

# Screening, Brief Intervention, and Referral to Treatment (SBIRT) Guidance Document

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Oregon Health Plan

Version 5 – Revised December 2014

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## Introduction

The purpose of this document is to provide Coordinated Care Organizations (CCOs), Oregon clinics and administrative staff with guidance on implementing screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT), including coding and billing information and details on the CCO Incentive Measure specifications. This document has been updated to reflect the change in measure specifications for CY 2015. This document will be updated as appropriate to reflect the ongoing changes in policy and regulation.

## Executive Summary

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, and to help those with the disease of addiction enter into treatment. SBIRT services can be used in primary care settings and enables health care professionals to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. For more information on the benefits of SBIRT services, visit [http://www.integration.samhsa.gov/SBIRT\\_Issue\\_Brief.pdf](http://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf).

For CY 2013 and 2014, the CCO incentive measure specifications focus on patients ages 18 years and older who have had a qualifying outpatient visit or home visit during the measurement year, and who completed a full, standardized screening tool (e.g., AUDIT, DAST) because they indicated risky or problematic substance use during the brief, annual screen. For CY 2015, adolescents aged 12-17 years have been added to the measure.

Note: The brief annual screen cannot be billed and is not part of the measure specifications. The full list of AMH-approved evidence based screening tools is included in Appendix A.

**Numerator:** members in the denominator who completed a full, standardized screening tool as indicated by one of the following CPT or HCPCS codes (see Appendix B for how G codes are counted):

- 99420, with diagnoses code v79.1 or v82.9 – used for patients who received a full screen based on responses to the annual brief screening. There are no time limitations or requirements for this code. This is also used when a brief intervention lasting less than 15 minutes is performed.
- 99408 – used for patients who were screened and received a brief intervention (15-30 mins).
- 99409 – used for patients who were screened and received a brief intervention (> 30 mins).
- G0396 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (15-30 minutes).
- G0397 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (>30 minutes).
- G0442 – Annual alcohol misuse screening
- G0443 – Brief face-to-face behavioral counseling for alcohol misuse.

Note: the Metrics & Scoring Committee added diagnosis code v79.1 to the CY 2014 measure specifications as a standalone code to identify SBIRT services. Use of this diagnostic code to indicate

alcohol screening without any of the defined CPT codes listed above will count as a qualifying SBIRT service in 2014 and 2015.

G0442 and G0443 were added to the measure specifications to identify SBIRT services upon Metrics & Scoring Committee approval in April 2014.

**Denominator:** Unique counts of members ages 12 years as of December 31 of the measurement year who received a qualifying outpatient service between January 1 – December 31 of the measurement year. Qualifying visits include:

- Office or other outpatient visits: 99201-99205, 99211-99215, 99241-99245
- Home visits: 99341-99345, 99347-99350
- Preventive medicine: 99383-99384, 99385-99387, 99393-99394, 99395-99397, 99401-99404, 99408, 99409, 99411, 99412, 99420, 99429, G0396, G0397, G0402, T1015, and diagnosis code v20.2.

## Background

SBIRT stands for screening, brief intervention and referral to treatment. SBIRT is an evidence-based, effective method to intervene in alcohol and drug misuse<sup>1,2</sup> and can successfully reduce healthcare costs.<sup>3</sup>

The US Preventive Services Task Force (USPSTF), which makes recommendations about preventive care services for patients, has assigned a “B” recommendation for the SBIRT process. They have found adequate evidence that numerous screening instruments can detect alcohol misuse with acceptable sensitivity and specificity.<sup>4</sup> They’ve also found evidence that brief counseling interventions effectively reduce heavy drinking episodes in adults engaging in risky or hazardous drinking. Combined study results from the USPSTF review suggest that compared to control groups, implementation of SBIRT among adults resulted in the following:

- A reduction in alcohol consumption by 3.6 drinks per week from baseline,
- Twelve percent fewer adults reported heavy drinking episodes, and
- Eleven percent more adults reported drinking less than the recommended limits over a 12-month period.

SBIRT is endorsed by the National Council for Community Behavioral Health Care and the Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA).

### SBIRT for Adolescents

While most efficacy studies on SBIRT have been conducted with adult populations, the benefits for adolescents have been recognized: SBIRT is part of the continuum of substance abuse care – deemed “essential services” – required of all health plans as part of the Affordable Care Act. Additionally, most state Medicaid systems have approved codes for reimbursement of SBIRT for adolescents. SBIRT for adolescents ages 12 – 17 has been added to the CCO incentive measure beginning in 2015.

SBIRT for adolescents is recommended annually by the Society of Adolescent Medicine, the Maternal and Child Health Bureau, the American Academy of Pediatrics, and the Substance Abuse and Mental Health Services Administration. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and*

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<sup>1</sup> Madras BK, Compton WM, Avula D et al. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months later. *Drug and Alcohol Dependence* 2009; 280-295.

<sup>2</sup> Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief intervention for alcohol problems: A review. *Addiction*, 88, 315–335

<sup>3</sup> Quanbeck A, Lang K, Enami K, & Brown RL. (2010). A cost-benefit analysis of Wisconsin's screening, brief intervention, and referral to treatment program: adding the employer's perspective. *State Medical Society of Wisconsin*, Feb; 109(1):9-14.

<sup>4</sup> U.S. Preventive Services Task Force. (September, 2012). Behavioral counseling after screening for alcohol misuse in primary care. Retrieved July 22, 2013 from [www.uspreventiveservicestaskforce.org/uspstf12/alc misuse/alcomisart.htm](http://www.uspreventiveservicestaskforce.org/uspstf12/alc misuse/alcomisart.htm)

*Adolescents* recommends that adolescent primary care providers discuss substance use as a part of a comprehensive preventive visit using developmentally appropriate tools.<sup>5</sup>

The adolescent well care visit provides a strong vehicle for delivering SBIRT services to adolescents. However, providers often cite a lack of time and expertise in conducting SBIRT, and electronic SBIRT workflows are not widely available. Further, strong systems need to be in place to ensure adequate referral and follow-up for adolescents in need of additional care. Increased training on how to effectively conduct the SBIRT process within a busy family or pediatric practice or school-based health center are necessary.

