

An expanded opportunity to provide tobacco cessation services in primary care

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Abstract

The Patient Protection and Affordable Care Act, and Centers for Medicare and Medicaid Services (CMS) decision on tobacco cessation counseling support the need for expanded cessation coverage. Primary care practices receiving CMS payments will soon be mandated to offer these services. This commentary discusses the salience of tobacco cessation policy in terms of opportunities for primary care, and anticipated issues in meeting healthcare reform requirements. Comments build upon recent federal policy and suggest areas to which primary care practices will need to attend when operationalizing tobacco cessation policies. Research supports efficacious tobacco cessation interventions delivered in a primary care context. To effectively implement tobacco cessation in primary care, practices will need to address coding and payment issues, define service offerings, identify reporting requirements, align with the medical home model, and increase provider buy-in.

Keywords

Tobacco cessation, Prevention, Healthcare reform, Insurance benefits, Healthcare policy

INTRODUCTION

What is killing the majority of the U.S. population is not infectious disease, genetics, or lack of insurance, but our chronic and modifiable behaviors [1, 2]. Tobacco use remains the most preventable cause of illness in the United States [3]. Among adults, 19.8% of the U.S. population still uses tobacco [4–6]. The National Centers for Disease Control and Prevention estimates that smoking accounts for premature deaths of 443,000 persons annually in the United States, with an additional 8.6 million disabled from smoking-related diseases [6]. Tobacco use costs the nation \$193 billion annually in health-related costs and lost productivity directly related to smoking, and second hand smoke exposure leads to over \$10 billion in health-related expenditures [6, 7]. The burden of these costs is often felt on a state level where tobacco-related illnesses account for 10% to 15% of all Medicaid expenditures [8].

In the primary care context, the call for better coverage of evidence-based cessation medications and counseling continues to grow [9, 10]. As of August

Implications

Practice: The Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) decision on tobacco cessation counseling, and other recent policy has significant implications for primary care providers. Practices will soon be mandated, according to policy, to offer some level of tobacco use screening and tobacco cessation services.

Policy: Federal policy supports the need for expanded cessation coverage. While recent policies provide expanded service opportunities for primary care, hurdles to meeting new federal policy requirements are also anticipated.

Research: Recent federal policy suggests areas to which primary care practices will need to attend when operationalizing tobacco cessation services. But there is a need for study of most efficient and effective means of meeting new tobacco use screening and treatment policy standards.

2010, the Centers for Medicare and Medicaid Services (CMS) began covering tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries, regardless of whether the patient has signs and symptoms of tobacco-related disease [11]. Medicaid covers cessation medications in all but a handful of states [12]. The Obama Administration has also strongly supported expansion of prevention and wellness services, including tobacco-control services, through the recently enacted Patient Protection and Affordable Care Act (PPACA; i.e., healthcare reform bill), the President's 2011 budget, and the American Recovery and Reinvestment Act. Moreover, medical societies representing more than 343,000 physicians and medical students nationwide have recently cosigned letters urging that insurance plans' standard certificate of coverage include benefits and adequate payment for tobacco cessation counseling during routine office visits [13].

Primary care remains the largest platform of healthcare delivery in the United States [14], and the convergence of healthcare policy mentioned above provides a remarkable opportunity for practices to strengthen tobacco cessation interventions. Although well positioned to take advantage of the emerging

healthcare environment, primary care providers will need to address several areas to capitalize on this opportunity. We comment below on some of the most salient issues.

CODING AND PAYMENT

Reimbursing tobacco cessation services has been shown to be cost-effective in the larger context of healthcare [15], and employers, payers, and health plans have recognized that payment/reimbursement of tobacco cessation leads to increased use of proven treatments [16]. Under the new CMS decision, Medicare providers have the flexibility to aid patients' quit attempts multiple times each year. Medicare Part B, which pays for physician services, covers two levels of tobacco cessation intermediate (>3 to 10 min) or intensive (>10 min) cessation counseling sessions for each attempt. Medicare Part D prescription drug program continues to cover cessation medications. While these payment codes now exist for tobacco cessation, much confusion remains regarding what codes can be used in what treatment settings, by what type of healthcare professional, and under what documentation processes.

