

**Screening, Brief
Intervention and Referral
to Treatment
SBIRT**

**Coding, Billing and
Reimbursement
Manual**

**Prepared For: Wisconsin Initiative to
Promote Healthy Lifestyles (WIPHL)**

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Chapter 1 – Background Information

1.0 – General

The purpose of this document is to provide Wisconsin clinic and administrative staff with guidance on obtaining Medicare, Medicaid and commercial insurance payment for SBIRT services. This document will be updated as appropriate to reflect the ongoing changes in policy and regulation.

1.1 - Background

Most of the clinical sites that have been working with the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) to implement alcohol and drug screening, brief intervention, and referral-to-treatment (SBIRT) services are supported through WIPHL's grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). One of WIPHL's main objectives is to determine ways to support the program's sustainability so that SBIRT services can continue throughout the state even after grant funding ends in August 2011. Some sites and practitioners may decide to continue providing SBIRT services simply because they are an important component of good, comprehensive health care. However, identifying ways to secure payment for providing SBIRT services will be a key strategy to promote widespread implementation of SBIRT services.

1.2 - Overview on the Status of Billing Recognition

SBIRT coding and billing policies and regulations are a patchwork in evolution. There are three billing methods that must be considered for purposes of reimbursement for SBIRT services. Coding and coverage policy varies based on payer: Medicaid, Medicare, and commercial health plans. While Medicare is already providing payment for services, bills can be submitted only for patients who are seen for illness or injury. As a result of the Medicaid and BadgerCare Plus Rate Reform Project and the 2009-2011 state biennial budget (2009 Wisconsin Act 28), Wisconsin Medicaid has expanded the SBIRT benefit for all patients and for a wide-range of provider types. Nationally, implementation of billing codes varies across commercial health plans. In certain scenarios, reimbursement may also be sought using appropriate evaluation and management (E&M) codes based on standard components or time criteria.

Under the current patchwork, providers may be eligible for reimbursement for a majority of their patients. However, great care must be taken to ensure compliance in service delivery and bill submission.

Chapter 2 – Key Clinical Definitions

2.0 - General

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

2.1 - Brief Screen

A screen is defined as "a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur." A brief screen may involve one to several short questions relating to drinking and drug use. A brief alcohol and drug screen is considered an integral part of routine preventive care and is therefore not separately reimbursable by Medicare, Medicaid, or private payers. Brief screens may be administered by providers or any other staff member. They may be administered in writing, orally, or via various technologies.

2.2 - Assessment or Full Screen

Assessments or full screens more definitively categorize a patient's substance use. Assessments are indicated for patients with positive brief screens and for patients with signs, symptoms, and medical conditions that suggest risky or problem drinking or drug use.

Providers may be able to obtain reimbursement for conducting assessments according to their clinical judgment. However, some payers may require that structured, validated questionnaires be used, especially if ancillary providers are administering services. Examples of such questionnaires are the Alcohol Use Disorders Inventory Test (AUDIT), the Drug Abuse Screening Test (DAST), and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). An assessment places the patient on a continuum of use and suggests whether no intervention, brief intervention, brief treatment, or a referral to treatment is appropriate. A brief assessment or full screen is reimbursable when other requirements are met.

2.3 - Brief Intervention

Brief interventions are interactions with patients which are intended to induce a change in a health-related behavior. Often one to three follow-up contacts are provided to assess and promote progress and to evaluate the need for additional services. 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 may qualify for a DSM-IV diagnosis of alcohol or drug abuse and patients who may not qualify for any DSM-IV substance-related diagnosis.

2.4 - Referral

Patients who are likely alcohol or drug dependent are typically referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment.

2.5 - Brief Treatment

A brief treatment is a planned, several-session course of interaction with patients designed to help patients with alcohol or drug use disorders quit or cut down or reduce the negative impacts of substance use on their lives. Brief treatment is typically provided to patients with likely dependence who cannot or will not obtain conventional treatment, or to other patients with numerous and serious negative consequences of their drinking or drug use (which usually qualifies for a DSM-IV diagnosis of abuse). Brief treatments may also be provided to patients who are receiving pharmacologic treatment for alcohol or opioid dependence in general healthcare settings.

2.6 - Follow-up

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

2.7 - Clinical Service Definitions for Billing

In general, billable services are referred to as either screening or intervention services.

2.7.1 - Screening

For general billing purposes, screening is defined as administration of a full screen or brief assessment (see Section 2.2). Administering a brief screen (see Section 2.1) is not a billable service.

2.7.2 - Intervention

A billable intervention service could be any of the following:

- A session of brief intervention (see Section 2.3)
- A session of brief treatment (see Section 2.5)
- A session in which a referral is made or attempted(see Section 2.4)
- A follow-up service (see Section 2.6)

Chapter 3 – SBIRT Billing Codes

3.0 – General

Depending on the payer, provider of service and additional variables, there are different codes used to report SBIRT services for reimbursement. This chapter will provide a comprehensive overview of the fundamental elements necessary to determine how to report SBIRT services in variable billing scenarios.

3.1 - SBIRT Service Providers

Medicare typically makes direct payment for services only to credentialed providers, such as physicians, nurse practitioners and physician assistants. Similarly, commercial payers also tend to make direct payment only to credentialed providers, although not all commercial payers recognize nurse practitioners and physician assistants as credentialed provider types. As a result of the Medicaid and BadgerCare Plus Rate Reform Project and the 2009-2011 state biennial budget (2009 Wisconsin Act 28), Wisconsin Medicaid has expanded the SBIRT benefit to a wide-range of provider types. Please refer to Chapter 5 of this manual for details on this expansion of Wisconsin Medicaid coverage and provision.

Ancillary providers, such as health educators, are non-credentialed providers and must perform services under the direct supervision of a credentialed provider. The definition of direct supervision varies based on payer. Medicare's definition of direct supervision as part of the "incident-to" guideline will be covered in detail in chapter 4 of this manual. For a complete understanding of the supervision and signature requirements and to verify types of credentialed providers for commercial payers, you will need to contact your carriers or review your contracts. For services performed by ancillary staff, best practices would suggest the credentialed provider be on the premises and directly available to intervene if necessary. Additionally, the credentialed provider should co-sign the documentation prior to submitting the claim for payment. Any ancillary services should adhere to an established plan of care.

3.2 – The Code Sets

The Healthcare Common Procedure Coding System (HCPCS) was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. HCPCS codes are based on the Current Procedural Technology (CPT) codes developed by the American Medical Association (AMA). After the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory. There are two (2) distinct types of HCPCS codes sets, Level I and Level II. Level I codes are comprised of the AMA's CPT codes set and is numeric. Level II HCPCS codes are alphanumeric and primarily used by Medicare and Medicaid to represent items and services and non-physician codes not adequately captured by CPT codes. Level II HCPCS, referred to as "HCPCS" are maintained by the Centers for Medicare and Medicaid Services (CMS).

3.3 - CPT Codes

At the annual AMA CPT Symposium in November 2007, the AMA released two (2) new CPT codes for the provision of SBIRT services for implementation January 1, 2008. When new codes are introduced, it is standard that significant background be provided on the decision process that ultimately results in adoption of the new code. In reference to the creation of these two (2) new codes the following guidance was shared, “A screening & brief intervention (SBI) describes a different type of patient-physician interaction. It requires a significant amount of time and additional acquired skills to deliver beyond that required for provision of general advice. SBI techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying problematic alcohol or substance use.” The importance of screening and intervening for those patients who aren’t necessarily identified as abusers and a comprehensive list of components that should be included in provision of the codes was also outlined. The components include, but are not limited to:

- A standardized screening tool should be used.
- The patient should receive feedback concerning the screening results.
- There should be discussion of negative consequences that have occurred; and the overall severity of the problem.
- Action should include motivating the patient toward behavioral change.
- A joint decision-making process regarding alcohol and/or drug use should be used.
- Plans for follow up are discussed together and agreed to.

The CPT codes below were created to be reported when performed by physicians. Medicare and Medicaid do not currently recognize or accept these CPT codes for payment. These codes may be reported to commercial payers that are reimbursing for SBIRT services when provided and billed by a credentialed provider. Ancillary staff, including health educators, may perform SBIRT services under the supervision of a credentialed provider. The services should relate to a plan of care and will require billing under the supervising physician. It is suggested that commercial carriers be contacted or contracts, attachments and amendments be reviewed for a complete understanding of unique billing and coding requirements. SBIRT services that do not meet the minimum fifteen (15) minute threshold are not separately reimbursable.

