DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

FACT SHEET

Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services

http://www.integration.samhsa.gov/clinical-practice/sbirt

What Is SBIRT?

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.

When Will Medicare Pay for SBIRT Services?

Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians' offices and outpatient hospitals. In these settings, providers assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

What Types of Health Care Providers May Provide SBIRT Services 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 licensed (or certified) to perform mental health services by the state in which the services are performed. Refer to Change Request (CR) 2520 (Transmittal AB-03-037, March 28, 2003) at http://www.cms.gov/Transmittals/downloads/AB03037.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Physician

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

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

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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.

Refer to 42 Code of Federal Regulations (CFR) 410.74 at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec410-74.pdf and the "Medicare Benefit Policy Manual" (Publication 100-02: Chapter 15, Section 190) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for information on covered PA services.

Nurse Practitioner (NP)

If an NP obtained Medicare billing privileges as an NP for the first time on or after January 1, 2003, he or she must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as an NP in accordance with state law. He or she also must be certified as an NP by a recognized national certifying body that has established standards for NPs and possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.

For NPs who obtained Medicare billing privileges for the first time before January 1, 2003, they must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as an NP in accordance with state law. They also must be certified as an NP by a recognized national certifying body that has established standards for NPs.

For NPs who obtained Medicare billing privileges for the first time before January 1, 2001, they must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as an NP in accordance with state law.

The organizations that are recognized national certifying bodies for NPs at the advanced practice level are as follows:

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

Refer to 42 CFR 410.75 at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec410-75.pdf and the "Medicare Benefit Policy Manual" (Publication 100-02: Chapter 15, Section 200) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for information on covered NP services.

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 CNS in accordance with state law; have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and be certified as a CNS 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:

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

Refer to 42 CFR 410.76 at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec410-76.pdf and the "Medicare Benefit Policy Manual" (Publication 100-02: Chapter 15, Section 210) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for information on covered CNS services.

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. The CP also must be 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.

Refer to 42 CFR 410.71 at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec410-71.pdf and the "Medicare Benefit Policy Manual" (Publication 100-02: Chapter 15, Section 160) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for information on covered CP services.

Clinical Social Workers (CSW)

A CSW must possess a master's or doctor's degree in social work, have performed at least 2 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. The CSW must also 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.

Refer to 42 CFR 410.73 at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec410-73.pdf and the "Medicare Benefit Policy Manual" (Publication 100-02: Chapter 15, Section 170) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for information on covered CSW services.

Billing and Coding Information

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. Refer to the Medicare Learning Network® (MLN) Matters Article MM5895, "Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount," (related to CR 5895, Transmittal R1423CP, February 1, 2008) at http://www.cms.gov/MLNMattersArticles/downloads/MM5895.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 that are not provided as screening 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.

Additionally, these services are paid under the hospital Outpatient Prospective Payment System (OPPS). Refer to the "Medicare Claims Processing Manual" (Publication 100-04: Chapter 4, Section 200.6) at http://www.cms.gov/manuals/downloads/clm104c04.pdf on the CMS website.

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.

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 to 2014. The MLN Matters® Article MM6686, "Outpatient Mental Health Treatment Limitation," (related to CR 6686, Transmittals R60GI, R114BP, and R1843CP, October 30, 2009) at http://www.cms.gov/MLNMattersArticles/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.

The 62.5 percent limitation was in effect until January 1, 2010. Effective January 1, 2010, through January 1, 2014, the limitation will be phased out as illustrated in Table 1.

Table 1. Phasing Out Medicare's Outpatient Mental Health Treatment Limitation

Effective for the Year …	The Limitation Percentage Is …	Medicare Pays …	Patient Pays …
January 1, 2010 – December 31, 2011	68.75%	55%	45%
January 1, 2012 – December 31, 2012	75%	60%	40%
January 1, 2013 – December 31, 2013	81.25%	65%	35%
January 1, 2014 – onward	100%	80%	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.

Documentation

It is important to remember that information in the patient's medical record must support all claims for Medicare services, 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. Refer to CR 2520 (Transmittal AB-03-037, March 28, 2003) at http://www.cms.gov/Transmittals/downloads/AB03037.pdf on the CMS website.

- Medical records should be complete and legible;
- All services provided/ordered must be signed by the provider;
- Appropriate health risk factors should be identified;
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented;
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes;
- 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; and
  - Date and legible identity of observer/provider;
- Past and present diagnoses should be accessible for the treating and/or consulting physician;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred; and
- The Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim should be supported by documentation in the medical record.

It is essential that providers of mental health services fully document their services in the medical record. In the event of a claims audit, if records are incomplete, the provider is at risk of partial/full denial of Medicare payments.

Resources

For additional details about the outpatient mental health treatment limitation, refer to 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, Fiscal Intermediary (FI), or A/B Medicare Administrative Contractor (MAC) at its 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, visit the Substance Abuse and Mental Health Services Administration's (SAMHSA) website at http://www.integration.samhsa.gov/clinical-practice/sbirt on the Internet.