Questions asked on SBIRT TA Webinar

Housekeeping

- **Could you send out the link to download the updated SBIRT guidance document?**

  The updated SBIRT guidance document is available online here: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

- **Will the slides be posted online?**

  Yes, the slides are posted online here: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

- **Are you going to be scheduling another webinar similar to today's session?**

  ~~The slides will be posted online and there may be other opportunities for technical assistance, but OHA does not plan to provide another webinar on SBIRT billing at this time.~~

  OHA is holding a second SBIRT billing webinar on December 18, 2013 at 2:00 pm.

Additional Questions

If you have additional SBIRT-related questions, please send them to Sarah Bartelmann (sarah.e.bartelmann@state.or.us).

Updated Answers (October 21, 2013)

- **Do tribal clinics still bill the negotiated amount for these services?**

  Individuals do not usually come in for only an SBIRT service. For the most part, SBIRT services would be "incident to" a core provider visit. Tribes will bill for an encounter as defined in rule (OAR 410-146-0085((6)). An encounter includes all services, items and supplies provided to a client during the course of an office visit, and "incident-to" services (except as excluded in section (15) of this rule)….

  (OAR 410-146-0085((10)) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that

take place on the same day and at a single location constitute a single visit. For exceptions to this rule, see OAR 410-146-0086 for reporting multiple encounters.

OAR 410-146-0086(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period receiving distinctly different diagnoses may be reported as two encounters….

Provider Types

- **Can QMHA's also administer screenings?**

  Yes, under incident-to guidance.

- **Do Community Health Workers need to be trained and assessed for competency before they can conduct the full screening (e.g., AUDIT, DAST)?**

  Ideally, all ancillary staff conducting screening and/or brief intervention should be trained and assessed for competency. Consult the licensed practitioner that is supervising and signing for the services rendered.

- **Is it permissible for medical assistants to hand out the AUDIT or DAST tool to the patient, but the provider reviews the results and conducts the brief intervention?**

  Yes, the medical assistant can distribute the screening tool following a brief screening, but to bill for SBIRT screening or screening and brief intervention services, a licensed provider or ancillary provider under the supervision of a licensed provider must review the screening and conduct the brief intervention.

- **What defines a Health Educator? Are there education requirements?**

  See www.nchec.org for a list of the areas of responsibility, competencies and sub-competencies that guide the professional preparation and employment of health educators.

Health educators are ancillary staff working under the supervision and licensure of a physician, nurse practitioner, physician's assistant, licensed psychologist, or licensed clinical social worker. Incident-to rules apply.

- **Can masters level interns provide SBIRT?**

  Yes, as ancillary providers under the supervision / direction of a licensed provider.

- **Can CADCI or II working under supervision of a licensed provider bill for SBIRT services?**

  Yes, if they are following all incident-to guidance.

- **When will LPCs be considered Licensed Providers?**

  DMAP and AMH are working towards adding Licensed Professional Counselors (LPCs) and Licensed Married and Family Therapist (LMFTs) as professionals that can perform and bill for SBIRT.

  At this time, there are system limitations within DMAP's MMIS (claims processing system) that do not allow these provider type to bill SBIRT.

- **Can an MD, nurse practitioner, or physician's assistant who is contracted to provide services at a facility (but not employed) bill for SBIRT services?**

  Yes. As MDs, NPs, and PAs are all licensed providers. The billing provider is submitting claims on behalf of the facility using the contracted employee's licensure as a rendering provider.

  Ancillary staff providing SBIRT services must be employed by the facility and their medical services provided under the supervision of the contracted licensed provider whose licensure is used as the rendering provider.

- **Can public health nurses (RNs) bill for SBIRT screening if there is a written protocol or standing order that is signed by the Health Officer / physician, but the Health Officer is not in the building at all times when the screening takes place?**

  If public health nurses cannot bill incident-to without a supervising practitioner present, screenings that take place during preventative visits at Public Health Departments will not count towards the SBIRT incentive measure?

Incident-to rules apply: the licensed provider who is supervising the auxiliary provider or personnel must be present in the office and immediately available to provide assistance and direction throughout the time the auxiliary provider or personnel is providing the service.

The CPT codes included in the incentive measure are "Preventative Medicine Services" and would need to be billed using a practitioner's licensure. CPT 99381-99397 should only be billed if performed by a RN under the direct supervision of a licensed provider. However, there may be provisions for this in the public health setting as a means to improve access to care.

