The following selected questions were posted by participants of an April 25, 2011 CIHS webinar on SBIRT. We have included follow-up responses from presenter Dr. Bill McFeature, Director, SVCHS Integrative Behavioral Health Care Services. To access a recording of the webinar and copy of the PowerPoint presentation, please visit www.centerforintegratedhealthsolutions.org.

"Q: Are BHC's billing CPT codes for the screenings? Just Md's and APN's, and PA's??
Check with your Medicare and Medicaid regulatory reimbursement policies, differ from State to State. Virginia Medicaid allows the BHC/BH licensed provider to be reimbursed for the 99408 and 99409 as well as for same day services (PCP- and BHC visits).

"Q: Are there any studies that show that harm reduction (or BI) works at the dependence level of use? (top 1.5%) and do those drinkers at the next lowest level meet DSM IV TR criteria for alcohol dependence?
I can only speak from a primary care perspective – we are usually talking about the 5- 8-% diagnosable alcohol and or drug dependent patients seen in are clinics which have to meet DSM criteria. There are SA studies that show harm reduction intervention can be effective given an array of services rendered (Medical, BH, family and social support systems(NA, AA, etc.). These patients are referred to local CSB's operating intensive SA wrap around services.

"Q: But the Medicare quotes would be the same?
Speaking from a FQHC perspective- Medicare rates are slightly higher than Medicaid reimbursement, however, You will more than likely rely on Medicaid rates revenue due to the larger percentage of patient base.

"Q: Can the presenters speak to the use of the SBIRT CPT codes in conjunction with an E&M code, e.g., 99211-99214?
The medical practitioner will use the E & M management code that first fits the patients medical care complexity and where there is a positive result on the brief alcohol and drug screening measure(Cage, Audit, PHQ-9) which is administered by supportive nursing staff during the health status examination and reviewed by the PCP during exam room visit. The PCP will use the 99408(15-30) with a modifier 59 which distinguishes between the PCP and BHC/BH provider. Patient could then be streamlined into the BHC/BH schedule either same day or ASAP. The BHC will use 99409(30 min) and can use the 99409 code as long as it is medically necessary. There are many States that will not allow reimbursement so you have to advocate with your MCO's/Medicaid system to do so, especially if you are employed within a primary care setting.

"Q: Can you use SBI for depression, anxiety, PTSD, etc. or is it only allowed and evidenced based for alcohol only?
SBI codes 99408 and 99409 are brief alcohol and drug assessment and intervention codes. Virginia has been advocating that are licensed masters level behavioral health providers should be reimbursed for the HBA codes(96150 and 96151)(health assessment and intervention codes used for medical diagnoses associated with emotional and/or mental (psychological impact on the patients medical condition). The HBA codes are 15 min increments that can be used within the exam room or streamlined scheduling(can use up to 4 units (15 min) sessions. Virginia Medicaid are currently reviewing reimbursement for the HBA codes/masters level provider. It only makes sense since 70-75 percentage of the patients seen in primary care are psychosocial stressor related, 20 percentage with a major psychiatric disorder, and approx 8 – 10 percentage with co- occurring disorders(psych and substance abuse.dep). This webinar was tailored for primary care and can't speak for community mental health systems. If you using mostly traditional psychotherapeutic services within primary care or vise versa community mental health with primary care services, then you will use the 90801, 90804, and 90806(carved out mental health services). When are BHC's conduct 30 min sessions , they will bill for 90801 and 90804. SVCHS works out of a primary care philosophy versus your traditional psychotherapy model of care due to the nature of practice and the goals are about functionality not process(traditional therapy).

Q: What do you use for children and adolescents on SA and MH screening?
Primary care setting- the BHC's coordinate care with are pediatricians. Most of the screens revolve around ADD/ADHD diagnosis. There are numerous brief tools/instruments that can be used inn screening for ADD/ADHD , depression, and anxiety/PTSD and that work well within primary care settings.