- **99408**
 - Alcohol and/or substance use structured screening (eg, AUDIT, DAST), and brief intervention services; 15-30 minutes
- **99409**
 - Greater than 30 minutes

It is important to note that these are time-based codes; therefore, your documentation must denote start/stop time or total face-to-face time with the patient.

3.4 – HCPCS Codes

Medicare and Wisconsin Medicaid recognize HCPCS codes for reporting the provision of SBIRT services. Typically, this decision is made because the language of the CPT codes is either too broad or does not accurately capture the reason(s) that Medicare and/or Wisconsin Medicaid will make payment. The two (2) sub-sections below will provide guidance on the codes that should be used when reporting to these payers.

3.4.1 – Medicare

CMS released two (2) new HCPCS codes concurrent with the release of the two (2) new CPT codes for SBIRT services in November of 2007. These codes became effective on January 1, 2008 and are designed to be reported by Medicare credentialed providers, such as physicians, nurse practitioners and physician assistants, for the provision of SBIRT services. Ancillary providers, including health educators, may not perform SBIRT services under physician supervision using the below codes. Information on reporting ancillary services as “incident-to” another Medicare service, can be found in Chapter 4 of this manual. As noted below in the HCPCS code narratives, CMS felt the verbiage used in the CPT codes for SBIRT services could be construed to be “routine screening” and screening services are statutorily excluded from Medicare coverage, per §1862(a)(1)(A) of the Social Security Act. Therefore, the term screening was eliminated when creating the HCPCS codes below. CMS also specifically excluded tobacco from the codes. See Chapter 8 of this manual for information on smoking and tobacco cessation services.

- **G0396**
 - Alcohol and/or substance abuse (other than tobacco) **structured assessment** (e.g. AUDIT, DAST) and brief intervention, 15 to 30 minutes
- **G0397**
 - Greater than 30 minutes

It is important to note that these are time-based codes; therefore, your documentation must denote start/stop time or total face-to-face time with the patient.

3.4.2 – Wisconsin Medicaid

As a direct result of the Medicaid and BadgerCare Plus Rate Reform Project and the 2009-2011 state biennial budget (2009 Wisconsin Act 28), Wisconsin Medicaid has expanded the SBIRT benefit resulting in the acknowledgement and acceptance of two (2) new HCPCS codes. These codes are used for reporting SBIRT services when provided by both credentialed providers and when ancillary staff performs SBIRT services under the supervision of credentialed providers. Information on the training requirements and detailed coverage criteria may be found in Chapter 5 of this manual.

- **H0049**

- Alcohol and/or drug screening
- **H0050**
 - Alcohol and/or drug service, brief intervention

Wisconsin Medicaid members who are pregnant are eligible for separate substance abuse screening and intervention services under the Mental Health and Substance Abuse Screening for Pregnant Women benefit. Providers are required to report the services under either the SBIRT benefit or the Mental Health and Substance Abuse Screening for Pregnant Women benefit. When receiving such services under the Mental Health and Substance Abuse Screening for Pregnant Women benefit, the two (2) HCPCS codes below are to be utilized. For additional details on this benefit refer to Chapter 5 of this manual and see the following link:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx?ia=1&p=1&sa=54&s=2&c=609>

- **H0002**
 - Behavioral health screening
- **H0004**
 - Alcohol or drug intervention, per 15 minutes

When reporting the above HCPCS codes under the Mental Health and Substance Abuse Screening for Pregnant Women benefit, modifier HF must be appended to the HCPCS codes to denote substance abuse screening.

3.5 – Evaluation and Management Coding (E&M)

There may be instances when ancillary providers, including health educators, are providing SBIRT services and based on payer requirements the SBIRT services are not reportable using one of the CPT or HCPCS codes defined above. For example, when billing Medicare for incident-to services in the clinic or billing Wisconsin Medicaid for substance abuse and intervention services under the Mental Health and Substance Abuse Screening for Pregnant Women, E&M codes will need to be submitted under the supervising provider's National Provider Identifier (NPI). In order to bill for E&M services, it is important to understand the basic components of E&M services and how to adequately capture the necessary documentation to support the service billed.

There are seven (7) key components to an E&M code which are used to define a level of service (LOS) and they are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem
- time

The first three of these components (history, examination and medical decision making) are the key components used in selecting a level of E&M service. An exception to this rule is the case when visits consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E&M service. The two most applicable E&M codes that might be reported by ancillary staff, including health educators, when providing SBIRT services are both representative of established patients, whether using components or counseling or coordination of care to determine LOS.

- 99211 – Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically 5 minutes are spent performing or supervising these services.
- 99212 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components

CPT code 99211 is used to bill incident-to services to Medicare and is considered the lowest-level E&M. It is expected the documentation contain elements of both evaluation and decision making. When billing 99212, which would be allowed as an ancillary service billed to Wisconsin Medicaid, documentation of at least two (2) of the three (3) (history, exam and medical decision making) elements is required.

In the case where counseling and/or coordination of care dominates more than fifty-percent (50%) of the face-to-face time, it is considered the key or controlling factor in determining the LOS. The start and stop time or total length of the E&M must be documented in the medical record. Additionally, the face-to-face counseling and/or activities involved in coordinating care must be described and documented the medical record.

For additional information on E&M coding and documentation, refer to the CMS 1995 Documentation Guidelines.

<http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>

3.6 - ICD-9 Diagnosis Codes

The International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9-CM), is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization. When referring to diagnosis codes, it is common to omit the Clinical Modification (CM) portion and refer to diagnosis codes solely as ICD-9.

Diagnosis codes play a critical role in supporting the medical necessity of the CPT or HCPCS codes that are performed. Depending on payer, SBIRT services may fall into a

medical benefit category or a mental health benefit for a patient. The diagnosis code selected and submitted on the claim will often time guide which benefit the payer selects. Below is a table of common diagnosis codes for reporting SBIRT services. It should be noted that Medicare requires an actual sign, symptom, illness or injury to be clearly evident in the selected ICD-9 code to verify medical necessity of non-screening services.

Common ICD-9 Codes Used for SBIRT	
V82.9	Screening for Unspecified Condition
V28.9	Unspecified Antenatal Screening
V65.40	Other Counseling, Not Otherwise Specified (NOS)
V65.42	Other Counseling, Substance Use and Abuse
V65.49	Other Specified Counseling

3.7 - Health Professional Shortage Area (HPSA) Modifiers

Section 1833(m) of the Social Security Act provides Medicare bonus payments for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Service Administration (HRSA) as primary medical care Health Professional Shortage Areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act. Medicare will make 10% incentive payments to physicians when services are performed in a designated HPSA zip code. Modifier AQ is not required on the claim if the services are provided in zip code areas that:

- Fall entirely in a county designated as a full-county HPSA; or
- Fall entirely within the county, through a USPS determination of dominance; or
- Fall entirely within a partial county HPSA.

For current information on the Medicare HPSA benefit see <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>

Wisconsin Medicaid also makes enhanced reimbursement for services provided in HPSA's , but the HPSA incentive varies widely from Medicare. Medicaid enhanced reimbursement is made to Medicaid-certified primary care providers and emergency medicine providers when one or both of the following applies:

- The rendering or billing provider is located in a [HPSA-eligible ZIP code](#).
- The member has a residential address (according to enrollment records) within a HPSA-eligible ZIP code.

Medicaid primary care providers and emergency medicine providers are defined as

- Physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics.
- Physician assistants.

- Nurse practitioners.
- Nurse midwives.

Standard enhanced reimbursement for HPSA-eligible primary care procedures is an additional 20 percent of the physician maximum allowable fee. Modifier AQ must be submitted on the claim.

3.8 – Reimbursement Fundamentals

It is important to understand the basic fundamentals of how your services are reimbursed. Both Medicare and Wisconsin Medicaid reimburse using a “fee schedule” methodology. Commercial payers may also have fee schedules, or they may reimburse based on what is considered to be “usual and customary” in a specific geographic area, a capitated rate or a different reimbursement model altogether. The driving force behind commercial payer reimbursement is typically based on if you have a contract and contract negotiation.