- **Must the credentialed provider see the patient and include SBIRT in an individualized written plan of care before SBIRT is delivered?**

  The medical record must include a "link" between the licensed provider and the SBIRT services provided by ancillary staff. The medical record must support the services being billed for.

Brief Interventions

- **Is there any guidance on how many times per year you can bill for brief interventions?**

  There is not a limit on how many times you can bill for brief intervention services.

Documentation

- **Does time spent need to be documented in the medical record?**

  Yes.

- **Does documentation of time spent need to be "from x time to y time" or should it be "18 minutes spent on brief intervention, etc"?**

  Ideally, the medical record would include a more detailed breakdown of time spent. Include start and stop times of the face-to-face time spent performing the full screen and brief intervention.

Screening

- **How is the Full Screening defined?**

  The full screening is the secondary screening in the SBIRT process, used if the patient indicates problematic or risky behavior on the initial, or brief screen. The full screen should be an evidence-based standardized screening tool. See the list of AMH-approved evidence-based screening tools available online here: http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx

- **The CAGE and T-ACE are only four questions. Is there a "brief" screen for these?**

  The Cage and T-ACE are considered full health risk assessment tools just the same as the AUDIT or DAST.

  Clinics would use the same "brief" annual screening tool, regardless of the full health risk assessment tool that is being utilized.

- **Is the 5Ps considered a Full Screen? This might be done in place of the annual questionnaire for a pregnant woman.**

  Yes. The 5Ps is on the list of AMH-approved evidence-based screening tools, available online here: http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx

- **Does the screening need to be done by a staff person or can it be a self-reported screening from a web site or kiosk machine?**

  The brief screening can be done online, via kiosk machine, over the phone, or in person. The full screening needs to be done in a face-to-face encounter.

- **Is there a code to use for the brief screening?**

  No. The brief screening is not reimbursable and there is not an encounter code for reporting brief screenings. Brief screenings are only documented in the medical record.

- **Is the OHA-recommended form considered a full screening that should be coded as 99420?**

  No. The OHA-recommended form is for the brief screening and there is no reimbursement or encounter code for the brief screening.

- **Is the PHQ-2 a mandated part of the annual SBIRT screen or just alcohol and drug use questions? (Is SBIRT by definition just for A/D screening/ prevention or other health risks as well - tobacco use and depression)?**

  SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on substances (alcohol and/or drugs). The PHQ-2 is not part of SBIRT, but is related to depression screening.

  However, the annual brief screening tool approved by OHA/AMH has three sections: alcohol use, drug use and mood. This tool is not SBIRT specific, but it is the first step in the SBIRT process and is the first step in the depression screening process as well.

- **Can you use CPT 99420 for tobacco dependence screening as well? For example, the Fagerstrom Test for Nicotine Dependence, if a tobacco use question is added to annual screen.**

  Tobacco cessation is not part of the SBIRT process, and one question on tobacco should not be added to a standardized, evidence-based screening tool. However, we know some clinics have added tobacco screening questions to the brief screen, which is not a billable service.

  For billing requirements on tobacco cessation, refer to OAR 410-130-0190.

- **What are the appropriate steps if a patient screens positive for alcohol and/or drug use on the brief screening, and also screens positive on the mood questions?**

  The brief screening would be followed by all full screening tools that are indicated in the brief screening responses.

  - If the patient screens positive on the alcohol questions, they should be given the AUDIT screen;
  - if they screen positive on the drug questions, they should be given the DAST screen (or other AMH-approved evidence-based screening tools);
  - if they also screens positive on the mood questions, they should receive a full depression screening using an evidence-based standardized screening tool.

- **Some clinics have chosen to skip the brief screen and instead administer full screens to all patients, then coding 99420 if the screen is negative and 99408 or 09 if positive and BI is provided. But the new guidance document says a full screen should only be administered if the brief screen is positive. So if a full screen is administered, but it comes out all negative, can clinics still code 99420?**

"A full health risk screening (99420) should not be performed when the brief screening was 'negative'. ~~A full health risk screening (99420) should not be billed if "negative".~~

~~-~~From a clinical practice stand point, it doesn't make sense to provide for and reimburse a full screening if the responses to the brief screen are negative. A full screen would not be indicated if the brief screen was 'negative,' unless other clinical indications were apparent.

