CENTER OF EXCELLENCE
for Integrated Health Solutions

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INTEGRATED CARE FINANCING SERIES
MODULE 2

SCREENING IN BEHAVIORAL HEALTH AND PRIMARY CARE SETTINGS

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Background

This brief is part of a series that aims to accelerate implementation of evidence-based integrated care interventions across a myriad of organization settings. It also provides context for and complements the Integrated Care Financing Decision Support Tool which provides billing, reimbursement and aggregate financial modeling guidance to support implementation. Like all its counterparts, this screening module can be used independently or in conjunction with the other modules. Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

Introduction

Screening and assessment are integral steps toward understanding the holistic needs of patients. Within the context of billing and reimbursement, screening opens the door to providing and sustaining services that are responsive to clients' needs. While physical health screenings and mental health and substance use screenings have been traditionally siloed and relegated as the purview of their respective professional disciplines, the integrated care movement strives to maximize patient access to primary care screening in mental health and substance use treatment settings and vice versa. Thus, organizations should seek opportunities to expand access to screening to sustain responsive services and propel the integrated care movement. This brief aims to highlight considerations salient to the aim of cross pollinating screenings in mental health and substance use and primary care settings.

Application and Limitations

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage policies and payer priorities. The information herein is as specific as possible while acknowledging these variations in local payment and delivery landscape and operational diversity across organization settings. Guidance on how to adapt this information to your local landscape is highlighted throughout this brief in the *Implementation Considerations* subsections.

This brief and series overall will primarily focus on fee-for-service (FFS) financing considerations for care coordination and care management. Despite this FFS lens, the guidance that follows is broadly applicable to organizations that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, acknowledging that FFS costing considerations are often the financial benchmark to structure alternative payment mechanisms.

Please note this module is accurate as of publication date (November 2022).

Local Payer Landscape and Coding Considerations

Please note that this module focuses on nonlaboratory screening and assessment. Organizations interested in laboratory screening within the context of integrated care should check out the Metabolic Monitoring module.

While there is widespread understanding of the value of integrated care among most payers, major barriers to cross-discipline screening remain, including antiquated restrictions on the extent to which specific professional disciplines and facility settings can seek reimbursement for screening and assessment. Despite these possible limitations, screening and assessment services are broadly covered by Medicare, Medicaid and qualified health plan benefit designs. There may also be restrictions on

the extent to which professional disciplines seek reimbursement for patient education and risk reduction counseling. For example, in an initial intake with a new client, a psychiatrist could notice that the client is living with obesity and high blood pressure. Depending on their local payer landscape and their organization's payer contracts, they may not be able to seek reimbursement for nutritional counseling or other risk-reduction interventions. Likewise, psychiatric assessments might face coverage limitations by a primary care physician.

Mental Health and Substance Use Screening in Primary Care Settings Considerations

Generally, mental health screenings for common conditions such as depression and anxiety for new and existing patients in primary care settings will often be covered under standard intake codes (CPT 99201-99215). Some payers may separately reimburse for behavioral screenings and assessments under CPT 96127, which covers administration of standardized instruments for brief emotional/behavioral assessments such as those for depression, anxiety, suicide risk, eating disorders, substance abuse and/or attention-deficit/hyperactivity disorder (ADHD). While screening for tobacco use is typically not separately reimbursable, providers can use 99406 or 99407 to bill for smoking and tobacco use cessation and counseling services. Organizations may also seek higher reimbursement for patients that require higher level of medical decision making (MDM). This may be appropriate for patients living with mental health and substance use challenges. Organizations are encouraged to review the payer contracts for additional specificity regarding MDM levels salient to their care setting.

In addition to mental health screening, there are specific CPT codes for integrated screening, brief intervention and referral to treatment (SBIRT) for substance use disorders that can be applied in a primary care setting. Table 1 below notes these specific codes by payer.

Table 1. SBIRT Codes by Payer

PAYER	CODE	DESCRIPTION
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes.
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes.
	Please note that 99408/9 often require modifiers for the purposes of billing. Modifiers 25 and 29 may be opportunities for non-prescribers to offer SBIRT services.	
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes.
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes.
Medicaid	H0049	Alcohol and/or drug screening.
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes.

Primary Care Screenings in Mental Health and Substance Use Treatment Settings

Organizations are encouraged to review the extent to which their payer contracts allow for reimbursement of primary care assessment in mental health or substance use treatment settings and the extent to which their staffing mix is allowed to seek reimbursement for specific services. Additionally, residential and intensive outpatient services may allow for primary care screening as part of a bundled or episodic payment arrangement. Despite these restrictions, there are several physical health

screenings that may be broadly applicable to mental health and substance use treatment organizations. A sample of these screenings are in Table 2.

Health care provider assessments of weight, body mass index (BMI), blood pressure and waist circumference are typically not reimbursed separately, but rather are included as part of a standard evaluation and management visit codes (e.g., 99201-99205, 99211-99215). However, some insurers have started reimbursing separately for documentation of BMI (e.g., CPT code 3008F) as well as ambulatory blood pressure monitoring (e.g., CPT codes 93784, 93786, 93788, and 93790). For more details on billing considerations specific to metabolic monitoring for individuals on antipsychotic treatment, see *Integrated Care Financing Series Module 4: Metabolic Monitoring*.

Table 2. Sample of Primary Care Screening Covered

SCREENING/CONDITION	CPT CODE	DESCRIPTION
HIV	86701	HIV 1; single result (RAPID)
	86702	HIV 2, single result (RAPID)
	86703	HIV 1 & HIV 2; single result (RAPID)
	86689	HIV confirmatory (Western Blot)
Hepatitis C	86701.92	Antibody with reflex to quantitative real-time PCR
Pregnancy	81025	Urine pregnancy test
COVID-19	87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2
Tuberculosis (TB)	86481 99211, 99212, 99213	T-SPOT test for TB; in vitro diagnostic test for effector T cells activated by mycobacterium tuberculosis For care coordination and treatment options after positive test

Closing

Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

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