MGMA Health Care Consulting Group

SBIRT Assessment with Recommendations

Presented to:

Peer Assistance Services

Prepared by:

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MGMA
Medical Group Management Association

SBIRT Assessment with Recommendations

SBIRT Assessment Project

Summary of interviews with key informants in medical practices and payers, analyzing current experience and reimbursement history for substance abuse (alcohol) screening and brief intervention.

Analysis of potential barriers to screening and brief intervention including coding, reimbursement practices, practice workflow patterns, and patient experience for alcohol, substance, abuse screening and brief intervention.

Recommendations to Peer Assistance for future interventions to meet goals of SBIRT utilization and payment.

Introduction

SBIRT Colorado is an initiative funded by the Substance Abuse and Mental Health Services Administration and administered through the Colorado Office of Behavioral Health. Peer Assistance Services Inc. manages SBIRT Colorado.

Peer Assistance Services approached the MGMA Health Care Consulting Group in May 2016 to conduct an assessment of practices and payers to determine barriers to SBIRT, screening for potential alcohol abuse providing brief intervention when screen is positive. The assessment results and follow-up initiatives will serve to meet the goals of Peer Assistance five areas of growth:

- Establish substance use screening as a vital sign.
- Focus on effective screening and brief intervention for adolescents.
- Ensure SBIRT is included in healthcare delivery and payment reform initiatives.
- Promote inclusion of SBIRT in health professional education.
- Demonstrate effect of screening and brief intervention on health outcomes and health care costs.

Background

SBIRT is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT consists of three major components:

> **1. Structured Assessment:** Assessing a patient for risky substance use behaviors using standardized assessment tools; **or** Screening a patient for risky substance use behaviors using standardized assessment or screening tools
>
> **2. Brief Intervention:** Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
>
> **3. Referral to Treatment:** Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services

SBIRT is covered by the preventive services (as defined in section 2713 of the PHS Act, added by section 1001 of the ACA) and are part of essential health benefits (EHB). The act states: preventive services must be covered, cannot be subject to cost-sharing (i.e., no patient co-pay or coinsurance), and must be paid on a first-dollar basis (i.e., the plan must pay even if the participant has not yet met his/her deductible under the plan. ***However, the ability to bill for SBIRT varies from state to state.*** Benefit substitution is permitted and federal rules allow insurers to offer coverage that differs from the state's benchmark plan by replacing one benefit in an essential health benefits category with a different one from within the same category. Substitution must involve "actuarially equivalent" benefits, may not occur across benefit categories—insurers cannot exchange a maternity benefit for unrelated ambulatory services, for example.

The Mental Health Parity and Addiction Equity Act (MHPAEA) parity requirements will apply in the context of EHB. One of the 10 categories of EHB is mental health and substance use disorder services. Applying the MHPAEA parity requirements **means *plans that must provide EHB*** *cannot impose higher annual dollar limits or aggregate lifetime dollar limits, or more restrictive financial requirements or treatment limitations on mental health or substance use disorder benefits than are imposed on medical/surgical benefits.* Additionally, a plan that provides out-of-network medical/surgical benefits also must provide out-of-network mental health and substance use disorder benefits. (U.S. Department of Health & Human Services)

The Common Wealth Fund report, *Realizing Health Reforms Potential,* points out one of the challenges with "essential benefits" at a state level and what they believe should happen at the federal level. States are continuing to define their essential benefits much as they had originally—despite the opportunity to revisit this decision for 2017 and beyond. They also find significant variation in how states have developed their essential health benefits packages, including their approaches to benefit substitution. Federal regulators should use insurance company data describing enrollees' experiences with their coverage—information called for under the law's delayed transparency requirements—to determine whether states' differing strategies are producing the coverage improvements promised by reform.

Practice observations

Phone Interviews were conducted with six practices selected by Peer Assistance (See Appendix A). The purpose of the interviews was to determine:

1. Awareness and acceptance of SBIRT by the practice team
2. Experience administering SBIRT at the practice level, including tools used
3. Reimbursement issues when SBIRT is billed
4. Patient perception and acceptance of screening

Awareness and acceptance of SBIRT by the practice team

With the advent of "value-based" contracting, reimbursement reform, the practice transformation required for survival will present a positive format for SBIRT. Many of the practices interviewed revealed attributes noted in most medical practices today.

1. Lack of care concepts across the continuum; by this I mean awareness of hospitalizations, visits to other providers (mental health) or other community entities that reflect the health of an individual.
2. Team workflow awareness; by this I mean billing team member is not in touch with clinical to know what is done to gain reimbursement. Billing team not familiar with the contracts to know how to communicate payment protocol for SBIRT to the clinical members of the team.
3. Understanding the importance of population health management; by this I mean looking at the importance of prevention and the ability to aggregate and analyze patient data to impact the health outcomes of a group of individuals, including the distribution of such outcomes within the group. What is the impact of a positive screening score to a practice population? How does this impact your practice initiatives for wellness and health?

To properly take advantage of these value-based programs, practices must begin to engage in population health management. For most practices the first exercise is awareness of their theoretical frameworks, the lens by which they see their practices today. Making explicit what has traditionally been implicit will allow the practices to create a new framework or lens by which to view healthcare and create positive cultural change to engage in and meet the demands of population health management.

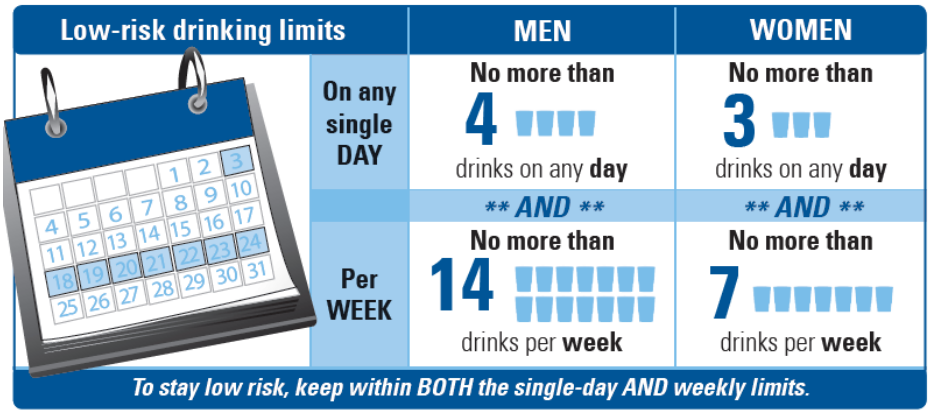
Two of the practices interviewed had a strong population health/preventive perspective. They also created a workflow designed to capture screening for alcohol with brief intervention if appropriate and realize reimbursement. I will point out their accomplishments in the summary section.