Implementing SBIRT with adolescents requires a unique set of considerations compared to adult populations, namely ensuring confidentiality. Adolescents are less likely to seek services or disclose information on risky behaviors if they do not believe the information will be kept confidential. Strong guidance related to sharing patient information for care coordination while balancing patient privacy is necessary. Providers should be aware of potentially sensitive information that is sent home in billing communications or shared in online patient portals and build a discussion about confidentiality into any adolescent care workflow.

## Overview of SBIRT in Oregon

There have been several SBIRT pilot projects implemented in Oregon, the largest and most well-known being the Oregon SBIRT Primary Care Residency Initiative<sup>6</sup>, situated at OHSU Family Medicine and funded by SAMHSA. This initiative focuses on teaching the SBIRT method to primary care physicians.

As Oregon strives to make a meaningful difference in the health of Oregon communities, SBIRT has been identified as an incentive measure for Oregon's CCOs, tied to incentive funding. Additional information about the CCO incentive measures is available online at <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx> and below.

OHA's Transformation Center is establishing and coordinating learning collaboratives to create opportunities for peer-to-peer learning and networking, identifying and sharing information on evidence-based best practices and emerging best practices, and helping advance innovative strategies in all areas of health care transformation. The first Statewide CCO Learning Collaborative with the CCO Medical Directors is focusing on SBIRT and the other CCO incentive measures.

Screening for substance use issues is also a core component of Oregon's Patient-Centered Primary Care Home Program criteria for recognition<sup>7</sup>. To become recognized as a primary care home, clinics must routinely provide assessment of mental health, substance use or developmental conditions and provide

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<sup>5</sup> American Academy of Pediatrics, Bright Futures Steering Committee. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3<sup>rd</sup> ed. Hagan JF, Shaw HS, Duncan P., eds. Elk Grove Village, IL: American Academy of Pediatrics; 2007.

<sup>6</sup> [www.sbirtoregon.org](http://www.sbirtoregon.org)

<sup>7</sup> <http://www.oregon.gov/oha/ohpr/Pages/healthreform/pcpch/index.aspx>

appropriate treatment, referral and care coordination for these conditions. SBIRT is a recommended tool for substance use screening, and the Patient-Centered Primary Care Institute has a variety of tools and resources available to help clinics adopt the SBIRT model<sup>8</sup>.

The Oregon Public Health Division (PHD), in partnership with the Addictions and Mental Health Division, is working with the Oregon Pediatric Society's START Program and the Oregon Pediatric Improvement Partnership to deliver training and practice improvement assistance to pediatric providers across the state to increase utilization of SBIRT within the context of adolescent well care visits. Trainings have been conducted with pediatric practices, federally qualified health centers, and school-based health centers. A second cohort of participants is planned for 2015. Objectives include:

- Increasing knowledge and behavior toward addressing adolescent substance use;
- Assisting clinics in sustainably implementing adolescent SBIRT clinic workflows;
- Identifying and addressing barriers to clinic implementation, as well as sharing strategies for success;
- Providing clinic tools and stronger linkages to referral resources in the community.

SBIRT in the Emergency Department has been adopted as one of the incentivized measures for Oregon's new Hospital Transformation Performance Program (HTPP), which rewards hospitals quality pool funds based on their performance on eleven measures. Additional information about the HTPP program and SBIRT in the Emergency Department is available online at <http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx>.

The Oregon Health Authority is working towards standardizing the billing and payment policies across all payer sources, until that goal is reached, great care must be taken to ensure compliance in service delivery and claims submission to different payer types (e.g. Medicare and Commercial).

Identifying ways to secure payment for providing SBIRT services will be a key strategy to promote widespread implementation of SBIRT services across Oregon. SBIRT coding and billing policies and regulations are a work in progress and coding and coverage policy varies based on payer. SBIRT is a covered benefit for all Oregon Medicaid patients and for a wide-range of provider types. Under the current billing policies and regulations, Oregon providers may be eligible for reimbursement for a majority of their patients.

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<sup>8</sup> <http://www.pccpci.org/>

## Clinical Definitions

This section provides an overview of the key clinical definitions integral to the provision of SBIRT services and the related billing definitions of such services.

There are several definitions of alcohol and substance abuse and misuse, including:

- **Alcohol Abuse:** as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* is drinking that leads an individual to recurrently fail in major home, work, or school responsibilities; use alcohol in physically hazardous situations (such as while operating heavy machinery); or have alcohol-related legal or social problems.<sup>9</sup>
- **Alcohol Dependence/Alcoholism:** as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* includes physical cravings and withdrawal symptoms, frequent consumption of alcohol in larger amounts than intended over longer periods, and a need for markedly increased amounts of alcohol to achieve intoxication.<sup>10</sup>
- **Alcohol Misuse:** a spectrum of behaviors, including risky or hazardous alcohol use.<sup>11</sup>
- **Substance Abuse:** as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DMS-IV) is substance use that leads an individual to recurrently fail in major home, work, or school responsibilities; use substances in physical hazardous situations; or have substance-related legal problems.
- **Substance Dependence:** as defined by the DSM-IV includes physical cravings and withdrawal symptoms, frequent consumption in larger amounts than intended over longer periods, and a need for increased amounts of the substance. Dependence also includes repeated unsuccessful attempts to quit using the substance, giving up important social, occupational, or recreational activities, and continued use of the substance despite knowledge of adverse consequences.

Note: OHA recognizes that DSM-V replaces abuse and dependence diagnoses with a focus on a continuum of problematic use reflected by level of function. The SBIRT measure is currently based on ICD-9 diagnosis codes and CPT/HCPCS codes. Although DSM-V is currently available, OHA has delayed implementation of DSM-V to align with implementation of ICD-10 and will update this guidance document to reflect these changes at a later date.

