

Coding Change Request Form

➔ **Category I CPT Code(s)**

➔ **Category III CPT Code(s) – Emerging Technology**

This form plays a vital role in maintaining and increasing the efficiency of the CPT process. It can be used to submit a coding change request for any one of the three categories of CPT codes. As you fill out the form please consider which category of code change you are requesting. For more information on the three categories please see the attached instructions.

Please complete this entire form (insert additional lines and pages as needed). Refer to the accompanying instructions if necessary. Once the application is completed, submit the request electronically via diskette, CD or e-mail to ccsubmit@ama-assn.org

Date: July 11, 2006

Change requested
by:

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Please attach this cover sheet to your proposal.

1. Does the procedure/service involve the use of a drug or device that requires approval from the Food and Drug Administration (FDA)?

Yes (go to 2.)

No (go to 3.)

If approval is necessary, has FDA approval been received for the device or drugs for the specific use that you are proposing?

2. Is the procedure/service for which you are proposing a code change performed nationally?

Yes

Trained practitioners conduct screening and brief intervention (SBI) throughout the United States in healthcare settings. The nation's largest health insurers and managed behavioral healthcare companies – WellPoint, United Healthcare, Aetna, Cigna, Magellan, ValueOptions and Ceridian – and numerous regional healthcare plans have instituted alcohol and drug SBI programs for disease management and behavioral health patients. A national survey of workplace SBI programs operating outside primary care and emergency services identified more than 250 businesses and 150 healthcare vendors reporting some level of SBI (Goplerud & McPherson, 2006). Occupational health clinics, employee assistance programs, wellness and health promotion programs, disability management and disease management programs implement workplace SBI programs.. Level I and II Trauma Centers admit more than one million patients annually. The Substance Abuse and Mental Health Services Administration (SAMSHA) Center for Substance Abuse Treatment (CSAT) awarded \$175 million in grants to ten states/tribal organizations to implement statewide SBI programs in primary care and hospital emergency services and to 12 colleges and universities to implement SBI programs targeting college-age youth.

3. Is the procedure/service for which you are proposing a code change performed by a large number (as a proportion of practitioners within the specialty or subspecialty) of physician or non-physician health professionals?

X Yes

Primary care: Thirteen percent of primary care practitioners, obstetrician/gynecologists and psychiatrists use standardized screening instruments to discuss alcohol use with their patients (Friedmann et al., 2000). Some 10-20 percent of patients in primary care are screened for alcohol misuse (Denny et al, 2002).

Pediatricians and family practice physicians: A survey by Millstein & Arik (2006) found that 23-43 percent of pediatricians and 14-27 percent of family physicians ask adolescents whether they use alcohol, and 17 percent inquire more fully and systematically about alcohol use through a standardized screening instrument.

Emergency physicians and trauma surgeons: Twenty-nine percent of emergency physicians routinely ask about alcohol quantity and frequency. More than two-thirds of trauma surgeons say they frequently check a blood alcohol concentration (BAC), with one-third reporting that they always do (Schermer et al, 2003). One-fourth reported use of formal screening questionnaires, with more than one-third (36 percent) reporting that their trauma center performs brief interventions with patients with alcohol problems. A study of quality care found that 15.5 percent of hospitalized trauma or hepatitis patients have medical record notations that alcohol or drug use was assessed (McGlynn et al, 2003).

General medical, surgical and orthopedic inpatients: One in five acute-care inpatients with an alcohol use disorder identified through research diagnostic interviews at general hospitals received inpatient alcohol intervention and less than one-fourth (24 percent) were referred for alcohol treatment at discharge (Smothers, Yahr, Ruhl, 2004).

4. Has the clinical efficacy of the procedure/service for which you are requesting a code change been established and well documented?

X Yes

SBI conforms to best available scientific evidence of effective treatments for alcohol and drug use. The US Preventive Services Task Force in 2004 made the following recommendation:

“To prevent or reduce alcohol misuse, the U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling for all adults, including pregnant women, in the primary care setting. The USPSTF found good evidence that screening in primary care setting can accurately identify those patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity or mortality and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6 to 12 month periods or longer” (Whitlock et al, 2004).

Researchers have compared the strength of research designs, breadth of outcomes and the size of treatment effects and found that SBI is the strongest of more than 40 alcohol treatment modalities (Miller and Wilbourne, 2002). The 31 controlled clinical trials of SBI showed the greatest and most consistent evidence of effectiveness of any of the alcohol treatments studied. A meta-analytic review of 54 controlled investigations of brief interventions for alcohol problems (Moyer, Finney et al, 2002) found moderate effect sizes (0.669) for alcohol consumption at three months. Five studies examining clinical and social impact of motivational interviewing on drug use produced moderate treatment effect sizes ($d=0.56$) on drug use and large effect sizes ($d=0.90$) on social outcomes such as substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence) (Burke et al, 2003). A study that assessed effects of SBI after a 48-month follow-up found that the intervention group had a 20 percent reduction in emergency department visits, 33 percent reduction in nonfatal injuries, 37 percent fewer hospitalizations, 46 percent fewer arrests and 50 percent fewer motor vehicle crashes relative to controls (Fleming et al, 2002). The intervention group experienced a 20 percent reduction in binge drinking episodes, a 10 percent reduction in drinks/week and a 4 percent reduction in those reporting no binge drinking episodes relative to controls. A meta-analysis found that brief counseling interventions reduce mortality (Cuijpers et al, 2004).

The USPSTF identified 12 randomized, controlled trials of SBI for risky/harmful drinking conducted in multiple primary care practices and found that high-quality brief, multicontact behavioral counseling interventions reduced risky and harmful alcohol use by primary care patients. Patients experiencing brief multicontact interventions were more likely than controls at follow-up to drink sensibly and to reduce weekly drinking amounts (Whitlock et al, 2004).

The largest and most rigorous study of brief interventions in a hospital emergency setting is Gentilello’s clinical trial in a Level I trauma center (Gentilello et al, 1999). Of 2,524 patients screened using BAC, gamma glutamyl transpeptidase level and the Short Michigan Alcoholism Screening Test (S-MAST), 1,153 screened positive for presence of alcohol. Among the patients randomly assigned to a brief intervention group, 12-month and 36-month outcomes were quite favorable. Patients receiving the single session intervention reduced their weekly drinking by 22 drinks per week compared with a reduction of seven drinks fewer per week for the control group. At 12-month follow-up, re-injury rates were nearly 50 percent lower in the treated group than the control group (5 percent vs. 10 percent) and at 36 months, re-hospitalization for injuries was 48 percent lower in the treated group than the control group (3 percent vs. 5 percent).

5. Is the procedure/service for which you are requesting a code change used as a performance or quality measure by any national organization? If yes, please state the organization and name of measure.

X Yes

Veterans Health Administration: Alcohol Screening (one of nine performance measures that make up the VHA Prevention Index, a required quality measure reported quarterly for each Veterans Integrated Service Network).

National Committee for Quality Assurance: HEDIS Chemical Dependency Identification and HEDIS Chemical Dependency Initiation rates (required HEDIS access measures since 2004 for commercial, Medicaid and Medicare managed care plans accredited by NCQA. A new code for screening will facilitate increases in HEDIS CD Identification rates. In the 2005 HEDIS, CD Identification was 0.7 percent in commercial-sector health plans, less than 1/10 of estimated population prevalence of substance use disorders. A new code for brief intervention (as the service is defined) will facilitate increases in HEDIS CD Initiation of treatment of patients with substance use disorders. Presently CD Initiation rates are 46 percent for commercial sector and Medicaid, and 54 percent for Medicare managed care.

The Joint Commission on Accreditation of Healthcare Organizations and the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI): Hospital-based, Inpatient Psychiatric Services (HBIPS) Candidate Core Measure Set, Assessment of Alcohol and Other Drug Use. Performance measure test set for potential requirement of all separate inpatient psychiatric units and all free standing psychiatric inpatient hospitals accredited by JCAHO.

National Business Coalition on Health (NBCH): The coalition requires that all commercial HMO and PPO health plans reporting annually to its eValue8 Request for Information to record HEDIS chemical dependency identification, initiation and engagement rates, and uses this information along with other information about plans' chemical dependency screening, brief intervention and treatment services. Large employers, such as General Motors, Marriott International and American Express use this quality information, along with other healthcare quality measures, to differentially subsidize employees' premiums. In 2005, more than 300 health plans covering approximately 140 million lives, responded to the NBCH eValue8 RFI. In 2006, a similar number of plans responded to the RFI. For 2007, NBCH in partnership the Human Resources Policy Association and three international benefits consulting firms – Watson Wyatt Worldwide, Mercer, and Towers Perrin – is developing a common RFI that includes the HEDIS chemical dependency identification, initiation and engagement measures. With their combined purchasing leverage, virtually the entire commercial HMO and PPO sector will be assessed by the common RFI, one component of which will be the HEDIS chemical dependency identification, initiation, and engagement measures.

