of minutes counseled (CT) and the total number of minutes (TT) treating the patient.

For preventive medicine services, billing codes are based on the age of the patient, regardless of whether he/she is a new or established patient, whether the counseling is individual or group, whether the treatment was part of a comprehensive preventive medicine examination (codes 99383-99387), or whether it was specific preventive medicine counseling to intervene with the risk factor of tobacco dependence. These billing codes can be used for initial and follow-up treatments of tobacco use. For comprehensive preventive medicine examinations, the term "comprehensive" is not synonymous with the comprehensive examination requirements in the evaluation and management service codes (90201-90350).

1. Tobacco Dependence Treatment as Part of the Initial or Periodic Comprehensive Preventive Medicine Examination

a) New Patient

- **99383** Initial preventive medicine evaluation and management of an individual, including a comprehensive history, a comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; late childhood (age 5-11 years)
- **99384** Initial preventive medicine evaluation and management of an individual, including a comprehensive history, a comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; adolescent (age 12-17 years)
- **99385** Initial preventive medicine evaluation and management of an individual, including a comprehensive history, a comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; adult (age 18-39 years)
- **99386** Initial preventive medicine evaluation and management of an individual, including a comprehensive history, a comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; adult (age 40-64 years)
- **99387** Initial preventive medicine evaluation and management of an individual, including a comprehensive history, a comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; adult (age 65 years and older)

b) Established Patient

- **99393** Periodic preventive medicine re-evaluation and management of an individual, including a comprehensive history, comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; established patient, late childhood (age 5-11 years)
- **99394** Periodic preventive medicine re-evaluation and management of an individual, including a comprehensive history, comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; established patient, adolescent (age 12-17 years)
- **99395** Periodic preventive medicine re-evaluation and management of an individual, including a comprehensive history, comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; established patient, adult (age 18-39 years)
- **99396** Periodic preventive medicine re-evaluation and management of an individual, including a comprehensive history, comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; established patient, adult (age 40-64 years)
- **99397** Periodic preventive medicine re-evaluation and management of an individual, including a comprehensive history, comprehensive examination, and counseling/anticipatory guidance, to treat the risk factor of tobacco use and the ordering of appropriate laboratory/diagnostic procedures; established patient, adult (age 65 years and older)

2. Tobacco Dependence Treatment as Specific Counseling and/or Risk Factor Reduction Intervention

– These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury. As such, they are appropriate for the specific treatment of tobacco use and dependence. They are appropriate for initial or follow-up tobacco dependence treatments (new or established patient). For the specific preventive medicine counseling codes, the number of minutes counseled determines the level of billing (codes 99401-99404 for 15 to 60 minutes of counseling).

a) Preventive Medicine, Individual Counseling

- **99401** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 15 minutes
- **99402** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 30 minutes
- **99403** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 45 minutes
- **99404** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 60 minutes

b) Preventive Medicine, Group Counseling

- **99411** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 30 minutes
- **99412** Preventive medicine counseling and/or intervention to treat the risk factor of tobacco use provided to an individual (separate procedure); approximately 60 minutes

- B. Psychiatric Therapeutic Procedures/Codes for Billing** – The psychiatric therapeutic procedure billing codes are typically used for insight-oriented, behavior modifying and/or supportive psychotherapy. This refers to the development of insight (i.e., understanding one's emotional/mood alterations), the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change. All of the counseling interventions for tobacco dependence demonstrated to be effective in this guideline would fall under these headings.

It should be noted that these billing codes can be modified for those patients receiving only counseling (psychotherapy) and for others that receive counseling (psychotherapy) and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (e.g., evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, and interpretation of laboratory or other medical diagnostic studies and observations. Thus, the use of a psychiatric therapeutic billing code with medical evaluation and management services would be appropriate for the clinician who provides both of the key tobacco dependence interventions documented as effective in the guideline: counseling and pharmacotherapy.