### Provider types include:

- **Auxiliary Provider or Personnel:** any individual who is acting under the supervision of a physician or licensed professional working within their scope of practice.

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<sup>9</sup> American Psychiatric Association (APA).(2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*. Washington, DC: APA, Retrieved July 22, 2013 from [www.ncbi.nlm.nih.gov/books/NBK44358/](http://www.ncbi.nlm.nih.gov/books/NBK44358/)

<sup>10</sup> American Psychiatric Association (APA).(2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*. Washington, DC: APA, Retrieved July 22, 2013 from [www.ncbi.nlm.nih.gov/books/NBK44358/](http://www.ncbi.nlm.nih.gov/books/NBK44358/)

<sup>11</sup> <http://www.uspreventiveservicestaskforce.org/uspstf12/alc misuse/alc misusefinalrs.htm>

- **Supervising Licensed Provider:** this is the individual supervising the incident to service. This does not need to be the individual who performed the initial assessment and initiated the course of treatment.

**Brief Annual Screen (Adults)**

A screen is defined “a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur.”<sup>12</sup> Oregon’s approved brief annual screen for adults involves several short questions relating to drinking, drug use, and mood. Note that the adolescent brief screening and full screening have different questions and processes than adults.

A brief annual screen is considered an integral part of routine preventive care and is therefore not separately reimbursable by Medicaid. There are no CPT codes for billing the brief annual screen. Brief annual screens may be administered by providers or any other clinic staff member. They may be administered in writing, orally, or via various technologies (e.g., on the phone prior to an office visit, electronically).

Image 1: OHA-recommended brief annual screening form;

**Annual questionnaire**  
 Once a year, all our patients are asked to complete this form because drug use, alcohol use, and mood can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_

Are you currently in recovery for alcohol or substance use?  Yes  No

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
<b>MEN:</b> How many times in the past year have you had 5 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>
<b>WOMEN:</b> How many times in the past year have you had 4 or more drinks in a day?	<input type="radio"/>	<input type="radio"/>

**Drugs:** Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	<input type="radio"/>	<input type="radio"/>

**Mood:**

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>

<sup>12</sup> Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), SBIRT Coding, Billing, and Reimbursement Manual. January 2010.

## Full Screen (Adults)

A full screen more definitively categorizes an adult patient’s substance use. Full screens are indicated for patients with positive brief annual screens, and for patients with signs, symptoms, and medical conditions that suggest risky or problem drinking or drug use. A full screen places the patient on a continuum of substance use and suggests whether no intervention, brief intervention, brief treatment, or referral to treatment is appropriate. The full screen may be administered and interpreted by a variety of health professionals (see below).

The Oregon Legislature directed OHA and four other state agencies to spend increasing shares of public dollars on evidence-based services. Medicaid requires that structured, validated questionnaires be used (e.g., the Alcohol Use Disorders Inventory Test (AUDIT), the Drug Abuse Screening Test (DAST), and the Alcohol Smoking and Substance Involvement Screening Test (ASSIST). See Appendix A for the current list of the Addiction and Mental Health Division’s (AMH) approved evidence-based screening tools. See OAR 410-120-0000(75), 410-120-0000(124) and 410-120-1320(3) for additional information on evidence based practice and medical necessity.

## Screening for Adolescents

Screening processes and tools are unique for adolescents ages 12-17. The central tool for adolescent screening is the CRAFFT (an acronym representing screening questions in the categories Car, Relax, Alone, Forget, Family & Friends, and Trouble).

### The CRAFFT Screening Interview

Begin: “I’m going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.”

#### Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke any marijuana or hashish?	<input type="checkbox"/>	<input type="checkbox"/>
3. Use anything else to get high? (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)	<input type="checkbox"/>	<input type="checkbox"/>

For clinic use only: Did the patient answer “yes” to any questions in Part A?

No

Yes

Ask CAR question only, then stop

Ask all 6 CRAFFT questions

#### Part B

	No	Yes
1. Have you ever ridden in a <b>CAR</b> driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to <b>RELAX</b> , feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or <b>ALONE</b> ?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever <b>FORGET</b> things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your <b>FAMILY</b> or <b>FRIENDS</b> ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into <b>TROUBLE</b> while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

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The CRAFFT screening tool consists of two sections, Part A and Part B. The three questions in Part A are used, in addition to the “Car” question, as a brief screen to rule out adolescents who are at low risk for alcohol or drug misuse. The six questions in Part B can be asked as follow up (or full) screening for any at risk adolescents identified through Part A.

Although the CRAFFT screening tool is designed as a two-part process, similar to the adult brief and full screenings, often the whole form is given to adolescents to fill out in one step. Additionally, many providers prefer to ask follow-up questions and offer education and brief interventions even for low-risk adolescents due to higher risks in this population, the potential of under-reporting, and developing rapport with the adolescent for future screenings and interventions.

Because the CRAFFT is often used as a single-step screening process, it is unclear if it counts as a brief screening or a full screening. If the CRAFFT is completed (either partially or entirely) and:

- There is no discussion concerning the screening results, nor any education or brief intervention offered to the adolescents, then the tool is being used as a brief annual screen, and should not be billed / encountered. This use of the CRAFFT would not count toward the CCO incentive metric.
- Based on clinical judgment, the screening results were discussed with the adolescent and education or brief intervention was facilitated, then the tool is being used as a full screen, and should be billed / encountered. This use of the CRAFFT would count toward the CCO incentive metric.

Note that the determining factor to differentiate the CRAFFT screening is not based on the score, but on the education or brief intervention offered and facilitated by the provider.

Note that providers should also be aware of how sensitive adolescent information may be communicated back to parents / guardians via billing communication or in online patient portals, and discuss these issues with their adolescent clients.