Practices often bill Medicare CPT 99406 or 99407 when providing face-to-face tobacco cessation counseling by a physician or other qualified healthcare professional, using evidence-based practices [10]. Primary care providers can bill both for tobacco cessation counseling as the primary reason for the visit (305.1) or secondary to another medical problem—where an office visit CPT code is utilized rather than a counseling code. Given providers' common confusion regarding how to code tobacco interventions, it is useful if practices preprint the appropriate fields on billing and diagnostic coding sheets as a clinician “check-off.”

DEFINING INTERVENTIONS AND ANTICIPATING REPORTING REQUIREMENTS

Through a combination of PPACA, CMS policy changes, greater insurance plan coverage, and state policy trends, primary care providers soon will be mandated to provide some level of tobacco cessation services. The PPACA permits people to keep their existing insurance coverage as long as no material changes are implemented in the plan design. Once a material change is implemented, the insurance plan must include the U.S. Preventive Services Task Force (USPSTF) A and B recommendations—including tobacco screening and cessation counseling. The USPSTF guidelines are not written in benefit language format, and it is reasonable to assume that health plans will interpret items like quantity and age limits differently. Practices will need to define the range of reimbursable services, interpret existing and developing rules, and identify mandatory reporting linked to service offerings.

Primary care practices will also need to have a detailed understanding of the Health Information Technology for Economic and Clinical Health Act (HITECH). Under HITECH, eligible healthcare professionals and hospitals can qualify for Medicare and Medicaid incentive payments only when they adopt certified electronic health record (EHR) technology and use it to achieve specified objectives, which include tobacco cessation services. Primary care providers will need to comply with clinical quality measures, as well as “Meaningful Use Criteria” [17]. Meaningful Use Criteria insure that tobacco users are identified, while clinical quality measures track the tobacco cessation services providers' offer. Final regulations for Meaningful Use Criteria were issued in July 2010, incentive payments begin in 2011, and mandatory use begins in 2014 [18].

The Meaningful Use Criteria for smoking in Stage 2 directs clinicians to screen the smoking status of more than 50% of all unique patients, who are 13 years old or older and seen or admitted to the eligible hospital's inpatient or emergency departments. Tobacco use assessment and cessation intervention is also one of the three core clinical quality measures practitioners will be required to report. Primary care clinicians will specifically need to track the percentage of patients 18 years of age and older, who are current tobacco users, who are seen by a practitioner during the measurement year, and who receive advice, cessation interventions, or recommendations to use cessation medications and/or other strategies [19].

One important resource for primary care practices navigating the vagaries of healthcare reform are Regional Extension Centers (RECs) funded by the Office of the National Coordinator for Health Information Technology under the HITECH Act. RECs are responsible for working with primary care providers and practices to ensure that any EHR system they acquire will support achievement of Meaningful Use Criteria, or providers will not receive future CMS payments.

ALIGNMENT WITH THE MEDICAL HOME MODEL

Within the primary care setting, tobacco dependence often goes undiagnosed [20, 21], and if recognized, requires repeated intervention and multiple attempts to quit [10]. With nearly 70% of tobacco users seeing a physician each year, providers in primary care have significant opportunities to impact tobacco use and to promote tobacco cessation among their patients and families [22].