American Medical Association: Physician Consortium for Performance Improvement, Preventive Care and Screening (2005) Clinical performance measures – Problem Drinking.

6. Based on your responses to the above questions, what type of Code change are you proposing? (Refer to the attached instructions for explanation of each code category.)

Category I CPT Code

Category III CPT Code – Emerging Technology

7. Indicate the specific reasons *why* this code change is necessary (rationale).

SBI conforms to the best scientific evidence available. This practice leads to reduced alcohol and drug consumption among excessive drinkers and hazardous drug users, and reductions in alcohol- and drug-related health outcomes, including mortality. The implementation of unique CPT codes for SBI will likely:

Increase the frequency of SBI in clinical practice and increase clinicians' use of the standard, evidence-based SBI instruments.

- Improve awareness throughout the healthcare system that SBI is a primary care service that can be performed in ambulatory, emergency department and inpatient settings, and that it is not a practice limited to use by specialists in substance disorder treatment.
- Improve tracking of SBI, thereby facilitating widespread federal government, medical societies' and health foundations' efforts to increase adoptions of SBI.

Unique new CPT codes for alcohol and other drug screening, and alcohol and other drug screening with brief intervention are warranted for the following reasons:

SBI is integral to evidence-based clinical practice standards for treatment of substance use disorders promulgated by relevant professional medical societies, federal agencies, international health organizations and national health ministries of developed nations;

- Major commercial health insurers and government agencies consider SBI a core feature of clinical practice guidelines used to determine medical necessity and reimbursement;
 - The federal agencies responsible for public health and public safety recommend routine SBI;
 - Seventeen medical professions recommend SBI training and the demonstration of clinical competency in SBI for professional education;
 - Federal health services and major foundations are investing substantial resources in developing SBI demonstration programs to test the efficacy and effectiveness of these interventions, but the sustainability of these programs is jeopardized by the lack of accepted procedure codes;
 - The ratio of cost to implement SBI to healthcare cost savings of SBI is positive and substantial; and
 - CMS will release new, unique HCPCS Level II codes for SBI in fall 2006.
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8. If this is a *new* code, specify the recommended terminology (code descriptor) for the proposed CPT code. Specify the placement of the proposed code in the current text of CPT (list section, subsection (example: MUSCULOSKELETAL, HEAD, INCISION ●210XX)). Also list synonyms, eponyms or other technical names for the procedure (example: ●8661X *Borrelia burgdorferi* (Lyme disease) confirmatory test (e.g., Western blot or immunoblot)).

EVALUATION AND MANAGEMENT:

Alcohol and other drug screening and brief intervention

99445 Alcohol and/or drug screening

99446 Alcohol and/or drug services, brief intervention, per 15 minutes

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9. If this code is proposed for *revision*, specify the recommended terminology (code descriptor) for the proposed revised code. Use the conventional techniques of strike-outs for deletions and underlining for additions/revisions (example: 33420 Valvotomy, mitral valve (~~commissurotomy~~); closed heart). Also, indicate the revision(s) in context with the current code descriptor (list the complete family of codes related to your request). Please refer to code change request instructions.

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10. If you are recommending a code *deletion*, please provide the recommended cross-reference (i.e., how is the deleted service now to be coded? Example: (33100 has been deleted. To report, see 33030, 33031)).

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11. Please indicate which CPT or HCPCS Level II code(s) are currently being used to report this procedure/service.

For alcohol and other drug screening, a very large number of CPT codes may be used. In the absence of alcohol or drug-specific identifiers in administrative records, it is difficult to determine the extent that any of these possibly applicable CPT and HCPCS Level II codes are actually being used:

- 90801 Psychiatric diagnostic interview examination
- 96150 Health and behavior assessment
- 99201 Office or other outpatient visit for the E/M of a new patient
- 99212 Office or other outpatient visit for the E/M of an established patient
- 99221 Initial hospital care, per day, for the evaluation and management of a patient
- 99241 Office consultation for a new or established patient
- 99251 Initial inpatient consultation
- 99281 ED visit for self-limited or minor presenting problem
- 99420 Administration and interpretation of health risk assessment instrument
- H0001 Alcohol and/or drug assessment

For alcohol and other drug screening with brief intervention, the following CPT and HCPCS Level II codes may be currently used:

- 90804 Office or other outpatient facility individual psychotherapy, approximately 20-30 minutes face-to-face with the patient.
- 90816 Inpatient hospital, partial hospital or residential care facility, individual psychotherapy, approximately 20-30 minutes face-to-face with the patient.
- 96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
- 98960 Education and training for patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.
- 99202 Office or other outpatient visit for the evaluation and management of a new patient
- 99221 Initial hospital care, per day, for the evaluation and management of a patient
- 99241-99242 Office consultation for a new or established patient
- 99251-99252 Initial inpatient consultation
- 99281 ED visit for self-limited or minor presenting problem

- 99282 ED visit for low to moderate presenting problem
- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (approximately 15 minutes).
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (approximately 30 minutes).
- H0004 Behavioral health counseling and therapy, per 15 minutes

12. Why is (are) the present code(s) (in 11. above) inadequate to describe procedure/service?

To provide effective care, SBI must be conducted with fidelity to evidence-based practice standards. The addition of specific codes for screening and for SBI will promote consistency in the proper use these procedures across medical specialty, setting, patient status and diagnosis. In the absence of standardized alcohol and drug screening processes, clinicians cannot reliably identify those with substance misuse in primary care (Saitz et al, 1997), emergency departments and trauma centers (Gentilello et al, 1999; Ryden et al, 1992), or medical/surgical inpatient services (Smothers et al, 2004). Using their clinical judgment alone, primary care physicians, emergency physicians and nurses, and physicians treating medical, surgical and obstetric inpatients correctly identify fewer than 50 percent of patients with alcohol or drug problems. For example, Gentilello and his colleagues (1999) found that trauma center staff incorrectly suspected alcohol intoxication in 26 percent of patients who screened negative on structured questionnaires and had a blood alcohol concentration of zero (i.e., this 26 percent were false positives for alcohol intoxication). Physicians correctly identified only 77 percent of patients who were acutely intoxicated (BAC > 0.10 g/dl); with nursing staff performing only slightly better (84 percent) (i.e., true positives). Patients incorrectly suspected by staff to be intoxicated were more likely to be young, male, disheveled, uninsured, and have low income. More than half of the patients who screened positive for chronic alcohol abuse or dependence were not suspected of having an alcohol problem by both physicians and nursing staff. Physicians and medical personnel are also particularly unsuccessful in using their clinical impression to accurately detect alcohol intoxication in patients who have closed head injuries, who are endotracheally intubated, or who are severely injured and in pain. Existing nonspecific codes used inconsistently to record SBI procedures fail to guide physicians and other healthcare providers in the use of effective SBI.

Existing HCPCS Level II Alcohol and Drug Abuse Treatment Services (H0001 to H2037), which could be used to record SBI services, are specifically identified in the HCPCS manual as “codes used by those state Medicaid agencies that are mandated by state law to establish separate codes for identifying mental health services that include alcohol and drug treatment services.” The HCPCS manual identifies all of the “H” codes as “noncovered by Medicare (AMA, 2004). The “H” codes (as well as T1012 “alcohol and/or substance abuse services”) identify these services as specialty substance use treatments, failing to recognize that SBI is a primary care service that can be performed in ambulatory, emergency department and inpatient settings.

13. Identify the major differences between the proposed code change and other related codes already in CPT (add additional codes as necessary):

Code **99445** Unlike related CPT codes, this proposed code, by its specificity, promotes use of standard screening instruments that have been proven effective in identifying patients that misuse alcohol and/or other drugs, and to detect patients meeting full dependence diagnostic criteria. The proposed code for alcohol and other drug screening specifies use of self-report and provider-administered questionnaires, which is different than the biological assays of alcohol and other drugs and their metabolites from blood, urine, breath, hair or other biological samples. Further, the proposed code differs from the HCPCS Level II “H” screening code which is defined as a specialty mental health/substance use code for use by Medicaid. The proposed code is a primary care service that could be used by physicians and health care providers across a range of specialties and settings.

Code **99446** Alcohol and other drug brief intervention involves specific substance misuse intervention approaches that have been thoroughly specified and supported by extensive clinical research trials (e.g., Miller & Rollnick, 1991; Whitlock et al, 2004). Brief intervention differs from the psychotherapy codes (e.g., 908XX) which are generally delivered by a psychiatrist, psychologist, or other highly trained physician or health care provider in the psychotherapeutic technique. Brief intervention can be reliably and effectively delivered by physicians, nurses, counselors, and social workers in ambulatory primary care, emergency departments, trauma centers, med/surg and obstetric inpatient units, as well as in specialty behavioral health settings. Similarly, the intervention procedures covered by the proposed code differ from the HCPCS Level II “H” codes and “T” codes (e.g., H0004 or T1012) which are designed for use in specialty substance use treatment settings and by mental health and substance use treatment professionals. The proposed code also differs from the preventive medicine counseling (99401, 99402) or health and behavior intervention (96152), which cover a wide range of preventive medical counseling or behavioral health counseling to assist patients with physical illnesses to better manage their diseases.