In documenting treatment for tobacco dependence using the psychiatric therapeutic procedure codes, the appropriate code is chosen on the basis of the type of psychotherapy (e.g., insight-oriented, behavior-modifying, and/or supportive using verbal techniques), the place of service (office vs. inpatient), the face-to-face time spent with the patient during the treatment (both for psychotherapy and medication management), and whether evaluation and management services are furnished on the same date of service as psychotherapy.

1. Office or Other Outpatient Facility – Insight-oriented, Behavior Modifying and/or Supportive Psychotherapy

- **90804** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
- **90805** With medical evaluation and management services
- **90806** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
- **90807** With medical evaluation and management services
- **90808** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
- **90809** With medical evaluation and management services

2. Inpatient Hospital, Partial Hospital, or Residential Care Facility – Insight-oriented, Behavior Modifying and/or Supportive Psychotherapy

- **90816** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
- **90817** With medical evaluation and management services
- **90818** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
- **90819** With medical evaluation and management services
- **90821** Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
- **90822** With medical evaluation and management services

3. Other Psychotherapy

- **90853** Group psychotherapy (other than a multiple-family group)

4. Dental Coding

- **D1320** Tobacco counseling for the control and prevention of oral disease

D. Smoking Cessation Coverage Worksheet

| Benefit Design Feature | Plan A | Plan B | Plan C |
|---|---------------|---------------|---------------|
| Pharmacotherapy | | | |
| Covered drugs | | | |
| Nicotine patch | | | |
| Nicotine gum | | | |
| Nicotine inhaler | | | |
| Zyban® | | | |
| OTC or prescription drugs | | | |
| MD prescription required for OTC coverage | | | |
| Counseling required for medication to be covered | | | |
| Counseling | | | |
| Methods covered: in person; online; telephone | | | |
| In-house (in provider’s office) or external | | | |
| Type of practitioner allowed to provide (e.g., MD, PA) | | | |
| Intensive; number of sessions | | | |
| Eligibility | | | |
| All members or only those with drug benefit | | | |
| Plan Design | | | |
| Co-pay required | | | |
| Is co-pay the same as regular pharmacy co-pay? | | | |
| Primary care physician/other preauthorization required | | | |
| Network providers provide specialized services | | | |
| Out-of-network coverage if no network providers | | | |
| Utilization cap (i.e., are multiple quit attempts covered); lifetime or annual limits | | | |
| Quality Bonus | | | |
| Capitation withhold/bonus | | | |
| Other | | | |

E. Clinical Practice Guidelines: Strategies 5 and 6 ²

STRATEGY 5

Include tobacco dependence treatments as paid or covered services for all subscribers or members of health insurance packages

Evidence

Smoking cessation treatments (both pharmacotherapy and counseling) are not consistently provided as paid services for subscribers of health insurance packages. The level of coverage is particularly surprising, since studies show that physician counseling against smoking is at least as cost-effective as several other preventive medical practices, including the treatment of mild or moderate hypertension or high cholesterol.

A goal of *Healthy People 2010*, the national health promotion and disease prevention initiative, is universal coverage of nicotine addiction services, such as tobacco-use cessation counseling by healthcare providers, tobacco-use cessation classes, prescriptions for nicotine replacement therapies, and other cessation service.²²

Action

Provide coverage to all insurance subscribers for effective smoking cessation treatments, including pharmacotherapy (nicotine replacement therapy) and counseling.

Strategies for Implementation

- **Cover:** Include effective smoking cessation treatments (both pharmacotherapy and counseling) as part of the basic benefits package for all individual, group, and HMO insurance packages
- **Evaluate:** Include the provision of smoking cessation treatment as part of "report cards" for managed care organizations and other insurers (e.g., Health Plan Employer Data and Information Set [HEDIS])
- **Educate:** Inform subscribers of the availability of covered smoking cessation services and encourage patients to use these services

STRATEGY 6

Reimburse clinicians and specialists for delivery of effective tobacco dependence treatments and include these interventions among the defined duties of clinicians

