Clinical Policy Title: Tobacco control interventions

Clinical Policy Number: 17.02.00

Effective Date: December 1, 2013
Initial Review Date: June 16, 2013
Most Recent Review Date: June 22, 2017
Next Review Date: June 2018

Policy contains:
- Acupuncture.
- Nicotine replacement.

Related policies:

CPI 03.02.03 Acupuncture

ABOUT THIS POLICY: AmeriHealth Caritas Pennsylvania has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Pennsylvania’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by AmeriHealth Caritas Pennsylvania when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Pennsylvania’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Pennsylvania’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Pennsylvania will update its clinical policies as necessary. AmeriHealth Caritas Pennsylvania’s clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas Pennsylvania considers tobacco use control to be medically necessary in patients who have a confirmed willingness to quit. Tobacco use control (e.g., smoking avoidance or cessation) includes health promotion, which fosters wellness in general and thus reduces the likelihood of disease, disability, and premature death in a nonspecific manner.

Covered preventive services include:

- Lifestyle counseling up to 70 sessions per calendar year with intensity determined by provider and patient.
- Pennsylvania coverage of smoking cessation drugs includes:
  - Nicotine replacement therapy (NRT) gum.
  - NRT patch.
  - NRT nasal spray.
  - NRT lozenge.
  - NRT inhaler.
- Varenicline (Chantix®).
- Bupropion (Zyban®).

**Limitations:**

AmeriHealth Caritas Pennsylvania considers the use of the following items not medically necessary for smoking cessation:

- Antidepressants other than those cited as covered (e.g., selective serotonin reuptake inhibitors [SSRIs]).
- Anxiolytics.
- Opioid antagonists.
- Silver acetate.
- Mecamylamine.
- Lobeline.
- Acupuncture.
- Hypnotism.
- E-cigarette.

**Alternative covered services:**

None.

**Background**

In the year 2000, the leading cause of death in the United States was tobacco use, which resulted in some 435,000 deaths, or 18.1 percent of total deaths.

The causal relationship between cigarette smoking and lung cancer was first documented in the 1950s. Smoking and other forms of tobacco use have since been implicated in preventable deaths and global burden of disease, including cancers (e.g., lung cancer), cardiovascular disease, lung disease (e.g., chronic obstructive pulmonary disease [COPD]) and complications of pregnancy and diabetes.

The direct and indirect costs (e.g., lost productivity) of tobacco use to individuals, the health care system, and society in general are enormous.

**Searches**

AmeriHealth Caritas Pennsylvania searched PubMed and the following databases:

- UK National Health Services Center for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other
The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on April 27, 2017. Searched terms were: "tobacco control" (MeSH), "smoking" (MeSH), and "cessation."

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

A large body of evidence accumulated over the last two generations of the American experience documents the risk and harms of cigarette smoking and use of other tobacco products. Sixty years into the study of this public health, there is still a tremendous amount of ongoing research to identify and clarify the multiple inputs that shape the use of, the withdrawal and cessation from, and the treatment of complications associated with tobacco.

Recent investigation has focused on financial incentives as part of formal smoking cessation programs. Tappan (2015) looked at a population truly at risk from lifestyle habits: pregnant women smokers and their newborn children. Although newborn weights were not affected by smoking cessation in women who quit, nearly a quarter of the participants offered monetary gains were enticed to stop smoking (for a while).

The pitfalls of financial incentives become obvious when the incentives stop. Cahill (2015) noted that a monetary reward of approximately $700 USD enticed 31 percent of pregnant women smokers in a large number of settings to quit smoking while they were in place. Mantzari (2015) noted a similar change in lifestyle among the general population that endured for 18 months overall but only three months after incentives stopped.

The nicotine patch failed to help pregnant women smokers quit in a clinical trial of 402 expectant women randomized to patches with nicotine and controls with placebo patches (Berlin, 2014). Compliance was measured by testing expired carbon monoxide (CO) levels in the subjects once weekly. Birth weights were roughly the same in treated and controls, as was the number of smokers in both groups at the trial's end.
Finally, pregnant women were not particularly helped by an exercise program as an adjunct to smoking cessation (Ussher, 2015). A large clinical trial found that not only were there no significant differences in activity (as shown by accelerometer data) between exercise and baseline-activity controls, the rates of smoking abstinence were also undifferentiated: 8 percent who reported exercising versus 6 percent who did not were able to stop smoking.

