Medicaid and the Expanded Smoking Cessation Counseling Benefit

Donna Shelley, MD, MPH
New York University School of Medicine
September 7, 2011

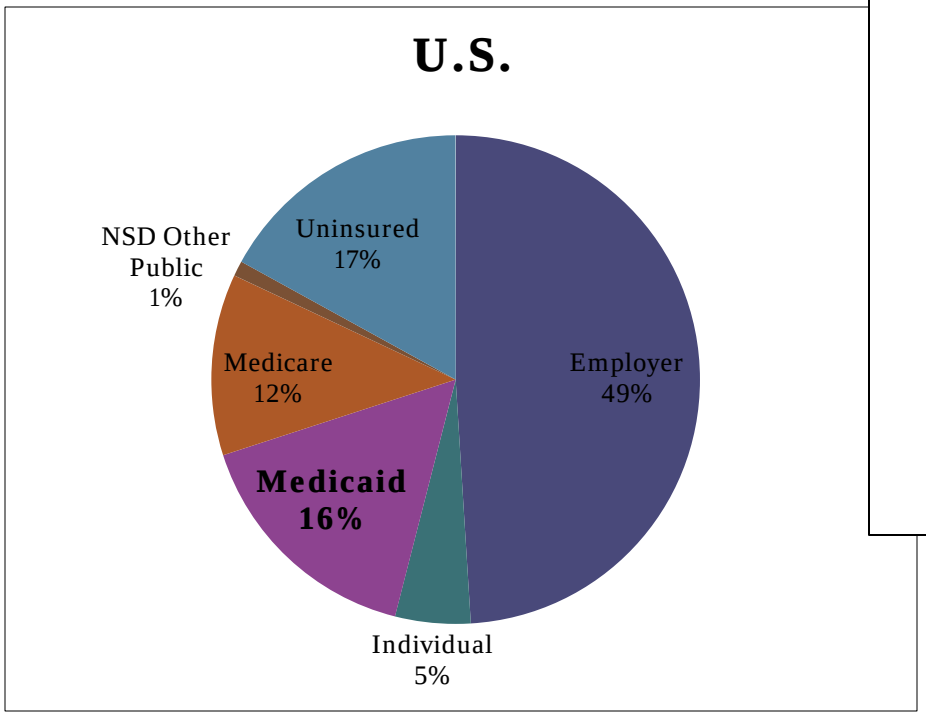
Disclosure Statement

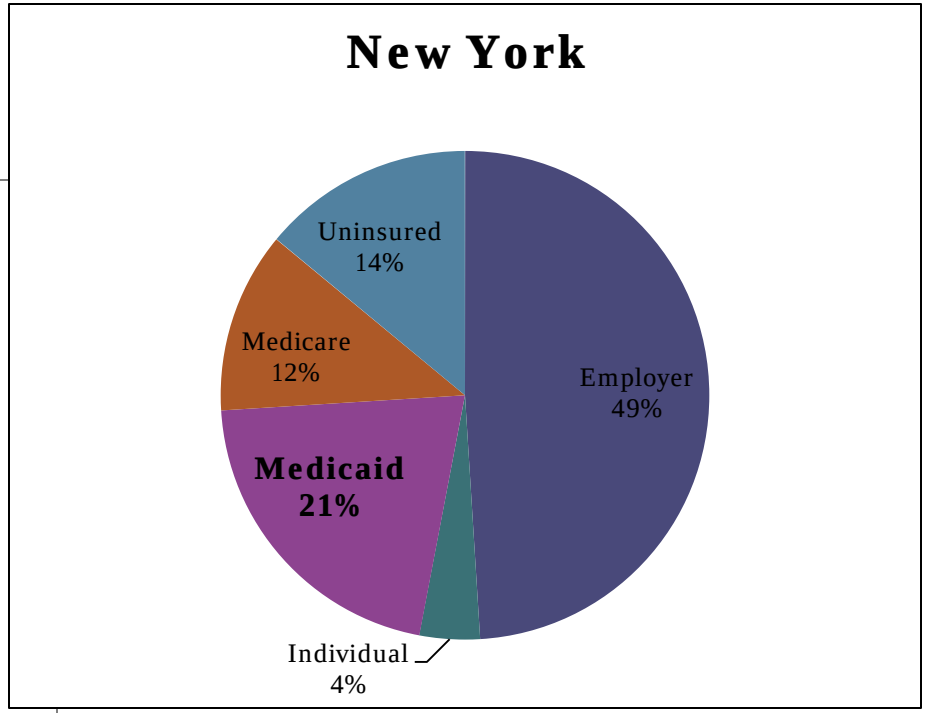
I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, and/or other corporations whose products or services are related to pertinent therapeutic areas.

Learning Objectives

1. Assess the tobacco use disparities in the Medicaid population and the importance of NYS Medicaid's expansion of the smoking cessation counseling benefit.
2. Discuss key components for intermediate and intensive smoking cessation counseling.
3. Using the Medicaid benefit, describe how health care providers can effectively counsel and treat their patients for tobacco use.