Evidence

Primary care clinicians frequently cite insufficient insurance reimbursement as a barrier to providing preventive services such as smoking cessation treatment. Insurance coverage has been shown to increase rates of cessation services use and therefore increase rates of quitting. Even the presence of prepaid or discounted prescription drug benefits increases patients' receipt of prescribed nicotine gum, the duration of gum use, and smoking cessation rates. Furthermore, an 8-year insurance industry study found that reimbursing physicians for providing preventive care resulted in reported increases in exercise, seat belt use, and weight loss, as well as decreased alcohol use and a trend toward decreased smoking.²³

Smoking cessation treatments (both pharmacotherapy and counseling) should be provided as paid services for subscribers of health insurance/managed care. Clinicians should be reimbursed for delivering effective smoking cessation treatments. Even if a smoker does not want to quit, clinicians are encouraged to ask questions at each visit that help the patient identify reasons to quit and barriers to quitting. Clinicians should pledge to assist the patient when he or she is ready to quit. For patients willing to attend such programs, insurers should encourage referral to intensive programs through education and incentives to primary care providers.

Action

Reimburse fee-for-service clinicians for delivery of effective smoking cessation treatments and include smoking cessation treatments in the defined duties of salaried clinicians.

Strategies for Implementation

- **Include** smoking cessation treatment as a reimbursable activity for fee-for-service providers
- **Inform** fee-for-service clinicians that they will be reimbursed for using effective smoking cessation treatments with every patient who uses tobacco
- **Include** smoking cessation intervention in the job description and performance evaluation of salaried clinicians

F. How to Derive the Cost Benefit Analysis for a Tobacco Control Initiative²⁴

Estimating Costs for Implementing a Tobacco Control System

Some basic plan numbers inserted into the formulas in Appendix G will provide a rough cost estimate for providing a tobacco control intervention. Providers should develop a page or two with an easy-to-read summary of these cost figures before approaching organizational leadership.

Curry et al., in a large, randomized control trial of 4 levels of coverage within Group Health Cooperative of Puget Sound (GHC), determined that the average cost to the health plan per smoker who quit ranged from \$797 with standard coverage to \$1,171 with full coverage.²⁵ The annual cost of a comprehensive program ranged from \$6 to \$33 per smoker. The annual cost per plan enrollee ranged from \$0.89 to \$4.92 with full coverage.

In 1999, Schauffler et al., conducted a study to determine the effect of instituting first-dollar coverage for tobacco cessation services during the year of the study.²⁶ This study was conducted in collaboration with Cigna and Blue Cross of California. A total of 1200 adult smoking enrollees of these plans were randomized into control and experimental groups. Both groups were mailed a video on smoking cessation and a self-help brochure. In addition, the experimental group was offered up to 4 8-week courses of nicotine replacement therapy (NRT). To access the benefits, participants called a toll-free number and were mailed NRT and/or a referral to a cessation program. The use of NRT, quit attempts, and quit rates was significantly higher in the experimental compared to the control group. Only 2% of smokers enrolled in the trial enrolled in a smoking cessation program. With material production, operation of the telephone line, and NRT, the intervention cost approximately \$0.47 per member per month.

Assessing the Existing Cost to the MCO of Current Tobacco Use

Determining current costs of tobacco use to the plan is more difficult. If the plan has an epidemiologist or a health economist, they may be able to provide assistance. Another possibility is the state health department. Group Health Cooperative of Puget Sound (GHC) used the Washington State Tobacco Analysis, done with the CDC's SAMMEC software (Smoking-Attributable Morbidity, Mortality, and Economic Costs), applying their membership percentage of the state's population and then estimating the cost for smoking in their plan's membership.

The SAMMEC software package is available through every state health department. It provides cost estimates when population-based prevalence data are entered. Like Group Health Cooperative, providers can find out the cost of smoking per capita in their state and multiply this by the number of members in their plan. If per capita cost is not available, the state health department can provide the estimated cost of smoking for the entire population of a state.

If, for example, we say a state's cost of smoking is \$2.5 billion for 9 million residents, this comes to \$277 per capita. If the example plan has 500,000 members, it can be guesstimated that smoking costs the plan \$138,500,000.