14. Please provide a list of CPT codes for all procedures/services which are an integral part of the proposed procedure/service. This list should include CPT codes for all procedures/services which, if coded in addition to the code for the procedure/service proposed here, would represent unbundling.

There are no procedures/services which have discrete CPT codes which cover integral components of alcohol and other drug SBI.

15. For each proposed coding change please provide (attach) a clinical vignette that describes the typical patient who would receive the procedure(s)/service(s) including diagnosis and relevant conditions. Please refer to the sample format and examples of appropriate of clinical vignettes included in the code change request instructions. This same vignette is used during the development of work values by the AMA/Specialty Society RVS Update Committee (RUC).

99445 Alcohol and/or drug screening

99446 Alcohol and/or drug services, brief intervention, per 15 minutes

Alcohol and Drug Screening and Brief Intervention in the Emergency Department

Typical patient:

A 23-year-old male was brought to the emergency department by ambulance after falling down a flight of stairs and briefly losing consciousness. He sustained a minor scalp laceration. His blood alcohol concentration (BAC) was 0.16 mg/dl. Further history revealed a pattern of heavy binge drinking and several prior injury-related emergency department visits.

Description of Procedure(s)/Service(s):

After evaluation, repair of laceration and resolution of intoxication the Emergency Department (ED) physician performs a 30-minute brief intervention. The patient's problem severity is measured using a questionnaire. Feedback about his drinking is presented, including a comparison of the patient's drinking quantity, frequency and amount of alcohol consumed to national norms; the level of intoxication at admission and its relation to common effects found at different BAC levels; negative social consequences of alcohol derived from the history and questionnaire; negative physical consequences as reflected by abnormal laboratory values; and the severity of the alcohol problem as measured by the questionnaire. The ED physician discusses these findings with respect to the increased risk for negative psychosocial and medical consequences, particularly subsequent trauma. He or she assists the patient in identifying methods of reducing/stopping drinking as a way to reduce this level of risk and helps the patient to develop a plan of action.

Alcohol and Drug Screening and Brief Intervention for Admitted Patients

Typical patient:

An 18-year-old male is brought to the trauma center after a single car rollover motor vehicle crash resulting in ejection from the vehicle through the windshield. He sustained facial laceration and cervical spinal fractures without spinal cord injury and required splenectomy for internal bleeding.

The patient had an admission blood alcohol concentration of 0.22 mg/dl and positive urine toxicology for marijuana metabolites. The alcohol intervention team is consulted.

Description of Procedure(s)/Service(s):

The RN, social worker, psychologist, certified addiction counselor, or MD interventionist performs an evaluation using the 10-question Alcohol Use Disorder Identification Test (AUDIT) and

continues with an assessment to determine if there is a harmful pattern of alcohol use. They provide recommendations, negotiate a drinking goal, agree on a plan, provide educational material, arrange for a referral to specialized treatment or to a mutual help group if indicated, arrange follow-up and coordinate care if the patient has accepted a referral.

Alcohol and Drug Screening and Brief Intervention in Primary Care

Typical patient:

A 27-year-old female visited her primary care physician for an annual physical. Along with collecting vital signs, the nurse administered a single-question alcohol screen by asking “When was the last time you had more than four drinks containing alcohol in a day?” When the patient responded, “Last Friday night” the nurse proceeded to administer the AUDIT, and then entered the results (a score of 10) and marked her chart for the physician to conduct a brief intervention.

Description of Procedure(s)/Service(s):

In the course of providing the preventive health examination, the physician reported the screening results to the patient and expressed her concern about the pattern of drinking. She asked about when the patient had feelings of guilt or remorse after drinking, as she had indicated on the AUDIT. They discussed the patient’s embarrassment over her actions when she got drunk recently. The doctor indicated that the patient’s typical weekly consumption and frequency of drinking to intoxication posed significant risks to health beyond embarrassment. She then asked if the patient wanted to reduce those risks. The patient expressed surprise that her drinking pattern was above normal, as many of her friends drank more than she did. The doctor reported the scientifically-based, U.S. drinking guidelines, and reiterated that the patient’s drinking exceeded those levels. The patient responded that she was not an alcoholic. The doctor suggested that drinking patterns and risks were her concern, not labels; and that the patient’s response to the nurse’s questions indicated that she was quite unlikely to be dependent on alcohol. Nevertheless, she stated, one can experience considerable physical, mental, social and legal problems from excessive alcohol use without being addicted. They then discussed the options of cutting back or stopping alcohol use entirely, and the patient chose to try cutting back. The physician reminded the patient of the recommended weekly and daily limits and suggested several ways to reduce consumption. They agreed that the patient would call the doctor if she found she could not cut back and that they would talk about the issue again at the next visit.

16. For each proposed coding change please provide (attach) a brief description of the procedure(s)/service(s) performed by the physician or non-physician healthcare professional. Please refer to the sample format and examples of appropriate of descriptions of service included in the code change request instructions. This should be a summary description and should not contain the detail or pre, intra and post service breakdowns that are required as part of the AMA/Specialty Society RVS Update Committee (RUC).

99445 Alcohol and/or Drug Screening

Alcohol and/or Drug Screening is the use of a valid brief questionnaire about the context, frequency and amount of alcohol or other drugs used by an individual. Alcohol and Drug Screening provides a quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one. Examples of valid questionnaires are: AUDIT (Alcohol Use Disorder Identification Test), MAST (Michigan Alcohol Screening Test), DAST (Drug Abuse Screening Test) and CAGE-AID (4-question screener about drug use), or the ASSIST (the Alcohol, Smoking and Substance Involvement Screening Test) developed by the World Health Organization to screen for risky use of 11 psychoactive substances, including injection drug use. Administration and interpretation of screening instruments generally takes 5-15 minutes. Alcohol and other drug screening through use of standardized questionnaires differs greatly from biological assays such as blood alcohol content (BAC) or drug toxicology assessments, for which existing CPT codes are adequate. (NIAAA, 2005; Ensuring Solutions to Alcohol Problems, 2004a)

99446 Alcohol and/or drug services, brief intervention, per 15 minutes

Brief Intervention is the use by the practitioner of the results of a valid brief questionnaire that indicates an alcohol or drug problem. The practitioner expresses concerns about the individual's drinking and advises the individual to cut down on his/her drinking or drug use. The healthcare provider uses a patient-centered, nonjudgmental, empathic manner in responding to the patient's resistance to change, acknowledging the patient's contention not to make change and exploring his/her opposition and/or ambivalence toward behavioral change. The basic strategy of the brief intervention is to identify benefits and hazards of using alcohol or other drugs and to use the patient's own values and assessment of the consequences of his/her use to increase motivation to reduce hazardous substance use. Counseling follows the counseling framework known as the "5-As" – to assess, advise, agree, assist and arrange:

- Providers should *assess* the degree of a patient's drinking, including any problems caused by alcohol and whether the person is alcohol dependent or not.
- Providers should *advise* patients to reduce their alcohol consumption to safer levels, or to abstain altogether from drinking.
- They should *agree* with patients on their goals for reducing alcohol consumption.
- Providers should *assist* patients in acquiring personal motivation, self-help skills, or outside resources necessary to achieve behavior change.
- Finally, providers should *arrange* for patients to receive appropriate follow-up support services and counseling, depending on the nature of their alcohol misuse.

Another organizing mnemonic for brief intervention is the acronym **FRAMES** originally devised by Miller and Sanchez (1994). The letters of **FRAMES** refer to the use of **F**eedback, **R**esponsibility for change lying with the individual, **A**dvice-giving, providing a **M**enu of change options, an **E**mpathic counseling style, and the enhancement of **S**elf-efficacy (see Bien et al., 1993; Miller and Rollnick, 1991). For patients who are dependent on alcohol or other drugs, a major emphasis of brief intervention is to increase motivation to engage in treatment with a behavioral health specialist. The responsibility for making behavioral changes remains with the patient at all times. The healthcare practitioner helps the patient develop an action plan to achieve this goal. Typically, brief interventions take place immediately following screening. Some models of brief intervention include one or more follow-up care management contacts with patients either in brief face-to-face counseling or by telephone (NIAAA, 2005; ESAP, 2004b).