Practice barriers to SBIRT

The most significant and consuming objection to screening patients, from all practices, was fear of patient response when they receive a bill for the screening. Practices did not want to "tick off" their patients, lose their patients, or fear the patients will not want to *tell them anything* if they are billed for giving information. The fear was not imagined, it actually happened.

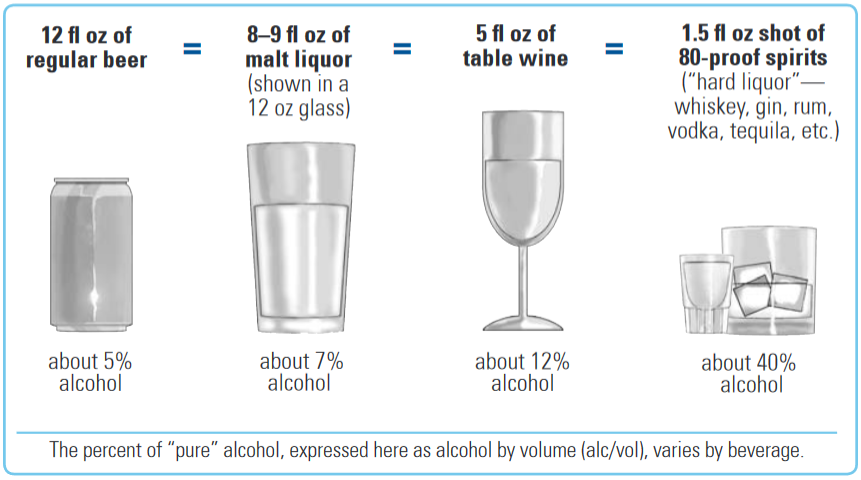
Another explicit barrier was the reluctance to address alcohol. Staff felt they would also be considered as "alcohol abusers" based on the definition. They felt resistant to "label" patients as high risk. One of my questions to this objection was, "What criteria are you using?" Not one could site me the evidence they used.

Based on research by the NIH U.S Dept. of Health and Human Services, the following is low risk.



Size of drink defined below

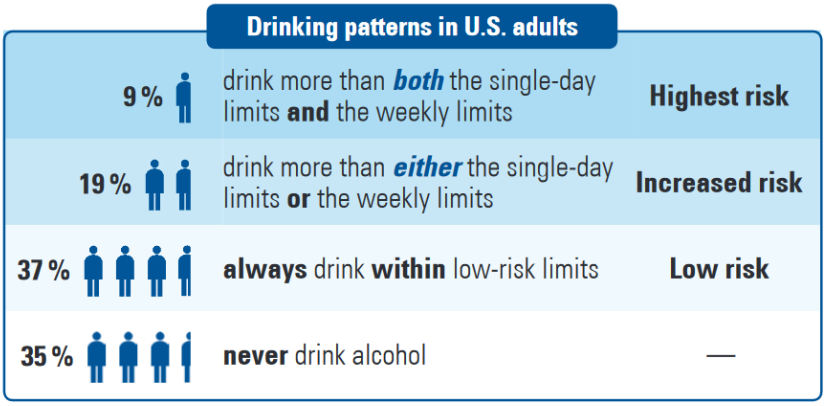
Many people are surprised to learn what counts as a drink. In the United States, a "standard" drink is any drink that contains about 0.6 fluid ounces or 14 grams of "pure" alcohol. Although the drinks pictured below are different sizes, each contains approximately the same amount of alcohol and counts as a single drink.



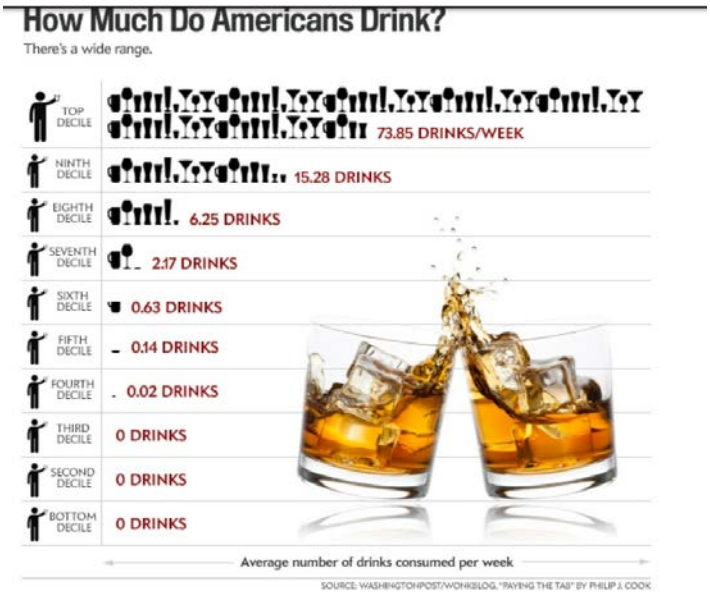
NIH U.S. Dept. of Health and Human Services 2010 statistics show

How much do U.S. adults drink?

The majority—7 out of 10—either abstain or always drink within low-risk limits. Which group are you in?



Research in 2014 shows 30% of U.S. adults (18 and over) never drink
Another 30% consume less than one drink a week
The top 10% of adult Americans, 24 million of them, drink an average of 74 drinks a week or 10 a day (Cook, 2014).
The 2014 stats stack up like this, showing top 20% at risk based on recommended amounts



Probably the most important barrier, which was often implicit in the interview, is the theoretical framework that does not encourage a medical practice to focus on preventive care. By this I mean the focus of the medical model of care has been to *treat* what comes in my office, prevention is not what I do and it is not why people go to the doctor.