Another way to examine cost is to take the cost *per smoker*. In the example above, if 68% of the plan members are adults and 20% of these are smokers, the cost per smoker is \$2,036. If you then look at the formulas in Appendix G and assume that 5% of smokers will utilize smoking cessation services (i.e., 3,400 persons) the plan cost for smoking cessation services is 3,400, multiplied by what you have calculated for the cost of medication plus the cost of counseling. The cost of implementing a smoking cessation program will be substantially less than the cost of smoking-related illness.

The socioeconomic mix of the population is an important consideration when assessing cost. The cost of tobacco use will tend to be higher in a lower income population, in part because a higher proportion of such a population smokes.

If you need additional assistance in developing cost data, contact your plans actuarial department.

G. Costing Out a Tobacco Control Initiative²⁴

The following is a format for estimating costs in a health plan implementation of a tobacco control initiative.

A. NUMBER OF SMOKERS IN PLAN:

| | |
|---|--|
| | Total number of plan members |
| – | Number of people aged 14 and younger (those presumed not to smoke) |
| x | 20%* |
| = | Number of smokers in plan |

*To calculate the number of Medicaid smokers, use 40% as a multiplier; the HEDIS tobacco measure from the Member Satisfaction Survey can also be used, although this will typically be a small sample.

Five percent of members has been chosen as a healthy estimate for service usage. Group Health Cooperative of Puget Sound has reported a 10% participation rate with a great deal of emphasis on tobacco control and 10 years of experience. Many plans find that only 1% to 2% of smokers use plan-provided smoking cessation services initially. There is data available on the cost of intervention, but nothing is published on costing out a comprehensive approach. Health Alliance Plan used the following:

B. COST OF PHARMACOTHERAPY:

| | |
|---|--|
| | Number of smokers in the plan (from above calculation) |
| x | 5% (people estimated to use the service) |
| x | Cost of 6 to 8 weeks supply of NRT or Zyban®** |
| = | Expenditure for NRT/Zyban per year |

**Call your pharmacy, benefits administrator, or local pharmacy, to determine actual costs. Therapeutic doses of NRT and Zyban cost approximately the same amount at this time (1999 Detroit, MI \$80-\$100/month). Combined therapies will obviously cost more.

C. COST OF SMOKING CESSATION CLASSES:

| | |
|---|--|
| | Number of smokers in the plan (from above calculation) |
| x | 2% (people estimated to use the service) |
| x | Cost of smoking cessation classes in your area (use a midpoint in the CLASSES range or set a maximum for which you will reimburse) |
| = | Expenditure for classes per year |

The number of people estimated to use the service—5% in Example B and 2% in Example C, above—estimate the percentage of smokers in the plan who might use a provided service. Initially, numbers may be smaller. Research suggests that some members will use more than one modality, but most will not use any. Also, a high percentage of smokers will quit "cold turkey" and will not utilize provided services. It will be important to work closely with the plan's actuarial/underwriting departments to develop cost figures. Most plans with fairly active programs are finding only 5% of members using tobacco control services.

D. COST OF TELEPHONE COUNSELING

Number of smokers in the plan
(from above calculation)

x 2% (people estimated to use the service)

x Cost of telephone counseling program
(estimated to cost \$50 to \$150 per person served)

= **Expenditure for telephone counseling per year**

E. COST OF INDIVIDUAL COUNSELING

Number of smokers in the plan
(from above calculation)

x 2%[†] (people estimated to use the service)

x Cost of 3 to 5 individual counseling sessions
(estimated to range from \$25 to \$150 per session)

= **Expenditure for individual counseling per year**

[†] It is assumed that fewer members will be referred for individual counseling.

F. COST OF PHYSICIAN INCENTIVES

Number of smokers in the plan
(from above calculation)

x 61% of smokers documented as receiving counseling
(or HEDIS data to estimate use)[‡]

x \$2

= **Cost of incentives per year**

[‡] Physician incentives will improve the frequency of patient counseling. Incentives provide an opportunity for a claims data entry which then provides more uniform centralized data on smokers in the plan. The mean 1998 HEDIS tobacco score reported 61% of smokers who had seen a physician in the past year said that they had been given advice to quit. In calculating an incentive payment, you may want to utilize your own HEDIS score, which may be higher or lower.