"Q: Has the PCP's been open to the integration and collaboration in working with BHC's? What has been your approach in getting PCP's to collaborate with this effort?
SVCHS has been conducting fully integrative care service(PCBH programming) for the past 7 years. You hit the nail of the head so to speak….educating PCPs about how BHC's can benefit patient care is critical to the program working effectively in behalf of the patient. I can send you a study we conducted onsite that speaks to 1) reduction in medical visits annually when you integrate a BHC, 2) BHC provides critical consultative feedback to the PCP which is highly appreciated especially when it comes to prescribing psychotropic medications and screening for alcohol and drug problems. The brief format of services offered by the BHC aligns well with primary care practice/philosophy, hence a nice marriage that provides effective results in managing a patients depression and/or anxiety levels and assisting the patient with alcohol and drug problems. The BHC can make the appropriate triage and referral to the local CSB for more chronically mental/emotional disordered patient populations. Other studies conducted have shown a reduction in ER/hospital visits when a BHC works with their primary care practitioners. I have a PCBH manual I can forward to those who are interested in developing a fully integrated care system. Other advantage is incorporate HIT/HER which allows same day communication between PCP and BHC without case mgmt meetings which no one has time for on a weekly base. Will improve your ability to render PCBH services- one plan of care (no mental health chart).

"Q: Has this been used on College campus'? If so, can you suggest any literature evaluating use in these setting?
College campus--- excellent—why not…. Integrated systems of care produce a more positive impact for the patient and provider regarding treatment. King College in Bristol, Virginia (Chuck Thompson, MFT).

"Q: How many total times can Virginia Medicaid bill the 99409?
You can bill the 99409 as many times as long as you can justify " medical necessity" in your clinical notes.

"Q: In order to be reimbursed (specifically Medicare), does it have to be a physician or can it be other staff (nursing, social work, etc)? Would these codes be valid in the inpatient setting or just outpatient?
The 99408 and 99409 are available for use in by both MD and BH for reimbursement(Medicare and Medicaid) you will need to check with your State Government Regulatory Councils- each State has different guidelines for reimbursing licensed behavioral health providers. Virginia allows reimbursement for both MD and BH, same day service as well.

"Q: In your opinion, what would be the best way to implement an SBIRT model in a jail or penal institution setting?
Incarcerated patient----- contracted physician offering medical care services and access your local community health systems- there is" bi-directional dollar available through those CSB's who have applied for the money. I don't know exactly how the funding can be used but this would seem at least one way to address access medical and behavioral health care services within the jail system.

"Q: Is BI for non-high/risk/complicated cases something for which peer/recovery support specialists could be used, and are there examples out there yet?
In my opinion… the SBIRT process and SBI coding for reimbursement is for identifying any patient who possesses an acute and or chronic alcohol and/or drug problem (across the spectrum) SBIRT is still a novelty for most in terms of developing SBIRT services for high risk patients- chronic disease/alcohol and drug dependent- excellent idea.

Q: What about substance abuse users with untreated MH disorders.. Bipolar etc
Regarding appropriate diagnosis of bipolar conditions and co- occurring use- Developing a primary care and behavioral health integrated system of care- in my opinion, will best serve these particular patients. PCPs in coordination with a BHC/BH provider is very capable of assessing for appropriate diagnostics of mood d/o's and working with the abusing use patient in working on this issue and discussing the appropriate psychotropic medication regimen and making a possible referral to an your local CSB for psychiatric care. We have a consulting psychiatrist who supervises are board cert psych nurse in attempting to maintain some functionality for this patient. Excellent question.

"Q: Related to billing did I see that there is a charge for the initial screen, even if it is negative and then if it is positive there is another charge that is also reimbursed on the same day related to the BHC?
No charge for a negative alcohol and drug screen

"Q: so there is a licensed SW or LPC, etc. on site at PCP?
Yes--- LPC, LCSW, Psychologist – co- located in the same facility- primary care and behavioral health integration model of care.