17. What diagnosis or conditions is this service/procedure designed to diagnose/treat?

Alcohol Dependence

Drug Dependence

Nondependent abuse of drugs

V11.3 Personal history of mental disorder: Alcoholism

V11.8 Personal history of mental disorder: Other mental disorders

V61.41 Health problems within family: Alcoholism in family

V65.42 Counseling on substance use and abuse

V70.2 General psychiatric examination, other and unspecified for persons without reported diagnosis encountered during examination and investigation of individuals and populations.

V79.1 Special screening for mental disorders and developmental handicaps:
Alcoholism

**18. What is the incidence of the disease(s) that this procedure is designed to diagnose/treat?
Please quantify when possible (e.g. patients per year; admissions per year).**

Alcohol misuse is the third leading preventable cause of death in the United States. In 2001, this illness was associated with 75,000 deaths and 2.3 million years of potential life lost (30 years per premature death) (Stahre et al, 2004). Among adults in the United States, approximately 30 percent of current drinkers exceed recommended daily or weekly limits; and more than 90 percent of these excessive drinkers binge drink (Naimi et al, 2003). Among those who drink excessively, approximately 15 percent meet criteria for alcohol abuse. Approximately 10 percent of those who drink excessively are alcohol dependent (Dawson et al, 2005). Other types of alcohol misuse include any alcohol consumption among high-risk populations (e.g., pregnant women, youth) and drinking in association with certain activities (e.g., driving a motor vehicle, operating heavy equipment).

Alcohol misuse is linked to increased risk for unintentional injuries (e.g., motor vehicle crashes and falls), violence (e.g., homicide and suicide), liver disease, diseases of the central nervous system (e.g., stroke and dementia), hypertension and various cancers (e.g., breast, head and neck, stomach, colon and liver). Alcohol misuse is also associated with a variety of adverse reproductive health outcomes including unintended pregnancy, sexual assault, sexually transmitted infections (STIs), fetal alcohol spectrum disorders including fetal alcohol syndrome, low birth weight and sudden infant death syndrome. Finally, alcohol misuse often coexists with mental health problems and/or other substance abuse (NIAAA, 2000; Corrao et al, 2004; Thun et al, 1997; Naimi et al, 2003; Gladstone et al, 1996; Iyasu et al, 2002).

Through SBI, practitioners detect alcohol misuse among high proportions of patients in the primary care, trauma/emergency care and general admission settings. In primary care settings where SBI is conducted, 10-25 percent of patients screen positive for alcohol misuse, depending on the setting and patient population (Naimi et al, 2003; USPSTF, 2004; Town et al, in press; Fiellin et al, 2000). In hospital emergency departments, 4 percent of patients meet the DSM-IV-TR criteria of substance dependence and 27 percent meet broader criteria of unmet substance use treatment need, based on positive BAC or drug toxicology, positive response to alcohol and drug screening questions (Rockett et al, 2003a,b). Rivara and his colleagues (2000) estimate that 25-40 percent of Level I and Level II Trauma Center admissions are impaired by alcohol at the time of their injury and that another 26 percent who are not impaired at the time of their injury have a pre-existing alcohol dependence or alcohol use disorder. In short-stay general hospitals, 7.4 percent of admissions are likely to meet diagnostic criteria of an alcohol use disorder (Smothers, Yahr, Sinclair, 2003), including 18.7 percent of admissions 18-44 years of age and 3.4 percent of admissions over 45 years of age. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates there are 1.8 million general hospital medical/surgical admissions annually of patients who meet diagnostic criteria of alcohol use disorders (Smothers et al, 2003; 2004).

**19. How long (i.e. numbers of years) has this procedure/service been provided for patients?
(Medical literature that indicates utilization of this procedure/service should be cited in
and a hard copy of literature should be provided)**

Studies demonstrating the clinical effectiveness of SBI for alcohol and other drugs have been published since the 1980s. In 1990, the Institute of Medicine (IOM) released *Broadening the Base of Treatment for Alcohol Problems*, a comprehensive review of current research and clinical practice. The IOM found that “*suitable methods of identification and readily learned brief intervention techniques with good evidence of efficacy are now available. The committee recommends that consideration be given to the broad deploying, in a wide variety of community settings, of identification and brief intervention capabilities, coupled with the referral of appropriate individuals to the specialized treatment system for alcohol problems*” (IOM, 1990, p. 8).

By 1993, the World Health Organization had developed a highly sensitive and specific alcohol screening questionnaire, the AUDIT (Sanders et al, 1993), which was employed in a 20 country pilot of SBI (Babor & Higgins-Biddle, 2001a,b).

In 1996, the US Preventive Services Task Force (USPSTF) found: “*Screening to detect problem drinking and hazardous drinking is recommended for all adult and adolescent patients (“B” recommendation). All pregnant women should be screened for evidence of problem drinking or risk drinking (“B” recommendation). Patients with evidence of alcohol dependence should be referred, where possible, to appropriate clinical specialists or community programs specializing in the treatment of alcohol dependence. Patients with evidence of alcohol abuse or hazardous drinking should be offered brief advice and counseling.*” The task force in 1996 found insufficient evidence to recommend routine drug screening but did state: “*All pregnant women should be advised about the potential risks to the fetus of drug use during pregnancy and the potential to transmit drugs to infants through breastfeeding. All patients who report potentially harmful use of drugs should be informed of the risks associated with their drug use and advised to cut down or stop.*”

In 2002, Miller and Willbourne released an analysis of 361 controlled clinical trials of treatments for alcohol problems. They rated the research design, methodological strength, clinical outcomes and breadth of subjects and outcomes for 40 specific treatments. SBI, the subject of 31 controlled trials, received the top ranking for clinical populations (i.e., with diagnosable alcohol use disorders) and all problem drinkers. A meta-analytic review of 54 controlled investigations of brief interventions for alcohol problems (Moyer, Finney et al, 2002) and for drug problems (Burke et al, 2003) found moderate effect sizes for reduced alcohol and drug consumption, and moderate to large effect sizes for social outcomes such as substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence).

The USPSTF in 2004 updated its recommendations on SBI. The new recommendation: “*To prevent or reduce alcohol misuse, the U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling for all adults, including pregnant women, in the primary care setting. The USPSTF found good evidence that screening in primary care setting can accurately identify those patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity or mortality and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6 to 12 month periods or longer*” (Whitlock et al, 2004).

20. Do many physicians or non-physician healthcare professionals perform this service across the United States?

X Yes

21. How often do physicians or non-physician healthcare professionals perform this service?

X Often

22. How often is this service provided nationally in a one-year period, (i.e., what is the yearly frequency)?

Primary care: In primary care settings, 10-20 percent of patients are screened for alcohol misuse (Denny et al, 2002).

Pediatricians and family practice physicians: Millstein & Arik (2006) found that 17 percent of family physicians ask their adolescent patients fully and systematically about alcohol use through a standardized screening instrument.

Emergency physicians and trauma surgeons: A study of quality of care found that 15.5 percent of hospitalized trauma or hepatitis patients have an indication in their medical records that alcohol or drug use was assessed (McGlynn et al, 2003). Twenty-nine percent of emergency physicians routinely ask about alcohol quantity and frequency. More than two-thirds of respondents asserting that they frequently check BAC, with one third reporting that they always do (Schermer et al, 2003). One-fourth reported use of formal screening questionnaires with more than one-third (36 percent) reporting that their trauma center currently performs brief interventions with patients with alcohol problems.

Physicians treating medical, surgical and orthopedic inpatients: Epidemiologists from NIAAA report that 42 percent of short-stay general hospital admissions who have an alcohol use disorder receive an alcohol-related diagnosis and in 57 percent there is some medical record notation of alcohol use.

23. Please identify the specialties or subspecialties that might perform this procedure/service.

Addictionology (physicians with advanced training in treatment of substance use disorders)

Emergency Medicine

Family Medicine

Internal Medicine

Nursing

Obstetrics-Gynecology

Osteopathic Medicine

Pediatrics

Psychiatry

Psychology

Social Work

Trauma Surgery

24. Did you contact any of these specialty groups? If yes, which one(s)?

Yes:

- American Academy of Addiction Psychiatry (Addictionology)
- American Academy of Family Physicians
- American Academy of Pediatricians
- American College of Obstetrics and Gynecology
- American College of Emergency Physicians
- American College of Physicians (Internal Medicine)
- American College of Surgeons (Trauma Committee)
- American Nurses Association
- American Osteopathic Association
- American Psychiatric Association
- American Psychological Association
- American Society of Addiction Medicine
- Association for Medical Education and Research for Substance Abuse
- National Association of Social Workers

25. What is the typical site of service that this procedure is performed in? (please check all that apply)

X Office or other outpatient setting

X Emergency department

Independent laboratory

Domiciliary/rest home

X Hospital inpatient

Patient's home

X Psychiatric facility

Nursing facility

X Hospital outpatient

X Ambulatory surgical center

Other (please specify) _____

26. If you are recommending a new code, please estimate the percentage of services performed using current codes that would now be coded using the proposed new code. Please cite your data sources (example: Current code 12345 will now be reported by ●123X1 30 percent of the time, ●123X2 70 percent of the time).