### **Brief Intervention**

Brief interventions are interactions with patients which are intended to induce a change in a health-related behavior. Brief interventions are typically used as a management strategy for patients with risky or problem drinking or drug use who are not dependent. This may include patients who qualify for a diagnosis of alcohol or drug abuse, and patients who do not qualify for substance-related diagnoses. The brief intervention may be conducted by a variety of health professionals (see below).

### **Referral**

Patients who are likely alcohol or drug dependent, or would benefit from community-based behavioral health services in collaboration with the medical home, are typically referred to alcohol and drug treatment experts for more definitive, in-depth assessments, and if warranted, treatment. The referral is not an independently reimbursable service, although it is part of the SBIRT process. The referral can be made by the licensed providers, ancillary provider or other clinic staff that have received sufficient training to make an appropriate referral.

A Substance Use Disorder treatment provider directory is available at;  
<http://www.oregon.gov/oha/amh/publications/provider-directory.pdf>

For individuals enrolled in a CCO, care should be coordinated with a network provider or services.

### **Follow-Up Services**

Follow-up services include interactions which occur after the initial intervention, treatment, or referral services, and are intended to re-assess a patient's status, progress, promote or sustain a reduction in alcohol or drug use, and/or assess a patient's need for additional services.<sup>13</sup>

### **Clinical Service Definitions for Billing**

In general, billable services are referred to as either administration of a full screen, or full screen and intervention services. Administering a brief annual screen is not a billable service.

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<sup>13</sup> Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), SBIRT Coding, Billing, and Reimbursement Manual. January 2010.

## SBIRT Services

SBIRT services apply to all age-groups. This section provides guidance on who can conduct and bill for SBIRT services as well as suggested coding for reporting and claim submission.

### **Who can administer and interpret the brief annual screen?**

A brief annual screen is not a reimbursable service. This part of the process can be done by the front desk staff or any other appropriate professional. The brief annual screen may be administered in writing, orally, or via various technologies. The non-billable, brief annual screen may be mailed to the individual to complete prior to the visit, given over the phone, online or in person.

### **Who can administer and interpret the full screen?**

A full screen is a reimbursable service. It must be administered and interpreted by a licensed provider or an ancillary provider working under the general supervision of the licensed provider (see list of provider types below). The full billable SBIRT services must be provided face-to-face (in-person or via simultaneous audio and video transmission) with the patient. A physician prescription is not required for screening or intervention.

### **Who can conduct a brief intervention?**

A brief intervention is a reimbursable service. It must be provided by a licensed provider or an ancillary provider working under the general supervision of the licensed provider (see list of provider types below).

### **Licensed providers who can independently conduct and bill for SBIRT using their provider number:**

- Physicians
- Physician's Assistant
- Nurse Practitioners
- Licensed Psychologist
- Licensed Clinical Social Worker

Note: Licensed Professional Counselors (LPC) and Licensed Marriage and Family Therapists (LMFT) are being incorporated into the list of approved independently licensed providers, which is likely to be completed by mid-2015.

### **Auxiliary providers or personnel who can conduct SBIRT under the general supervision of a licensed provider or entity listed above:**

*These provider types would bill "incident to" a licensed professional. This is not an exhaustive list.*

- Medical Assistants and Physician Assistants
- Nurses, Clinical Nurse Specialists, and Registered Nurses
- Health Educators, Community Health Workers, and Wellness Coaches
- Certified Alcohol and Drug Counselors (CADC)
- Qualified Mental Health Professional

- Students or graduates entering medical profession in areas such as medical, physician assistant, nursing, addictions, counseling, social work, and psychology.

### **Incident-To Guidance**

- **Location:** 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.

- **Employment:** Both the supervising physician and the auxiliary provider or personnel furnishing the service must be a part-time, full-time or leased employee or independent contractor.
- **Initial Service Requirement:** To bill incident-to, 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 auxiliary provider or personnel is an incidental part, and there must be subsequent services by the physician of a frequency that reflects their continuing active participation in an management of the treatment.

The auxiliary provider or personnel needs to document the "link" between their face to face service and the preceding physician service to which their service is incidental.

- **Direct Supervision Requirement:** 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(s).

## Oregon Health Authority and the CCO Incentive Measure

### Intent

SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The CCO incentive measure “Alcohol and Drug Misuse (SBIRT)” was developed by the Oregon Health Authority and focuses on full screening and brief intervention services provided to Oregon Health Plan members in primary care and outpatient settings. SBIRT services included in emergency departments and mental health settings (with the exception of co-located mental health and primary care services) are excluded from the measure.

Note: SBIRT in the emergency department has been adopted as an incentive measure for the new Oregon hospital quality pool (also known as the Hospital Transformation Performance Program). Additional information about the hospital quality pool is available online at <http://www.oregon.gov/oha/Pages/http.aspx> and <http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx>

### Specifications

OHA developed the specifications based on coding recommendations developed by CMS and SAMHSA, while using HEDIS specifications for identifying ambulatory outpatient care services to identify unique outpatient recipients by plan. Measure specifications are posted online at: <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>

Measure specifications for 2015 remain based in administrative (claims) data. OHA and the SBIRT workgroup are continuing to explore options for adopting an electronic Clinical Quality Measure (eCQM) for SBIRT in 2017, pending further development from SAMHSA and the Office of the National Coordinator for Health Information Technology (ONC).

**Numerator:** Unique counts of members age 12 years as of December 31<sup>st</sup> of the measurement year who completed a full, standardized screening tool for alcohol/ substance use, or received screening and a brief intervention, as indicated by one of the following CPT or HCPCS codes:

- 99420, with diagnosis code v79.1 or v82.9 –used for patients who received a full screen based on responses to the annual brief screening. There are no time limitations or requirements for this code. This coding combination is also used when a brief intervention lasting less than 15 minutes is performed.
- 99408 – used for patients who were screened and received a brief intervention (15-30 mins).