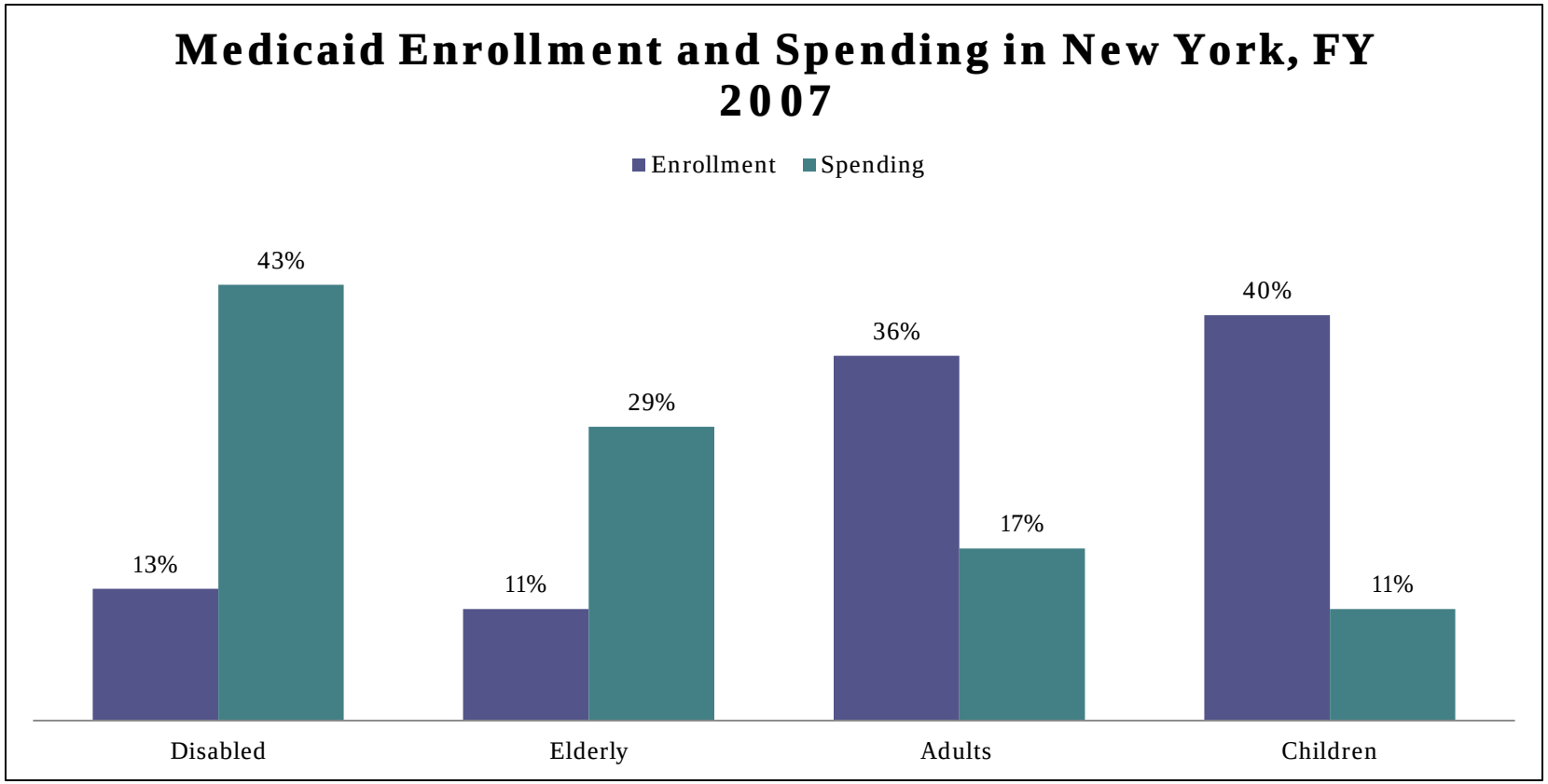
Distribution of Insurance Status, 2008-2009





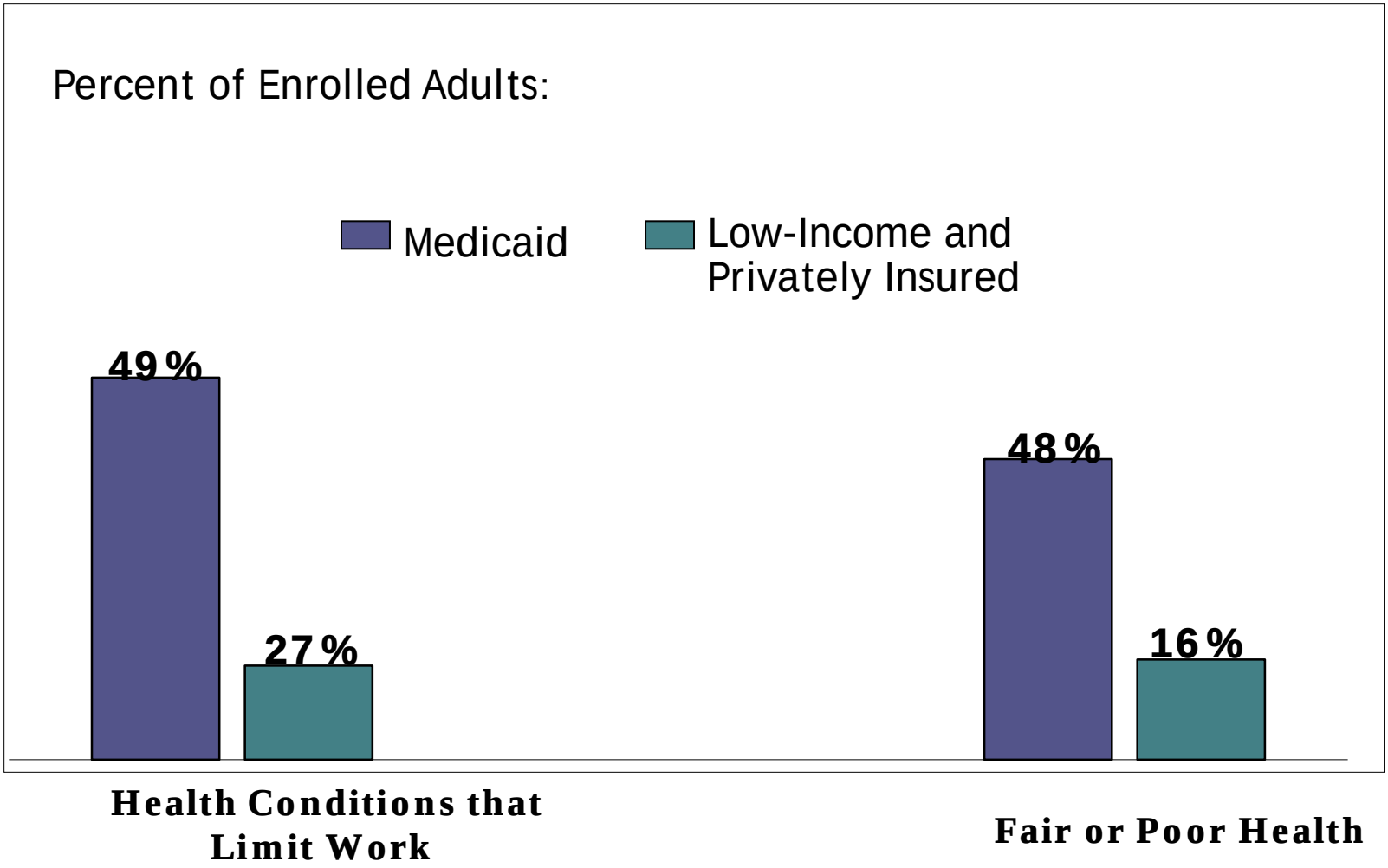
SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2010