Understanding fee schedules will help you with both commercial contracting and in understanding the Medicare and Medicaid payments you will receive. There three (3) key calculation factors are; payment methodology, relative value and conversion. The payment methodology will guide you to the appropriate relative values. Some of the most common methodologies include;

- RBRVS – Resource Based Relative Value Scale (Medicare)
- RVP – Relative Value Principal (St. Anthony’s/Ingenix)
- Medicaid Fee Schedule

The RBRVS is the most utilized in the United States. In addition to Medicare, many health maintenance organizations and managed care organizations use it. The RBRVS assigns procedures performed by a physician or other medical provider a relative value which is then adjusted by a geographic region. This value is then multiplied by a fixed conversion factor, which changes annually, to determine the amount of payment. Medicare RBRVS determines fees based on three separate factors: physician work, practice expense, and malpractice expense. The following table contains the current 2010 RBRVS relative values for SBIRT codes. Wisconsin Medicaid does not assign relative values, to see maximum allowable fees for Wisconsin Medicaid see chapter 5.

SBIRT Codes	Work RVU	Practice Expense RVU	Malpractice RVU
99408	0.65	0.27	0.03
99409	1.3	0.5	0.07
G0396	0.65	0.22	0.03
G0397	1.3	0.43	0.07

*The PE RVU value listed here is a non-facility transitioned PE. For facility PE RVU’s, see <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>.

Chapter 4 – Medicare Billing & Reimbursement

4.0 - General

Medicare coverage for SBIRT services by credentialed providers, including physicians, nurse practitioners, physician assistants, has been effective since January 1, 2008. CMS released two HCPCS G-codes for reporting these services.

- **G0396**
 - Alcohol and/or substance abuse (other than tobacco) **structured assessment** (e.g. AUDIT, DAST) and brief intervention, 15 to 30 minutes
- **G0397**
 - Greater than 30 minutes

Ancillary providers, including health educators, may not perform SBIRT services under physician supervision using the above codes. This chapter will provide direction on billing Medicare for SBIRT services provided by credentialed providers, provided by non-credentialed providers as “incident-to” another Medicare service and the specific billing, coding and documentation requirements in both scenarios. Guidance will be given for billing SBIRT services in various sites of service, supervision requirements, billing multiple services on the same day, and attention to the role of the resident will be included.

4.1 – Coding & Reimbursement

The following table provides a summary of the coding and reimbursement elements of providing SBIRT services to Medicare beneficiaries by credentialed Medicare providers and ancillary staff. The reimbursement in this table assumes services were billed by a physician group, which employs non-physician personnel and the services were performed in an office setting. Reimbursement is based on the physician fee schedule of a Medicare participating provider in January of 2010. Additionally, there are no correct coding initiative (CCI) edits that would preclude the billing of G0396 & G0397 on the same day as an E&M service. Modifier 25, “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service” is not required.

Provider Type	Procedure Code(s)	Diagnosis	E&M allowed	Fee Schedule Reimbursement	Fee Amount
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			on the Same Day		
MD, DO	G0396, G0397	Sign, symptom, illness or injury	Yes	100% of the physician fee schedule allowed amount	\$30.93 and \$61.67
Non-Physician Practitioner (i.e; NP, PA)	G0396, G0397	Sign, symptom, illness or injury	Yes	85% of the physician fee schedule allowed amount	\$26.29 and \$52.42
Non-Physician Practitioner (i.e.; NP, PA)*	99211-99215	Sign, symptom, illness or injury	No	100% of the physician fee schedule allowed amount Billed under MD/DO NPI	Will be 100% of the allowed amount for the specific code. The range is \$17.86 - \$125.37
Ancillary Staff (i.e.; health educators)*	99211	Sign, symptom, illness or injury	No	85% of the physician fee scheduled allowed amount	\$17.86

* Under the Incident-to policy. Refer to subsection 4.1.1 below for additional details.

4.1.1 - Incident-to

It is important to understand that incident-to pertains only to Medicare. Although it is common to hear the term used with other payers, the specific details outlined in this section will pertain to Medicare. When this term is used by other payers, it is important to seek written clarification of what exactly is meant paying special attention to the supervision, employment and documentation requirements.

The Medicare incident-to rules were created to cover services that are an integral, although incidental, part of the physician's personal professional services to the patient when performed by non-physician personnel. Services that are performed incident-to by the non-physician staff are submitted to Medicare as though they were performed by the physician and the non-physician staff is "invisible" on the claim. Although the non-physician staff is not visible on the claim, the medical record should contain documentation of the service by the non-physician rendering provider with appropriate credentials. For purposes of SBIRT services provided by ancillary staff, non-physician practitioners such as nurse practitioners and physician assistants, could function as both the ordering and/or supervising physician. If a non-physician practitioner was the ordering provider of the incidental service, the resulting reimbursement would be eighty-

five percent (85%) of the fee schedule amount instead of one hundred percent (100%) when the ordering provider is a physician.

SBIRT services provided by non-credentialed providers, including health educators, would bill Medicare under the incident-to guidelines if all five (5) key components of the Medicare incident-to policy are met. When billing incident-to using ancillary staff, CPT code 99211 is the only allowable code. When billing incident-to using other credentialed provider types, such as a nurse practitioner or physician assistant, CPT codes 99211 - 99215 would be appropriate based on documentation or time. For additional information on E&M coding, refer to chapter 3 of this manual. Following are the five (5) key components of the incident-to rules that must be met under this guideline.

- Professional service
 - Must be a service that is typically performed by a physician, for example, diagnostic testing would not fall under the professional service definition.
- Clinic location
 - Incident-to services must be performed in a clinic location. They are not payable per these guidelines in a hospital setting. Clinic location is defined as one that is confined to a separate location in which the physician pays staff, space and supply costs.
- Employment
 - The non-physician provider must be a W-2 or leased employee of the physician. The physician must have the ability to directly terminate the employee.
- Initial Service
 - The initial visit must be a direct, personal, professional service furnished by a the physician to initiate the course of treatment for which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her continuing active participation in and management of the course of treatment.
- Direct Supervision
 - A physician must be present in the office suite and immediately available to provide assistance and direction throughout the time non-physician provider is performing the service. This could be either the ordering physician or another designated supervising physician. It is important to track the supervising physician information when the supervising physician is not the ordering. Tracking can be accomplished by documenting the name of the supervising physician in the record. In large clinics, it is also common to have a supervising physician schedule that should be retained. It is important that the supervising physician be directly available to immediately “step-in” to assume the care if necessary.

In summary, when billing for SBIRT service performed by ancillary staff, including a health educator, the medical record must be adequately documented to reflect the medically necessary reason for the patient's visit, any treatment rendered, elements of history obtained, examination performed and/or clinical decision making and must also support physician supervision. Additionally, the health educator must be employed directly by the physician and the patient must be established.

For additional information on the Medicare incident-to billing policy, see www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf.

4.2 - Site of Service

Another component that must be considered when billing SBIRT services for Medicare beneficiaries, is the site of service. Reimbursement methodologies will vary based on the location where the service is provided. This section will focus on the intricacies of billing and coding for SBIRT services in common locations.

4.2.1 – Office

In the office setting, physicians and credentialed non-physician practitioners may receive direct reimbursement when providing SBIRT services when billing the SBIRT codes of G0397 and G0397. Non-physician practitioners and ancillary staff may also bill for SBIRT services under the incident-to guidelines outlined in section 4.1.1 of this manual. The diagnosis reported on the claim always requires a sign, symptom, illness or injury. The place of service code utilized on the CMS-1500 claim form is eleven (11). Reimbursement will be made from the physician fee schedule.

4.2.2 – Hospital

In the hospital setting there are several options for reporting SBIRT services. The appropriate coding and billing will depend on a number of variables including;

- Who is providing the service
- Who employs the staff providing the service
- Where in the hospital is the service provided

This section will provide guidance on how to appropriately bill Medicare for SBIRT services when provided by credentialed providers or ancillary staff. It will also outline the nuances in reimbursement structure based on employment arrangements and where in the hospital the services are physically performed.

4.2.2.1 – Outpatient

When providing SBIRT services in the hospital outpatient department it is important to identify the type of provider performing the service, the employment arrangement of the service provider and the facility designation, for example: provider-based, critical access, etc. This information is imperative for determining accurate billing of SBIRT services. When a physician group is not a direct employee of the facility, it is common for separate facility and professional charges to be submitted for payment. Depending on the facility designation, professional fees may be submitted on a CMS-1500 to the Part B Carrier or Medicare Administrative Contractor (MAC) and the facility fee may be submitted on a UB-04 claim form to the Part A fiscal Intermediary or MAC. For purposes of SBIRT, physicians and other Medicare enrolled non-physician practitioners may bill the SBIRT code G0396 & G0397 for direct payment when performed in the hospital outpatient department; place of service is twenty-two (22). When professional fees are reimbursed based on the Medicare Physician Fee Schedule (MPFS), non-physician practitioners will be reimbursed eighty-five percent (85%) of the allowed amount. Professional fees that are included in the facility bill due to employment arrangement will primarily be reimbursed as part of the ambulatory payment classification (APC) payment. The diagnosis reported on the claim will always require a sign, symptom, illness or injury. Medicare does allow a separate medically necessary E&M service on the same day.