Screening and brief intervention are not often coded because there is no identifiable code for the services. Therefore there are no estimates of the percentages of services performed using current codes. The existence of specific identifiable codes will assist in tracking and further implementation of the technology and general improvement in the quality of patient care.

27. Are you aware of any practice parameters/guidelines or policy statements about this particular procedure? If yes, please identify and provide them as is feasible.

X Yes No Don't Know

Routine provision of SBI is warranted because SBI conforms to best available scientific evidence of effective treatments for alcohol and other drug use. The US Preventive Services Task Force in 2004 made the following recommendation:

“To prevent or reduce alcohol misuse, the U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling for all adults, including pregnant women, in the primary care setting. The USPSTF found good evidence that screening in primary care setting can accurately identify those patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity or mortality and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6 to 12 month periods or longer” (Whitlock et al, 2004).

Professional medical societies that recommend SBI:

- American Psychiatric Association (APA, 1994)
- American Academy of Pediatrics (Kulig, 2005; AAP, 2005)
- American Academy of Family Physicians (Leawood, 2005)
- American Academy of Child and Adolescent Psychiatry (Bukstein, 2004)
- American Society of Addiction Medicine (ASAM, 1997)
- American College of Emergency Physicians (ACEP, 2005, 2006)
- American College of Surgeons – Committee on Trauma (ACS 2006)
- American College of Obstetricians and Gynecologists (<http://acog.org/>)

Federal and state health agencies that have promulgated practice guidelines that include strong recommendations for SBI:

- The Veterans Administration and Department of Defense joint guidelines for substance use treatment (VA/DOD, 2002).
- The Substance Abuse and Mental Health Services Administration Treatment Improvement Protocols numbers 35, 34, 32, 32, 24, 16, 11 and 3 (CSAT, various dates).
- New York State Department of Health (2005).
- The Michigan Quality Improvement Consortium (2005).
- National Quality Forum (2005)

Major payers that have developed practice standards that include specific recommendations to use SBIs:

- Magellan and ValueOptions, the largest managed behavioral healthcare companies, published guidelines (Magellan, 2005; ValueOptions, 2006).
- WellPoint and United Healthcare, the largest and second largest healthcare companies recommend primary care SBI (UHC, 2005, MAMSI, 2005);
- National Business Coalition on Health and the National Business Group on Health recommend and monitor health plans' SBI (NBCH, 2006; NBGH, 2006).

International health organizations and national health ministries that have developed practice standards that incorporate SBI:

- World Health Organization (Babor, Higgins-Biddle, 2001a,b)
- United Kingdom (2004)
- Scotland (2003)
- Australia (2004)
- Canada (2005)
- European Union 17-country collaborative guideline (Anderson et al, 2005)

28. Please provide hard copy(s) (and internet addresses, if available) of literature to support your request (U.S. PEER REVIEWED JOURNALS ONLY) and cite the author, title, journal, volume, page and year as necessary. Each item of submitted literature shall be identified according to each of the four following categories: 1) review articles/practice standards; 2) peer-reviewed literature with instruction that unpublished but accepted literature requires simultaneous submission of a letter of acceptance; 3) protocol description; and/or 4) other medical evidence to support the validity of the application.

For Category III codes please reference quality studies or research performed by national organizations.

See attached bibliography

29. Other comments:

Rationale for the Routine Provision of Screening and Brief Intervention

Routine provision of SBI is warranted because SBI conforms to best available scientific evidence of effective treatments for alcohol and drug use. The US Preventive Services Task Force in 2004 made the following recommendation:

“To prevent or reduce alcohol misuse, the U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling for all adults, including pregnant women, in the primary care setting. The USPSTF found good evidence that screening in primary care setting can accurately identify those patients whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, but place them at risk for increased morbidity or mortality and good evidence that brief behavioral counseling interventions with follow-up produce small to moderate reductions in alcohol consumption that are sustained over 6 to 12 month periods or longer” (Whitlock et al, 2004).

A comprehensive analysis of 361 controlled clinical trials of treatments for alcohol use disorders (Miller and Wilbourne, 2002) found the evidence of effectiveness of SBI was the strongest of more than 40 alcohol treatment modalities studied. Researchers compared the strength of research designs, breadth of outcomes and the size of treatment effects. The 31 controlled clinical trials of SBI showed the greatest and most consistent evidence of effectiveness of any of the alcohol treatments studied. A meta-analytic review of 54 controlled investigations of brief interventions for alcohol problems (Moyer, Finney et al, 2002) found moderate effect sizes (0.669) for alcohol consumption at three months. In a meta-analysis of controlled clinical trials of motivational interviewing (MI), a core therapeutic technique in SBI, Burke and his colleagues identified five studies that examined clinical and social impact of motivational interviewing on drug use. The five studies produced moderate treatment effect sizes ($d=0.56$) on drug use and large effect sizes ($d=0.90$) on social outcomes such as substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence).

Studies show that reductions in alcohol-related health problems may exceed reductions in alcohol consumption itself. For example, one randomized study that assessed effects of SBI after a 48-month follow-up found that the intervention group had a 20 percent reduction in emergency department visits, 33 percent reduction in nonfatal injuries, 37 percent fewer hospitalizations, 46 percent fewer arrests and 50 percent fewer motor vehicle crashes relative to controls (Fleming et al, 2002). These reductions exceeded reductions in consumption; the intervention group experienced a 20 percent reduction in binge drinking episodes, a 10 percent reduction in drinks/week and a 4 percent reduction in those reporting no binge drinking episodes relative to controls. A meta-analysis found that brief counseling interventions reduce mortality (Cuijpers et al, 2004).

The USPSTF identified 12 randomized, controlled trials of SBI for risky/harmful drinking conducted in multiple primary care practices and found that high-quality brief, multi-contact behavioral counseling interventions reduced risky and harmful alcohol use by primary care patients. Patients experiencing brief multi-contact interventions were more likely than controls at follow-up to drink sensibly and to reduce weekly drinking amounts (Whitlock et al, 2004).

Additional reasons to routinely provide SBI include:

SBI is integral to evidence-based clinical practice standards promulgated by relevant professional medical societies, federal agencies, international health organizations and national health ministries of developed nations;

Professional medical societies that promulgate evidence-based clinical practice guidelines for their members recommend routine use of SBI for substance using patients. A review of the clinical practice guidelines maintained by the Agency for Healthcare Research and Quality (AHRQ) at guidelines.gov shows the following professional medical societies recommend SBI:

- American Psychiatric Association (APA, 1994)
- American Academy of Pediatrics (Kulig, 2005; AAP, 2005)
- American Academy of Family Physicians (Leawood, 2005)
- American Academy of Child and Adolescent Psychiatry (Bukstein, 2004)
- American Society of Addiction Medicine (ASAM, 1997)
- American College of Emergency Physicians (ACEP, 2005, 2006)
- American College of Surgeons – Committee on Trauma (2006)

American Medical Association (1999, 2001) passed resolution H-30.942 affirming support for SBI as medical services to be provided by physicians:

1) Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors and self-help groups in their communities and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

(2) Our AMA urges the National Committee on Quality Assurance to consider developing a HEDIS (Health Plan Employer Data and Information Set) measure for problem drinking or alcohol use disorders. (CSA Rep. 14, I-99; Reaffirmation I-01)

Accreditation organizations are promulgating standards which include SBI. For example, the American College of Surgeons – Committee on Trauma, which is responsible for accrediting the nation's trauma centers, set out an SBI standard for all Level I and Level II trauma centers. Starting in January 2007, trauma centers must demonstrate:

Trauma centers can use the teachable moment generated by the injury to implement effective primary prevention, for example alcohol counseling for problem drinkers. Alcohol is such a significant associated factor and contributor to injury that it is vital that trauma centers have a mechanism to identify patients who are problem drinkers. Such mechanism is essential in Level I

and II trauma centers (CD 18-5). In addition, Level I centers must have the capability to provide an intervention for patients identified as problem drinkers (CD18-6). These have been shown to reduce trauma recidivism by 50 percent.

International health organizations and national health ministries have developed practice standards that incorporate SBI:

- World Health Organization (Babor, Higgins-Biddle, 2001a,b)
- United Kingdom (2004)
- Scotland (2003)
- Australia (2004)
- Canada (2003)
- European Union – 17-country collaborative guideline (Anderson et al, 2005)

Federal and state health agencies have promulgated practice guidelines that include strong recommendations for SBI.