The Patient-Centered Medical Home (PCMH) is the redesign of primary care and has the potential to provide a higher standard of quality care to individuals, including those who are tobacco dependent [23–26]. With its roots in the chronic care model [27], the PCMH attempts to promote productive interactions between interdisciplinary healthcare providers and informed patients motivated

to take an active part in their healthcare [28]. PCMH objectives align considerably with current clinical practice guidelines for tobacco cessation which stress the necessity of coordinated, multidisciplinary interventions [10, 28]. Primary care is the logical setting in which to address tobacco cessation because clinicians often have long-term relationships in which they can build the therapeutic alliances that might best foster and facilitate behavioral change [29, 30]. Using evidence-based practices to treat tobacco dependence, healthcare providers working in the PCMH context may focus on objectives consistent with best practices in the delivery of tobacco cessation services: patient-centered treatment, comprehensive, coordinated care; enhanced access through systematic screening and diagnosis, and system-based quality improvement resulting in positive health outcomes [10].

PROVIDER BUY-IN

Nearly six in ten office visits are made to a primary care clinician (i.e., general and family medicine, internal medicine, pediatrics, or obstetrics/gynecology) [31], putting these clinicians in a unique position to help patients quit tobacco. Even so, many clinicians may believe tobacco interventions fall outside of the scope of their practice or that they do not have the necessary time or training to intervene [32].

Only 4–7% of unaided quit attempts are successful, but proven treatments exist that significantly enhance these odds [10, 33]. While the most effective intervention is a combination of counseling and nicotine replacement therapy or other FDA-approved smoking cessation medications [10], it needs to be emphasized that even minimal interventions will significantly increase tobacco quit attempts and abstinence rates [10]. Compared with smokers who do not receive counseling, those who do receive quit aids from a clinician are 1.7 (non-physician clinician) to 2.2 (physician) times as likely to successfully quit for five or more months [10].

A basic platform for all tobacco cessation services is the “5 A’s” (Ask, Advise, Assess, Assist, and Arrange) and includes (a) asking all patients about their tobacco use status, (b) advising tobacco users to quit, (c) assessing tobacco users’ readiness to quit, (d) assisting patients in their quit attempts or promoting motivation to quit, and (e) arranging follow-up. This protocol can be accomplished by one clinician or a multidisciplinary team. If clinicians are unable to complete all five A’s, even the extremely low burden practice of asking if someone smokes, and then, advising them in a personalized manner to quit will make a significant impact on quit attempts and abstinence. This is commonly referred to as the “2 A’s and R” model or “Ask, Advise, and Refer.”

To facilitate tobacco use screening, many practices are now building alerts into EHRs and/or including assessment of tobacco use as a vital sign. There are also a number of sources of brief training and resources to prepare practices for tobacco assessment and inter-

vention. One of the best national online training sources is found at the Smoking Cessation Leadership Center (SCLC) at the University of California San Francisco. SCLC has training modules appropriate for primary care providers (<http://rxforchange.ucsf.edu/curricula/>) available at no cost, as well as links to many other national resources.

Outside of training concerns, clinicians sometimes question whether screening for tobacco use is an effective use of time when there may not be a referral base for tobacco cessation services. In response to this concern, primary care practices should be aware that they all have at least one community resource, the state quitline. Quitlines are available in every state and can be accessed at state specific numbers or the national number 1-800-QUIT-NOW. The quitline will offer some combination of telephone counseling, self-help materials, cessation medications, and referrals for additional support. Several quitlines also have the capacity for fax referrals from primary care practices.

A large percentage of individuals seen in primary care have mental illnesses and/or addictions. There is a common concern among providers that these individuals do not wish to quit and that tobacco cessation may exacerbate psychiatric symptoms or lead to renewed drug or alcohol abuse. Persons with mental illnesses and/or addictions are at great risk, using tobacco at two to three times the rate of the general population [34]. Even so, the smoking cessation rates of persons with mental illnesses and/or substance abuse disorders, who desire to quit, are comparable to the general population, and studies find that 77–79% of these individuals intend to quit, many in the next month [35, 36]. A meta-analysis of 18 addictions studies found that treating the tobacco use of clients improved their alcohol and other drug outcomes by an average of 25% [37]. On the mental health side, studies have also found that individuals with current psychiatric disorders who quit experienced no exacerbation of psychiatric symptoms [38, 39].