Although the concept(s) of incident-to as outlined in section 4.1.1 do not apply in a hospital setting, the 2010 outpatient perspective payment system (OPPS) final rule, effectively January 1, 2010, clearly indicates that physicians, clinical psychologists, nurse practitioners, physician assistants, clinical nurse specialists, or certified nurse-midwives may provide direct supervision for hospital outpatient therapeutic services that they may perform themselves under State law and are within their scope of practice and hospital-granted privileges. Additionally, Medicare Part B payment will be made “incident-to” such services furnished under OPPS. CMS has verified that procedures reported with the same HCPCS or CPT code that are inherently both diagnostic and therapeutic in nature, or could begin as diagnostic and become therapeutic, are considered therapeutic for purposes of payment and direct supervision. Therefore, SBIRT services are considered therapeutic, and ancillary providers, including health educators, may perform both screening and intervention under direct supervision in the hospital outpatient department. CMS states that the supervision can be provided by an appropriate practitioner who is located anywhere on the hospital campus, provided that the practitioner is immediately available to respond. CMS will continue to require that each off-campus hospital department have an appropriate supervising practitioner within the department whenever therapeutic services are rendered. CMS also specifically states that a single practitioner cannot supervise services in multiple departments, even if those departments are co-located in the same off-campus hospital building. CMS further explains that the supervising practitioner must be prepared to step in and perform the service.

When SBIRT services are provided by a health educator employed by the facility under direct supervision as defined above, the facility would report either G0396 or G0397 with revenue code 942 on the facility bill. These services would be reimbursed as part of the facility payment. There is no mechanism for Part B reimbursement when services are provided by health educators regardless of supervision and employment requirements.

Therefore, a supervising physician or non-physician practitioner billing Medicare Part B for professional service performed in the hospital outpatient department may not bill for services provided by his/her own staff or hospital staff which they are supervising. All services performed by health educators must be bundled into the facility bill. If a health educator is employed by a physician group and performing hospital services, the physician group may move to provide such services “under arrangement” resulting in payment from the hospital.

For additional information related to the 2010 OPPS final rule, see <http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf>.

4.2.2.2– Inpatient

When SBIRT services are provided to Medicare beneficiaries in the inpatient setting, denoted with place of service code twenty-one (21), this could include patients in any inpatient area. Physicians and Medicare enrolled non-physician practitioners that are not employed by the facility may direct bill Medicare Part B using G0396 or G0397, whichever is appropriate. The diagnosis reported on the claim will always require a sign, symptom, illness or injury. Non-physician practitioners will be reimbursed eighty-five percent (85%) of the allowed amount based on the Medicare Physician Fee Schedule (MPFS). Medicare will allow a separate medically necessary E&M service on the same day. If SBIRT services are performed by physicians or non-physician practitioners that are employed by the facility, there is no separate allowed professional reimbursement. The charges would be included in the facility fees and reimbursed through the diagnosis related group (DRG) payment to the facility.

If ancillary staff, such as health educators employed by the facility provides SBIRT services to Medicare beneficiaries in the inpatient setting, the charges will be rolled into the DRG payment. Since incident-to will not apply in the hospital setting, ancillary staff is unable to provide SBIRT services as incident-to a physician or non-physician practitioner in the inpatient setting.

4.2.3 - Emergency Department

When providing SBIRT services in the hospital emergency department, there is commonly both a facility and professional fee. Services that are performed in the emergency department by physicians and Medicare enrolled non-physician practitioners that are not employed by the facility are reported to Medicare Part B on a CMS-1500 claim form using place of service code twenty-three (23). For purposes of SBIRT, physicians and other Medicare enrolled non-physician practitioners may bill the SBIRT code G0396 & G0397 for direct payment when performed in the emergency department. The diagnosis reported on the claim always requires a sign, symptom, illness or injury. Medicare allows a separate medically necessary emergency department E&M code to be reported on the same day.

If ancillary staff, such as health educators, employed by the facility provides SBIRT services to Medicare beneficiaries in the emergency department setting, the charges will be rolled into the facility payment. Since incident-to will not apply in the hospital setting, including emergency departments, ancillary staff is unable to provide SBIRT services as incident-to a physician or non-physician practitioner in the emergency department setting.

4.2.4 - FQHC, RHC

Payment to independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to Medicare beneficiaries is made through an all-inclusive rate for each visit. The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies. The term "visit" is defined as a face-to-face encounter between the Medicare beneficiary and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. 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:

- After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment;
- The patient has a medical visit and a clinical psychologist or clinical social worker visit.

When SBIRT services are provided to Medicare beneficiaries in a RHC/FQHC, they are included in the encounter rate and no separate payment is made, regardless of who is providing the service. For additional information on RHC/FQHC billing and reimbursement, see <http://www.cms.hhs.gov/manuals/downloads/clm104c09.pdf>.

4.3 - Resident Billing

For Medicare program purposes, the CMS defines "residents" as:

- physicians participating in approved postgraduate training programs, and
- physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Where a senior resident has a staff or faculty appointment or is designated as a "fellow", it does not change the resident's status for the purposes of Medicare coverage and

payment. As a general rule, Medicare fiscal intermediaries make payment directly to the hospital for services of residents. For additional information on residency billing as part of Graduate Medical Education (GME) or for SBIRT services provided under the supervision of the teaching physician see

<http://www.cms.hhs.gov/transmittals/downloads/r811cp.pdf>.

4.3.1 – Moonlighting Services Provided Outside the Scope of Approved Training Programs

Medical and surgical services furnished by residents that are not related to their training program, and are performed *outside the facility* where they receive their training, i.e.; in an urgent care clinic, are covered by Medicare Part B as physician services where both of the following requirements are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition; and,
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

When both of the above requirements are met, the services are considered to have been performed by residents in their capacity as physicians. When resident physicians meet these requirements, they may enroll in Medicare Part B and bill directly for reimbursement. This would include reimbursement for the provision of SBIRT services when provided.

Medical and surgical services furnished by residents that are not related to their training program, and that are *performed in an outpatient department or emergency room of the facility* where they receive their training, are covered as physicians' services where all three of the following criteria are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition;
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and,
- The services performed can be separately identified from those services that are required as part of the training program.

When these three criteria are met, the residents' hospital outpatient department and emergency room services are considered to have been furnished by the residents in their capacity as physicians. When resident physicians meet these requirements, they may enroll in Medicare Part B and bill directly for reimbursement. This would include reimbursement for the provision of SBIRT services when provided.

When residents are performing services in their capacity as physicians, they must be covered under medical malpractice insurance and no payment will be made to a teaching physician. When residents are functioning in the physician capacity, they may also supervise ancillary staff and bill such services to Medicare and Medicaid. Commercial payers do not recognize residents as credentialed physicians until completion of their training.

For additional information on resident billing or teaching physician guidelines, see <http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>.

Chapter 5 – Wisconsin Medicaid Billing and Reimbursement

5.0 – General

Effective for dates of service beginning January 1, 2010, BadgerCare Plus and Medicaid expand coverage of SBIRT services for all patients. This benefit has been added as a result of the Medicaid and BadgerCare Plus Rate Reform Project and the 2009-2011 state biennial budget (2009 Wisconsin Act 28). This chapter will provide guidance on eligibility, coverage, billing & coding, reimbursement and documentation requirements when SBIRT services are provided by physicians and ancillary staff, including health educators, to Wisconsin Medicaid and BadgerCare Plus members. For comprehensive information on the new SBIRT benefit, the ForwardHealth Update see the following link: <https://www.forwardhealth.wi.gov/kw/pdf/2009-96.pdf>.

5.1 – Eligibility

The SBIRT benefit is available to members enrolled in BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan and Wisconsin Medicaid. Members enrolled in a Medicaid HMO or managed care organization must receive SBIRT services through the HMO. The SBIRT benefit is available to the above members that are ten (10) years of age or older on the date of service.