Another stated barrier, yet more implicit, is workflow dysfunction. The practices do not think of SBIRT only; they have many items to incorporate into interactions with patients such as depression screening, and smoking. With the exception of two practices, the office workflow did not present a team approach to these behavioral questions.

Reimbursement is not a significant barrier except when the patient is billed for it; *in this scenario billing is a barrier.*

Several practices were not even sure they were being reimbursed. One practice was billing 99420 (Health Risk Analysis/Assessment) and being paid by all plans, to their knowledge. The experience of reimbursement by codes varied. Some of the issues were:

- subject to co-pay and deductible, billing becomes a barrier to conduct screening and intervention
- cannot be used with another EM code

- not paid at all due to patient's (employer) contract terms; once again in this scenario billing becomes a barrier to screening
- paid maybe yes maybe no with 25 or 59 modifier

Insurance (Payer) barriers to SBIRT

The description of SBIRT states it is covered by the preventive services (as defined in section 2713 of the PHS Act, added by section 1001 of the ACA) and it is part of essential health benefits (EHB). The act also states; preventive services must be covered, cannot be subject to cost-sharing (i.e., no patient co-pay or coinsurance), and must be paid on a first-dollar basis (i.e., the plan must pay even if the participant has not yet met his/her deductible under the plan. The reality is the State determines which essential benefit and how they are defined and administered.

The Colorado Insurance commission, Dayle Axman states:

"Colorado Insurance Bulletin B-4.83, "Preventive Services Covered by Health Benefit Plans." Insomuch as the services you are describing (SBIRT) fall within the parameters of the preventive services listed in the bulletin, specifically within the "A" and "B" recommendations of the U.S. Preventive Services Task Force, the services would not be subject to cost-sharing requirements. Those services that do not, should be covered in alignment with mental health parity requirements. Axman goes on to say, please note that Colorado insurance laws, regulations, and bulletins only apply to health insurance policies issued in Colorado. ***Our laws do not apply to policies that are issued in other states even when the patient lives here,*** *self-funded plans, federal employee benefit plans, Medicare or Medicaid.*

Large group plans are not required to cover essential health benefits. Therefore, our state mandate applies to these groups. In general, the only time state law is not pre-empted by federal law is when the state law has more consumer protections" (Axman 2016).

Further clarification for the state mandate from the U.S. Department of Health and Human Services, "Insurance Standards Bulletin Series–Extension of Transitional Policy through October 1, 2016 states: ***The essential health benefits requirement applies to health coverage sold in the individual and small-group markets, both inside and outside of the Affordable Care Act's new insurance marketplaces (also known as exchanges).*** Public Health Service Act § 2707(a) (codified at 42 U.S.C. § 300gg-6(a)); 45 C.F.R. §147.150. ***It does not apply to the large-group market, to self-insured health plans, to grandfathered plans*** *(those plans in existence before the Affordable Care Act that have not made significant changes since its enactment in March,*

2010), or to policies renewed pursuant to the Obama Administration's transitional policy for expiring coverage.

The interviews with the insurance plans came down to two issues:

1. The beneficiary's plan decides if the screening and brief intervention is covered
2. The SBIRT codes in question are ether covered or not covered based on the contract plan

The payers may give descriptions on their websites about the screening for alcohol and brief intervention as a covered benefit, however in calling the company claims department, the story was, "It depends on the beneficiary's plan."

Medicare SBIRT payment guidelines

Medicare payment for SBIRT is clear: Medicare covers only reasonable and necessary SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) per the Social Security Act (Section 1862(a)(1)(A); Medicare defines SBIRT as an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a Substance Use Disorder. The service can be performed by physicians, non-physician practitioners, and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs) for certain mental health services provided to Medicare beneficiaries.

Medicare created two Healthcare Common Procedure Coding System (HCPCS) G-codes to allow for the appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services. These two HCPCS G-codes are:

G0396 (Alcohol and/or substance (other than tobacco) abuse **structured assessment** (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes), and

G0397 (Alcohol and/or substance (other than tobacco) abuse **structured assessment** (for example, AUDIT, DAST) and intervention greater than 30 minutes).

It is important to note, to accurately provide screening and bill Medicare you must pay attention to the definition of Medicare coverage: ***It only covers reasonable and necessary SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) per the Social Security Act (Section 1862(a)(1)(A);***

It is highly recommended that a quick question questionnaire, documented in the medical record, be given to Medicare patients to determine the need for the screening. For example:

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Patients who answer "1 or more" should receive a full alcohol screen (AUDIT).

Like all providers of services billed to Medicare (or any insurance carrier), it is essential that providers document their services fully in the medical record; if the records are incomplete, the provider is at risk of losing Medicare payments (or other payers) in the event of a claims audit. The medical records should be complete and legible; documentation of each patient encounter should include, for all payers:

- Reason for encounter and relevant history
- Physical examination findings and prior diagnostic test results
- Assessment, clinical impression, and diagnosis
- Plan for care
- Date and legible identity of observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes

- Past and present diagnoses should be accessible for the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented

Interpretation for brief intervention services are provided by licensed professionals designated by the state and include:

- Physician
- Clinical Psychologist (CP)
- Clinical Social Workers (CSW or LCSW)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS), i.e. specialist in mental/behavioral health
- Physician Assistant (PA)

Colorado Medicaid SBIRT payment guidelines (updated May 2016)

- The SBIRT benefit is available to members ages 12 and older who are enrolled in the Colorado Medical Assistance Program. Members enrolled in a Medicaid HMO or managed care organization (MCO) must receive SBIRT services through the HMO or MCO
- *Brief Screen or Pre-Screen: one to several short questions relating to drinking, tobacco and drug use. Payers consider this to be an integral part of routine preventive care and is therefore not separately reimbursable. It can be administered by providers or any other staff member, in writing, orally, or through other technologies.*
- Full Screen or Brief Assessment: this more definitively categorizes a patient's substance use and is indicated for patients with positive brief or pre-screens.
- Providers are required to use an evidence-based screening tool for this step such as the AUDIT, DAST, ASSIST, CRAFFT, or POSIT.
- Brief Intervention: brief motivational conversation with a patient intended to induce a change in health-related behavior; typically used as a management strategy for patients with risky or problem drinking or drug use who are not dependent. May also be used as a method of increasing motivation and acceptance of a referral for substance use

treatment. Services are typically covered for patients who, through the use of an evidence-based screening tool, are identified as at-risk for a substance use disorder.