To calculate the cost of a tobacco intervention, add the costs of the component parts above that you would like to provide:

$$\begin{array}{rcl} \$ & & \$ \\ \hline \text{Pharmacotherapy costs} & + & \text{Telephone counseling costs} \\ & & = \text{Costs of interventions} \end{array}$$

or

$$\begin{array}{rcl} \$ & & \$ \\ \hline \text{Pharmacotherapy costs} & + & \text{Individual counseling costs} \\ & & = \text{Costs of interventions} \end{array}$$

Sample Presentation of Cost Benefit Analysis

| | |
|--|---|
| 1. Costs to plan of smoking | \$ (See "Assessing the Existing Cost to the MCO of Current Tobacco Use") |
| 2. Estimate of cost of smoking cessation strategy implementation | \$ (e.g., pharmacotherapy + counseling/classes + incentives from above equations) |
| 3. Estimate of cost savings to plan if 3% of smokers quit | \$ _____ |

H. Cost of Smoking Cessation Interventions

The following table shows the average cost for each smoking cessation intervention, assuming that the entire U.S. population over the age of 18 years would be willing to undergo an intervention to quit smoking. The cost is the total average cost per smoker and includes the costs of screening, advising, motivating, and directly intervening. The cost of each intervention varies according to the amount of provider counseling. The provision of nicotine replacement will add to this cost, depending on the type of medication and the duration of therapy.

Cost of Smoking Cessation Counseling

| <i>Intervention</i> | <i>Cost Per Smoker</i> |
|--|------------------------|
| Minimal counseling (≤ 3 min) | \$33.20 |
| Brief counseling (>3 min to <10 min) | \$56.48 |
| Full counseling | \$94.24 |
| Individual intensive counseling | \$123.19 |
| Group intensive counseling (7 1-hour sessions) | \$71.83 |

I. Sample Tobacco Control Benefit Language²⁴

Health Alliance Plan

Smoking Cessation Services. Smoking cessation services are a benefit of Health Alliance Plan (HAP). In addition to cessation counseling by HAP-affiliated primary care physicians, smoking control programs are a covered benefit (including smoking control classes). Smoking cessation services do not count as mental health services. The member must possess an authorized referral by the patient's HAP-affiliated primary care physician and services are rendered by a HAP-affiliated provider. For office visits, the co-pay in effect for the member's contract applies. When smoking cessation services are not available within the member's HAP network, authorized services through another HAP network are covered when each of the above criteria are met.

Nicotine Replacement Therapy. Nicotine replacement therapy is a benefit of HAP under its prescription drug rider. The benefit includes prescription agencies and OTC nicotine replacement, but members must have the prescription drug rider. The nicotine replacement therapy (patch, gum, inhaler, nasal spray) must be FDA-approved. The nicotine replacement therapy must be prescribed by a HAP-affiliated provider and must be dispensed by a HAP-affiliated pharmacy with physician prescription. The usual co-pay for prescription medication applies. A 30-day supply may be dispensed at one time. The benefit is limited to a 3-month supply in any one calendar year, and may be repeated in subsequent years if all criteria are met.

Group Health Cooperative of Puget Sound

Smoking Cessation Services. When provided through Group Health Cooperative (GHC), services related to tobacco cessation are covered but are limited to:

1. Participation in one individual or group program per calendar year, covered at 100% of the total charges;
2. Educational materials; and
3. One course of nicotine replacement therapy per calendar year, subject to the outpatient prescription drug co-payment for each 30-day supply (or less) of a prescription when provided at GHC facilities and prescribed by a GHC provider (provided the Member is actively participating in the Group Health Free and Clear Program).