Medicaid's Role: New York State



SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2010

Medicaid Enrollees are Sicker Than the Low-Income Privately-Insured



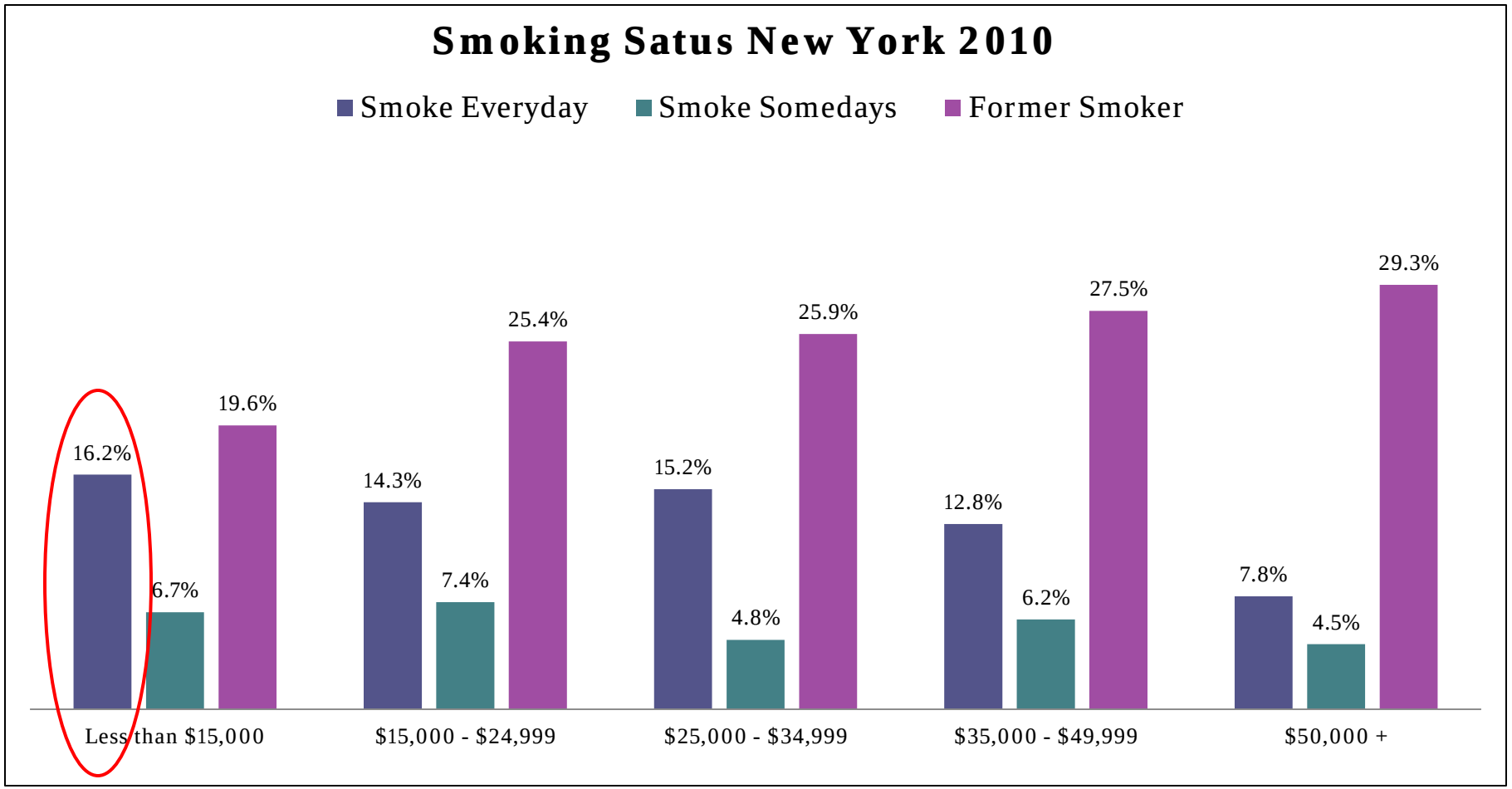
SOURCE: Coughlin et al, "*Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States*," Health Affairs, July/August 2005.

Smokers with Medicaid in New York

- 48% of all smokers are on Medicaid or have no health insurance.
- 15.5 % of New Yorkers smoke, while 30% of New York Medicaid recipients are smokers.
- Smokers on Medicaid were more likely to have attempted to quit smoking in the past year than those with private insurance.
- However, smokers with Medicaid were less likely to quit smoking successfully than those with private health insurance.