- For billing purposes, a brief intervention is defined as a period of time of at least 15 minutes of screening, intervention and delivery support.
- Follow-up: interactions that occur after initial intervention. Intended to reassess a patient's status, progress, and/or need for additional services. Billable if service provided is 15 minutes or greater.
- Referral: patients who are likely alcohol or drug dependent are typically referred to alcohol and drug treatment experts for more in-depth assessment and treatment.
- Payment for up to two (2) full screens per state fiscal year.
- Payment for up to two (2) sessions of brief intervention referral per year.
- When applicable, attach bypass modifiers (typically 25 or 59) to H0049, 99408, and 99409 line items to indicate that a separate amount of time was spent conducting the SBIRT process from other office procedures (see manual for additional details).
- Negative ***full screens*** may be billed using H0049.
- Emergency department may bill for SBIRT.
- FQHC SBIRT reimbursement is included in the encounter rate payment. No separate payment for SBIRT is allowed. ***Providers must still attach the SBIRT codes H0049, 99408 or 99409 to the claim.*** NOTE: This is NOT being done by FQHC at this time, at least the one I interviewed.
- SBIRT and other services, EM codes can be paid on same visit, except when billing under the Mental Health and Substance Use disorder using procedure codes H0002 and H0004 or with any code that represents the same or similar service (usually true for all payers).

Rocky Mountain Health Plan SBIRT payment guidelines (2016)

Rocky Mountain Health Plan was very cooperative with my questions. However, like most plans I talked with, it came down to "the codes." The substance of SBIRT is not their concern. The codes trigger any insurance company to act. They are covered or they are not; the plan dictates the coverage. Information came from Greg Coren, Rocky Mountain Health Plans
Senior Manager Provider Relations and Western Colorado Network Manager, Office and Fax: 970.255.5673
Email: greg.coren@rmhp.org

Specific questions to Greg concerning FQHC and the G codes which are subject to co-pay.

#1 If a Federally Qualified Health Center (FQHC) were to bill you the codes below would you pay them the same way for the codes? Providing of course that you have a contract with them to provide services to patients. Yes, for commercial members. For Medicare they would be paid according to Medicare guidelines for FQ's, i.e. encounter-based rates.

#2 Why are the codes G0396 and G0397 subject to copay when screening and brief intervention are covered as essential benefits, not subject to deductible or copay, under ACA? What is the difference between them and 99408 and 99409? Thanks again for your cooperation. I'm not a professional coder so I don't have an answer for you. All I can tell you is that is how our configurations are mapped.

99408, 99409 – Payable for both Commercial and Medicare for inpatient and outpatient. For commercial and Medicare these codes receive the Alcohol/Substance rehab benefit inpatient and outpatient.

99420 – Payable inpatient and outpatient for Commercial and Medicare. Inpatient for both Commercial and Medicare gets inpatient hospital benefit. Outpatient for both Commercial and Medicare gets preventive medicine screening benefit.

G0396, G0397 - Payable for both Commercial and Medicare for inpatient and outpatient. Commercial and Medicare these codes receive the Alcohol/Substance rehab benefit inpatient and outpatient.

Rocky Mountain Health Plan Code Mapping

Below is a breakdown of the mapping for physician claims, for their Commercial and Medicare members. None of this applies to Medicaid since all of these codes would have to be paid by the BHO. As you can see the Alcohol Screening and Preventive codes are covered in full with no member out-of-pocket.

CPT	Commercial Service ID	CATEGORY	BENEFIT	Medicare Service ID	CATEGORY	BENEFIT/RULE
99408	ASOO	Alcohol Screening	Covered in full	VPSI/VPSO	Visit, Psych, Substance	Cost Share (specialist copay)
99409	ASOO	Alcohol Screening	Covered in full	VPSI/VPSO	Visit, Psych, Substance	Cost Share (specialist copay)
99420	SSI/PEVC	Preventive Medicine Screening/Counseling	Covered in full	SSI/PEVC	Preventive Medicine Screening/Counseling	Covered in full
G0396	VPSI/VPSO	Visit, Psych, Substance, Outpatient	Cost Share (usually PCP copay)	VPSI/VPSO	Visit, Psych, Substance	Cost Share (specialist copay)
G0397	VPSI/VPSO	Visit, Psych, Substance, Outpatient	Cost Share (usually PCP copay)	VPSI/VPSO	Visit, Psych, Substance	Cost Share (specialist copay)
H0049	NABI/NABO		Not a Benefit	NABI/NABO	Not a Benefit	Not a Benefit
H0050	NABI/NABO		Not a Benefit	NABI/NABO	Not a Benefit	Not a Benefit

Aetna Health Plans SBIRT payment guidelines (effective October 2015)

Aetna literature describes their SBIRT benefit. However, speaking with claims department the codes were *all* subject to beneficiary's plan, *no exception*. The Aetna Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) program is designed to support primary care physicians in screening for alcohol abuse, providing brief intervention and referring individuals to treatment. The program incorporates the evidence-based protocol established by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The Aetna SBIRT program offers reimbursement for screening and brief intervention. The program is open to Aetna participating primary care physicians treating any patient who is 18 years of age or older and has Aetna medical benefits (Aetna 2015).

How the Aetna SBIRT program works

The program follows the steps outlined by the NIAAA in *Helping Patients Who Drink Too Much: A Clinician's Guide.*

Step 1:
Screening begins with a single question about heavy drinking days, as well as the option for the patient to use a self-reporting instrument — such as the alcohol use disorders identification test (AUDIT).

Step 2:
The clinician completes an assessment to determine if an individual has a maladaptive pattern of alcohol *use* ***causing clinically significant impairment or distress.***

Step 3:
The clinician then makes a recommendation based on the assessed extent and severity of all alcohol-related symptoms.