Another special population group with regards to smoking, the hospitalized mentally ill, were shown to benefit from tobacco control programs that included NRT products (i.e., nicotine replacement gum and patches). At 18 months, 20 percent of those in the treatment group (which included a variety of psychiatric illnesses) stopped smoking, compared to just 7.7 percent of controls (Prochaska, 2013). A helpful side benefit of smoking cessation was a reduction in rates of readmission to the hospital compared to control.

Operative risk increases substantially in the presence of chronic disease, and smoking is one of the most common pre-operative risk factors cited in studies of morbidity and mortality from surgical procedures. Measures intended for the short-term gain of reduced peri- and post-operative complications (i.e., wound complications) were also effective at long-term control of tobacco in a systematic review inclusive of 2,010 participants (Thomsen, 2014). The effect was enhanced by weekly counseling sessions and behavioral modification instruction over four to eight weeks postoperatively.

Attention-deficit/hyperactivity disorder (ADHD) is a frequent comorbid concomitant of cigarette smoking. A systematic review (n = 2360) linked treatment with the stimulants d-amphetamine and methylphenidate to lower smoking rates among treated ADHD patients (Schoenfelder, 2014). A notable side finding was that the impact of the stimulants on smoking reduction is greater with more severe concurrent psychopathology.

Evidence for pharmaceutical measures in tobacco control continued to accumulate weight, with a number of drugs showing promise and benefit to smokers:

- A sizable systematic review of 3,336 participants found NRT effective and safe for smoking cessation (Hollands, 2015).
- A large (n = 10,761) systematic review found varenicline safe (with regards to suicidal behavior) for promoting smoking cessation, though it does prompt nightmares and insomnia (Thomas, 2015).
- A randomized controlled trial (RCT) of 1,510 participants found varenicline increases cessation rates at one year after an initial 24 weeks of treatment (Ebbert, 2015).
- Varenicline in combination with NRT shows more promise than monotherapy with varenicline (Koegelenberg, 2014).
- Bupropion and nortriptyline have similar efficacy in tobacco control as NRT, according to another large systematic review (n = 13,728), though they are not as beneficial as varenicline (Hughes, 2014).
The same study concluded that SSRIs and monoamine oxidase inhibitors (MAOIs) do not aid smoking cessation (Hughes, 2014).

In what may be the most comprehensive assessment yet of multiple allopathic and homeopathic treatments for smoking cessation, Cochrane (Hughes, 2014) reviewed 44 trials including 13,728 patients.

Among their conclusions:
- Bupropion and nortriptyline aid long-term smoking cessation.
- Evidence suggests the mode of action of bupropion and nortriptyline is independent of their antidepressant effect and that they are of similar efficacy to nicotine replacement.
- Adverse events are rare and rarely lead to stopping medication.
- Evidence also suggests that bupropion is less effective than varenicline, but further research is needed to confirm this finding.
- Evidence suggests that neither SSRIs (e.g., fluoxetine) nor MAOIs aid in smoking cessation.

Acupuncture and acupressure continue to lack evidence of efficacy in tobacco control. In a small systematic review of 393 subjects, the results of acu-service were no different than those from being put on a waiting list control for long-term abstinence and tobacco cessation (White, 2014).

No report on smoking can conclude without illuminating some of the darker sides of the habit. A retrospective review of colorectal cancer victims over a term of 20 years found smoking was associated with higher all-cause and colorectal-specific mortality (Yang, 2015). Stopping smoking did confer some benefit with regards to cancer mortality.