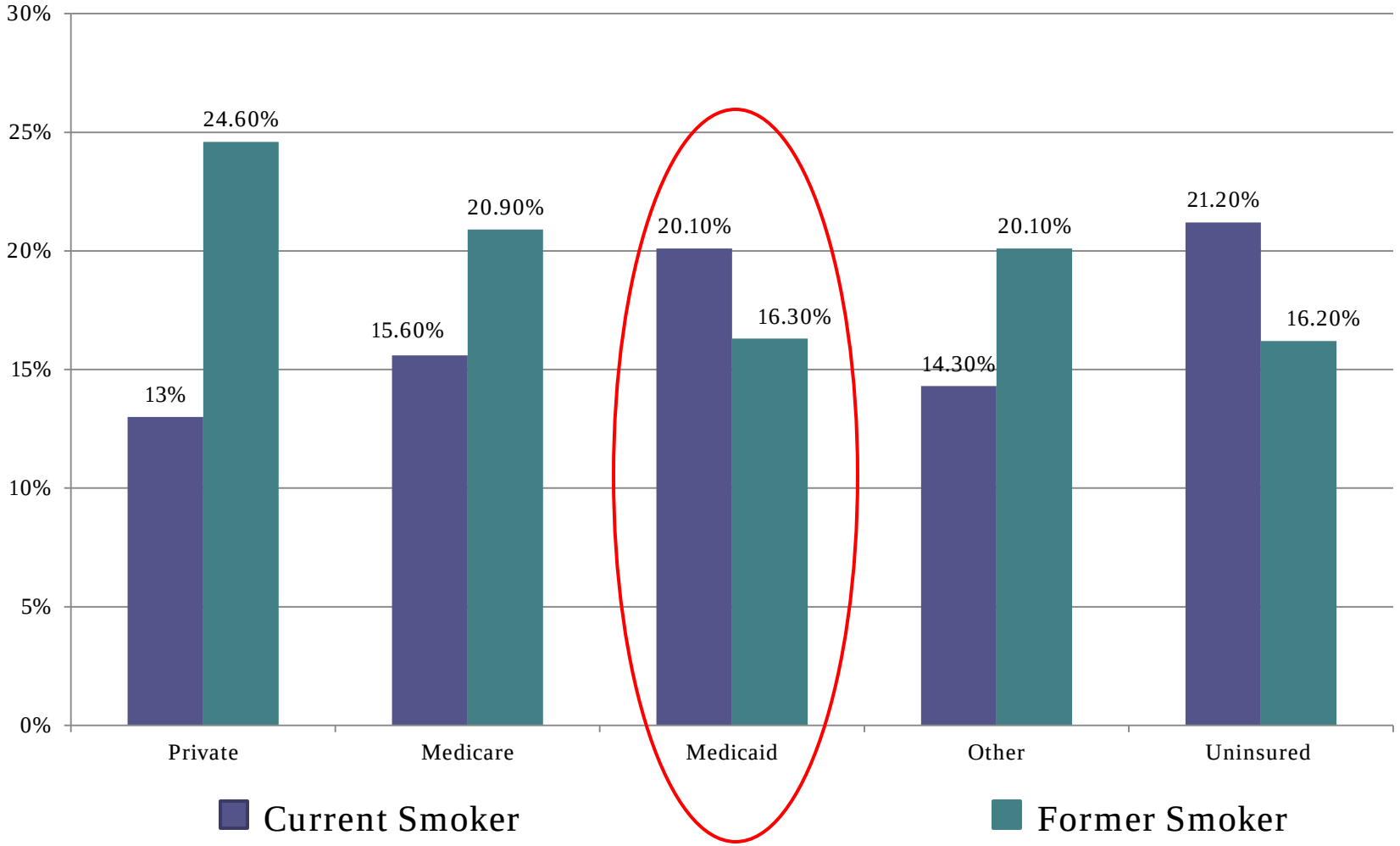
SOURCE: RTI, 2010 Independent Evaluation Report for the New York State Tobacco Control Program.

Smoking in New York State: Income



SOURCE: Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2010].

Smoking in New York City: Insurance Status



SOURCE: Bureau of Epidemiology Services, NYC DOHMH

Cost-Benefit of Smoking Cessation Treatment

- Health plans investing $35-$410 per participant in a one-year cessation program generated a positive return on investment (ROI) within two years.
- After 5 years, the ROI per cessation service recipient for the health plan is $750- $1,120
- Insurers with higher member retention, like Medicaid, would likely achieve faster gains.

SOURCE: Fellows JF, Rehm B, Hornbrook M, Hollis J, Haswell TC, Dickerson J, Volk C. Making the Business Case and ROI Calculator. Center for Health Research. 2004. Association of Health Insurance Providers (AHIP). Tobacco Cessation and Prevention Programs. Business Case for Smoking Cessation Website and ROI Calculator. Updated December 2008.

Health Impact and Cost-Effectiveness

Rankings of Preventive Services for the US Population

Clinical Preventive Services	CPB	CE	Total
Discuss daily aspirin use—men 40+, women 50+	5	5	
Childhood immunizations	5	5	10
Smoking cessation advice and help to quit—adults	5	5	
Alcohol screening and brief counseling—adults	4	5	9
Colorectal cancer screening—adults 50+	4	4	
Hypertension screening and treatment—adults 18+	5	3	8
Influenza immunization—adults 50+	4	4	
Vision screening—adults 65+	3	5	
Cervical cancer screening—women	4	3	
Cholesterol screening and treatment—men 35+, women 45+	5	2	7
Pneumococcal immunizations—adults 65+	3	4	
Breast cancer screening—women 40+	4	2	
Chlamydia screening—sexually active women under 25	2	4	6
Discuss calcium supplementation—women	3	3	
Vision screening—preschool children	2	4	

Treating tobacco use is one of the top three most important and cost-effective preventative services.

Brief one-time counseling:
Saves $65 per smoker counseled and $1,100 in Quality Adjusted Life Years (QALY)