CONCLUSIONS

Along with a growing list of federal agencies, and national medical and health associations, we are recommending expanded brief intervention, counseling, and medication coverage for tobacco cessation in primary care. More deaths are caused each year by tobacco use than by all deaths from AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined [6]. The burgeoning prevalence of chronic obstructive pulmonary disease alone points to the importance of greater smoking cessations screening and treatment in primary care [40]. CMS and the current administration are to be applauded for taking significant step toward full coverage of tobacco cessation services. Healthcare providers also have a role in addressing this epidemic. There are valid issues, such as those described above, that need to be addressed in implementing tobacco

services in primary care, but expanded cessation coverage is essential to improving the public health.

- Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. *JAMA*, 291(10), 1238–1245.
- McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, 21(2), 78–93.
- U.S. Department of Health and Human Services. (2004). *The health consequences of smoking: a report of the surgeon general*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
- Centers for Disease Control and Prevention. (2005). State-specific prevalence of current cigarette smoking among adults—United States, 2004. *MMWR*, 54, 1124–1127.
- Centers for Disease Control and Prevention (2005) Cigarette smoking among adults—United States, 2004. *MMWR* 54.
- Centers for Disease Control and Prevention. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR*, 57(45), 1226–1228.
- Behan, D. F., Eriksen, M. P., & Lin, Y. (2005). *Economic effects of environmental tobacco smoke report*. Schaumburg: Society of Actuaries.
- Armour, B. S., Finkelstein, E. A., & Fiebelkorn, I. C. (2009). State-level Medicaid expenditures attributable to smoking. *Preventing Chronic Disease*, 6(3), A84.
- Anszak, J. D., & Nogler, R. A., 2nd. (2003). Tobacco cessation in primary care: maximizing intervention strategies. *Clinical Medicine & Research*, 1(3), 201–216.
- Fiore, M. C., Jaen, C. R., Baker, T. B., et al. (2008). *Treating tobacco use and dependence: 2008 update. Clinical practice guideline*. Rockville: U.S. Department of Health and Human Services. Public Health Service.
- U.S. Department of Health and Human Services (2010) Decision memo for counseling to prevent tobacco use (CAG-00420N). <http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=242&> Accessed August 26, 2010.
- American Lung Association (2009) State tobacco coverage database. www.lungusa.org/cessationcoverage Accessed August 9, 2010
- Letter to Cindy Mann CMS Deputy Administrator and Director Center for Medicaid, CHIP and Survey & Certification (2010) http://www.naquitline.org/resource/resmgr/news/100614_letter-to-cms.pdf. Accessed August 27, 2010
- Green, L. A., Fryer, G. E., Jr., Yawn, B. P., Lanier, D., & Dovey, S. M. (2001). The ecology of medical care revisited. *The New England Journal of Medicine*, 344(26), 2021–2025.
- Vemer, P., Rutten-van Molken, M. P., Kaper, J., Hoogenveen, R. T., van Schayck, C. P., & Feenstra, T. L. (2010). If you try to stop smoking, should we pay for it? The cost-utility of reimbursing smoking cessation support in the Netherlands. *Addiction*, 105(6), 1088–1097.
- Hopkins, D. P., Briss, P. A., Ricard, C. J., et al. (2001). Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental smoke. *American Journal of Preventive Medicine*, 20, 16–66.
- U.S. Department of Health and Human Services (2010) Electronic health records and meaningful use. <http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2> Accessed August, 26, 2010
- U.S. Department of Health and Human Services. 42 CFR Parts 412, 413, 422 et al (2010) Medicare and Medicaid programs; electronic health record incentive program; final rule. *Federal Register* 75(144)