Step 4:
The clinician includes reinforcement and support of continued adherence to recommendations in follow-up visits.

"To start the Aetna SBIRT program — simply follow the steps in the NIAAA guide to begin the process."

Aetna Reimbursement

The initial screening and brief intervention is a reimbursable service (please note: reimbursement for capitated membership is included in capitation payments). The primary care physician's office can bill for each screen by submitting:

- **99408:** Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, drug abuse screening test [DAST]) and brief intervention (SBI) services of 15 to 30 minutes
- **99409:** Alcohol and/or substance (other than tobacco) abuse structured screening (for example, AUDIT, DAST) and SBI services greater than 30 minutes

UnitedHealth Plans SBIRT payment guidelines

United gives acknowledgement to screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, diet and nutrition. However, once again the claims department was insistent the codes paid were totally dependent upon the beneficiary's plan. They expressed no awareness of information concerning essential benefits or substance abuse screening and brief intervention; they believed this to be a "mental health" benefit and again subject to beneficiary plan.

UnitedHealth Plan states: The Affordable Care Act contains a provision to make certain preventive service available without co-pays, co-insurance or deductibles. A non-grandfathered group health plan and a health insurance issuer offering group or individual health insurance coverage must provide coverage for preventive care without any cost-sharing (copayments,

coinsurance or deductible) requirements as long as services are rendered by physicians and other healthcare professionals who participate in the plan's network. This preventive services provision applies to both fully insured and self-funded plans. While grandfathered plans are not required to implement these changes, some grandfathered plans have chosen to offer preventive care services at no cost-share. ***All UnitedHealth Plan members at an appropriate age or risk status qualify for screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, diet and nutrition (United Preventive Care Services 2014).***

United makes a distinction between preventive vs. diagnostic. Documentation in the medical record in addition to diagnosis codes plays a role in payment for the codes without co-pay or deductible payments owed. Also a disclaimer applies as well: Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the health plan ID card.

Preventive vs. diagnostic

United Healthcare has determined that a health service is preventive when performed on a patient without symptoms (when age and gender appropriate) and at the stated intervals supported by scientific evidence. A service is diagnostic when performed on a patient with symptoms or is performed earlier or more frequently than the recommended intervals because of risk factors identified earlier. ***Unless specified otherwise in the plan, only services defined as preventive will be covered without cost-sharing. Keep in mind that wellness or reward programs may offer incentives for certain services, but only services described in our Preventive Care Services Coverage Determination Guideline are covered without cost-share.***

United Medicare Advantage SBIRT coverage in the following manner (UnitedHealthcare Medicare Advantage Policy Guideline Approved 07/13/2016)

CMS will cover annual alcohol screening, and for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and

- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the behavioral counseling interventions should be consistent with the 5A's approach that has been adopted by the USPSTF to describe such services. They are:

- **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For the purposes of this policy, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.

Nationally Non-Covered Indications

- Alcohol screening is non-covered when performed more than one time in a 12-month period.
- Brief face-to-face behavioral counseling interventions are non-covered when performed more than once a day; that is, two counseling interventions on the same day are non-covered.
- Brief face-to-face behavioral counseling interventions are non-covered when performed more than four times in a 12-month period.

Accepted codes accepted for screening and behavioral health counseling interventions in primary care to reduce alcohol misuse are:

99408
99409
G0442
G0443

Medicare coinsurance and Part B deductible are waived for this preventive service.

"The list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. ***Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service.*** *The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply."*

G0442 Annual alcohol misuse screening, 15 minutes
G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Place of service codes include:

11 Physician's office
19 Off Campus - Outpatient Hospital
22 Outpatient hospital
49 Independent clinic
71 State or local public health clinic

Anthem SBIRT payment guidelines (Updated December 2014)

Anthem's bulletin for providers in Colorado gives guidance on: Preferred Practice Guidelines Behavioral Health Screening, Assessment and Treatment.

"With *respect to the issue of coverage, each individual should review his/her Policy or Certificate and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The practice guidelines do not supersede the Policy or Certificate and Schedule of Benefits."*

Anthem defines Alcohol Misuse and Dependence: The US Preventive Services Task Force recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.

Alcohol misuse includes “risky or hazardous” and “harmful” drinking defined as:

- Risky/hazardous –
  - Women – More than 7 drinks per week or more than 3 drinks per occasion
  - Men – More than 14 drinks per week or more than 4 drinks per occasion
- Harmful –
  - Persons who are experiencing physical, social, or psychological harm related to alcohol use, but do not meet clinical criteria for alcohol dependence.

Screening tools

Screening tools should be used based on a full assessment using standard diagnostic criteria such as those from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (2013).

Many effective screening tools are available, including, but not limited to:

- AUDIT (Alcohol Use Disorders Identification Test). This is the most studied alcohol screening tool for use in primary care settings. Effective in detecting alcohol misuse, abuse, and dependence.
- CAGE or CAGE/AID. Click here to access: CAGE AID. This 4-item tool is the most popular tool for detecting alcohol abuse or dependence in primary care settings.
- MAST (Michigan Alcohol Screening Test). Click here to access: MAST. This widely used measure consists of a 25-item questionnaire designed to provide an effective screening for lifetime alcohol-related problems and dependence. It can be used for both adults and adolescents.
- CRAFFT: This is a validated 6-item alcohol screening test for use with adolescents.

It is recommended that all pregnant women and women contemplating pregnancy should be informed of the harmful effects of alcohol on the fetus, and advised to remain abstinent during pregnancy.

According to the U.S. Preventive Services Task Force, the optimal interval for screening and intervention is unknown. Patients with past alcohol problems, young adults, and other high-risk groups, such as smokers, may benefit from frequent screening.

Anthem suggests that PCP's utilize a brief screening procedure known as "Screening, Brief Intervention, and Referral for Treatment (SBIRT)” on an annual basis with all patients, using a brief screening tool such as the CAGE or CAGE-AID. Patients who screen positive should receive a brief and clear intervention to decrease or stop use.

Effective interventions to reduce alcohol misuse include an initial counseling session of about 15 minutes, feedback, advice, and goal setting, as well as an offer of further assistance and follow-up.