5.2 – Screening & Intervention Services

The substance abuse screening and intervention services are designed to prevent 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. SBIRT services are not designed to address smoking and tobacco cessation services. For direction on billing smoking and tobacco cessation to Wisconsin Medicaid, see Chapter 8, Section 3 of this manual.

SBIRT services must be provided face-to-face (in-person or via simultaneous audio and video transmission) with the member. A physician prescription is not required for screening or intervention. Following is a table of allowable places of service, which would be reported on a CMS-1500 claim form.

Medicaid Allowable Place of Service Codes	
03	School
11	Office
12	Home

21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
99	Other Place of Service

5.2.1 - Screening

Medicaid policy indicates screening should be used as a primary method for educating members about the health effects of using alcohol and other drugs. Wisconsin Medicaid and BadgerCare Plus intend to cover screening services in wide variety of settings to increase the chance of identifying people at risk.

A few brief questions may be asked to identify those members that would benefit from a more in-depth screening. Asking a few questions is not a reimbursable service.

Providers are required to use an evidence-based screening tool to identify members at risk for substance abuse problems. The screening tool should be simple enough to be administered by a wide range of health care professionals. The tool must demonstrate sufficient evidence of validity and reliability to accurately identify members at potential risk for substance abuse disorder. Enough information must be generated from utilizing the tool to customize an appropriate intervention based on the identified level of substance use. Providers may use more than one screening tool during the screening process if appropriate; however, no additional reimbursement will be made.

Wisconsin Medicaid has approved several evidence-based screening tools. Providers may choose a tool that is not on the list, but before implementing and billing for screening services utilizing such a tool, they are required to obtain prior approval by writing to DHSSBIRT@wisconsin.gov.

Areas of focus for any evidence-based screening tool must include:

- The quantity and frequency of substance use over a particular period of time. (generally 1 to 12 months)
- Problems related to substance use.
- Dependence symptoms.
- Injection drug use.

The current approved evidence-based screening tools are:

- The Alcohol Use Disorders Inventory Test (AUDIT)
- The Drug Abuse Screening Test (DAST)
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- The CRAFFT, which has been validated for adolescents
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

5.2.2 – Intervention

Brief substance abuse intervention services are covered for members who through the use of an evidence-based screening tool, are identified as at-risk for a substance abuse disorder(s). Brief intervention may be a single or multiple sessions focused on motivational discussion that increases insight and awareness regarding substance use and motivation toward changes in behavior. Alternatively, brief intervention may also be used as a method of increasing motivation and acceptance of a referral for substance abuse treatment. Intervention services may occur on the same date of service as the screening or on a later date. Brief intervention is not covered prior to screening.

Although Wisconsin Medicaid is not endorsing a specific approach for intervention, providers are required to use effective strategies for the counseling and intervention. Examples of demonstrated effective strategies include the following:

- The SBIRT protocols, available at <http://sbirt.samhsa.gov/about.htm>
- “Helping Patients Who Drink Too Much,” A Clinician’s Guide, Update 2005 Edition, available at <http://pubs.niaaa.nih.gov/publications/Practitioner/cliniciansGuide2005/guide.pdf>

5.3 – Services for Pregnant Women

Wisconsin Medicaid members who are pregnant are eligible for separate substance abuse screening and intervention services under the Mental Health and Substance Abuse Screening for Pregnant Women benefit. Providers are required to report the services under either the SBIRT benefit or the Mental Health and Substance Abuse Screening for Pregnant Women benefit. Health Educators would not be permitted to bill for SBIRT services using the SBIRT HCPCS codes under supervision of a credentialed provider if performed under the Mental Health and Substance Abuse Screening for Pregnant Women benefit. When ancillary staff such as a health educator, performs screening and intervention services under this benefit, reimbursement up to a level-two office visit (CPT code 99212) may be made. The supervising provider is required to be listed as the rendering provider on the claim. The documentation must support the level of service provided. The member must have a verified pregnancy on the date services are rendered.

The coding, billing and documentation requirements will vary based on the methodology selected. See Chapter 5, Section 5 of this manual for additional details.

Additional information on the Mental Health and Substance Abuse Screening benefit, including a list of eligible professionals is available at the following link:
<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx?ia=1&p=1&sa=54&s=2&c=609>

5.4 – Training and Requirements for Eligible Providers

In an effort to maximize early detection and treatment of substance abuse problems, Wisconsin Medicaid and BadgerCare Plus are allowing a wide-range of eligible providers to administer these services. Therefore, the DHS has outlined training requirements for both licensed and unlicensed individuals. Providers are required to retain documentation confirming that staff providing screening and intervention services meet the training, education and supervision requirements.

5.4.1 – Training for Licensed Health Care Professionals

In order to directly deliver screening and intervention services, licensed health care professionals are required to complete a minimum of four (4) hours of DHS approved training. Training may be accomplished face-to-face or via the Internet. Licensed health care professionals with expertise in the field of substance abuse screening and motivational interviewing or motivational enhancement may receive an exemption on a case-by-case basis. For additional information on training or exemptions, contact DHS at DHSSBIRT@wisconsin.gov.

5.4.2 – Training for Unlicensed Health Care Professionals

Unlicensed health care professionals may provide screening and brief intervention services if they meet the following specific requirements outlined by DHS:

- Successfully complete sixty (60) hours of training related to provision of screening and brief intervention. This training will include the DHS approved-training and a minimum of thirty (30) training hours must be face-to-face.
- Screening and brief intervention services must be performed under the supervision of a licensed health care professional. The supervising physician is not required to complete training.
- The unlicensed health care professional must follow written or electronic protocols for evidence-based practice during the delivery of the screening and intervention services. Quality assurance procedures should be in place to ensure consistent adherence to protocols.

5.5 – Coding, Billing & Documentation Requirements

The SBIRT benefit will correspond with two (2) HCPCS procedure codes, as noted in Chapter 3, Section 2 of this manual. Both screening and brief intervention will require specific diagnosis codes on the claim. If opting to bill pregnant women under the Mental Health and Substance Abuse Screening Benefit, two (2) separate HCPCS codes will be used and appending a modifier will be required for payment. Neither benefit requires a prior authorization (PA). Providers are required to retain documentation concerning the

health care professional’s education, training and supervision for provision of SBIRT services. For assistance in documenting these requirements, see Appendix A.

5.5.1 Screening Requirements

For members enrolled in Medicaid or the BadgerCare Plus Standard Plan, the screening benefit is limited to one (1) unit of service per rolling twelve (12) months, which means no less than eleven (11) months must pass between billings for screening. For members enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan, the screening is limited to one (1) unit of service per enrollment year. 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 (1) regardless of time spent completing the screening.

In addition to documenting the service, providers using an electronic health record (EHR) should document in the EHR what screening tool was used and the member’s responses to the screening questions. In order to meet this requirement, it is permissible to document the overall results of the screening in the EHR. The completed screening tool should be available for review in the case of an audit. For additional information on EHR functionality and documentation, see Chapter 9 of this manual.

To report screening under the SBIRT benefit, use HCPCS code H0049. The appropriate diagnosis is V82.9, Screening for Unspecified Condition.

To report screening under the Mental Health and Substance Abuse Screening Benefit for pregnant women, use HCPCS code H0002. This is reported once per patient, per pregnancy and requires a HF modifier to denote substance abuse screening. The appropriate diagnosis is V28.9, Unspecified Antenatal Screening.

Substance Abuse Screening Coding & Billing Requirements				
Procedure Code	Description	Modifier	Diagnosis	Units of Service
H0049 SBIRT Benefit	Alcohol and/or drug screening	None	V82.9	1
H0002* Substance Abuse Screening for Pregnant Women Benefit	Behavioral Health Screening	HF	V28.9	1

*When performed by an eligible provider. If performed by a health educator, reimbursement up to a level-two office visit (CPT code 99212) may be made when reported under the supervision of an eligible credentialed provider.

Additional information on the Mental Health and Substance Abuse Screening benefit, including a list of eligible professionals is available at the following link:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx?ia=1&p=1&sa=54&s=2&c=609>

5.5.2 Intervention Requirements

For members enrolled in Medicaid and the BadgerCare Plus Standard Plan, the intervention services are limited to four (4) hours per rolling twelve (12) months, which means that over an eleven (11) month period, a total of four (4) hours of intervention can be billed. For members enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan, the intervention services are limited to four (4) hours per enrollment year. A unit of service is fifteen (15) minutes, so the four (4) hour limit is equal to sixteen (16) units of service. Up to one (1) hour or four (4) units of intervention services may be provided per patient, per day for a total of sixteen (16) units per pregnancy under the Mental Health and Substance Abuse Screening benefit. Intervention services may be provided on the same date or a later date than the screening.