- 99409 – used for patients who were screened and received a brief intervention (> 30 mins).
- G0396 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (15-30 minutes).
- G0397 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (>30 minutes).
- G0442 – Annual alcohol misuse screening
- G0443 – Brief face-to-face behavioral counseling for alcohol misuse.

Note: the Metrics & Scoring Committee added diagnosis code v79.1 to the measure specifications as a standalone code to identify SBIRT services in 2014. Use of this diagnostic code to indicate alcohol screening without any of the defined CPT codes listed above will count as a qualifying SBIRT service in 2015.

G0442 and G0443 were added to the measure specifications to identify SBIRT services upon Metrics & Scoring Committee approval in April 2014. Note only CCO members are included in the measure based on use of these codes; in other words, Medicare-only members who do not also have Medicaid coverage are not counted toward the SBIRT measure through these codes.

**Required exclusions for numerator:**

None.

**Deviations from cited specifications for numerator:**

None.

**Denominator:** Unique count of members age 12 years as of December 31<sup>st</sup> of the measurement year, and having received an outpatient service as identified by the following CPT codes:

- Office or other outpatient visits: 99201-99205, 99211-99215, 99241-99245
- Home visits: 99341-99345, 99347-99350
- Preventive medicine: 99383-99384, 99385-99387, 99393-99394, 99395-99397, 99401-99404, 99408, 99409, 99411, 99412, 99420, 99429, G0396, G0397, G0402, T1015, and diagnosis code v20.2.

Note: the member only needs to be 12 years of age by December 31<sup>st</sup> of the measurement year; some qualifying members could be 11 on the date of their outpatient service.

Note: OHA will report a combined adult (ages 18+) and adolescent (ages 12-17) rate for public reporting and for the purposes of the incentive payment, but OHA will also provide CCOs with separate adult and adolescent rates for quality improvement purposes.

**Required exclusions for denominator:**

None.

**Deviations from cited specifications for denominator:**

None.

**What are the continuous enrollment criteria:**

None.

**What are allowable gaps in enrollment:**

n/a

**Define Anchor Date (if applicable):**

None.

**Denied Claims**

Denied claims are included for the numerator, and excluded for the denominator. This variation made to address denied claims that were qualifying for the denominator that had been denied because they were submitted for the wrong CCO (e.g., a claim was submitted for CCO 1 and was denied because it should have been submitted for CCO 2).

Excluding denied claims from the denominator only also aligns with the HEDIS guidance on denied claims for the ambulatory care: outpatient utilization measure, which the SBIRT denominator is based on.

**Limitations**

Provision of the initial “brief” screen is not reimbursable and therefore cannot be included in claims data for measurement. Only those patients that necessitated the “full” screen or a screening and brief intervention based on responses to the brief screen can be identified in claims data with the use of the codes included in the numerator and denominator of the incentive measure.

The services of “screening”, “brief intervention”, and “referral to treatment” cannot be separately identified in claims data. The “full” screening is the only portion of SBIRT that can be captured in claims data using the CPT code 99420 (Health Risk Assessment & Interpretation) for SBIRT services that do not meet the 15 minute threshold requirement of CPT codes 99408/99409 or HCPCS codes G3096/G3097 (Screening, Brief Intervention, and Referral to Treatment; 15 minutes or more). See Billing & Reimbursement.

The SBIRT benefit will correspond with three CPT procedure codes. Both full screening and brief intervention will **require specific diagnosis codes on the claim**. See above for diagnosis, CPT, and HCPCS codes that will be identified through claims data. As this measure is under development, data collection and/or reporting may change for subsequent measurement years.

## Eligibility

SBIRT is a benefit available to all OHP eligible individuals. While the CCO incentive measure focuses on SBIRT services for adolescents ages 12-17 and adults 18 years of age or older, the SBIRT benefit is available to individuals that are 10 years of age or older on the date of service.

For members enrolled in a Medicaid Coordinated Care Organization (CCO) or Fully Capitation Health Plan (FCHP), SBIRT services are to be coordinated with those organizations for reimbursement.

For Fee For Service (FFS) members (i.e., Open Card members), SBIRT is a covered service and does not require a prior authorization (PA).

## Screening Frequency

For members enrolled in Medicaid, the screening benefit is limited to medical appropriateness. Usually one screen per rolling twelve months is sufficient; however, there may be clinical indication that an additional screen is needed. When billing 99420, a unit of service is equivalent to the total amount of time required to administer the screening. Therefore when billing the screening, the unit of service should always equal one regardless of time spent completing the screening.

## Brief Intervention Requirements

It is important to note that these are time-based codes; therefore, documentation must denote start/stop time or total face-to-face time with the patient. The total time would include the administration of the screening tool, interpretation of the tool, the intervention and time spent on a referral if applicable. Note the screening code 99420 and standalone v79.1 diagnosis code are not time based.

SBIRT services (including screening and brief intervention) that do not meet the minimum fifteen minute threshold identified by the CPT/HCPCS codes are not separately reimbursable; however, the administration and interpretation of the screening tool (99420) is reimbursable and will meet the CCO Incentive measure when submitted with the diagnosis V79.1 (Screening for Alcoholism) or V82.9 (Screening for Unspecified Condition).

## Documentation Requirements

To support coding and claim submission, the Medical Record must:

- Be complete and legible;
- Denote start/stop time or total face-to-face time with the patient (because some SBIRT codes are time-based codes);
- Document the patient's progress, response to changes in treatment, and revisions of diagnosis;
- Document the rationale for ordering diagnostic and other ancillary services, or ensure that it can be easily inferred;

- For each patient encounter, document:
  - Assessment, clinical impression, and diagnosis;
  - Date and legible identity of observer/provider
  - Physical examination findings and prior diagnostic test results;
  - Plan of care; and
  - Reason for encounter and relevant history
- Identify appropriate health risk factors;
- Include documentation to support all CPT and ICD Diagnosis codes reported on the health insurance claim;
- Make past and present diagnoses accessible for the treating and/or consulting physician; and
- Sign all services provided/ ordered

Medicaid documentation requirements are outlined in OAR General 410-120-1360

<http://www.dhs.state.or.us/policy/healthplan/guides/main.html>

In addition, providers should document what screening tool was used and the member's responses to the screening questions. The completed screening tool should be available for review in the case of an audit. To report the full screening only under the SBIRT benefit, use CPT code 99420 with the appropriate diagnosis code that identifies the encounter for SBIRT services.