Q: I have a question regarding co-occurring. I have had patients come in on Xanax or another benzo for many years. their goal is to reduce their anxiety, however given the short acting nature they are in a constant state of withdrawal and thus constant anxiety. reduction in this medication seems very difficult since it is addictive and they do not get the results if they reduce their benzo. how do you handle this. I often tell patients that as long as they remain on Xanax, even with coping skills the anxiety will always remain to some level.
Regarding benzodiazepine addicted patients. You so correct that patients have a difficult time weaning off the benzo when the only available services are PCP. I would suggest integrating a BHC/BH provider because most of the problem is addressed both from a physicality and psychological point of view. These patients need the psychological support as well in order to reduce the withdrawal effect/impact and reach some form of functionality. Are clinics receive numerous Benzo addicted patient who have been seen by a previous PCP who would usually titrate up on the med leaving the patient in despair and usually terminating them from their clinic because the medication no longer had the same effect. These patient usually end up back at the ER and are difficult to wean off at this point. There are other medication options that the PCP can use that might help with the withdrawal sx's(SSRI tx)- again difficult patient at that point and a commitment by both PCP and BH to assist this patient in weaning off the med. Hope this helps.

Q: Do these codes apply to tobacco as well?
Tobacco- yes.

"Q: The CPT manual specifies that the physician needs to be trained in validated interventions. What is the recommended level, type of training that a physician should receive prior to implementing the SBI process?
Physicians—SBIRT training would suffice since most of the MD's, PA's and FNP's will be conducting an alcohol and drug screen and not necessarily treatment. I am speaking to integrated care settings only. Difficult for the lone PCP to take on this health issue endeavor alone.

"Q: What is your experience between alcohol use and diabetes identification and treatment in your primary care settings?
Regarding Diabetics and alcohol use- spiking sugar/liver enzyme impact with abusing alcohol …. Would discuss with the patient the health issues that correlate with blood sugar imbalance. Again , a BHC would be helpful at this point .

"Q: What's the frequency of screening? Is it every time a patient presents for primary care?
ALL patients are politely asked the Cage- A screen questions as a part of the health status examination……. and should……. since it can be a health risk from a medication point of view as well as other health issues where alcohol and/or drug use elevates BP, Wt/BMI, sugar, etc.

Q: In your experience, do most patients receiving a brief intervention follow-through/comply with subsequent sessions? if so, what percentage?
Regarding follow up visits—if you take the primary care " everyone needs a PCP and we do and work with the patient from a " health conscious" approach the percentages are better than addressing from a " silo/fragmented care system approach. Base on level of commitment by the patient with either harm-reduction methods for alcohol and drug use as well as it would be for diabetics who don't self- monitor and comply with tx.

Q: Do I understand correctly that primary care patients needing a brief intervention generally receive the service within 2-4 days of the positive screen? Is it ever possible to conduct the brief intervention on the same day as the screen?
The primary care clinics goal is to always ATTEMPT quick access for services. With PCP's they use the every 3rd appt rule where as the BHC's schedule is always monitored for no shows and rescheduled patients usually leaving an opening with that 3- 4 day period.. Yes , if we can work it out for same day service, will. Va Medicaid will reimburse both providers the same day of service.

Q: Do you find most primary care practices can readily accommodated inserting the BI into patient flow?
It you operate a fully integrated system with HIT/EHR and co- locate your BHC/BH within the clinic …that is a yes…..

Q: Are LCSWs authorized to bill Medicare for SBIRT services, using the G codes?
Depending on the State……. Va Medicare will allow LCSW's and Psychologist to be reimbursed for SBI services using the G codes.

"Q: Would you recommend Motivational Interviewing as the preferred method of communication with the patient in the BI protocol process?
One the most important trainings that SVCHS required of are BHC's was to receive MI training in working with noncompliant patients (alcohol and drug, diabetics/meds, cardiovascular/meds. COPD /smoking cessation, etc.