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## Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services

### Provider Types Affected

This article is for physicians, non-physician practitioners, and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for certain mental health services provided to Medicare beneficiaries.

### Impact on Providers

This article is informational only and does not alter existing Medicare policy nor does it introduce new policy.

### Background

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS), working with the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform Medicare providers about reporting and payment for

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the appropriate delivery of alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention (SBIRT) services.

SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a Substance Use Disorder.

In the 2008 Medicare Physician Fee Schedule (MPFS), Medicare created two Healthcare Common Procedure Coding System (HCPCS) G-codes to allow for the appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services. See MM5895 (related to CR 5895, Transmittal R1423CP, February 1, 2008 (Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount) at <http://www.cms.gov/MLN MattersArticles/downloads/MM5895.pdf> on the CMS website.

Additionally, these services are paid under the hospital Outpatient Prospective Payment System (OPPS). See the January 2008 Update of the OPPS – Manualization, which includes a summary of the OPPS policies regarding these codes at <http://www.cms.gov/MLN MattersArticles/downloads/MM5946.pdf> on the CMS website.

These two HCPCS G-codes are:

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

**These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury.**

Medicare Contractors will consider payment for HCPCS codes G0396 and G0397 only when medically reasonable, and necessary (i.e., when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) as per the Social Security Act (Section 1862(a)(1)(A)). It is important to remember that Medicare only covers SBIRT services that are reasonable and necessary and meet the requirements of diagnosis or treatment of illness or injury.

### **Structured Assessment and Brief Intervention (SBIRT) Services**

Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians' offices and outpatient hospitals. Providers

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assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

### [General Principles of Medical Record Documentation for Individual Mental Health Services](#)

It is important to remember that all claims for Medicare services must be supported by information in the patient's medical record, and the general principles of medical record documentation for the reporting of SBIRT services for Medicare payments include the following as applicable to the specific setting/encounter (See CR 2520 (Transmittal AB-03-037) at <http://www.cms.gov/Transmittals/downloads/AB03037.pdf> on the CMS website):

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history,
  - Physical examination findings and prior diagnostic test results,
  - Assessment, clinical impression, and diagnosis,
  - Plan for care,
  - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes;
- Past and present diagnoses should be accessible for the treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- The CPT and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim should be supported by documentation in the medical record.

Like all providers of services billed to Medicare, it is essential that providers of mental health services document their services fully in the medical record, because if the records are incomplete, the provider is at risk of losing Medicare payments in the event of a claims audit.

### [Qualifications of Practitioners Providing Mental Health Services that are Covered Under Medicare](#)

In order to bill Medicare, providers of mental health services must be qualified to perform the specific mental health services rendered. In order for these services to be covered, mental health professionals must be working within their State Scope of Practice Act, and

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licensed (or certified) to perform mental health services by the state in which the services are performed. See CR 2520 (Transmittal AB-03-037, March 28, 2003) at <http://www.cms.gov/Transmittals/downloads/AB03037.pdf> on the CMS website.

### **Physician**

A qualified physician must be legally authorized to practice medicine by the state in which he/she performs his/her services, and perform his/her services within the scope of his/her license as defined by state law.

### **Clinical Psychologist (CP)**

A CP must hold a doctoral degree in psychology; and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

In general, CP services are covered in the same manner as physician's services. CPs must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

See 42 CFR 410.71 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.71.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.71.htm) on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 160) at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a CP.

### **Clinical Social Workers (CSW)**

A CSW must possess a master's or doctor's degree in social work; have performed at least two years of supervised clinical social work; and be licensed or certified as a clinical social worker by the state in which the services are performed.

In the case of an individual in a state that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed. As well, the CSW must have completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, Skilled Nursing Facility (SNF), or clinic.

See 42 CFR 410.73 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.73.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.73.htm) on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 170) for the covered services of a CSW.

### **Nurse Practitioner (NP)**

An NP must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. They must also be certified as a nurse practitioner by a recognized national certifying body

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that has established standards for nurse practitioners, or be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. As well, they must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must possess a master's degree in nursing or a DNP degree from an accredited institution, be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

See 42 CFR 410.75 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.75.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.75.htm) on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 200) for the covered services of an NP.

### **Clinical Nurse Specialist (CNS)**

A CNS must be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law, have a master's degree in a defined clinical area of nursing from an accredited educational institution, and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for a CNS. The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

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- National Board on Certification of Hospice and Palliative Nurses.

See 42 CFR 410.76 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.76.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.76.htm) on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 210) for the covered services of a CNS.

### **Physician Assistant (PA)**

A PA must have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation), or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and be licensed by the state to practice as a PA.

See 42 CFR 410.74 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.74.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.74.htm) on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 190) for the covered services of a PA.

### **Medicare's Outpatient Mental Health Treatment Limitation**

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program. This limitation does not apply to payment made to facilities under the OPPTS.

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a 5-year period, from 2010 - 2014. MM6686 (related to CR 6686 - see <http://www.cms.gov/MLN MattersArticles/Downloads/MM6686.pdf> on the CMS website) alerts providers that CMS is phasing out the outpatient mental health treatment limitation over this 5- year period.

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The 62.5 percent limitation will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%. (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%. (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 – onward, the limitation percentage is 100%. (Medicare pays 80% and the patient pays 20%).

**Note:** There is no national policy that establishes whether the outpatient mental health treatment limitation (the limitation) applies to these SBIRT services. Therefore, the application of the limitation to the SBIRT services would be made by the local Medicare contractor.

## Additional Information

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For additional details about the outpatient mental health treatment limitation, please see the Medicare Claims Processing Manual (Publication 100-04; Chapter 5, Section 100.4; Chapter 9, Section 60; and Chapter 12, Section 210 & Section 210.1E) at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

For more information on SBIRT, please visit SAMHSA's website at <http://sbirt.samhsa.gov> on the Internet.

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