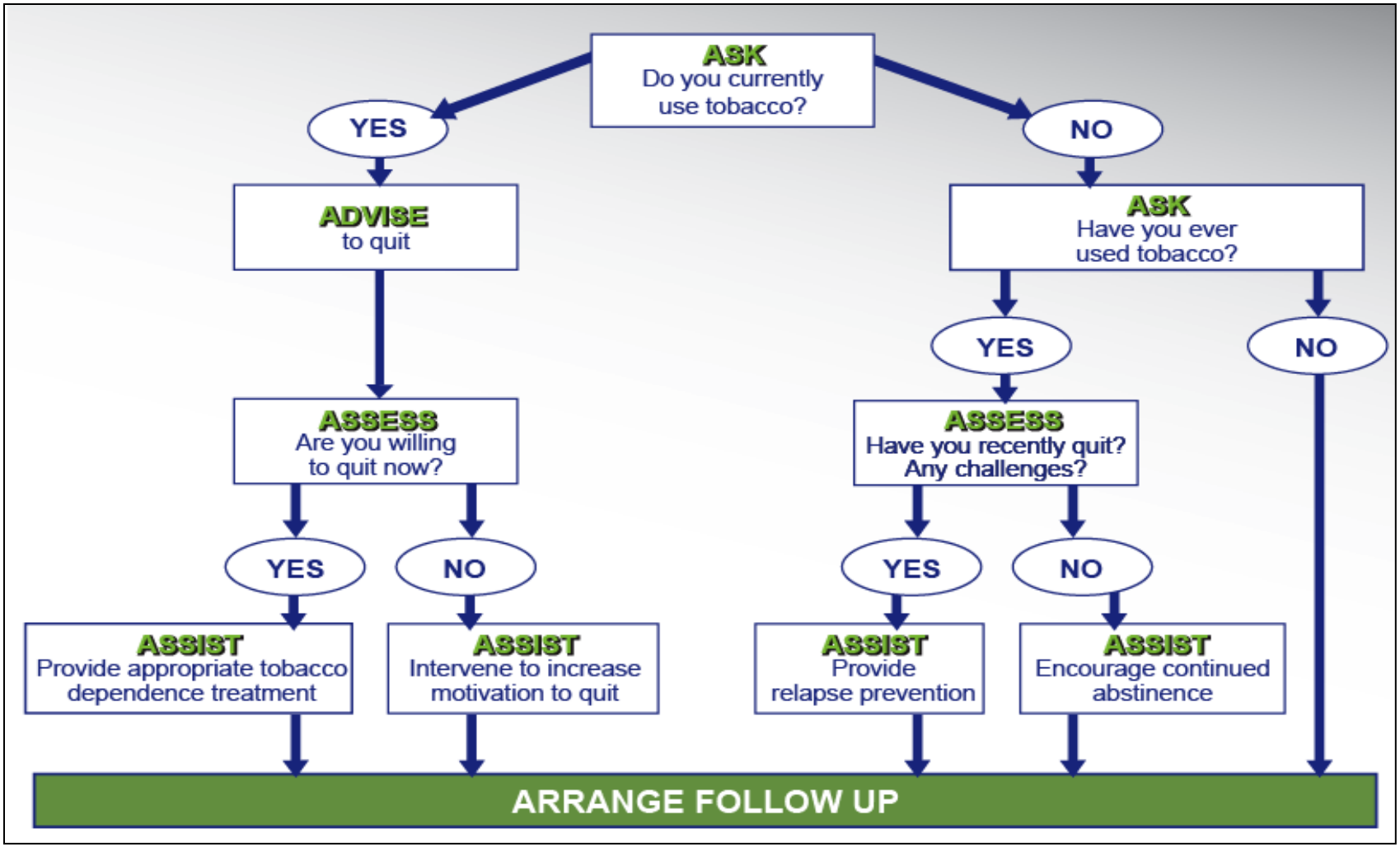
Repeated counseling:
Saves >$500 per smoker counseled and $2,000 in QALY

SOURCE: Solberg L, Maciosek M, Edwards N, Khanchandani H, Goodman, M. "Repeated Tobacco-Use Screening in Clinical Practice: Health Impact and Cost Effectiveness. Am J Prev Med 2006; 31 (1): 62-71.
Partnership for Prevention. Rankings of Preventative Services for the US Population. 2011. Available at: http://www.prevent.org/National-Commission-on-Prevention-Priorities/Rankings-of-Preventive-Services-for-the-US-Population.aspx

Treating Tobacco Use in the Medicaid Population

- 2008 Public Health Service Clinical Practice Guideline Update
  - Treat tobacco use as a chronic disease
  - Deliver brief clinical interventions and tailored assistance at each visit
  - Use the 5 A's as a framework to discussing tobacco use
  - Offer approved smoking cessation medications
  - For patients unwilling to quit, increase motivation to quit by using the 5 R's

The 5 As: Treating Tobacco as a Chronic Disease



Intervention as a Covered Health Benefit

Recommendation: Providing tobacco dependence treatments (both medication and counseling) as a paid or covered benefit by health insurance plans has been shown to increase the proportion of smokers who use cessation treatment, attempt to quit, and successfully quit. Therefore, treatments shown to be effective in the Guideline should be included as covered services in public and private health benefit plans. (Strength of Evidence = A).

SOURCE: Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: USDHHS, PHS, May 2008.

Counseling to Treat Tobacco Use

Brief interventions have been proved effective in increasing a patient's motivation to quit

Meta-analysis (2000): Effectiveness of and estimated abstinence rates for various intensity levels of session length (n = 43 studies)

Level of contact	Number of arms	Estimated odds ratio (95% C.I.)	Estimated abstinence rate (95% C.I.)
No contact	30	1.0	10.9
Minimal counseling (< 3 minutes)	19	1.3 (1.01, 1.6)	13.4 (10.9, 16.1)
Low intensity counseling (3-10 minutes)	16	1.6 (1.2, 2.0)	16.0 (12.8, 19.2)
Higher intensity counseling (> 10 minutes)	55	2.3 (2.0, 2.7)	22.1 (19.4, 24.7)

SOURCE: Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: USDHHS, PHS, May 2008.

Smoking Cessation Counseling and the Medicaid Reimbursement

Medicaid Benefit	Counseling Service Reimbursable for the Following Provider Types:
Counseling: • Applicable to all Medicaid beneficiaries • Six face-to-face counseling sessions during any 12 continuous months • Counseling may be group or individual counseling sessions	✓ Physician (MD or DO) ✓ Registered Nurse Practitioner (RNP) ✓ Licensed Midwife(LM)
Medication: • Nicotine replacement therapies: patch, gum, nasal spray and inhaler (lozenge is excluded), Bupropion (Wellbutrin or Zyban) and Varenicline (Chantix) • Two 3 month courses are covered per year • Combination therapy is allowed	✓Article 28 Hospital Outpatient Departments (OPDs) ✓ Diagnostic and Treatment Centers (D&TCs) ✓ Federally Qualified Health Centers (FQHCs), including school-based FQHCs that bill using Ambulatory Patient Groups (APGs)