The medical record must support that the coding for the services reported on the health insurance claim are correct and accurate.

## Exclusions

SBIRT services are not designed to address smoking and tobacco cessation services; the CPT codes specifically exclude tobacco as a substance within SBIRT. For direction on billing Medicaid for smoking and tobacco use cessation, contact Provider Services at 1-800-336-6016. See OAR 410-130-0190 for Tobacco Cessation guidelines.

## Billing and Reimbursement

It is the responsibility of each provider to select the most appropriate diagnosis and procedure codes when billing for services. It is the providers' responsibility to comply with the CCO's prior authorization requirements or other policies necessary for reimbursement, before providing services to any Medicaid client enrolled in a CCO. It is the providers' responsibility to be compliant with federal and state laws (see OAR 410-120-1160).

The following diagnoses, CPT, and HCPCS codes will be used to identify full screening and brief intervention services provided to members age 12 years and older who had a qualifying outpatient or home visit during the measurement year.

### Diagnosis Codes

- V79.1 Screening for Alcoholism (in combination with CPT 99420 or standalone)
- V82.9 Screening for Unspecified Condition (in combination with CPT 99420 only)

Note: the Metrics & Scoring Committee added diagnosis code v79.1 to the measure specifications as a standalone code to identify SBIRT services in 2014. Use of this diagnostic code without any of the defined CPT codes listed below will count as a qualifying SBIRT service in 2015.

### HCPCS Codes

Beginning January 1, 2008, Medicare recognized two G-codes to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and interventions services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.<sup>14</sup>

#### Structured Assessment and Intervention Services

- **G0396** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST), and brief intervention services; 15-30 minutes.
- **G0397** – Alcohol and/or substance use structured screening (e.g., AUDIT, DAST), and brief intervention services; Greater than 30 minutes.

These codes should not be reported separately with an evaluation and management (E&M) for the same work/ time. If the E&M would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, G0396 or G0397 should not be additionally reported.

If a physician reports either of these G-codes with an E&M, utilizing an NCCI-associated modifier, the physician is certifying that the G-code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M and is a service that is not included in the E&M level of service based on the clinical reason for the E&M visit.<sup>15</sup>

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<sup>14</sup> <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>

<sup>15</sup> National Correct Coding Initiative Policy Manual for Medicare Services – INTRODUCTION\_FINAL10312012.doc, Revision Date: 1/1/2013

G0396/G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPC codes and the clinical resources expended should be included in determining the level of the visit service reported.<sup>16</sup>

Beginning October 14, 2011, Medicare also recognized two G codes to address screening and brief counseling for alcohol misuse.<sup>17</sup>

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

Medicare will cover up to four brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries for those beneficiaries who screen positive. Medicare allows payment for both G0442 and G0443 on the same date (except in rural health clinics and federal qualified health clinics), but will not pay for more than one G0443 service on the same date.

Counseling provided under G0443 must be based on the Five As (Assess, Advise, Agree, Assist and Arrange). Documentation in the medical record must reflect this.<sup>18</sup>

## CPT Codes

### Full Screening

- **99420** - Administration and interpretation of a health risk assessment instrument (not time based); billed as one unit regardless of time spent on screening. 99420 is separately reimbursable when performed by the same provider for the same patient on the same date of service as an E&M visit.

### Screening and Brief Intervention

- **99408** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAFFT), and brief intervention services; 15-30 minutes. NOTE: 99420 (Administration and interpretation of a health risk assessment instrument) is included in the CPT code 99408 and cannot be billed together.
- **99409** – Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAFFT), and brief intervention services; Greater than 30 minutes. NOTE: 99420 (Administration and interpretation of a health risk assessment instrument) is included in the CPT code 99409 and cannot be billed together.

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<sup>16</sup> <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>

<sup>17</sup> <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7633.pdf>

<sup>18</sup> Section 180 – Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>

**Special Note:** CPT codes 99408/99409 describe services which are similar to those described by HCPCS codes G0396/G0397, but are “screening” services which are not covered under the Medicare program.<sup>19</sup> Based on NCCI edits, these are not separately reimbursable when services are completed by the same provider on the same date as an E&M visit.

CPT codes 99408/99409 and an Office/Home visit can be billed together only when the screening and brief intervention is handed off to a separate licensed professional or to an individual being supervised by a licensed professional separate from the provider of the office/ home visit.

### **Preventative Visit/Preventative Counseling CPT Coding Associated with SBIRT Incentive Measure**

- 99383-99384, 99385-99387, 99393-99394, 99395-99397 and 99401-99404

Preventative visit CPT codes do not have NCCI edits associated with them and may be reimbursable on the same date of service as 99420, 99408/99409 when performed by a single licensed provider.

### **Office or Home Visit CPT Coding Associated with SBIRT Incentive Measure**

- 99201-99205, 99211-99215, 99241-99245, 99341-99345 and 99347-99350

Office and Home visit CPT codes are associated with NCCI edits and may not be reimbursable on the same date of services as 99408/99409 when performed by a single licensed provider.

## **Modifiers**

When billing CPT codes 99201-99215 and 99341-99350 with G0396 or G0397, the E&M service must have the accompanying modifier 25, indicating separately identifiable service.

## **Coding Resources**

The National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services and NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The NCCI is maintained for CMS by Correct Coding Solutions, LLC.