Policy updates:

2017:

A Cochrane review (Stead, 2017) examined the proposition that group therapy offers individuals the opportunity to better learn behavioral techniques for smoking cessation and provides mutual support that is missing from individual therapy. At least two group meetings were required, and follow-up of smoking status was evaluated at least six months after the start of the program. The main outcome measure was abstinence from smoking. Group programs demonstrated an increase in cessation over self-help programs (N = 4,395, risk ratio [RR] 1.88, 95 percent confidence interval [CI] 1.52 to 2.33, I² = 0 percent). Group programs with brief support from a health care provider yielded a small increase in cessation (N = 7,286, RR 1.22, 95 percent CI 1.03 to 1.43, I² = 59 percent). Similarly, there was benefit of group programs compared to no-intervention controls, (nine trials, N = 1,098, RR 2.60, 95 percent CI 1.80 to 3.76 I² = 55 percent). The authors failed to detect evidence that group therapy was more effective than a similar intensity of individual counseling (six trials, N = 980, RR 0.99, 95 percent CI 0.76
to 1.28, I² = 9 percent). The GRADE quality of evidence was judged to be moderate overall, but was downgraded due to several included studies at low risk of bias. The authors concluded there is insufficient evidence to evaluate whether groups are more effective, or cost-effective, than intensive individual counseling, and that there is not enough evidence to support the use of particular psychological components in a program of smoking cessation.

2016:

McQueen (2016) examined past and present tobacco use in head and neck cancer patients (n = 106) enrolled in a smoking cessation program. Sixty-nine (65 percent) successfully quit smoking by various means, including adoption of the e-cigarette as a substitute for tobacco. Age of first tobacco use did not differ between the smoking and cessation groups (p = .14), nor did hazardous drinking (p = .072). “Cold turkey” (i.e., stopping abruptly without smoking cessation aids) was the most common method attempted (n = 88, 83 percent) and most successful (n = 65, 94 percent). Nonusers achieved higher quit rates compared to e-cigarette users (72 percent vs. 39 percent; p = .0057). E-cigarette use did not decrease the number of cigarettes smoked (463 cigarettes/month) versus that of nonusers (341 cigarettes/month; p = .2). The authors concluded that the e-cigarette did not decrease tobacco use, and patients who utilize e-cigarettes are less likely to achieve smoking cessation.

A systematic review (Malas, 2016) examined the effectiveness of e-cigarettes as smoking cessation aids. The quality of the evidence in support of e-cigarettes’ effectiveness in helping smokers quit was assessed as very low to low, and the evidence on smoking reduction was assessed as very low to moderate. The majority of included studies found that e-cigarettes, especially second-generation types, could alleviate smoking withdrawal symptoms and cravings in laboratory settings; however, the evidence remains inconclusive due to the low quality of the research published to date. Well-designed RCTs and longitudinal population studies are needed to further define the role of e-cigarettes in smoking cessation.

Sherratt (2016) examined current practice in Great Britain for recommending use of the e-cigarette as a smoking cessation aid. The authors queried thoracic physicians (n = 2,009), requesting them to complete an online survey concerning patient smoking history, perceptions of patient e-cigarette use, practitioner knowledge regarding sources of guidance pertaining to e-cigarettes, and practitioner advice. The majority of practitioners (81.4 percent) reported responding to patient queries pertaining to e-cigarettes within the past year; however, far fewer (21.0 percent) felt confident providing patients with e-cigarette advice. Practitioner confidence was found to differentiate by gender (p = 0.012) and medical specialty (p = 0.030), with nurses reporting particularly low levels of confidence in advising. The authors concluded that patients defer to practitioners as a source of e-cigarette guidance, yet few practitioners feel confident advising, and highlighted that training should be delivered to equip practitioners with the knowledge and confidence to abet smoking cessation.