- The Veterans Administration and Department of Defense joint guidelines for substance use treatment specifically recommend screening for hazardous substance use at initial clinical visits and at least annually and brief interventions for hazardous or harmful use of substances. (VA/DOD, 2002).
- The Substance Abuse and Mental Health Services Administration has published a series of consensus practice guidelines, the Center for Substance Abuse Treatment's Treatment Improvement Protocols (numbers 35, 34, 32, 32, 24, 16, 11 and 3) for substance use screening for adolescents and adults and brief interventions (CSAT, various dates).
- New York State Department of Health promotes SBI in its substance use treatment guidelines (2005).
- The Michigan Quality Improvement Consortium, which is made up of the health plans throughout Michigan implemented a common guideline for screening and management of substance use disorders (2005).
- ◆ **Major commercial health insurers and government agencies consider SBI a core feature of clinical practice guidelines used to determine medical necessity and reimbursement:**
 - The two largest managed behavioral healthcare companies, Magellan and ValueOptions, covering together 86 million lives, promulgate clinical practice guideline for substance abuse specifying SBI (Magellan, 2005; ValueOptions, 2006).
 - The two largest U.S. healthcare companies, WellPoint and United Healthcare, recommend clinicians use substance use treatment guidelines that include primary care, emergency department and specialty behavioral health SBI (UHC, 2005, MAMSI, 2005); and other major health insurers, including Aetna, Kaiser-Permanente, HealthPartners and HIP, have implemented routine telephonic alcohol SBI processes;
 - National Business Coalition on Health, an organization representing more than 90 regional and state business coalitions with over 7000 employer members covering 35 million lives, monitors alcohol SBI delivered by more than 300 commercial sector health plans through its eValue8 RFI, alcohol module (NBCH, 2006; ESAP, 2004).

- National Business Group on Health, which represents more than 200 of the largest employers in the US, produced an employer roadmap to behavioral health services recommending SBI (NBGH, 2006)

The federal agencies responsible for public health and public safety recommend routine SBI:

- The White House Office of National Drug Control Policy's 2006 National Drug Control Strategy states: A key priority of this Administration has been to make drug screening and intervention programs part of the Nation's existing network of health, education, law enforcement and counseling providers. This requires training professionals to screen for drug use, identify users and refer the users for treatment. (ONDCP, 2006)
- The National Highway Traffic Safety Administration in the Department of Transportation (NHTSA) identifies substance use SBI as one of its three critical strategies for reducing impaired driving (NHTSA, 2006)
- Center for Disease Control and Prevention's National Center for Injury Prevention and Control published results of two conferences it convened on SBI in hospital emergency departments and trauma centers (CDC, 2006) and CDC is producing the Community Prevention Guide (in collaboration with the National Business Group on Health) to assist employers to implement the USPSTF SBI recommendations.
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) released a guide for primary care clinicians on SBI (NIAAA, 2005)
- The Institute of Medicine (2005) specifically identified the failure to cover SBI in hospital emergency services as a primary example of health insurance coverage policy that discriminates against patients seeking treatment for mental health and substance use disorders.

Seventeen medical professions recommend SBI training and the demonstration of clinical competency in SBI for professional education:

It is the official policy of the American Medical Association (H-30.983) that medical education include exposure to early identification, treatment and prevention of alcoholism and other chemical dependencies (Res. 67, I-86; Reaffirmed: Sunset Report, I-96: CMS Rep. 10, A-99). In 2002, the Association for Medical Education and Research in Substance Abuse (AMERSA) forged a consensus among representatives of psychiatry, social work, nursing, psychology, family medicine, emergency medicine and nine other health professions on discipline-specific core competencies and cross-disciplinary core knowledge and competencies needed by health professionals to identify and treat alcohol and other drug problems in the patients that they serve (Haack and Adger, 2002). The 17 medical and health professional groups forged a 4-point statement to broadly describe the minimum knowledge and skills related to substance use disorders (SUD) for all health professionals.

- "All health professionals should receive education in their basic core curricula to enable them to understand and accept alcohol and other drug abuse and dependence as disorders that, if appropriately treated, can lead to improved health and well-being.
- All health professionals should have a basic knowledge of substance use disorders and an understanding of their effect on the patient, the family and the community.
- All health professionals should be aware of the benefits of screening for potential or existing substance-related problems, as well as of appropriate methods for intervention.

- All health professionals should have core knowledge of treatment and be able to initiate treatment or refer patients for further evaluation and management”
- ◆ **Federal health services and major foundations are investing substantial resources in developing SBI demonstration programs to test the efficacy and effectiveness of these interventions, but the sustainability of these programs is jeopardized by the lack of accepted procedure codes:**

The Center for Substance Abuse Treatment/SAMHSA/DHHS has invested more than \$175 million to create SBI programs in primary care, hospital emergency services and college campuses. Through CSAT’s national network of Addiction Technology Transfer Centers (ATTCs), more than 40 courses and training programs on SBI are being offered between June and November 2006.

- NIAAA and CDC jointly awarded grants to 10 academic medical centers to test SBI in emergency services. In 2005, NIAAA and NIDA issued grant program announcements specifically calling for research proposals on SBIs in primary and specialty care.
- The Robert Wood Johnson Foundation has invested more than \$1 billion to reduce the harm caused by alcohol and other drug misuse in America. A major, current RWJF emphasis of its JoinTogether national program and Demand Treatment community grants are the initiation and expansion of SBI services in primary care and hospital emergency services.
- NHTSA has awarded numerous SBI-related grants. For example, it supports work by the Network of Employers for Traffic Safety to identify SBI workplace programs operating in settings other than primary care and emergency services. NHTSA has awarded training and demonstration grants to the American College of Emergency Medicine, the Emergency Nurses Association and other medical associations to train emergency services providers in SBI techniques.
- SAMHSA, CDC, NHTSA, NIAAA and NIDA are jointly supporting efforts to remove legislative and practice barriers to routine SBI in hospital emergency departments and trauma centers.

The ratio of cost to implement SBI to healthcare cost savings of SBI is positive and substantial; the clinical outcome is positive as well:

The economic evaluation studies involving screening and counseling for alcohol misuse commonly convert outcomes in natural units (e.g., reduced hospitalizations) to dollars in order to enable direct comparison of benefits and costs. There have been several cost-benefit analyses of screening and brief counseling, all of which demonstrate cost-savings. Project TREAT (Trial for Early Alcohol Treatment) was a randomized clinical trial of screening and brief counseling conducted in 64 primary care clinics in Wisconsin; study participants were those identified with nondependent alcohol misuse. Over the study’s 48 month follow-up period, there was a \$4.30 cost savings due to reductions in future healthcare costs for each \$1.00 invested in the intervention (Fleming et al, 2003). Another study assessed the cost-effectiveness of alcohol screening and counseling for trauma patients (Gentilello et al, 2005). The researchers based their cost/benefit estimates on a large (>700 patient) randomized control trial of SBI in a Level I trauma center. The cost analysis was restricted to medical costs only and found that there was \$3.81 in savings for each \$1.00 spent on the intervention. Similar positive returns on investment in SBI have been reported for inpatient medical/surgical patients (Storer, 2003) and specialty substance use treatment. A large randomized trial of brief treatment in the UK (UKATT, 2005) found that investment in treatment for alcohol problems reduced one-year healthcare costs by \$2.30 for every \$1.00 invested in SBI.

Most recommended screening instruments reliably identify alcohol misuse. Most screens have a sensitivity of 70-90 percent for detecting alcohol dependence and single-question screens also detect

milder forms of alcohol misuse with similar sensitivity. In primary care settings, 10-25 percent of patients will screen positive for alcohol misuse, depending on the setting and patient population.

Brief counseling with appropriate follow-up results in moderate reductions (approximately 13-34 percent) in alcohol consumption lasting 6-12 months or longer. Studies also show that reductions in alcohol-related health problems may exceed reductions in alcohol consumption itself. For example, one randomized study that assessed long-term (48-month follow-up) effects of screening and brief counseling found that the intervention group had a 20 percent reduction in emergency department visits, a 33 percent reduction in nonfatal injuries, 37 percent fewer hospitalizations, 46 percent fewer arrests and 50 percent fewer motor vehicle crashes relative to controls. These reductions exceeded reductions in consumption; the intervention group experienced a 20 percent reduction in binge drinking episodes, a 10 percent reduction in drinks/week and a 4 percent reduction in those reporting no binge drinking episodes relative to controls. A meta-analysis found that counseling interventions reduce mortality.

CMS will announce new HCPCS Level II codes for SBI in Fall 2006

The Office of National Drug Control Policy (ONDCP), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) collaborated on the development of new HCPCS Level II procedure codes related to SBI.

On June 2, 2006, CMS and ONDCP announced that CMS will formally change the new codes this fall as part of its annual update to the Healthcare Common Procedure Coding System. These new codes, which can be used by healthcare providers, States and others to electronically report services on medical claims, will facilitate improved tracking of the utilization of these important services, and enable private insurers, state Medicaid programs and others to pay for them should they choose to do so.