Smoking Cessation Counseling and the Medicaid Reimbursement

ICD-9 Diagnostic Code	Evaluation & Management (E&M) or Appropriate Preventive Medicine Codes	Counseling Sessions	CPT Code	Office-Based Practitioners	Article 28 & FQHCs (that bill APGs)
305.1 Tobacco Use Disorder *Medicaid will only pay for services associated with the diagnosis code.*	Bill with or without E&M code. Smoking cessation may be the sole reason for visit.	Each Medicaid beneficiary will be allowed 6 face-to-face counseling sessions during any 12 continuous months.	**99406** Intermediate SCC, 3 to 10 minutes. **Billable only as an individual**	$10.00	OPD - $20.00 D&TC - $17.00 (Approximate statewide averages)
			99407 Intensive SCC, greater than 10 minutes. **Billable as individual or group session**	$19.00 – Individual SCC $9.50 – Group SCC	OPD $20.00 –Individual $10.00 – Group D&TC $17.00 – Individual $8.50 – Group (Approximate statewide averages)

SOURCE: New York State Medicaid. (2011). *Medicaid Reimbursement Rate for Smoking Cessation Counseling*. Volume 27-Number 6, page 8.

Individual Smoking Cessation Counseling

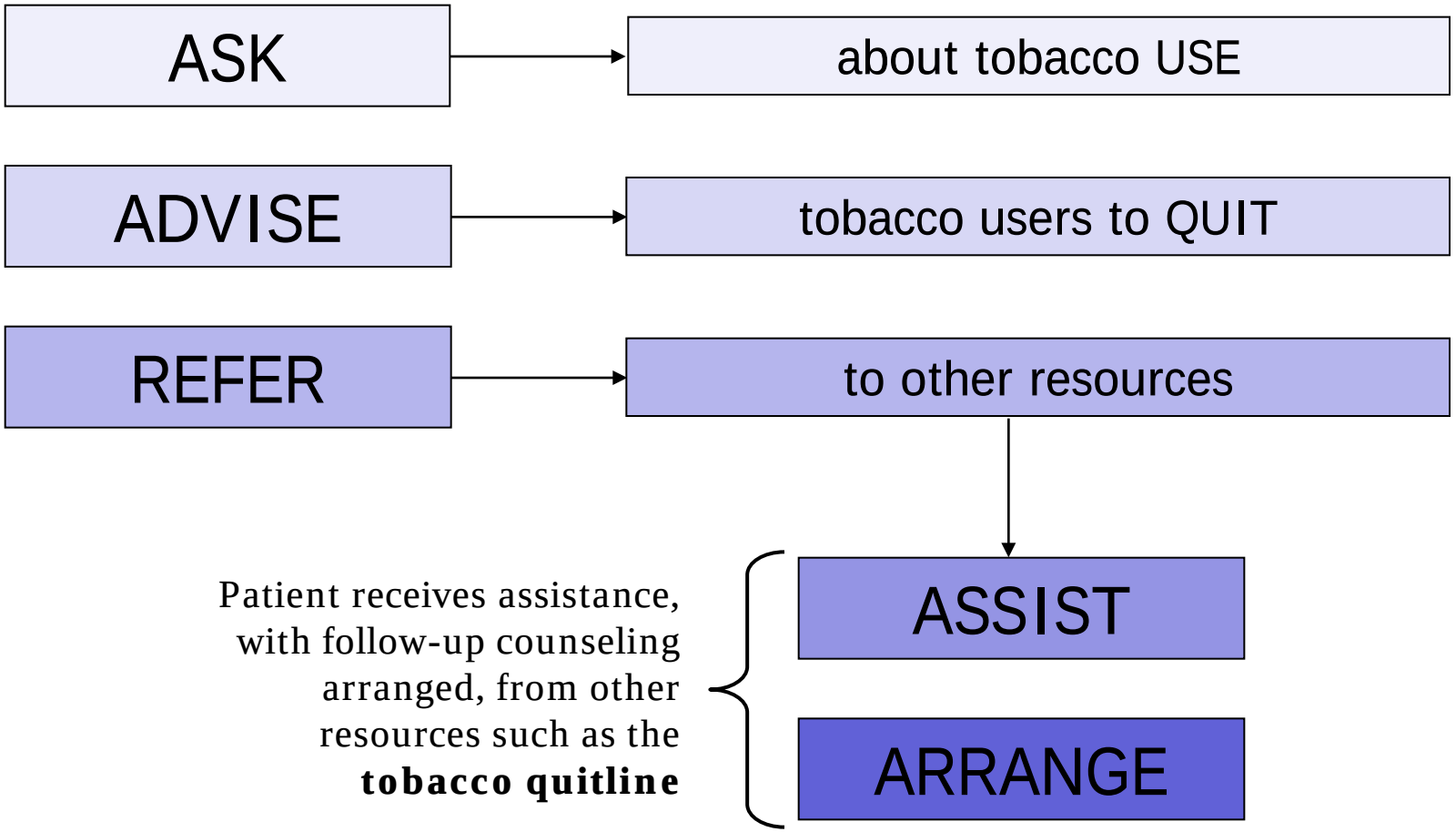
- CPT Procedure Code
  - 99406 (3-10 minutes)
  - 99407 (>10 minutes)
- Documentation must support the charges, medical necessity of the services and the diagnosis code that is used

Group Smoking Cessation Counseling

- CPT Procedure Code
  - 99407 (>10 minutes)
- Group sessions include up to 8 patients
  - Minimum of 2 patients and a maximum of 8
  - Billing amount is applied to each patient in session
  - Session must be over 10 minutes
- All group sessions must be identified with the HQ modifier (Goes on the claim)
  - HQ modifier designates that the session is a group

What Can You Do in 3 Minutes?

ASK, ADVISE, REFER



3 minute counseling strategy

STEP 1: ASK

- ASK about tobacco use
  - "Do you, or does anyone in your household, ever smoke or use any type of tobacco?"
    - "We like to ask our patients about tobacco use, because it has the potential to interact with many medications."
    - "We like to ask our patients about tobacco use, because it contributes to many medical conditions."

STEP 2: ADVISE

- ADVISE tobacco users to quit (clear, strong, personalized)
  - “It’s important that you quit as soon as possible, and I can help you.”
  - “Occasional or light smoking is still harmful.”
  - “I realize that quitting is difficult. It is the most important thing you can do to protect your health now and in the future. I have training to help my patients quit, and when you are ready, I will work with you to design a specialized treatment plan.”