**Summary of clinical evidence:**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>Stead (2017)</td>
<td><strong>Key points:</strong></td>
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</table>
| Group behaviour therapy programmes for smoking cessation. | - Systematic review of group therapy for smoking.  
- Minimum of two group meetings and follow-up at six months required.  
- Group programs demonstrated an increase in cessation over self-help programs (N = 4,395, RR 1.88, 95% CI 1.52 to 2.33, I² = 0%).  
- Group programs with brief support from a health care provider yielded a small increase in cessation (N = 7286, RR 1.22, 95% CI 1.03 to 1.43, I² = 59%).  
- There was benefit of group programs compared to no-intervention controls, (nine trials, N = 1098, RR 2.60, 95% CI 1.80 to 3.76 I² = 55%).  
- Authors concluded there is insufficient evidence to evaluate whether groups are more effective than intensive individual counseling, or to commend particular psychological components in smoking cessation. |
| McQueen (2016)    | **Key points:**                   |
| Smoking cessation and electronic cigarette use among head and neck cancer patients | - Of 110 studied patients, 106 (96%) enrolled in the smoking cessation program (83% male, 82% Caucasian), of whom 69 (65%) successfully quit smoking by various means, including adoption of the e-cigarette as a substitute for tobacco.  
- Age of first tobacco use did not differ between the smoking and cessation groups (p = .14), nor did hazardous drinking (p = .072).  
- “Cold turkey” (i.e., stopping abruptly without smoking cessation aids) was the most common method attempted (n = 88, 83%) and most successful (n = 65, 94%).  
- Nonusers achieved higher quit rates compared to e-cigarette users (72% vs. 39%; p = .0057).  
- E-cigarette use did not decrease the number of cigarettes smoked (463 cigarettes/month) versus that of nonusers (341 cigarettes/month; p = .2).  
- The authors concluded that the e-cigarette did not decrease tobacco use, and patients who utilize e-cigarettes are less likely to achieve smoking cessation. |
| Malas (2016)      | **Key points:**                   |
| Electronic Cigarettes for Smoking Cessation | - The quality of the evidence in support of e-cigarettes’ effectiveness in helping smokers quit was assessed as very low to low, and the quality of evidence on smoking reduction was assessed as very low to moderate.  
- The majority of included studies found that e-cigarettes, especially second-generation types, could alleviate smoking withdrawal symptoms and cravings in laboratory settings; however, the evidence remains inconclusive due to the low quality of the research published to date.  
- Well-designed RCTs and longitudinal population studies are needed to further define the role of e-cigarettes in smoking cessation. |
| Sherratt (2016)   | **Key points:**                   |
| Electronic cigarettes | - Examined provider habit in recommending use of the e-cigarette as a smoking cessation aid.  
- The majority of practitioners (81.4%) reported responding to patient queries pertaining to e-cigarettes within the past year; however, far fewer (21.0%) felt confident providing patients with e-cigarette advice.  
- Practitioner confidence was found to differentiate by gender (p = 0.012) and medical |
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<th>Citation</th>
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RCT of 612 pregnant smokers randomized to financial incentives to abstain during term.  
More (22.5%) incentive smokers quit than non-incentive (8.6%).  
Newborn mean birth weight was 3,140 g (SD 600 g) in the incentives group and 3,120 g (SD 590) in the control group (P = 0.67).  
Authors concluded incentives for smoking cessation in pregnancy are effective.                                                                                                                                                                                                                                                                                   |
| Cahill (2015)  | Monetary incentives promote smoking cessation in pregnancy.  
Systematic review (SR) of 21 studies involving more than 8,400 participants.  
Monetary rewards to quit up to $700 USD.  
Twelve-week pregnancy and postpartum program yielded quit rate of 31% at six weeks compared with no quitters in the control group.  
Authors concluded incentives appear to boost smoking cessation rates while they are in place.                                                                                                                                                                                                                                           |
SR of 34 studies weighed unspecified financial incentives offered to help smokers quit.  
Financial incentives increased behavior change, with effects sustained three months after removal and 18 months overall.                                                                                                                                                                                                                       |
| Ussher (2015)  | Exercise not effective as adjunct in pregnant smokers.  
RCT of 789 pregnant smokers randomized to exercise regimen versus baseline.  
No significant difference was found in rates of smoking abstinence at end of pregnancy between the physical activity and control groups (8% vs. 6%).  
According to the accelerometer data, there was no significant difference in physical activity levels between the groups.                                                                                                                                                                                                                      |
SR and meta-analysis of 39 randomized controlled trials (10,761 participants).
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<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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| varenicline | - Found no evidence of an increased risk of suicide or attempted suicide, suicidal ideation, depression, or death with varenicline.  