- U.S. Department of Health and Human Services (2010) Quality measures: electronic specification http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp Accessed July, 13, 2010
- Denny, C. H., Serdula, M. K., Holtzman, D., & Nelson, D. E. (2003). Physician advice about smoking and drinking: are U.S. adults being informed? *American Journal of Preventive Medicine*, 24, 71–74.
- Thomdike, A. N., Rigotti, N. A., Stafford, R. S., & Singer, D. E. (1998). National patterns in the treatment of smokers by physicians. *Journal of the American Medical Association*, 279, 604–608.
- Centers for Disease Control and Prevention. (1993). Physician and other health-care professional counseling of smokers to quit—United States, 1991. *MMWR*, 42, 854–857.
- American Academy of Family Physicians (AAFP) (2008) Definition of patient-centered medical home. <http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html>. Accessed August 13, 2009
- Future of Family Medicine Project Leadership Committee. (2004). The future of family medicine: a collaborative project of the family medicine community. *Annals of Family Medicine*, 2 (suppl_1), S3–S32.
- National Committee for Quality Assurance (2008) Standards and guidelines for physician practice connections—patient-centered medical home. Washington, DC: National Committee for Quality Assurance (NCQA)
- Starfield, B., & Shi, L. (2004). The medical home, access to care, and insurance: a review of the evidence. *Pediatrics*, 113, 1493–1498.
- Wagner, E. H., Austin, B. T., & Von Korff, M. (1996). Organizing care for patients with chronic illness. *The Milbank Quarterly*, 74, 511–544.
- American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA) (2007) Joint principles of the patient-centered medical home. <http://www.medicalhomeinfo.org/Joint%20Statement.pdf> Accessed August 13, 2009
- Guthrie, B., Saultz, J. W., Freeman, G. K., & Haggerty, J. L. (2008). Continuity of care matters. *British Medical Journal*, 337, a867.
- Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: a multi-disciplinary review. *British Medical Journal*, 327, 1219–1221.
- Cherry DK, Woodwell DA, Rechtsteiner EA (2007) National ambulatory medical care survey: 2005 summary. *Advance Data* 387:1–39
- Lando, H. A., & Hatsukami, D. K. (1999). Low rates of physicians counseling adolescents about smoking: a critical wake-up call. *Journal of the National Cancer Institute*, 91(21), 1795–1796.
- Mottillo, S., Filion, K. B., Bélisle, P., et al. (2009). Behavioural interventions for smoking cessation: a meta-analysis of randomized controlled trials. *European Heart Journal*, 30(6), 718–730.
- Morris, C. D., Giese, A. A., Turnbull, J. J., Dickinson, M., & Johnson-Nagel, N. (2006). Predictors of tobacco use among persons with mental illnesses in a statewide population. *Psychiatric Services*, 57(7), 1035–1038.
- Prochaska, J. J., Rossi, J. S., Redding, C. A., et al. (2004). Depressed smokers and stage of change: implications for treatment interventions. *Drug and Alcohol Dependence*, 76(2), 143–151.
- Joseph, A. M., Willenbring, M. L., Nugent, S. M., & Nelson, D. B. (2004). A randomized trial of concurrent versus delayed smoking intervention for patients in alcohol dependence treatment. *Journal of Studies on Alcohol*, 65(6), 681–691.
- Prochaska, J. J., Delucchi, K., & Hall, S. M. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology*, 72(6), 1144–1156.
- Baker, A., Richmond, R., Haile, M., et al. (2006). A randomized controlled trial of a smoking cessation intervention among people with a psychotic disorder. *The American Journal of Psychiatry*, 163(11), 1934–1942.
- Hall, S. M., Tsoh, J. Y., Prochaska, J. J., et al. (2006). Treatment for cigarette smoking among depressed mental health outpatients: a randomized clinical trial. *American Journal of Public Health*, 96(10), 1808–1814.
- Gershon, A. S., Wang, C., Wilton, A. S., Raut, R., & To, T. (2010). Trends in chronic obstructive pulmonary diseases prevalence, incidence, and mortality in Ontario, Canada, 1996 to 2007: a population-based study. *Archives of Internal Medicine*, 170(6), 560–565.