To report intervention under the SBIRT benefit, use HCPCS code H0050. The appropriate diagnosis is V65.42, Other Counseling, Substance Use and Abuse.

To report intervention under the Mental Health and Substance Abuse Screening Benefit for pregnant women, use HCPCS code H0004. This is limited to four (4) hours per patient, per pregnancy and requires a HF modifier to denote substance abuse intervention. The appropriate diagnosis is V65.42, Other Counseling, Substance Use and Abuse or V65.49, Other Specified Counseling. Utilization of either diagnosis is appropriate.

Intervention Coding & Billing Requirements				
Procedure Code	Description	Modifier	Diagnosis	Unit of Service
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	None	V65.42	Up to four (4) units or one (1) hour of service per day, limited to sixteen (16) per enrollment year or rolling 12 months based on plan type.
H0004*	Alcohol or drug	HF	V65.42 or	Up to four (4)

	intervention, per 15 minutes		V65.49	units or one (1) hour of service per day, limited to sixteen (16) units or four (4) hours per pregnancy.
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*When performed by an eligible provider. If performed by a health educator, reimbursement up to a level-two office visit (CPT code 99212) may be made when reported under the supervision of an eligible credentialed provider.

Additional information on the Mental Health and Substance Abuse Screening benefit, including a list of eligible professionals is available at the following link:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx?ia=1&p=1&sa=54&s=2&c=609>

5.6 – Reimbursement

Reimbursement for SBIRT services will be made at the lesser of the provider’s usual and customary charge or the BadgerCare Plus and Wisconsin Medicaid maximum allowable fee for the service. Wisconsin Medicaid will pay for separate and additional services on the same day as SBIRT, including medically necessary E&M services. The SBIRT codes will not be separately reimbursed when billing under the Mental Health and Substance Abuse Screening benefit using codes H0002 and H0004, or with any other HCPCS or CPT code that represents the same or similar services. The 2010 maximum allowable fee amount for screening is \$35.35. The maximum allowable fee for intervention is dependent on the provider type. The table below summarizes the 2010 maximum allowable fees.

Provider Type	Intervention Maximum Allowable Fee
Advanced practice nurse prescribers with psychiatric specialty	\$20.23 per 15 minutes
Crisis intervention providers	\$14.70 per 15 minutes
HealthCheck providers	\$12.20 per 15 minutes
Master’s level psychotherapists	\$13.89 per 15 minutes
Nurse Practitioners	\$20.23 per 15 minutes
Physicians	\$20.23 per 15 minutes
Physician Assistants	\$18.21 per 15 minutes
Prenatal care coordinators	\$12.20 per 15 minutes
Psychiatrists	\$20.23 per 15 minutes
Psychologists in outpatient mental health clinics	\$16.41 per 15 minutes
Substance Abuse Counselors	\$8.07 per 15 minutes

To obtain current fee information for Wisconsin Medicaid, you may download specific fee schedules or to use the interactive fee schedule at the following link:

<https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/76/Default.asp>

[X](#)

Chapter 6 – Commercial Insurance Billing and Reimbursement

6.0 – General

Commercial payers, especially managed care plans, will have individual rules for the provision of SBIRT services. In general, when submitting claims to commercial carriers, the CPT codes 99408 and 99409 would be appropriate. Coding and billing rules may also apply differently based on the provider of service. This chapter will provide guidance on supervision of ancillary providers, tips for contracting and an overview of payers in Wisconsin which are currently reimbursing for SBIRT services. It is suggested that commercial carriers be contacted or contracts, attachments and amendments be reviewed for a complete understanding of billing and coding requirements. State scope of practice for providers rendering the service is also a component that must be considered in provision of services.

6.1 – Supervision of Ancillary Services

When SBIRT services are provided by non-credentialed providers, such as health educators, commercial payers will typically define a required level of supervision and training that is appropriate for the specific service. Supervision categories could be personal, direct or general. There may also be employment or contract requirements necessary between the ancillary staff and the credentialed billing provider. Individuals who are not licensed health care professionals must also have appropriate training or a combination of training and work experience to administer ancillary services. Training requirements will be defined by the payer through contracting or coverage and payment policy. If you are providing SBIRT services to patients with commercial insurance in which you are not a participating provider, it would be suggested to follow the Medicare incident-to guidelines as outlined in Chapter 4 of this manual.

6.2 – Contracting

Contracting is a strategic process, but it also offers opportunity. Providers should not assume that payers are only looking for the lowest contract reimbursement cost. Instead, recognize that payers will also be looking for quantifiably high quality service. Therefore, the provider who can demonstrate through accurate and easily obtainable data that SBIRT services are both cost-effective and provide for measurable quality may have an advantage. Providers may also be able to demonstrate integration of SBIRT services in such a way that highlights the overall reduction of costs. The opportunity to explore credentialing of health educators should not be overlooked either.

6.3 - Coding & Reimbursement

Currently in Wisconsin, several commercial carriers have acknowledged their intent to reimburse for SBIRT services provided by credentialed providers when submitted with CPT codes 99408 and 99409. Carriers may vary in their reimbursement for SBIRT services when provided by ancillary staff, such as health educators. Billing for SBIRT services provided by ancillary staff, if allowed, would also be reported using CPT 99408 and 99409. Documentation must be on file that supports the services provided and the supervising physician. Additionally, commercial payers will allow credentialed providers to report an E&M service on the same day as SBIRT services when they are significant and separate. There are no correct coding initiative (CCI) edits that would preclude the billing of 99408 & 99409 on the same day as an E&M service; therefore, modifier 25, “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service” is not required. Commercial payers may have proprietary software edits that will require the use of this modifier. Clinical sites will need to monitor claim denials or commercial payer coverage policies.

Example: A level four (4) established patient visit in addition to a twenty (20) minute screening would be reported with CPT 99214 and CPT 99408 by the credentialed provider. If allowed, the ancillary staff, such as a health educator, could provide the screening under supervision and the credentialed provider would provide the E&M service.

Below is a list of commercial carriers in Wisconsin that are currently reimbursing for SBIRT services. Reimbursement rates vary by geographic location and payer.

Carrier	Additional Information
Anthem (Wisconsin Members)	No payment for SBIRT codes if billed with preventive medicine CPT codes 99381-99387 and 99391 - 99397
Physician Plus Insurance Corporation	Time and discussion must be documented
United Healthcare	Claims processing determines if payment falls under the medical or behavioral health benefit
Unity	Payment made under the behavioral health benefit
WEA	
WPS	Claims are pended and sent to medical management for review of medical necessity
Cigna	The screening instrument and the nature of the intervention activity should be documented in the medical record. The work effort for the SBIRT codes is separate and distinct from all other E&M services

	performed in the same session. If the screening shows no intervention is required, the screening should be included in an E&M or preventive medicine service
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Chapter 7 – Compliance

7.0 – General

Compliance continues to be a hot topic across all areas of health care. Although coding, billing and documentation of health care services remain top targets, they are not the only targets and the list continues to grow. Significant movement in the health care industry to develop corporate compliance programs came after passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This Act gives the Department of Health and Human Services' Office of Inspector General (OIG) and the U. S. Department of Justice more investigational funding and authority to increase penalties for health care fraud and abuse. Using these and other enforcement tools the government continues to investigate health care institutions across the U. S. searching for violations of the False Claims Act and other federal laws.

As a direct result of HIPAA, the OIG finalized the “Compliance Guidance for Individual and Small Group Physician Practices” on September 25, 2000. This publication was created to assist physicians in developing compliance programs for their practices. In fact, the OIG has compliance guidance documents for multiple types of providers including; hospitals, hospices, ambulance suppliers, clinical laboratories and third-party billing companies just to name a few. These documents can be found at <http://oig.hhs.gov/fraud/complianceguidance.asp>. The compliance program guidance is built on the seven (7) elements outlined in the U.S. Sentencing Guidelines. In this chapter we will review those seven (7) elements and focus on some potentially problematic areas that require further clarification.