CMS has approved two new codes:

- Alcohol and other drug screening and
- Alcohol and other drug screening with brief intervention.

The implementation of unique CPT codes for SBI will likely:

- increase the frequency of SBI in clinical practice and increase clinicians' use of the standard, evidence-based instruments.
- increase the tracking of SBI, thereby better facilitating widespread efforts to increase SBI. The federal government, professional medical associations and foundations are promoting expanded use of SBI

Current coding practices do not permit tracking of SBI. The absence of unique CPT codes for SBI make it very difficult for federal government, professional medical associations, accrediting bodies and healthcare foundations to track the effects of efforts to increase rates of SBI. The lack of well specified codes describing which research-validated screening instruments and brief intervention techniques encompass SBI undermines quality improvement and accountability initiatives. A wide range of HCPCS level II and CPT codes exist which can be used to cover screening and counseling for substance use in ambulatory, emergency departments and inpatient settings. These include the CPT Evaluation and Management, Behavioral Assessment/Intervention, Preventive Counseling, Psychotherapy (AMA, 2006) and the HCPCS substance use assessment and treatment "H" and "T" codes (AMA, 2004). These non-specific codes make it impossible to track progress in increasing use of effective SBI in clinical practice.

CPT codes for psychiatric therapeutic services (90801-90862) generally require an accompanying ICD-9 mental health/substance abuse diagnosis and often can be performed by a psychiatrist or trained and licensed behavioral health professional. SBI is provided by a wide range of health professions across many types of settings for patients who may have hazardous or harmful alcohol or other drug use patterns, but who would not meet a substance use disorder diagnostic criteria. The HCPCS Level II Alcohol and Drug Abuse Treatment Services codes (H0001 to H2037) are specifically identified as “codes used by those state Medicaid agencies that are mandated by state law to establish separate codes for identifying mental health services that include alcohol and drug treatment services” (AMA, 2004). The “H” codes (as well as T1012 “alcohol and/or substance abuse services”) identify these services as specialty substance use treatments, failing to recognize that SBI is a primary care service that is performed in ambulatory, emergency department and inpatient settings by physicians and other primary healthcare providers.

- improve awareness throughout the healthcare system that SBI is a primary care service that can be performed in ambulatory, emergency department and inpatient settings by primary care practitioners and generalists, and that it is not a practice limited to use by specialists in substance disorder treatment.

Primary care: In a nationally representative survey of general internal medicine physicians, family medicine physicians, obstetrician/gynecologists and psychiatrists, Friedmann and his colleagues (2000) found that, although most (88 percent) reported asking their patients about alcohol use, only 13 percent used standardized screening instruments (Friedmann et al., 2000). A survey of primary care patients with diagnosable substance use disorders found that more than 50 percent said their primary care physician did nothing about their substance abuse; 43 percent said their physicians never diagnosed their condition (Fleming et al, 2003). Only 10-20 percent of patients in primary care settings are screened for alcohol misuse (Denny et al, 2002), making it one of the least commonly performed of the USPSTF-recommended clinical preventive services (Coffield et al, 2001). In the absence of screening, clinicians cannot reliably identify those with alcohol misuse (Saitz et al, 1997).

Pediatricians and family practice physicians: Millstein & Arik (2006) found that between 23-43 percent of pediatricians and 14-27 percent of family physicians ask adolescents whether they use alcohol, but only 17 percent inquire more fully and systematically about alcohol use through a standardized screening instrument.

Emergency physicians and trauma surgeons: A nationally representative study of the quality of care delivered conducted by McGlynn and her colleagues at RAND (2003) found that only 15.5 percent of hospitalized trauma or hepatitis patients have any indication in their medical records that alcohol or drug use was assessed, despite evidence that 40-60 percent of trauma admissions are caused by alcohol or drug use. In a self-report survey of emergency physicians, O’Rourke et al (2006) found that 29 percent assert that they routinely ask about alcohol quantity and frequency. A survey of trauma surgeons (Schermer et al, 2003) reported that over two-thirds of respondents asserting that they frequently check a blood alcohol concentration, with one-third of the group reporting that they always do. However, only one-fourth reported use of formal screening questionnaires. Just over one-third (36 percent) reported that their trauma center was currently performing brief interventions with patients with alcohol problems.

General medical, surgical and orthopedic inpatients: A nationally representative study of nonmaternity, acute-care admissions to nonfederal, short-stay, general hospitals compared research-based alcohol use disorder diagnoses derived from structured, computer-assisted, personal interviews and record documented diagnoses of alcohol-related problems, inpatient intervention and referral for

alcohol treatment. Treating physicians recorded an alcohol-related diagnosis in 42 percent of interview-positive admissions and any medical record notation of alcohol use was observed in 57 percent of interview-positive admissions. Only one in five patients with an alcohol use disorder received any inpatient alcohol intervention and less than one-fourth (24 percent) were referred for alcohol treatment at discharge (Smothers, Yahr, Ruhl, 2004).

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Applicant may benefit financially from the code change proposal; and/or
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Signature *Dan Jensen MD* Date July 11, 2006

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In consideration of the American Medical Association's review of your proposed coding change(s) to CPT, you and the requesting organization, assign to the AMA all rights including copyright, if any, in your proposed changes to CPT. The signature below acknowledges that you have authority to sign this form; and, to the best of your knowledge, the information provided accurately depicts current clinical/surgical practice.

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Print Name _____ David C. Lewis, M.D. _____

Organization (if applicable) _____ Physicians and Lawyers for National Drug Policy _____

Date _____ July 11, 2006 _____

Submit your request to:

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Department of CPT Editorial Research and Development
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ccsubmit@ama-assn.org

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An incomplete application may delay processing of your request and may be returned.

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Physicians and Lawyers for National Drug Policy:

A PUBLIC HEALTH PARTNERSHIP

July 6, 2006

The American Medical Association
Department of CPT Editorial Research and Development
515 North State Street
Chicago, IL 60610

To Whom It May Concern:

On behalf of the Board of Directors and the Physicians and Lawyers for National Drug Policy (PLNDP) we enthusiastically support this application to establish two new CPT codes for screening and brief interventions (SBI) for alcohol and other drug problems. PLNDP has been working on ways to include SBI into routine practice for many years, including in our early work with Project Vital Sign in 2000. We believe now that there is a critical mass of research and public policy supporting this need for CPT codes and the need to incorporate SBI as a standard of care for all primary care settings. The recent announcement that the Centers for Medicare and Medicaid Services (CMS) has approved two new alcohol and other drug screening and brief intervention codes for the 2007 HCPCS level II reinforces the timeliness of this application.

PLNDP believes that it is imperative that the AMA recognize the need to have CPT codes for SBI and provide the much needed mechanism to support the medical community in their effort to more effectively address this public health problem.

Sincerely,



David C. Lewis, MD
Board of Directors, PLNDP

George Lundberg, MD
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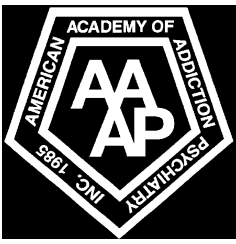
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July 10, 2006

The American Medical Association
Department of CPT Editorial Research and Development
515 North State Street
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To Whom It May Concern:

On behalf of the Board of Directors and the membership of the American Academy of Addiction Psychiatry (AAAP) we applaud and enthusiastically support the Physicians and Lawyers for National Drug Policy application requesting two new CPT codes be established for screening and brief interventions (SBI) for alcohol and other drug problems. AAAP is an international organization of psychiatrists specializing in substance abuse and mental health disorders whose mission is to:

- Promote accessibility to highest quality treatment for co-occurring disorders for all who need it
- Promote excellence in clinical practice in addiction psychiatry
- Educate the public and influence public policy regarding addictive illness
- Provide continuing education for addiction professionals
- Disseminate new information in the field of addiction psychiatry
- Encourage research on the etiology, prevention, identification and treatment of the addictions

AAAP believes that research and public policy support the need to have separate CPT codes for screening and brief interventions for alcohol and other drug problems in all primary care settings. The recent announcement that the Centers for Medicare and Medicaid Services (CMS) has approved two new alcohol and other drug screening and brief intervention codes for the 2007 HCPCS level II reinforces the timeliness of this application.

It is our hope that the AMA recognize the need to have CPT codes for SBI and provide the support that the medical community needs to more effectively address this public health problem.

Sincerely,

Kathryn L. Cates-Wessel
Executive Director
American Academy of Addiction Psychiatry

cc: Michael H. Gendel, MD, President, AAAP



Association for Medical Education and Research in Substance Abuse

Phone (401) 349-0000

Fax (877) 418-8769

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July 10, 2006

The American Medical Association
Department of CPT Editorial Research and Development
515 North State Street
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To Whom It May Concern:

On behalf of the Executive Board of the Association for Medical Education and Research in Substance Abuse (AMERSA) and AMERSA's members, I am writing to support this application to establish two new CPT codes for screening and brief intervention (SBI) for alcohol and other drug problems.