STEP 3: REFER

- **REFER** tobacco users to other resources

Referral options:

- A doctor, nurse, pharmacist, or other clinician, for additional counseling
- A local group program
- The support program provided free with each smoking cessation medication
- Outside NY toll-free quit line: **1-800-QUIT-NOW**
- IN NEW YORK **1-866-NYQUITS**

Intermediate Smoking Cessation Counseling

- 3-10 minutes
  - CPT Code 99406
- Goals of brief counseling
  - Assess patient's readiness to quit
  - Enhance motivation to quit
  - Increase confidence that they will have support
- Targets smokers who
  - Are willing to quit (5 A's)
  - Are unwilling to quit (5 R's)
  - Have recently quit (Relapse prevention)

Intermediate Smoking Cessation Counseling: 3-10 Minutes

- **Ask: Introduce the topic of smoking (1 minute)**
  - Use general, non-threatening statement to open the discussion
  - "I'm going to start discussing smoking more with my clients here at the clinic."
  - "Are you currently smoking cigarettes or use other tobacco products?"
- **Advice: Provide advice to quit (1 minute)**
  - "I think quitting smoking is one of the best ways to strengthen and improve one's (your) health."
  - Provide quit smoking educational material, local quit resources, and information on the NY State Quitline.

Intermediate Smoking Cessation Counseling: 3-10 Minutes for patient not ready to quit

- **Assess** readiness
  - Are you ready to quit? If no:
  - Explore ambivalence and enhance motivation
    - Provide information (available resources)
    - Ask noninvasive questions to identify reasons for tobacco use and concerns about quitting
    - Raise relevance (health concerns, consequences)
    - Demonstrate empathy and foster communication
    - Leave decision to the patient
    - DO NOT provide a treatment plan

Intermediate Smoking Cessation Counseling: 3-10 Minutes for patient ready to quit

Assess readiness

- Are you ready to quit in the next month? If yes:
  - Assess tobacco use history (2 minutes)
    - Current use
    - Past quit attempts (What led to relapse in the past?)
  - Facilitate quitting process (6 minutes)
    - Discuss importance of identifying triggers
    - Explore potential coping strategies
    - Discuss withdrawal symptoms
    - Discuss methods for quitting (counseling and pharmacotherapy)
    - Make referral for additional counseling

Intensive Smoking Cessation Counseling

- 10 or more minutes
  - CPT code 99407
- Goals of intensive counseling
  - Assess patient's readiness to quit
  - Increase patients' motivation and confidence in quitting
  - Explore smoking history and behavioral aspects
  - Educate and discuss treatment options
- Targets smokers who
  - Are willing to quit (5 A's)
  - Are unwilling to quit (5 R's)
  - Have recently quit (Relapse prevention)

Topics to be Discussed in Intensive Counseling

- Not Ready to Quit
  - Use the 5 R's and open-ended questions
  - Education on health risks of smoking and benefits of quitting
  - Decisional balance

Intensive Counseling: 5 R's for patients not ready to quit

Relevance	Encourage the patient to indicate why quitting is personally relevant. Motivational information has the greatest impact if it is relevant to patient: - Disease risk, family/social situation, health concerns, age, gender, etc.
Risks	Clinician should ask patient to identify potential negative consequences of tobacco use. Clinician should highlight the risks associated with tobacco use. *Acute Risks*: Shortness in breath, exacerbation of asthma or bronchitis, increased risk of respiratory infections, harm to pregnancy, impotence, infertility. *Long-term Risks*: Heart attacks and strokes, lung and other cancers, chronic obstructive pulmonary disease, osteoporosis, and long-term disability. *Environmental Risks*: Increased risk of lung cancer and heart disease in spouses, increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.
Rewards	Clinician should ask patient to identify potential benefits of quitting tobacco. Examples of rewards: - Improved health - Saving money - Setting a good example for children - Feeling better physically - Improved appearance including reduced wrinkles/aging of skin and whiter teeth. - Food will taste better, improved sense of smell - Home, car, clothing, breath will smell better - Having healthier babies and children
Roadblocks	Clinician should ask patients to identify barriers or impediments to quitting and provide treatment that could address barriers. Examples of barriers: - Withdrawal symptoms - Fear of failure - Being around other tobacco users - Enjoyment of tobacco - Lack of support - Depression - Limited knowledge of effective treatment options
Repetition	The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful and that you will continue to talk about their tobacco use with them.

Topics to be Discussed in Intensive Counseling

- Preparing to Quit
  - Prepare environment for being smoke-free
  - Review past quit attempts-what led to relapse in past
  - Social support
  - Set a quit date
- Dealing with Withdrawal
  - Review withdrawal symptoms and rationale for use of pharmacotherapy
  - Plan coping strategies for withdrawal
- Dealing with Triggers
  - Review sources of triggers: physical, thoughts, feelings, behaviors
  - Plan coping strategies for each type of trigger

Documentation of Counseling

- 99406 and 99407 documentation must go beyond writing “counseled for tobacco use”
- Provide detailed notes on counseling session
  - Include topics discussed, plan of care, medication, counseling techniques utilized, follow-up plan
- Since it is a timed service, start and stop time will ensure payment and deter any future audits

Appropriate Documentation

Evidence-Based Counseling Techniques Should be Used as a Guide to Documenting SCC

STEP One: ASK about Tobacco Use

➲ Suggested Dialogue

- ✓ Do you ever smoke or use any type of tobacco?
  - – I take time to talk with all of my patients about tobacco use—because it's important.
- ✓ Condition X often is caused or worsened by exposure to tobacco smoke. Do you, or does someone in your household smoke?
- ✓ Medication X often is used for conditions linked with or caused by smoking. Do you, or does someone in your household smoke?