CMS makes all decisions about the contents of NCCI and the manual. Correspondence from Correct Coding Solutions, LLC reflects CMS’ policies on coding and NCCI.<sup>20</sup> Inquiries may be submitted to:

National Correct Coding Initiative  
Correct Coding Solutions LLC  
P.O. Box 907  
Carmel, IN 46082-0907  
Fax number: (317) 571-1745

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<sup>19</sup> National Correct Coding Initiative Policy Manual for Medicare Services – INTRODUCTION\_FINAL10312012.doc, Revision Date: 1/1/2013

<sup>20</sup> National Correct Coding Initiative Policy Manual for Medicare Services – INTRODUCTION\_FINAL10312012.doc, Revision Date: 1/1/2013

Additional resources include:

- AMA's Current Procedural Terminology (CPT) Manual
- CMS' HCPCS Level II code descriptors and Pub 100 References

## Federally Qualified Health Centers

Current FQHC billing requirements and encounter rates apply.

- Reimbursement for SBIRT will be the "encounter rate" and is all inclusive.
- Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist:
  - (a) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment;
  - (b) the patient has a medical visit and a clinical psychologist or social worker session visit.

Refer to the federally qualified and rural health centers Oregon Administrative Rules for additional guidance. [http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_147.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html)

FQHCs will need to bill utilizing the SBIRT codes outlined above to "count" towards the CCO incentive measure. Federal FQHC reporting on SBIRT may not align with the CCO incentive measure specifications.

## Resources

AMH approved screening tools are available at the Addictions and Mental Health Services Home page, click on the SBIRT link <http://www.oregon.gov/OHA/amh/pages/index.aspx>

Additional resources are available through the Patient Centered Primary Care Home Institute (PCPCI), <http://www.pcpci.org/>, and through the CCO Learning Collaborative, <http://transformationcenter.org/>

Other recommended resources include:

- The SAMHSA SBIRT protocols and Technical Assistance Publication (TAP 33)  
<http://sbirt.samhsa.gov/about.htm>
- The SBIRT primary Care residency initiative  
<http://www.sbirtoregon.org/>
- The Institute for Research, Education & Training in Addictions  
<http://ireta.org/ebpsbirt>
- The Center for Applied Behavioral Health Policy  
<http://cabhp.asu.edu/professional-development/sbirt-development/sbirt-resources>
- Brief Intervention Group B.I.G  
<http://hospitalsbirt.webs.com/>
- Motivational Interviewing, resources and information  
<http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx>
- SBIRT – Centers for Medicare & Medicaid Services; fact sheet –  
[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt\\_factsheet\\_icn904084.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf)
- The American Academy of Pediatrics; Bright Futures Screening Handbook  
<http://brightfutures.aap.org/pdfs/Preventive%20Services%20PDFs/Screening.PDF>

## For More Information

For questions related to the CCO incentive measure, please contact: [Metrics.Questions@state.or.us](mailto:Metrics.Questions@state.or.us)

To submit a new screening tool for AMH review or for technical assistance with SBIRT, please contact: Michael Oyster at [michael.w.oyster@state.or.us](mailto:michael.w.oyster@state.or.us) or (503) 945-9813

For questions related to Medicaid billing, please contact: Provider Services at 1.800.336.6016

## Appendix A: AMH Approved Evidence-Based Screening Tools

This list of AMH approved evidence-based screening tools is current as of December 2014. To submit a new tool for AMH review, please contact SBIRT Specialist Michael Oyster at [michael.w.oyster@state.or.us](mailto:michael.w.oyster@state.or.us) or (503) 945-9813.

AMH approved screening tools are available online at:  
<http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx>

OHA does not require use of a specific screening tool or tools to qualify for the CCO incentive metric. Implementation of one or multiple screening tools is at the provider or clinic's discretion, although health plans may have their own requirements related to which screening tools will be utilized. However, the tool(s) used must be an AMH-approved screening tool or a compilation of screening tools.

### Brief Annual Screen, All Patients

This is not a Medicaid reimbursable service.

- **Annual Questionnaire**  
3 questions.
- **Car, Relax, Alone, Forget, Friends, Trouble (CRAFT) –Part A.** See Screening for Adolescents on page 12 above

### Full Health Risk Assessment Screen, Adults

This is a Medicaid reimbursable service.

- **The Alcohol Use Disorders Identification Test (AUDIT)**  
10 questions.
- **The Drug Abuse Screening Test (DAST)**  
Versions include the DAST 10 and the DAST 20.
- **Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)**  
8 questions.
- **Parents, Peers, Partner, Past, Pregnancy (5Ps)**  
8 question version that including screening for depression and domestic violence.  
Note a modified version of the 5Ps is being pilot tested in several local clinics.
- **Global Appraisal of Individual Needs – Short Screener (GAIN-SS)**  
20 questions, this is the only full screening tool for alcohol and substance use and depression.
- **Tolerance, Worried, Eye-opener, Amnesia, K/Cut down (TWEAK)**  
5 questions.

- **Tolerance, Annoyed, Cut-down, Eye-opener (T-ACE)**  
4 questions.
- **Cut down, Annoyed, Guilty, Eye-opener (CAGE or CAGE-AID)**  
4 questions.

### **Full Health Risk Assessment Screen, Adolescents (age 10-17)**

This is a Medicaid reimbursable service.

- **Michigan Alcohol Screening Test (MAST)**  
22 questions.
- **Global Appraisal of Individual Needs – Short Screener (GAIN-SS)**  
20 questions.
- **Car, Relax, Alone, Forget, Friends, Trouble (CRAFTT) – Part B** – See Screening for Adolescents on page 12 above.  
6 questions.

## Appendix B: Frequently Asked Questions

### ***Who is supposed to complete (“fill out”) the SBIRT screening tools?***

The brief annual screen may be conducted by a variety of health professionals or any other clinic staff member (e.g., front desk staff). The full screen may be conducted and interpreted by a variety of health professionals. See pages 12-13 above.