The full screen is used to determine where on a spectrum of risky behavior a patient falls when there is information that indicates a need for further assessment. ~~A full screen should never be "negative".~~

For example: The OHA-recommended brief screen asks women how many times in the last year they have had more than 4 drinks in a day. If the response is "never" or "I don't drink", then a full screening tool for alcohol use would not be used. If a female patient's response is that she only has "about 4 drinks a week but not in the same day" a full screen may not be used unless there are other medical conditions that may be affected.

It must be kept in mind that the use of these screening tools are intended to be patient specific and should be meant to individualize their plan of care. They should be used as an opportunity that opens up discussions about the risky behaviors and the impact on the patients' concurrent health conditions.

It would be medically inappropriate to perform and then submit for billing a full screening for alcoholism for a patient that has never had an alcoholic beverage. A full health risk screening tool is selected based on initially identified risky behavior. If a clinic is using the same "full screen" on every patient and billing CPT code 99420 for negative results, then post review of the medical record is not likely to support the claim payment.

The only tool that can be used "universally" is the brief screening tool. SBIRT is not intended to identify all patients that drink alcohol responsibly. SBIRT services are aimed at preventing the unhealthy consequences of alcohol and drug use among

those whose use may not have reached the diagnostic level of a substance use disorder.

Coding Guidance

- **When billing for SBIRT, do 99408/99409 AND 99420 need to be used, or is it 99408/99409 OR 99420?**

  It is either / or.

- **Does use of 99420 imply that both the full screening and a brief intervention were conducted, but took less than 15 minutes?**

  Yes. But OHA can only identify this as an SBIRT screening / intervention if the diagnosis codes are used with CPT 99420.

- **How do you decide whether to use a G Code versus a 99408 or 99409? How do you decide which is best - the G Codes, or the 99408/9?**

  When SBIRT services are provided on the same date of service as an office or home visit under the licensure of a single provider then the G-code may be used.

  The primary difference between the two sets of codes is that the 99408/99409 cannot be billed with an E/M code on the same date of service when performed by the same licensed provider.

  The G-codes may be used when SBIRT is provided by the same licensed provider on the same date of service as an E/M visit (w/ modifier to indicate that the E/M service is a clearly distinct and separate from the SBIRT service). The medical record must clearly support the claim coding for services rendered.

- **Please give an example of when 99408 or 99409 would be used?**

  - For SBIRT services 15 minutes or more; and,
  - When provided by a licensed provider or ancillary staff working under the supervision of that licensed provider not associated with a home or office visit; or,
  - When provided by a licensed provider or ancillary staff working under the supervision of that licensed provider in the context of a preventive visit.

- **When does the clock start for the full screening, when using 99420?**

  99420 is not time based. However, in the context of whether or not the client will need a brief intervention then the time spent on screening and the brief intervention are included in the coding of 99408/99409 or G0396/G0397.

  The medical record should include the time spent when the licensed provider or ancillary staff sat down to administer and review the screening with the patient. The clock would not start when the medical assistant hands the screening to the patient to fill out while waiting in the exam room for the practitioner to return. The clock begins when the practitioner begins reviewing the answers with the patient face-to-face.

- **Can you bill for SBIRT delivered during a home visit?**

  Yes, when provided by a licensed provider.

- **Can a clinic do a warm handoff to an ancillary provider on the same day as billing incident-to?**

  Yes. Criteria for coding and NCCI edits apply when submitting a claim for services performed under a single rendering licensed provider.

- **Must the services to be reimbursed under incident-to rules be the only services delivered during that visit? SBIRT is rarely the only service delivered during a visit.**

  No. SBIRT is an additional service that contributes to a complete assessment and educational process to improved health.

- **Is incident-to billing permissible only in primary care clinics that are not affiliated with hospitals?**

  Incident to billing applies in outpatient physician's office or clinic settings, but not outpatient hospital clinic settings.

  Incident to billing does not apply in an "institutional setting", such as a hospital or skilled Nursing Facility. If a physician's office is located within an "institution", it must be confined to a separately identified part of the facility used solely as the physician's office and cannot be construed to extend throughout the entire institution.