Multi-contact interventions for patients ranging widely in age (12-75 years) are shown to reduce mean alcohol consumption by 3 to 9 drinks per week, with effects lasting up to 6 to 12 months after the intervention.

These interventions can be delivered wholly or in part in the primary care setting and by one or more members of the healthcare team, including physician and non-physician practitioners.

Upon calling the Anthem office in Colorado to ask about specific codes related to SBIRT, I received the following information about the codes, however, additional information about copays deductibles and use of codes with other EM codes, were not addressed.

"The information gathered indicates the codes below are reimbursed currently within the medical contracts at this time. We have not had a discussion to date to add to the behavioral health contract. We can look at discussing this." Here are the codes that are currently reimbursed: from Itha Gabriel, LPC Provider Solutions, Anthem Blue Cross and Blue Shield.

Codes currently reimbursed

99408
99409
G0396
G0397
G0442
G0443

Cigna Health Plans SBIRT payment guidelines

Cigna was one of the rare plans that actually allowed me to speak with a supervisor and ask all my questions concerning the SBIRT codes and payment. However, the person never heard of SBIRT; she knew nothing about it being an "essential benefit." When a claim comes in they look for EM, codes and diagnosis codes; it is all about codes and the benefit plan. If the code is subject to co-pay or deductible depends on the plan contract benefit.

Cigna literature states:

Cigna's preventive care coverage complies with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include periodic well visits, routine

immunizations, and certain designated screenings for symptom-free or disease-free individuals. They also include designated services for individuals at increased risk for a particular disease.

The PPACA requires health plans to cover preventive care services with no patient cost-sharing, unless the plan qualifies under the grandfather provision or for an exemption. The majority of Cigna plans fall under the PPACA, and cover the full cost of preventive care services, including copay and coinsurance. Typically, these services must be provided by in-network healthcare professionals. There are some exceptions. ***This information does not supersede the specific terms of an individual's health coverage plan.*** To determine whether or not your patient's Cigna-administered plan covers preventive care and at what coverage level (100% or patient cost share), visit the Cigna for Health Care Professionals website (**CignaforHCP.com**) to verify benefit and eligibility information, or call **1.800.88Cigna** (**882.4462**).

Payment of preventive services

Payment of preventive services by Cigna is dependent on claim submission using diagnosis and procedure codes which identify the services as preventive. The coding guidance will assist billing staff.

CPT codes 99401–99404 are designated to report services provided to individuals at a face-to-face encounter for the purpose of promoting health and preventing illness or injury. Included in this category is substance misuse/abuse, with the understanding that if behavior change interventions are required beyond what is described in the preventive medicine counseling code descriptions, then see specific codes in the following section which represent smoking and tobacco cessation counseling, alcohol or substance abuse screening and counseling.

Behavior change intervention codes **CPT codes 99406–99412** are designated to report services provided to individuals at a face-to-face encounter and are utilized for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. *Behavior change services may be reported when performed as part of the treatment of conditions related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness.* Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

Humana Health Plans SBIRT payment guidelines

Humana, like most of the plans, directs the clinicians to educational material and guidance for administering and billing SBIRT. Humana, like all the plans, would not commit to the codes

being paid without knowing the plan/contract terms, diagnosis codes and in some cases medical records documentation.

In 2011 Humana issued a bulletin to inform practices, effective 10/14/2011: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. CMS will now cover an annual alcohol misuse screening and up to four, brief face-to-face behavioral counseling visits in a primary care setting to reduce alcohol misuse. In accordance with CMS guidance, Humana will now allow for these preventive services. Humana defines the components of SBIRT and refers clinicians to the following sites for additional information:

- Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov/sbirt
- Institute for Research, Education & Training in Addictions http://ireta.org/ebpsbirt

Screening is defined as a way to identify individuals who have or are at risk for developing alcohol- and/or drug-related problems and, within that group, identify patients who need further assessment to diagnose their substance use disorders and develop plans to treat them.

Brief intervention is a pretreatment tool or secondary prevention technique that primary care clinicians can easily incorporate into their medical practice settings.

Referral to treatment refers to the Primary care clinician who needs to be familiar with treatment resources available for their patients who are diagnosed with substance use or dependence disorders. Additionally, the primary care clinician may work with Humana case management team to help coordinate further treatment, if needed.

Humana's Provider Source newsletter summer 2016 reminds practices they can be paid for SBIRT. Can I get reimbursed for providing SBIRT services?

Yes. The following provider types are eligible for reimbursement:

- Advanced practice registered nurses or licensed clinical psychologists
- Physicians (both MD and DO)
- Licensed master's-level associates and physician assistants in a behavioral health outpatient facility
- Behavioral health inpatient facility
- Use payable code 99408 for billing.

Kaiser Health Plans SBIRT payment guidelines

Kaiser never returned my calls to discuss SBIRT with them. However, they are supportive of screening. Recently at the SBIRT Colorado *Building the Future on a Decade of Progress* event, Dylan Ross, PhD, LMFT, LPCC, Senior Manager, Department of Behavioral Health, Kaiser Permanente stated, "Approximately 30 medical office buildings have implemented SBIRT in an effort to make alcohol a vital sign in Colorado. Kaiser is working to leverage technology to improve the reliability of screening during routine visits. As of today, 88% of eligible members are screened during routine visits." Research articles are available from Kaiser showing the importance of alcohol screening, intervention for adults and adolescents.

Kaiser Permanente Northern California is reportedly the first private U.S. healthcare system to roll out a systematic alcohol-consumption screening tool to be used with all adult primary care patients on an annual basis (News & Views, Kaiser 2014).

The "Alcohol as a Vital Sign" questions and a provider prompt to intervene were rolled out in Kaiser Permanente's electronic health record in all adult and family medicine modules region wide on June 20, 2013, with the power to reach a significant number of people: 60 percent of the region's members have primary-care visits each year.

During the screening, medical assistants ask patients how many times they have had five or more drinks a day in the past three months. (For women and senior men, the cut-off is four drinks.) If a patient has had no such incidences, the screening is complete. If not, physicians ask more questions to determine if the patient needs only brief intervention or a referral to chemical dependency services.