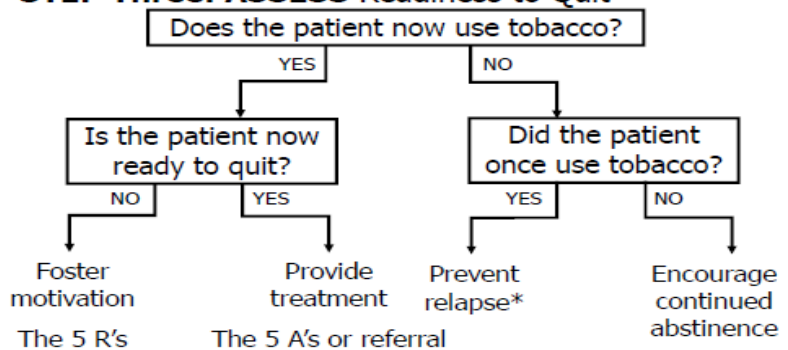
STEP Two: ADVISE to Quit

➲ Suggested Dialogue

- – Quitting is the most important thing you can do to protect your health now and in the future. I have training to help my patients quit, and when you are ready I would be more than happy to work with you to design a treatment plan.
- – What are your thoughts about quitting? Might you consider quitting sometime in the next month?

Prior to imparting advice, consider asking the patient for permission to do so – e.g., "May I tell you why this concerns me?" [then elaborate on patient-specific concerns]

STEP Three: ASSESS Readiness to Quit



* Relapse prevention interventions are not necessary if patient has not used tobacco for many years and is not at risk for re-initiation.

Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

STEP Four: ASSIST with Quitting

Rx for Change

- ✓ **Assess Tobacco Use History**
  - Current use: type(s) of tobacco used, amount
  - Past use:
    - – Duration of tobacco use
    - – Changes in levels of use recently
  - Past quit attempts:
    - – Number of attempts, date of most recent attempt, duration
    - – Methods used previously—What did or didn't work? Why or why not?
    - – Prior medication administration, dose, compliance, duration of treatment
    - – Reasons for relapse
- ✓ **Discuss Key Issues** (for the upcoming or current quit attempt)
  - Reasons/motivation for wanting to quit (or avoid relapse)
  - Confidence in ability to quit (or avoid relapse)
  - Triggers for tobacco use
  - Routines and situations associated with tobacco use
  - Stress-related tobacco use
  - Concerns about weight gain
  - Concerns about withdrawal symptoms
- ✓ **Facilitate Quitting Process**
  - Discuss methods for quitting: pros and cons of the different methods
  - Set a quit date: ideally, less than 2 weeks away
  - Recommend Tobacco Use Log
  - Discuss coping strategies (cognitive, behavioral)
  - Discuss withdrawal symptoms
  - Discuss concept of "slip" versus relapse
  - Provide medication counseling: compliance, proper use, with demonstration
  - Offer to assist throughout the quit attempt
- ✓ **Evaluate the Quit Attempt** (at follow-up)
  - Status of attempt
  - "Slips" and relapse
  - Medication compliance and plans for discontinuation

STEP Five: ARRANGE Follow-up Counseling

- ✓ Monitor patients' progress throughout the quit attempt. Follow-up contact should occur during the first week after quitting. A second follow-up contact is recommended in the first month. Additional contacts should be scheduled as needed. Counseling contacts can occur face-to-face, by telephone, or by e-mail. Keep patient progress notes.
- ✓ Address temptations and triggers; discuss strategies to prevent relapse.
- ✓ Congratulate patients for continued success.

TOBACCO CESSATION COUNSELING GUIDESHEET

Steps to Translating Medicaid Policy into Practice

1. Implement clinical reminder system
2. Ensure that staff (clinical and administrative) receive training on 2008 Update on Tobacco Use Treatment Guidelines
3. Implement tobacco use referral systems

Steps to Translating Medicaid Policy into Practice

4. Identify tasks for key personnel
   - Billing department and administrators
     - Ensuring correct CPT and ICD-9 codes are in electronic or paper charts
   - Providers
     - Medical directors and practice administrators communicate and educate on billing and reimbursement updates
     - Educate re who can bill for counseling services
       - MDs/DOs, RNP, LM
- Cessation Centers

Frequently Asked Questions on the Medicaid Reimbursement Update

- Can I bill for both 99406 and 99407 if I've counseled a patient for more than 10 minutes?
  - No, only one procedure code may be billed per day per patient
- What if my claim is denied?
  - You can resubmit or appeal, make sure you are using the correct code
- We know DRs, NPs, and LMs qualify for reimbursements, do PAs?
  - No, PAs cannot bill Medicaid for any services including SCC. However, PAs can provide SCC in a practitioners office (physician, RNP, or LM) or in an Article 28 clinic. The clinic or practitioner bills and receives payment for the SCC services.

Frequently Asked Questions on the Medicaid Reimbursement Update

- Is in-patient counseling reimbursable**?**
  - No, it is not, SCC codes are for out-patient counseling only
- Is Chantix covered immediately or does the patient have to try other cessation methods first?
  - Yes, Chantix is covered immediately. Chantix is treated the same as other Medicaid covered medications for smoking cessation.
- Can you receive reimbursement for relapse prevention?
  - Yes as long as it doesn't exceed 6 sessions in any 12 continuous months

Frequently Asked Questions on the Medicaid Reimbursement Update

- If a parent of the patient is counseled, can the provider be reimbursed?
  - A parent(s) can be in attendance during the SCC session; however, the child has to be a smoker in order to bill for SCC services and proper documentation needs to be in the medical record to support the length of time and information included during the counseling session.

- Does the HCPO need to document what was discussed during the smoking cessation counseling session to receive reimbursements**?**
  - Yes, the length of time, as well as specific evidenced based intervention provided during the counseling session, eg. current tobacco use, pharmacotherapy, withdrawal symptoms, 5R's,etc. (See STEPs Four and Five on RX for Change, "Tobacco Cessation Counseling Guidesheet")

- If a surgeon counsels a patient at the post-op visit, will that qualify for reimbursement or is it part of global billing for the surgery**?**
  - No, under these circumstances SCC services should be part of the global billing for the surgery.

More Questions on NYS Medicaid SCC Reimbursement?

- Smoking cessation counseling billing questions
  - eMedNY Call Center (800) 343-9000
- Policy questions
  - Division of Financial Planning and Policy

  (518) 473-2160
- New York State Medicaid Updates
  - April 2011
  - May 2011

Thank you