### ***Are dental providers included in the CCO incentive metric?***

No, dental providers are not included in the CCO incentive metric and dental visits are not included in the denominator. They do not use the CPT or HCPCS codes described above for billing.

### ***Who can be reimbursed for SBIRT?***

See pages 12-13 above.

### ***Does the brief annual screen count for the CCO incentive metric?***

No. Only the full screen or full screen with brief intervention services are included in the CCO incentive metric.

### ***Can the brief annual screen be conducted over the phone (i.e., prior to a clinic visit)?***

Yes. We know that some clinics are conducting the brief annual screen over the phone. Depending on the results, with the client comes in for their appointment, they are asked to fill out the appropriate full screen and the results are then reviewed with the client.

### ***Can the full screen be completed through a patient portal or through the mail, prior to a medical appointment?***

Yes, a patient may complete a full screen prior to a medical appointment; however, it should not be billed / encountered until the medical appointment itself, when the full screen can be scored and discussed with the patient face-to-face. The timeframe between when the patient answers the questions and the medical appointment should be relatively short (such as two weeks) so that the patient still remembers their responses and why. Otherwise, the screen may not be relevant.

### ***Can brief interventions and referral to treatment be facilitated through telehealth?***

Yes, under Medicaid-Surgical OAR 410-130-0610. Note an update to this rule is planned for 2015.

### ***How should the brief annual screen be coded?***

The brief annual screen is not reimbursable and there are no associated billing codes. The codes listed in the document and the incentive measure specifications are not for the brief annual screen.

### ***Can CPT code 99420 be used for a brief annual screen?***

No. CPT code 99420 should be used for the full screen only.

***Are H0049 and H0050 the appropriate screening codes to report for SBIRT?***

The HCPCS codes H0049 and H0050 are used by Oregon Medicaid for licensed alcohol and drug treatment programs. These codes are not included in the specifications for the CCO incentive metric and will not count towards a CCO's SBIRT rate.

***Are G0396, G0397, G0442, and G0443 included in the CCO incentive metric?***

Yes, these codes are counted if they are used for Medicaid members; note Medicare-only members are not included in the CCO incentive measure. These codes were added for the second measurement year (CY 2014) and continue in 2015. See Measure Specifications section above.

***Is H0002 an appropriate screening code to report for SBIRT?***

No. H0002 is used when an AMH-approved provider such as a behaviorist, certified alcohol or drug counselor (CADC), or qualified mental health professional (QMHP) conducts a more comprehensive screening soon after an individual seeks treatment/services. This is not an SBIRT screening.

This screening indicates whether the individual is likely to have a substance use disorder and/or mental health disorder. Individuals who screen positive for substance use disorders are given a full, in-depth assessment. Individuals who screen positive for mental health disorders receive care, or are referred on to receive a full, in-depth assessment.

***Is the CCO incentive measure counting SBIRT services for ages 12+ or ages 18+?***

In 2013 and 2014, the CCO incentive measure only included SBIRT services for ages 18 years and up. Adolescents ages 12-17 were added to the CCO incentive measure for the third measurement year, CY 2015.

***Can combined screening tools be used (e.g., SBIRT and depression)?***

Yes. The recommended brief annual screening tool addresses alcohol and drug use, along with mood. As long as the brief annual screening for SBIRT asks about alcohol and drug use, other questions can be added, such as tobacco use, or domestic violence.

***Do combined screening tools still qualify for the CCO incentive metrics?***

A brief screening tool such as the Patient Health Questionnaire (PHQ) -2 for depression that does not also include alcohol and drug use is not appropriate for use as a brief annual screening tool *for SBIRT*.

Likewise, a brief screening tool that only asks about alcohol and drug use is not appropriate as a brief screening tool *for depression*.

If a practice uses a combined screening tool, note that only full screenings for alcohol and drug use (such as the evidence-based tools listed in Appendix A) count towards the CCO incentive metric for SBIRT. A brief annual screen may warrant multiple full screens for an individual (e.g., AUDIT for alcohol use and PHQ-9 for depression). Note that the GAIN-SS tool is an evidence-based, AMH-approved screening tool that addresses both depression and substance use.

***How will a CCO receive credit for SBIRT services if providers are not willing to use the CPT codes? Will non-claims-based data be included in the CCO incentive metric, or will OHA accept reports from a provider electronic medical record showing this activity?***

No – only claims data will be included in the CCO incentive metric. If a provider is not using the CPT, HCPCS, or diagnosis codes listed above and in the incentive measure specifications, the CCO will not receive credit for SBIRT services they are providing.

Note that OHA is working with a technical advisory workgroup on options for data collection/submission to supplement administrative (claims) data and electronic clinical quality data reporting for several measures in subsequent measurement years.

***Why is OHA using different measures for SBIRT for CCOs and for Hospitals?***

In an ideal world, the measures would be as similar as possible and the SBIRT process is similar in both settings, but due to the data sources used for each measure, and the national SBIRT measure for hospitals developed by the Joint Commission, there are variations in the measures.

The CCO incentive measure is currently based on claims data – therefore the CCO measure can only include SBIRT services that can be billed (full screening, brief intervention). When the SBIRT measure transitions to an electronic health record based measure in the future, the measure will be able to include the entire SBIRT workflow, from brief screening through referral to treatment.

The hospital incentive measure is based on the Joint Commission’s inpatient SBIRT measure, which uses separate rates for the brief screening, the brief intervention, and referral to treatment. The hospital measure includes the brief screening and brief intervention rates separately, rather than combined in the CCO measure. This helps assess how hospitals are doing on different aspects of the SBIRT process without the limitations of claims data (i.e., hospitals may be doing a great job screening, but have low intervention rates among those who screen positive).

Ideally, both the CCO and hospital incentive measures would incorporate referral to treatment rates, but as the CCO measure is claims based, and as hospitals need time to establish SBIRT workflows in their emergency departments and develop systems to capture SBIRT data, this is not currently part of either measure.