Preventive care services have always been part of Kaiser Health Plans; they specifically list discussion with primary care physician regarding alcohol misuse as a preventive service to expect from your primary care provider.

Bright Health and SBIRT (2017)

A new selective health plan for Colorado begins in 2017. My conversations with the office netted zero awareness of SBIRT. This plan should fall under the Colorado SBIRT guidance rules.

BRIGHT HEALTH PARTNERS WITH CENTURA HEALTH
TO BRING NEW HEALTH INSURANCE OPTION TO
COLORADO'S INDIVIDUAL MARKET

Starting for the 2017 plan year, Bright Health intends to offer individual health insurance plans to Colorado residents via its website, broker partners, Connect for Health Colorado and private health insurance exchanges; open enrollment period begins November 1, 2016. Bright Health has raised $80 million from a handful of venture capital firms and has its sights set on the Affordable Care Act exchanges, and eventually, Medicare Advantage.

Denver Health Plan SBIRT payment guidelines

Denver Health states it follows the USPSTF preventive guidelines, which include:
Alcohol misuse: screening and counseling

The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse, B recommendation Release date May 2013.

Denver Health Plan Quality Improvement program covers preventive care services and guidelines which include: Preventive Services for Adults 18 and over with a high priority for alcohol misuse screening and brief counseling.

Screen routinely includes asking:

> "When was the last time you had 4 or more (women/men >65 yrs.) or 5 or more (men ≤65 yrs.) drinks in one day?" Positive = in the past 3 months.
>
> "How many drinks do you have per week?" Positive = more than 7 for women/ men >65 yrs., and 14 or more drinks per week for men.

Denver Health Plan, health coaches, work with the clinicians to counsel patients utilizing intervention skills and resources for substance abuse. Dr. Kerry Broderick expressed concern over the Medicare Requirements for SBIRT intervention and screening (and other plans). Health coaches are not in the Medicare guidelines as qualified to provide SBIRT services. As a result, they have not been billing for SBIRT services for over 2 years, even though they are screening. Dr. Broderick believes the physician does not have time in their schedule for even brief intervention. She now believes having a LCSW or trained health coach to provide a warm handoff at the time of the visit works the best for the patient and the provider.

See Appendix B for all insurance companies doing business and registered in the State of Colorado.

Summary

Chronic disease is the most significant driver of healthcare costs in the nation, representing an estimated 85 percent of our annual spend. As patients bear a higher share of the expenses and both private and public payers react to rapid changes in our clinical and demographic profile, there is tremendous pressure to shift from a volume- to value-based payment system. The industry is moving toward preventive medicine with compensation based on outcomes. SBIRT, and other behavioral health indicators, will become a critical component to prevention and value-based payment models of care.

We know from research that 90% of older adults, 50 and over, use prescription and over-the-counter medications that may interact adversely with alcohol or illicit drugs (Harris, J 2012). Statistically, alcohol addiction has remained the primary substance abuse disorder for people age 50 and older, and this still holds true today.

While screening for unhealthy alcohol use with brief intervention ranks as one of the highest prevention priorities for adults, it has one of the lowest delivery rates, with screening or intervention typically completed only when a risk factor is evident (Johnson 2011).

Practice culture and workflow needs to be the focal points for adoption and dissemination of SBIRT. The practices demonstrated concern over patient responses when they received a bill for the screening. Practices did not want to lose their patients or fear the patients will not want to *tell them anything* if they are billed for information shared. Billing for SBIRT has in itself become a barrier to its use. Dr. Kerry Broderick informed me Denver Health has not billed for SBIRT for a couple of years (however they have a new administrator who is thinking about billing again if they can work out the details). They currently assess their patients, at the frequency they feel appropriate, and provide brief intervention utilizing health educators. She believes the codes and staff expected to administer the screen and provide intervention are too rigidly defined by CMS and other payers. In addition, the anxiety of patient receiving a bill for the service keeps them from billing.

From my conversations with the practices and providers, it appears the screening and brief intervention is taking place far more often than it is being billed. Payers need to streamline and be consistent with how SBIRT is administered and billed. In addition, payers need to evaluate the level of staff that can provide intervention for the screening. It is not practical to have a LCSW at every practice location. Health educators, social worker or other trained staff seem to be the best opportunity to accomplish SBIRT at the practice level. The guidelines from CMS preclude the use of non-license personnel for intervention creating a staffing burden for the average practice. Maybe a LCSW can also train as an MA, combining both skills, or can we teach MA's intervention skills? The providers would like to see some reimbursement for the time

and staff needed to fulfill the requirements of SBIRT. The providers can't endure all the responsibility for every screening tool and brief intervention especially in a fee-for-service world.

Two practices interviewed demonstrated both the theoretical framework and the workflow to carry out SBIRT in an effective effectual manner. Both practices sited outcomes that demonstrated effectiveness of screening and intervention. One practice made it a habit to conduct the substance screening tool yearly at the wellness or preventive exam, once the patient answered the brief question to see if they qualified for the AUDIT tool screening. In this manner the code was always paid and not subject to co-pay or deductible. The clinician was responsible for the brief intervention. In the second office, the practice employed a LCSW. The front desk asked patients to fill out several forms on first visit, and as needed based on previous scores. As patients came into the practice, front desk handed them the surveys. The surveys were scored by the LCSW; if positive, the social worker and/or clinician spoke with the patient the same day. In this office the clinicians believed the depression survey, alcohol, substance abuse and smoking surveys were as essential as blood work and vital signs. In both practices the clinicians set the tone, and the patients and staff complied.

For the insurance companies it is all about the codes and the contract benefit plan. The SBIRT research and knowledge pieces for provider and patients concerning alcohol screening and intervention do not reach awareness at the payment level. Practices moving into value-based models of care need to be aware of their contract requirements. This well-timed period in health care should serve to advance awareness of SBIRT at the contract level. The detailed information provided by the insurance companies gives a flavor of the variance in alcohol screening from their viewpoint. My concern with some of the practices, especially with Medicare, is the awareness as to who should be screened and accordingly billed. While the dollars paid are low, the opportunity of fraud risk exists with "over use" of SBIRT codes.