7.1 – The Seven Elements of an Effective Compliance Program

A compliance program is a management commitment to play by the rules. But it is not just words; it must be backed up with solid, ongoing management and organizational steps to prevent, detect and correct any wrong doing. The first step is recognizing that you do not have to reinvent things; your program should be customized for your organization, but you can adapt tools that already exist or are readily available elsewhere. When it makes sense to obtain special expertise, you should do so. What will work best varies by organization with smaller entities generally needing less formality, the OIG has acknowledged that implementing all seven components may not be feasible for all organizations. The compliance program guidance contains seven (7) components which will provide a foundation on which a practice can create a voluntary compliance program. The seven (7) compliance program elements are:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards

- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

The OIG recommends that when beginning from scratch, these steps be implemented gradually. Conducting internal monitoring and auditing is the suggested place to start, which requires the completion of a risk assessment. For purposes of monitoring and auditing coding, billing and medical record documentation, a chart audit will satisfy the risk assessment. Begin by identifying ten (10) to fifteen (15) medical records per physician for review. Compare the documentation to the charge ticket for an accurate comparative analysis and identify billing patterns. It is especially important to perform routine audits on services that you have just started billing for, like SBIRT, and provide any needed training or education in follow-up. Although most organizations tend to focus on coding, billing and documentation, a risk assessment should be performed to accurately capture the areas of highest risk for each organization.

7.2 – Is It A Compliance Issue? Fact or Fiction

There are many myths surrounding what is compliant and what is not as it relates to fees and charging. In this section we will address a few key compliance questions and provide answers and resources to help keep you at the least amount of risk.

7.2.1 – Can I Ask a Colleague or Another Entity What They Charge for a Particular Service?

This question will depend on “who” you are asking. If you are not direct competitors with a colleague, it may be appropriate to ask questions related to fees and charge structure, albeit no answer is required. For example, if you practice in Wisconsin and you have a colleague with a clinic in Florida, you are clearly not directly competing with each other and no antitrust issues should arise. If you are asking an entity of the same specialty, in the same community, the situation gets stickier and may violate the Sherman Anti-Trust Act. The law directs itself not against conduct which is competitive, but rather against conduct which might unfairly destroy competition itself. For additional information on the Sherman Anti-Trust Act see http://www.justice.gov/atr/public/guidelines/1791.htm#CONTNUM_49.

7.2.2. – Can I Charge Self-pay Patients Less than my Standard Fee?

If you are a Medicaid participating provider, you must adhere to the Wisconsin administrative code DHS Chapter 101 which defines “usual and customary charge” as the provider’s charge for providing the same service to person’s not entitled to MA benefits (DHS 101.03 (181). (<http://www.legis.state.wi.us/rsb/code/dhs/dhs101.pdf>) If an entity is using a sliding fee scale, the usual and customary charge is the median of the provider’s charge for the service when provided to non-program patients. For entities that have not established usual and customary charges, the charge should be reasonably related to the actual cost for providing the service. Wisconsin administrative code DHS chapter 106 also states that the provider has a responsibility to retain as evidence, a copy of the usual and customary charges to recipients and to persons or payers who are not recipients (DHS 106.02 (9)(c) (<http://www.legis.state.wi.us/rsb/code/dhs/dhs106.pdf>). In summary, if you are a Medicaid participating provider in Wisconsin, it would be suggested that you never discount below your lowest reimbursement amount for a particular service.

For Wisconsin non-Medicaid participating providers, the Office of Inspector General (OIG) has published provisions that state discounted or free care won’t be factored into the calculation of a “usual charge” for services. You may in fact, charge self-pay patients less than your usual charge or no charge at all. This won’t apply to Medicare since Medicare rates are based on a fee schedule amount. For additional information on the published provisions see the following federal register links:
<http://edocket.access.gpo.gov/2003/pdf/03-23351.pdf>,
<http://edocket.access.gpo.gov/2007/pdf/E7-11663.pdf>.

7.2.3 – May I Charge Medicare and Medicaid Patients for No-show Appointments?

In 2007 the Centers for Medicare and Medicaid Services (CMS) released transmittal 1279, which provides direction related to compliantly charging Medicare beneficiaries for missed appointments. Entities are free to establish no-charge policies for missed appointments as long as the policy is written and clearly communicated to the patient. In order to apply to Medicare beneficiaries, the policy must apply to non-Medicare patients as well. The charged amount should be based on the missed business opportunity and not on actually providing the services and must be consistent regardless of payer. Additionally the fee is collected directly from the patient. To read the transmittal, see <http://www.cms.hhs.gov/Transmittals/downloads/R1279cp.pdf>.

The CMS however, does not allow state Medicaid programs to permit providers to collect payments from a member for a missed appointment.

7.2.4 – When Can I Waive Co-pay and Deductibles?

There are several components of the law to consider when answering this question. It is important to consider both federal and state laws and to acknowledge the complexities of such guidance. For example, the Health Insurance Portability & Accountability Act (42 USC §1320a-7a(i)(6)(A) have listed the following requirements that must be met in order to waive co-pays and deductibles.

- Don't offer the waiver as part of any advertisement or solicitation and
- Don't routinely waive co-pays and deductibles and
- You must either
 - Waive the co-pay and/or deductible amounts after determining in good faith that the individual is in financial need; or
 - Waive the copy and/or deductible after making reasonable collection efforts that fail to obtain payment

Additionally, Wisconsin law (Wis. Stat. § 146.905) states a health care professional may reduce charges to patients if the total payment for the services would impose an undue financial hardship on the patient receiving the service or product. The law does not, however, define undue financial hardship, leaving the determination up to the health care professional. If a physician waives the co-payment or deductible due to financial hardship, an explanation of the financial hardship should be documented.

The Medicare reimbursement manual states, “you can waive the co-payment or deductible amount after making the same collection effort you do for comparable amounts from non-Medicare patients”. For example, if you typically send out two collection letters to non-Medicare patients, you must do the same for Medicare. One exception with Medicare relates to Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). As part of the attestation statement signed with the CMS, RHC's and FQHC's agree not to charge Medicare beneficiaries co-insurance or deductible amounts. For additional information on the waiver of these amounts, see Claims Processing Manual, IOM 100-04, Chapter 9, section 210.2; <http://www.cms.hhs.gov/manuals/downloads/clm104c09.pdf>.

Wisconsin Medicaid law suggests if a physician determines the cost of collecting the co-payment or deductible exceeds the amount to be collected; the physician need not attempt collection. To satisfy the reasonable collection effort standard, the interplay of the laws seems to suggest that Medicaid patients, at the very least, should be asked for their co-payment at the time of service.

With the exception of proven hardship, health care professionals are prohibited from reducing charges to patients with health insurance coverage. Specifically, physicians and other health care professionals may not waive co-payments and deductibles for which the patient or patient's responsible party is required to pay under an indemnity insurance plan, HMO or PPO plan. Self-insured plans and professional courtesies are exempt from this prohibition. There is much to consider related to this topic and while creating or revising your collection policies the involvement of a health care attorney for purposes of overall liability would be suggested.

7.2.5 – Must I Charge All Payers the Same Fee?

May I have multiple fee schedules? The short answer is, yes. In general, there are no national laws that prohibit this practice. An exception may occur when a payer contract specifically includes a “most favored nation clause.” A typical most favored nation

clause requires the provider to charge to the payer the provider's 'usual fee' with the 'usual fee' likely defined to be the lowest fee charged offered and received as payment in full. Similarly, a most favored nation clause may require that a provider not charge fees to an insurer higher than the fees the provider accepts from any other non-governmental group, group plan or other payer. A primary argument for maintaining multiple fee schedules typically centers around the reduced "write off" amount, but in reality the variance in the amount of write-offs may do nothing to impact the actual amount collected.

Section 7.2.2 includes specific Wisconsin Medicaid information that must also be considered if developing multiple fee schedules. Additional consideration should be given to entities that are non-Medicare participating. This may require an entity to develop a non-par fee schedule to ensure the Medicare balance billing limits are not exceeded when billing a Medicare beneficiary.

Chapter 8 – Smoking Cessation Billing and Reimbursement

8.0 – General

This chapter provides guidance on the appropriate coding, billing techniques and reimbursement for smoking cessation services provided by physicians and ancillary staff, such as health educators, when billed to Medicare, Wisconsin Medicaid and Third Party payers.

8.1 – Current Procedural Terminology (CPT) Codes for Smoking Cessation Services

CPT codes 99406 and 99407 were established to report a face-to-face encounter to discuss smoking and tobacco use cessation. This is accomplished by direct counseling with the patient. Code 99406 is designed for the intermediate intensity counseling session that will range from 3-10 minutes in time. Code 99407 was designed to capture an intensive counseling session, greater than 10 minutes.