- **What are the correct diagnosis codes to use with 99420 (Health Risk Assessment) to indicate SBIRT screening occurred?**

  V79.1 Screening for Alcoholism
  V82.9 Screening for Unspecified Condition

  OHA's guidance document previously published in July 2013 incorrectly included V65.42 (other counseling, substance use and abuse) as an appropriate diagnosis code. This code was not included in the final measure specifications or baseline data.

  OHA has corrected this error in the revised guidance document published in September 2013.

  Note that V65.42 *can* be used with 99420, but that claim will not be "counted" towards the CCO incentive measure.

- **Is a medical diagnosis also required with 99420 (Health Risk Assessment), or just the indicated V codes (V79.1 and/or V82.9)?**

  The header of the claim may have any diagnoses that are appropriate to the patient's situation. V79.1 and/or V82.9 are eligible as primary diagnoses and may be used as the only codes included on a claim billing for 99420.

- **If a patient is established at a clinic and is returning to confirm a new pregnancy, can SBIRT be billed at the confirmation appointment with ancillary staff prior to scheduling an appointment with the licensed provider? (The provider would see the patient on a later date).**

  Coding of the visit and NNCI edits apply, incident-to rules apply to ancillary staff performing SBIRT services.

  Be aware of the differences between the standard educational information about alcohol use during pregnancy and SBIRT's screening and brief intervention for risky behaviors involving alcohol and/or drugs. SBIRT is individualized based on the results of the screening. Generalized educational materials and handouts provided by ancillary staff based on a positive pregnancy test do not qualify as SBIRT services.

- **Can SBIRT be billed w/ a nurse visit (99211)?**

  There are NCCI edits that prevent billing 99211 with the 99408/99409. The screening code 99420 may be billed with the 99211.

  However, brief intervention services would not be captured in the level of service provided as a 99211. If screening and brief intervention is indicated then the level of service provided is likely more than 99211.

- **If an established patient screens positive on a brief screening, and a licensed provider reviews and documents in the patient's chart – can the licensed provider now order ancillary staff to do 99420 or 99408 if the licensed provider has not seen patient face-to-face in a set period of time (e.g., within one year?)**

  Screening and intervention do not require a physician's order. See the answer to the following question.

- **Incident to rule for SBIRT states PCP has already seen and established care with patient - does this mean for the current course of care or is it w/in the last 3 years?**

  There must have been a direct service furnished by the supervising physician to initiate the course of treatment of which the service being performed by the ancillary staff is an incidental part, and there must be subsequent services by the physician of a frequency that reflects their continuing active participation in and management of the treatment.

  If a patient hasn't been seen in 1-3 years and the responses to the annual brief screen are positive then it's probably time for the primary practitioner to see them, at which time SBIRT screening and other preventive services may occur.

- **If a provider goes to a treatment center to see a patient, is that considered a home visit?**

  Coding conventions apply for defining place of service.

- **Does the patient need to be an established client prior to SBIRT being performed and billed? For example: a client walks into the clinic with no appointment, has never seen the MD before, and is seen by an RN who does a full health risk assessment for SBIRT and other services to determine if the individual's medical needs are urgent enough to be seen that day, or within a day or two.**

  Is this a billable SBIRT service if the individual is not seen by the MD that day?

  No: triaging is about determining whether or not the medical complaints are urgent and need to be seen on the same day. It would not be appropriate to screen a patient that is too ill to participate fully or retain any educational or intervention recommendations. A health risk assessment should be adjunctive to complete medical assessment to establish an overall plan of care, not as a tool for triage.

  It may be appropriate to provide brief screening services if the patient is scheduled to see the MD that same day and the results of a brief screening indicate the need for a full screen. The incident-to services must be linked to a provider visit.

  If the patient is seen by the MD that day, depending on the results of their brief screen, it may be justified to perform a full screening while the patient is in the office. This would be a billable SBIRT service.

  If the patient's complaints are not urgent and the appointment is scheduled for another day, a full screening (99420) would be completed on the date of the appointment with the provider.

- **Can a public health nurse bill 99420 for depression on a home visit?**

  No. Nursing visits are not included in the Incentive measure and do not qualify under the incident to rules.

- **What are the appropriate diagnosis codes to use with 99420 to indicate depression screening?**

  Refer to coding manuals; note the CCO incentive measure for depression screening and follow up plan is not claims-based and will not be "counting" 99420 with or without diagnosis codes. The depression measure is not using diagnosis codes.