- There was evidence that varenicline was associated with a higher risk of sleep problems such as insomnia and abnormal dreams. |
| Yang (2015) | **Key points:**  
- Smoking tied to higher colon cancer.  
- Current smoking was associated with higher all-cause mortality and colorectal cancer-specific mortality.  
- Former smoking was associated with higher all-cause mortality but not with colorectal cancer-specific mortality.  
- Postdiagnosis current smoking was associated with higher all-cause and colorectal cancer-specific mortality. |
| Hollands (2015) | **Key points:**  
- NRT effective and safe.  
- SR of eight studies and 3,336 participants.  
- Evaluated pharmacological treatments for tobacco dependence (e.g., NRT).  
- Adjunctive behavioral support included.  
- NRT et al. safe and effective for smoking cessation. |
| Ebbert (2015) | **Key points:**  
- Varenicline for 24 weeks increases smoking cessation rates at one year.  
- RCT of 1,510 participant smokers randomized to varenicline 1 mg bid x 24 weeks or placebo.  
- Varenicline group (n = 760) had significantly higher continuous abstinence rates (32%) during weeks 15 through 24 versus placebo (6.9%).  
- Varenicline group had significantly higher continuous abstinence rates vs. placebo during weeks 21 through 24 (37.8% versus 12.5%) and weeks 21 through 52 (27.0% versus 9.9%).  
- Adverse events occurred in 3.7% of the varenicline group and 2.2% of the placebo group (P = .07). |
| Koegelenberg (2014) | **Key points:**  
- Varenicline with NRT more effective than varenicline alone.  
- Prospective study of 446 smokers randomized to varenicline versus varenicline with NRT for 12 weeks.  
- Combination treatment was associated with a higher continuous abstinence rate at 12 weeks (55.4% versus 40.9%), 24 weeks (49.0% versus 32.6%), and six months (65.1% versus 46.7%).  
- Combination users suffered greater incidence of nausea, sleep disturbance, skin reactions, constipation, and depression, with only skin reactions reaching statistical significance (14.4% versus 7.8%). |
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<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>Schoenfelder (2014)</td>
<td>Varenicline-alone group experienced more abnormal dreams and headaches.</td>
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<tr>
<td>Stimulant treatment of ADHD and cigarette smoking</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>ADHD treatment tied to lower smoking risk.</td>
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<td></td>
<td>SR of 14 studies (n = 2,360) linked stimulant treatments (i.e., d-amphetamine and methylphenidate) to lower smoking rates.</td>
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<td></td>
<td>Authors concluded consistent stimulant treatment of ADHD may reduce smoking risk.</td>
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<td></td>
<td>The effect was larger in samples with more severe psychopathology.</td>
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<tr>
<td>Thomsen (2014)</td>
<td>Preoperative smoking cessation may reduce postoperative morbidity and abet long-term abstinence.</td>
</tr>
<tr>
<td>Interventions for preoperative smoking cessation</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>SR of 13 trials and 2010 postoperative participants showed varenicline and use of NRT conferred significant risk reduction in long-term smoking cessation and on wound complications.</td>
</tr>
<tr>
<td></td>
<td>Varenicline and NRT did not confer effect on other postoperative complications.</td>
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<td></td>
<td>Effect was enhanced with adjuvant &quot;intensive&quot; behavioral therapy (i.e., weekly counseling sessions over four to eight weeks).</td>
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<tr>
<td>Hughes (2014)</td>
<td>Bupropion and nortriptyline aid long-term smoking cessation.</td>
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<tr>
<td>Antidepressants for smoking cessation</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>SR of 44 trials (n = 13,728).</td>
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<tr>
<td></td>
<td>Bupropion is less effective than varenicline.</td>
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<tr>
<td></td>
<td>Bupropion and nortriptyline have similar efficacy to nicotine replacement.</td>
</tr>
<tr>
<td></td>
<td>Neither SSRIs (e.g., fluoxetine) nor MAOIs aid cessation.</td>
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<tr>
<td>Nicotine patches in pregnant smokers</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>RCT of 402 pregnant smokers age 18 years and between 12 – 20 weeks’ gestation who smoked at least five cigarettes a day.</td>
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<tr>
<td></td>
<td>Randomized 203 to nicotine patches and 199 to placebo patches.</td>
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<td></td>
<td>Efficacy was measured by self-reporting and carbon monoxide levels in expired air.</td>
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<tr>
<td></td>
<td>The mean birth weight was 3,065 g in the nicotine patch group and 3,015 g in the placebo patch group (P = 0.41).</td>
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<tr>
<td></td>
<td>The nicotine patch did not increase smoking cessation rates or birth weights.</td>
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<tr>
<td>White (2014)</td>
<td>Acu-therapies of no benefit to long-term smoking cessation.</td>
</tr>
<tr>
<td>Acupuncture and related interventions for smoking cessation</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>SR of three studies, including 393 recruited volunteers, found acupuncture was no more effective than a waiting list control for long-term abstinence from smoking.</td>
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<tr>
<td></td>
<td>No apparent evidence that acupuncture or acupressure benefit smoking cessation.</td>
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</tbody>
</table>
### Hughes (2014)