- 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407: intensive, greater than 10 minutes

These codes are designed to be reported in addition to other evaluation and management (E&M) services on the same day. Codes 99406 and 99407 require time to be face-to-face with the practitioner during the provision of service. Time spent in smoking cessation counseling must be subtracted from any E/M billed on the same day.

Example: If the established E&M visit took 25 minutes and the smoking cessation was provided face to face for 15 minutes, if billing based on time, the E&M would be a total of 10 minutes. Both a level two E&M (99212) and a smoking cessation code (99407) could be billed for this encounter. It is suggested that a modifier 25 “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service” be appended to the E&M code.

These codes can be used multiple times, but only once per date of service. Additional restrictions may apply based on payer coverage policy. The description of the smoking cessation counseling and the time spent performing it must be clear in the documentation.

8.2 – Billing Medicare for Smoking and Tobacco Cessation

The CPT codes reported to Medicare for smoking and tobacco cessation are 99406 and 99407. The code definitions and associated times are the same. Medicare does however specify the number of attempts in a one-year period and also defines specific coverage conditions that must be met for payment under Medicare Part B.

The Centers for Medicare & Medicaid Services (CMS) defines coverage to include two (2) attempts of cessation per year. Each counseling attempt can include up to four (4) separate intermediate or intensive sessions. Practitioners and beneficiaries have the flexibility to choose between intermediate or intensive strategies for each session. A total of 8 separate sessions, or two (2) attempts are covered in a 12-month period.

The CMS also specifies that Medicare beneficiaries that qualify for smoking and tobacco cessation counseling must meet certain conditions. Cessation counseling is considered medically reasonable and necessary for beneficiaries that either currently have a condition that is adversely affected by tobacco use or a beneficiary that being treated with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco. ICD-9 diagnosis codes on the claim should reflect the condition that is adversely affected or the condition for which the therapeutic agent has been prescribed. Providers should maintain appropriate documentation on file in the medical record to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco-use cessation counseling.

When medically necessary, physicians and other recognized billing provider types may bill for a medical necessary E&M service on the same day. A modifier 25 should be appended to the E&M service. Any cessation counseling session less than three (3) minutes in duration is included in an E&M billed on the same day. Co pay and deductible amounts apply to the smoking and tobacco cessation codes 99406 and 99407.

For information on non-fee-for-service payment methodologies, please see the following resource.

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3834.pdf>

8.2.1 Smoking and Tobacco Cessation Provided by Health Educators

Smoking and tobacco cessation counseling may be provided either by or “incident-to” the services of a qualified practitioner. Health Educators that provide this service to Medicare beneficiaries would do so under the auspices of the “incident-to” guidelines. For complete details on Medicare “incident-to” billing, please refer to Chapter 4, Section 1 of this manual.

8.3 – Billing Wisconsin Medicaid for Smoking and Tobacco Cessation

Smoking and tobacco cessation services are reimbursed as part of an E&M office visit when provided by a physician, physician assistant, nurse practitioner or ancillary staff, including a health educator. Services must be one-on-one and face-to-face between the provider and the member. Wisconsin Medicaid and BadgerCare Plus do not cover group sessions or telephone conversations between the provider and member. Tobacco cessation services covered under the BadgerCare Plus Core Plan include medically necessary E&M visits, as appropriate. Wisconsin Medicaid also provides medically necessary smoking and tobacco cessation services under the outpatient substance abuse and outpatient mental health services benefit categories, as appropriate. Please refer to ForwardHealth update 2002-42 for specific requirements related to these benefit categories.

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx?ia=1&p=1&sa=50&s=2&c=101&nt=Tobacco%20Cessation%20Drugs%20and%20Services>

Ancillary staff, including health educators, may provide tobacco cessation services only when under the direct, on-site supervision of a Medicaid-certified physician. When an ancillary staff provides smoking and tobacco cessation services, reimbursement up to a level-two office visit (CPT code 99212) may be made. The supervising provider is required to be listed as the rendering provider on the claim. The documentation must support the level of service provided.

The ICD-9 diagnosis code 305.1 “Tobacco Use Disorder,” and appropriate E&M code from the preventive medicine treatment codes (99381-99397) the new patient E&M codes (99201-99205) or established patient E&M codes (99211-99215) must be on the claim. Office visits are subject to a co-pay of up to \$3.

Benefit information for patients enrolled in a Medicaid Managed Care or Medicaid HMO may be obtained by contacting the managed care plan directly.

8.3.1 Prescription Drugs

The Standard Plan and Medicaid cover legend drugs for tobacco cessation. The Benchmark Plan and Core Plan cover generic legend drugs for tobacco cessation. Nicotine gum or patches available over the counter (OTC) are covered by the Standard Plan, the Benchmark Plan, the Core Plan, and Medicaid. A written prescription from a qualified prescriber is required for both federal legend and OTC tobacco cessation products.

8.4 – Commercial Insurance Billing Tips

Commercial carriers will vary in respect to coverage, credentialing, supervision, reimbursement methodology and employment and signature requirements. It is suggested that commercial carriers be contacted or contracts, attachments and amendments be reviewed for a complete understanding of billing and coding requirements. State scope of practice is also a component that must be considered in provision of services.

8.5 – Reimbursement

Reimbursement for smoking and tobacco cessation services will vary by payer, geographic location, and place of service and will further be affected by updates to fee schedules, which typically occur annually or at point of contract negotiation.

8.5.1 Reimbursement Resources

Transparent fees for smoking and tobacco cessation services are available from federal and state payers. Commercial reimbursement rates are typically not publicly shared and will vary by region, payer and contract.

The Medicare physician fee schedule is a searchable database, by CPT code, and will provide the most current fee amount for both participating and non-participating physicians. To access the most current reimbursement rate for Wisconsin Medicare, access the following link:

http://www.wpsmedicare.com/part_b/fees/physician_fee_schedule/

Reimbursement for services will be made at the lesser of the provider's usual and customary charge or the BadgerCare Plus and Wisconsin Medicaid maximum allowable fee for the service. To obtain current fee information for Wisconsin Medicaid, you may download specific fee schedules or to use the interactive fee schedule at the following link:

<https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/76/Default.aspx>

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Appendix A – Sample Medicaid Document for Health Educators

Sample Document to Have on File Before Ancillary Providers Deliver SBIRT Services to Wisconsin Medicaid Members

Purpose of this Document

[Clinical site name] has developed this document to guide the systematic delivery of alcohol and drug screening and intervention services and to serve as documentation in support of confirming the health educator's education, training and supervision when providing SBIRT services.

Clinical Service Protocols

All patients of ages _____ are to complete a written brief screen (include an example as an attachment) once a year on arrival at the clinic. If any of the alcohol and drug items are positive, the patient is to see our health educator for a full screen. The full screen will include the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), which has been well validated by the World Health Organization. Patients are to receive no intervention, a brief intervention, brief treatment, or referral to treatment based on their ASSIST scores, as per the recommendations and electronic protocols of the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL).

Health Educator Designation, Training, and Support

_____ will serve as our health educator. S/he has successfully completed at least 60 hours of training on SBIRT, and at least 30 hours of such training occurred in person. S/he passed WIPHL's written final examination and a skill-based exam where s/he demonstrated appropriate skills with standardized patients. S/he participates in regular conference calls, health educator meetings, one-on-one calls, and review of audiotaped sessions with patients (with their written permission) as provided by WIPHL staff.

WIPHL's electronic protocols will guide the health educator in delivering all services. S/he is permitted to deviate occasionally from protocols only as necessary to establish rapport, show empathy, or respond to questions. S/he will notify the supervising credentialed clinician immediately if a patient expresses any thoughts of suicidality or homicidality, or divulges any information that suggests any possibility of child abuse or neglect. S/he will provide supplemental written documentation of each encounter detailing the screening and intervention service for inclusion in the medical record to the supervising clinician within [fill in a time interval here] after the completion of each encounter.

Supervising Licensed Health Care Professional Requirements

The health educator will always provide services under the supervision of a licensed health care professional who is on the premises and immediately available. When the health educator is providing services to a patient as part of that patient's visit on the same day to a Medicaid

credentialed provider, then that provider will be considered the supervising provider. When the health educator is the sole provider of services to a patient on a particular day, then the supervising provider will be as designated by schedule. In any case, the health educator will record the name of the supervising licensed health care professional in the member's medical record.

We agree with the above statement.

(All credentialed providers should provide signatures and dates.)