AMERSA has developed and published national core competencies for addressing addictions for all health professionals. The most important core competency for nonspecialists is screening and brief intervention. One of the barriers to widespread implementation has been the absence of a way to record implementation of SBI and to bill for the practice. New CPT codes that treat SBI like other preventive and health behavior services will certainly help with widespread implementation of SBI.

Sincerely,

A handwritten signature in black ink, appearing to read 'Richard Saitz', written over a white background.

Richard Saitz MD, MPH

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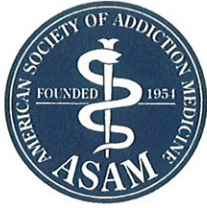
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July 7, 2006

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Marie Mindeman

The American Medical Association

Department of CPT Editorial Research and Development

515 North State Street, Fifth Floor

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Dear Ms. Mindeman:

The American Society of Addiction Medicine (ASAM) is pleased to extend its support for the submission of an application to establish two new CPT codes for screening and brief intervention (SBI) for alcohol and other drug problems prepared by Eric Goplerud, Ph.D., of Ensuring Solutions, George Washington University and by David C. Lewis, M.D., Physicians & Lawyers for National Drug Policy based at Brown University. Research has established the validity of screening instruments for alcohol and other drug disorders and the importance of incorporation of these procedures into the mainstream of medical care.

As you know, ASAM is dedicated to increasing access to and improving the quality of addiction treatment, educating physicians, medical and osteopathic students and the public and to promoting research and prevention about addictive disorders. Screening and Brief Intervention (SBI) for alcohol and other drug problems addresses a major medical and public health problem and ASAM, while a specialty organization, is totally committed to improving health through the integration of the recognition and treatment of addictive disorders in medical practice. (See enclosed ASAM Public Policy Statement on Screening for Addiction in Primary Care Settings.) The timeliness of this request is fortified by the recent announcement that the Centers for Medicare and Medicaid Services (CMS) has approved two new alcohol and other drug screening and brief intervention codes for the 2007 HCPCS level II.

The American Society of Addiction Medicine extends its enthusiastic support for this effort to establish these essential codes.

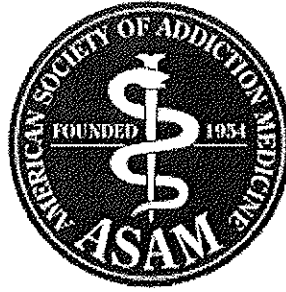
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Elizabeth F. Howell, M.D., FASAM
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Eileen McGrath, J.D.
Executive Vice President/CEO

PHONE: (301) 656-3920 • FACSIMILE: (301) 656-3815
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Plan to attend ASAM's 38th Annual Medical-Scientific Conference, April 26-29, 2007 - Miami, FL



AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement on Screening for Addiction in Primary Care Settings

BACKGROUND

Alcohol, nicotine, and other drug use are common behaviors: two thirds of American adults drink alcohol and one quarter of adults smoke tobacco. Problems from use are also common, and diagnosable substance use disorders are highly prevalent, over 12% of adults exhibiting addiction to alcohol or another drug (exclusive of nicotine), and almost 24% of adults being regular nicotine users (most of these being addicted to the nicotine).

Given that alcoholism and other drug dependencies are progressive conditions, early detection and early intervention can be effective strategies in diminishing the duration, and thus the prevalence, of these conditions in the population. Furthermore, early intervention can diminish the pattern of problems result from substance use.

It is estimated that over two-thirds of persons with addiction see a primary care or urgent care physician every six months. Thus, physicians have an opportunity to recognize, diagnose, and intervene in cases of substance use problems and substance-related disorders. Proper training in detection and intervention techniques, and proper motivation on the part of physicians to utilize these techniques, are necessary for these techniques to be widely employed. Screening techniques comprise one process by which physician and other primary health care providers can determine whether or not to intervene in the course of a substance-related disorder and whether and when to apply more specific diagnostic or therapeutic procedures on behalf of the patient.

A review of available literature by ASAM leads to the conclusion that screening for alcohol and other drug problems is a clinical process that is effective in enhancing health care outcomes, a cost-effective process that reduces overall healthcare expenditures, a preventive health care intervention that is of equivalent importance to other screening interventions, such as screening for breast or cervical cancer, and an activity that should be promoted so that it will become part of the public consciousness of health care consumers, providers, purchasers, administrators, quality managers, and public policy makers.

The quality and efficacy of routine health care services for any condition are compromised unless the patient's alcohol and other drug usage pattern and history are known to the clinician planning and providing primary health care interventions.

Therefore, ASAM recommends:

1. That the *services of primary care physicians* and other primary health care providers should at a minimum include the provision of the following four elements of care:

- *assessment* of the nature and extent of alcohol, nicotine, and other drug use by patients, with consistency of data collection and documentation akin to the consistence of assessment and documentation of vital signs;
- *routine screening* for the presence of alcohol, nicotine or other drug use problems in patients, as well as screening for risk factors for development of alcohol, nicotine and other drug dependence;
- appropriate *intervention* by the primary care provider;
- the provision of ongoing *general medical care services* to persons who manifest alcohol, nicotine or other drug problems, including dependence.

2. That health care services to prevent, screen for, assess, and intervene regarding alcohol, nicotine and other drug problems should be considered to be a component of *general medical practice* .

3. That screening for alcohol, nicotine and other drug use problems is of special importance in clinical situations (such as trauma patients, obstetrical patients and adolescent psychiatry patients) where substance use is particularly relevant to assessment and management.

4. That reimbursement policies and benefit structures for health care services should cover appropriate primary care and specialty provider *screening and treatment* activities regarding alcohol, nicotine and other drug problems, including dependence.

5. That benefits packages for health care services should address addictive diseases, including the diagnosable syndromes of substance use and dependence, equivalent to the way other chronic conditions are addressed.

6. That the interrelatedness of the biomedical and emotional-behavioral aspects of many chronic diseases, including alcohol, nicotine and other drug dependence, suggests that *an integrated approach to assessment and intervention will be preferable* to any approach that separates health care services delivery system structures, and reimbursement policies and benefit structures for alcohol, nicotine other drug, or mental disorders, from such services, structures, and policies for other health care conditions.

7. That *health care organizations* which provide, contract for, arrange, or purchase medical care should assure that screening processes are designed and implemented effectively and routinely in primary care settings, in order to ascertain the presence of alcohol, nicotine and other drug problems, including dependence.

8. That purchasers of health care services should make it a *specification* of services provided, as we

as a measure of the quality of services provided, that screening for alcohol, nicotine and other drug problems by primary care providers be a routine clinical function.

9. That contract language between purchasers (employers or governmental entities) and organized systems of health care delivery should follow a model which includes appropriate screening for chronic conditions, including alcohol, nicotine and other drug dependence, and which also include data collection regarding health care outcomes and health care expenditures for patients/enrollees identified as having alcohol, nicotine or other drug dependence.

- That the JCAHO, the NCQA, and other organizations which accredit, monitor and evaluate the performance of healthcare organizations should recognize that screening for alcohol, nicotine and other drug disorders is a fundamental function of primary health care service, and therefore should include such screening as a *standard* by which quality performance is measured.

11. That screening for alcohol, nicotine and other drug problems be included by the developers of HEDIS and other quality assurance and quality improvement standards as a "report card" item for evaluating the quality of services provided by an organized system of health care delivery.

12. That as states request waivers which may allow them to change the structure, processes, benefit structures, eligibilities, and policies of their Medicaid programs, the new structures, processes, etc. will include *requirements* for

- screening of all patients in primary health care settings for alcohol, nicotine and other drug use problems;
- appropriate care for persons with alcohol, nicotine and other drug use disorders, in either primary care or specialized care settings.

13. That clinical practice guidelines should be developed and utilized which describe appropriate integration of screening, assessment, and intervention for alcohol, nicotine and other drug problems into routine primary medical care processes.

14. That health care organizations should be encouraged to assure that the assessment of potential alcohol, nicotine and other drug use problems should, when feasible, involve the patient's family members and other collateral sources of information.

15. That individuals served by organized systems of health care should be screened to determine the impact upon them of the alcohol, nicotine and other drug use problems of their family members.

16. That organized systems of health care delivery, such as health maintenance organizations, should be encouraged to assure that primary care providers will provide, or refer for, appropriate counseling and referral services for family members affected by an alcohol or other drug use problem in the family.

17. That implementation of screening procedures for substance use and/or addictive illness should preserve the special needs for confidentiality of patients with substance use conditions.

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