J. State Medicaid Program Coverage of Tobacco-Dependence Treatments* by Area, Type of Coverage, and Year Coverage Began—United States, 1994–2001^{7†}

| Area | Year Any Coverage Began | Medication Coverage | | | | | Counseling Coverage | | |
|----------------------|-------------------------|---------------------|-----------|-----------|-----------|-----------|---------------------|------------|-----------|
| | | Nasal Spray | Inhaler | Zyban® | Gum | Patch | Group | Individual | Telephone |
| Arizona | 1997 | — | — | 1997 | — | — | — | — | — |
| Arkansas | 1999 | — | — | 1999 | — | — | — | — | — |
| California | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| Colorado | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| Delaware | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| District of Columbia | 1996 | 1996 | — | 1997 | — | — | — | — | — |
| Florida | 1998 | — | — | 1998 | 1998 | 1998 | 1998 | 1998 | — |
| Hawaii | 1998 | 1999 | 1999 | 1999 | — | — | — | — | — |
| Illinois | 2000 | 2000 | 2000 | 2000 | 2000 | 2000 | — | — | — |
| Indiana | 1999 | 1999 | 1999 | 1999 | 1999 | 1999 | — | 1999 | — |
| Kansas | 1999 | — | — | 1999 | — | 1999 | 1999 | 1999 | — |
| Louisiana | 1996 | 1996 | 1997 | 1997 | — | — | — | — | — |
| Maine | 1996 | 1996 | 1996 | 1996 | 1996 | 1996 | — | 2001 | — |
| Maryland | 1996 | 1996 | 1997 | 1997 | — | — | — | — | — |
| Michigan | 1997 | — | — | 1997 | 1997 | 1997 | — | — | — |
| Minnesota | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | 1996 | 1996 | — |
| Mississippi | 1996 | 2001 | 2001 | 2001 | 2001 | 2001 | — | — | — |
| Montana | 1996 | 2001 | 2001 | 1997 | 1996 | 1996 | — | — | — |
| Nevada | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| New Hampshire | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| New Jersey | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| New Mexico | 1996 | 1996 | 1997 | 1997 | 1996 | 1996 | — | — | — |
| New York | 1999 | 1999 | 1999 | 1999 | 2000 | 2000 | — | — | — |
| North Carolina | 1996 | 1996 | 1997 | 1997 | — | — | — | — | — |
| North Dakota | 1996 | — | — | 1996 | 1996 | 1996 | — | — | — |
| Ohio | 1996 | — | 1998 | 1998 | 1998 | 1998 | — | — | — |
| Oklahoma | 1999 | — | — | 1999 | 1999 | 1999 | — | — | — |
| Oregon | 1998 | 1998 | 1998 | 1998 | 1998 | 1998 | 1998 | 1998 | 1998 |
| Rhode Island | 1994 | — | — | — | — | — | 1994 | 1994 | — |
| South Dakota | 2001 | — | — | 2001 | — | — | — | — | — |
| Texas | 1996 | 1996 | 1997 | 1997 | 1996 | 1997 | — | — | — |
| Utah | 2000 | P [§] | P | P | P | P | P | P | P |
| Vermont | 1999 | 1999 | 1999 | 1999 | 1999 | 1999 | — | — | — |
| Virginia | 1996 | 1996 | 1997 | 1997 | — | — | — | — | — |
| West Virginia | 2000 | 2000 | 2000 | 2000 | 2000 | 2000 | — | 2000 | 2000 |
| Wisconsin | 1996 | 1996 | 1997 | 1997 | — | — | — | 1999 | — |
| Total | 36 | 26 | 26 | 35 | 24 | 25 | 6 | 10 | 3 |

* On the basis of response to the question, "Does your state Medicaid program cover any of the following tobacco-dependence treatments?" Each state also was asked to provide documentation regarding the year each covered treatment was first offered.

† N = 26. In 2001, a total of 15 states with Medicaid programs (AL, CT, GA, ID, IA, KY, MA, MO, NE, PA, SC, TN, WA, and WY) covered none of the tobacco-dependence treatments recommended in the 2000 Public Health Service Clinical Practice Guideline.

§ Medicaid coverage for pregnant women only.

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