**Antidepressants for smoking cessation**

**Key points:**
- Cochrane review of various tobacco control therapies.
- SR of 44 trials, n = 13,728 found bupropion and nortriptyline equally effective and of similar efficacy to NRT.
- Trials comparing bupropion to varenicline showed significantly lower quitting with bupropion than with varenicline.
- There was no evidence of a significant effect for SSRIs alone (i.e., fluoxetine, paroxetine or sertraline) or as an adjunct to NRT.
- Benefit was not detected for MAOIs (i.e., moclobemide or selegiline), the atypical antidepressant venlafaxine, the herbal therapy St John's wort (hypericum) or the dietary supplement SAMe.

### Prochaska (2013)

**Clinical management of tobacco dependence in inpatient psychiatry: provider practices and patient utilization.**

**Key points:**
- NRT effective in psychiatric inpatient cohort.
- RCT of 224 residents of a psychiatric hospital were randomized to control or nicotine gum or patch.
- At 18 months, 20% of those in the treatment group had quit smoking, compared with just 7.7% of controls.
- There were fewer hospital readmissions among those in the treatment group — 44% compared with 56% in the control group.
- Psychiatric diagnoses: depression, bipolar disorder and schizophrenia.
- 75% were actively suicidal.
- Patients’ diagnoses and the severity of their symptoms had no impact on intervention outcomes.
- Evidence-based tobacco dependence treatments can substantially increase quit rates among psychiatric inpatients.

### References

**Professional society guidelines/other:**


Smokers with mental illness can stop smoking. Lansdale, PA.

Peer-reviewed references:


**CMS National Coverage Determinations (NCDs):**


**Local Coverage Determinations (LCDs):**
No LCDs identified as of the writing of this policy.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>4000F</td>
<td>Tobacco use cessation intervention, counseling (COPD, CAP, CAD, Asthma, DM, PV)</td>
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<tr>
<td>4001F</td>
<td>Tobacco use cessation intervention, pharmacological therapy (COPD, CAP, CAD, Asthma, DM, PV)</td>
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<tr>
<td>99406</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate greater than 3 minutes, up to 10 minutes</td>
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<tr>
<td>99407</td>
<td>Smoking and tobacco use cessation counseling visit; intensive greater than 10 minutes</td>
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<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>F17.200</td>
<td>Nicotine dependence, unspecified, uncomplicated</td>
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<tr>
<td>F17.201</td>
<td>Nicotine dependence, unspecified, in remission</td>
<td></td>
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<tr>
<td>F17.210</td>
<td>Nicotine dependence, cigarettes, uncomplicated</td>
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<tr>
<td>F17.211</td>
<td>Nicotine dependence, cigarettes, in remission</td>
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<tr>
<td>F17.220</td>
<td>Nicotine dependence, chewing tobacco, uncomplicated</td>
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<tr>
<td>F17.221</td>
<td>Nicotine dependence, chewing tobacco, in remission</td>
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<tr>
<td>F17.290</td>
<td>Nicotine dependence, other tobacco product, uncomplicated</td>
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<tr>
<td>F17.291</td>
<td>Nicotine dependence, other tobacco product, in remission</td>
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<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
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<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>S4995</td>
<td>Smoking cessation gum</td>
<td></td>
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<tr>
<td>S9453</td>
<td>Smoking cessation classes, nonphysician provider, per session</td>
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