In reading the literature from the payers it is obvious the SBIRT regulation has cut and paste features from other payment regulation. Payers need to understand just what is SBIRT. SBIRT is preventive, it is exploratory, it is designed to find potential alcohol abuse before it becomes an illness or complicates current disease state. It is a social determinant, it is a behavioral component of one's health. SBIRT is not for the already- known abuser of alcohol. The very nature of the billing requirements and acceptable staffing credentials for screening and intervention often negate the preventive nature of SBIRT, limiting the screening and intervention they are trying to encourage. For example, Medicare regulations say "SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury)" will be paid.

Recommendations

Recommendations for increasing acceptance and use of SBIRT are addressed for the practice as well as the payer and consumer.

Practice Level Interventions

- Practice staff and clinicians explore their current theoretical framework related to alcohol misuse and intervention.
- Staff training revisited to address the topic of alcohol use, regardless of their own beliefs or practices.
- Development of positive, culturally sensitive scripts for staff to use with patients.
- Revisit with practices healthcare reform value-based care. Population health management is a big factor in value-based care, and prevention is a big part of population health.
- Practices develop awareness and understanding of their practice contracts, requesting specific guidance on SBIRT payment and coding.
- Practices prepare simple-to-use questions to justify use of AUDIT tool or other screening tool approved for reimbursement.
- Workflow mapping to include steps from administering screens to intervention and referral if applicable.

Practice interventions could be addressed by webinars and disseminated as part of SIM/TCPI practice transformation by the practice facilitators. Additional grants will be awarded to organizations this fall, assisting practices with adoption of MACRA. Quality measures and clinical practice improvement measures both directly support SBIRT, for example, a quality measure taken from federal registry MACRA guidelines.

	2152/431 ‡	N/A	Community/Population Health	Registry	Process	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.	American Medical Association-Physician Consortium for Performance Improvement

Consumer intervention

- Conduct patient focus groups to gain insight into patient's views and desired approach to SBIRT.
- Practices should develop patient councils to advise practices in patient-centered care.
- Press Ganey can be approached to add a question, similar to depression, so patients come to expect the screening questions.
- Practices can add to their own office surveys a question about alcohol screening.
- Public service announcements by payers including Medicare to highlight the risk of alcohol and prescription medications as well as the potential misuse of alcohol.

Payer interventions

- One option is to remove payment for SBIRT. Payment to practices should be a reward for time spent in prevention screening and intervention. Focusing on all the details of documentation, coding and "correct personnel" diminishes the desire to bill. However, as stated above, providers would like to see reimbursement for the time and staff needed to fulfill the requirements of SBIRT. The providers can't endure all the responsibility for every screening tool and brief intervention especially in a fee-for-service world.
- Visit large employers, educating them on the importance of SBIRT as an insurance benefit.
- On a local and national level, meet and educate key insurance carriers. There are five components to working relationships with payers.

    (1) Create on-going open channels of communication. The state insurance commission and other agencies should support an interactive relationship with the carriers through calls and in-person meetings.

    (2) Work with payers toward standardization of codes, and definitions.

    (3) Creation of templates, workbooks and other tools for practices to utilize.

    (4) Implementation of market conduct exams (the way insurance companies distribute their products in the market place) and network adequacy

assessments (the ability of a health plan to provide enrollees with timely access to healthcare services included in the benefit contract).

(5) Collaboration with multiple state and federal agencies, health insurance carriers, and stakeholder groups. Determining what health insurance carriers are providing appropriate coverage to consumers, and resolving potential noncompliance issues and violations by helping carriers better understand the essential benefit.

In conclusion I want to thank Cassidy and other staff members of Peer Assistance Services and the Colorado Office of Behavioral Health for the opportunity to research barriers to SBIRT. It has been an enlightening experience to research and interview both providers and payers. I trust MGMA Consulting will have an opportunity to support operationalizing the recommendations to promote greater compliance to improve the health of our populations.

Appendix A

Interviews conducted with the following practices.

San Luis Valley Health (hospital and primary care clinics)
JoAnna Lucero
JoAnna.Lucero@slvrmc.org

***Denver Health (Hospital and FQHC)**
Kerry Broderick, Attending Physician, ED; SBIRT supervisor
Kerry.Broderick@dhha.org

Salud Family Health Center (FQHC system in NE Colorado)
Rosario Morales, Billing Manger
rmorales@saludclinic.org
Jonathan Muther, Director of Behavioral Health & Psychology Training
jmuther@saludclinic.org

Rocky Mountain Family Practice (Private Practice in Leadville)
Dr. Lisa Zwerdlinger, Medical director
drlisa@leadvillermfp.com
Shanon Giffin, billing staff
shanongiffin@gmail.com

Foresight Family Medicine (Private Practice in Grand Junction)
Lisa Barnes, LCSW
integratedhealth@ffpdoc.com

Pediatric Associates of Durango
Sandy Williamson
(970) 259-7337

Department of Health Care Policy and Financing – Medicaid contact for SBIRT
Alex Weichselbaum
(303)-866-5931
Alex.Weichselbaum@state.co.us

Appendix B

Insurance companies researched, companies doing business in Colorado, registered with Colorado Dept. of Insurance Regulation.

- Rocky Mountain Health Plan
- Colorado Access
- Anthem (Anthem Blue Cross and Blue Shield is the trade name of: In Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc.)
- Cigna
- Medicaid – is run by Health Care Policy and Finance
- Humana
- HMO of San Luis Valley – small but "enlightened" Colorado Choice Health Plan
- Colorado Choice Health Plan
- Kaiser Foundation
- Kaiser Permanente
- Freedom Life - offers specialty plans only
- Coventry/First Health /Aetna
- Aetna Health
- Aetna Ins. Co/Cofinity
- Golden Rule owned by UnitedHealthcare
- National Foundation – underwrite health plans; do not sell them with their name
- Denver Health
- HMO Colorado Anthem
- All Savers - UnitedHealthcare small business plan
- Bright Health Ins. Co (new 2017 partnership with Centura)
- University of Colorado Health

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