ASK AND ACT
A TOBACCO CESSATION CAMPAIGN

Webcast Q&A
Beyond the Guidelines: Advances in Tobacco Cessation Treatment and Payment

Is there a resource that provides guidelines on using the different management therapies, including side effects, etc?
Try "Treating Tobacco Dependence in a Medical Setting: Best Practices" by Richard D. Hurt, M.D. at http://smokingcessationleadership.ucsf.edu/VA%20Proceeding/3.%20Topic%20Two2.pdf .

You can also try treatobacco.net .

I've had one Medicare visit so far, which I billed with the new Medicare tobacco cessation coverage. Any experience w/Medicare actually paying these, and how much? I presume it will be peanuts. Any advice, experience?
The AAFP has not received any feedback from members that they are not being paid. As for the Medicare allowance, G0375 ranges between $12-15, while G0376 ranges between $24-30; the actual allowance will vary by Medicare locality. You can look up the allowance in their specific locality on-line at http://www.cms.hhs.gov/apps/pfslookup/Step1.asp .

What is the reimbursement by Medicare for Smoking Cessation counseling for an in-patient acute care facility? If Medicare does reimburse an acute care facility, what is the code for billing?
The Medicare National Coverage Decision on tobacco cessation counseling (http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=210.4&ncd_version=1&basket=ncd%3A210%2E4%3A1%3ASmoking+and+Tobacco%2DUse+Cessation+Counseling) says that counseling is covered for both outpatient and hospitalized beneficiaries. It also says that inpatient hospital stays with the principal diagnosis of Tobacco Use Disorder are not reasonable and necessary for the effective delivery of tobacco cessation counseling services. Therefore, CMS will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.

Medicare will pay an acute care facility for smoking cessation counseling. For billing instructions, facilities should consult the Medicare transmittals at http://www.cms.hhs.gov/transmittals/downloads/R562CP.pdf and http://www.cms.hhs.gov/transmittals/downloads/R605CP.pdf .

On a Medicare patient, can a G code be billed for tobacco counseling along with the E&M code for the visit, i.e. for hypertension?
According to section 12.2 of Chapter 32 of the Medicare Claims Processing Manual, "Carriers shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use HCPCS 99201– 99215 to report an E/M service with modifier 25 to indicate that the E/M service is a separately identifiable service from G0375 or G0376." See the transmittal at http://www.cms.hhs.gov/transmittals/downloads/R562CP.pdf .

Who qualifies as a Medicare qualified provider in order to get reimbursement for smoking cessation interventions?
The definition of "qualified provider" is pretty broad and includes, among others, physicians, clinical social workers, psychologists, hospitals, and rural health clinics.

What approach do you recommend for the pregnant smoker?
While nonpharmacologic intensive counseling is best, most tobacco cessation experts believe that exposure to one component of smoke (nicotine) is much less hazardous than 4000-plus toxins in smoke, including CO. Intermittent dose forms (pregnancy category C) are best (lozenge, gum) as recent reports show a possible link between the patch and fetal limb malformations. Zyban is Category B for pregnancy.

How effective is acupuncture?
There is no current evidence that acupuncture is effective as a tool for tobacco cessation.

White AR, Rampes H, Campbell JL. Acupuncture and related interventions for smoking cessation. Cochrane Database Syst Rev. 2006 Jan 25;(1):CD000009.

What about ear stapling?
Not effective -- an acupuncture variant.

Tell us about injections available to patients administered where?-patients state "in the neck."
I haven't heard of this one...I did find an abstract in Chest concerning an anticholinergic cocktail injection used in a cessation clinic in Florida, claiming good results.
http://meeting.chestjournal.org/cgi/content/abstract/126/4/713S-a
Some have questioned the results of this study, stating, “The N is far too small and there is no control.”

How can one help the patient who becomes addicted to the Nicotine Replacement Therapy?
NRT has a low abuse potential compared with the addictiveness of smoking or use of moist snuff products. Products such as the nicotine nasal spray have a higher propensity for continued use beyond the recommended time periods following cessation, and less than 10% do so -- most smokers who are in the process of cessation use NRT for much shorter intervals than recommended.

The use of NRT among nonsmokers is almost unknown. NRT is not associated with long-term health risks. Patients who continue to use NRT for long periods of time after cessation can be weaned from the products, or may stop them “cold turkey” but must not resume cigarettes (even one), as relapse to former levels of smoking is likely.

In Georgia, the State Employees Plan added a $50 per month surcharge for beneficiaries who smoke. This has been effective in goading some patients to try and quit. Are there other states or insurers that are placing some of these penalties?
Yes.

Does imipramine work as well as nortripline?
The most recent Cochrane review of antidepressant therapy concludes that only nortriptyline and bupropion are useful.

Hughes J, Stead L, Lancaster T. Antidepressants for smoking cessation. Cochrane Database Syst Rev. 2004 Oct 18;(4):CD000031.

What are some combination treatments you have tried and found to be effective?
NRT and bupropion have been shown to be synergistic; the Mayo Clinic and others support the use of high-dose NRT, including patch plus gum/lozenge/nasal spray for highly addicted smokers, although the literature reviews are mixed in their findings.

If I decide to use wellbutin and nicotine patch together, how often do I have to see the patient to check blood pressure?
I can't find any literature that warns of hypertension as a side effect of the therapy -- the manufacturer's warnings for bupropion note that it had a 6.1% incidence of hypertension among users in one trial. The usual care approach for cessation counseling and follow-up should be sufficient (see patient about the time of the quit date, a week later, a month later).

What dose of nortriptyline have you found most helpful?
75-100 mg once daily is the recommended dose. You might want to review the article, “Nortriptyline for smoking cessation: a review” by Hughes JR, Stead LF, Lancaster T in the August 2005 issue of Nicotine Tob Res.

Is there an effective questionnaire available to address the physical and psychological aspects of quitting vs not quitting?
Having quit myself after 10 years of NRT my personal recommendation is to emphasize replacement pleasures and to teach the expectations and reality of withdrawal.

Any study yet addressed cold turkey?
Here is a web site that advocates for this approach: http://whyquit.com .

The Clinical Practice Guideline “Treating Tobacco Use and Dependence” estimates about a 10% efficacy rate for self-help/no clinician intervention attempts to quit smoking. A recent published report from Australia reports as high as a 40% quit rate for “cold turkey.”

Doran CM, Valenti L, Robinson M, Britt H, Mattick RP. Smoking status of Australian general practice patients and their attempts to quit. Addict Behav. 2006 May;31(5):758-66.

Please address the common objection of post cessation weight gain.
According to the CDC Office on Smoking and Health website: “Many smokers will gain some weight when they quit, usually less than 10 pounds. Eat a healthy diet and stay active. Don't let weight gain distract you from your main goal—quitting smoking. Some quit-smoking medications [NRT and bupropion] may help delay weight gain.”

Is nicotine fading a useful technique?
Nicotine fading refers to gradual reduction in nicotine consumption, usually by switching to brands with lower nicotine content than the patient’s usual brand. While a few studies have reported reasonable success from this method, many patients will compensate for lower nicotine by inhaling more deeply, smoking the new cigarette closer to the filter, or even smoking more per day in order to maintain a constant level of nicotine in the body. It is not a recommended method in the Clinical Practice Guidelines.