American Academy of Nursing on Policy

Removing reimbursement barriers to increase the use of screening, brief intervention, and referral to treatment to prevent risky alcohol use

Better preparation and positioning of nurses to identify and address modifiable risks associated with preventable behavioral health care issues is one of the strongest and most feasible actions that can be taken by health care providers to reduce harm from alcohol use. (This recommendation was a product of the "Harm Reduction To Transform Health Care" Policy Dialogue presented at the 2013 American Academy of Nursing annual meeting.) One modifiable risk that affects the health of about 25% of the U.S. population is risky alcohol use, which is associated with >200 illnesses and injuries and accounts for 5.1% of the global burden of disease (Centers for Disease Control and Prevention [CDC], 2014; World Health Organization [WHO], 2014). The Affordable Care Act provides a strong incentive to reduce risks through the preventive services provision that requires qualified health plans and Medicare to cover screening, brief intervention, and referral to treatment (SBIRT) with no cost sharing to enrollees. In addition, the WHO (2014) affirmed that "Health services play a critical role in tackling alcohol-attributable harm…" and recommends the use of SBIRT (pp. 63). Unfortunately, reimbursement for SBIRT has not been fully implemented.

It is essential to identify barriers if public policy is to be changed. This policy brief focuses on reimbursement barriers to full implementation of SBIRT and identifies several key policy changes needed immediately to increase the use of SBIRT as an evidence-based strategy to reduce harm associated with risky alcohol use. Addressing reimbursement is an essential first step to meet the WHO policy recommendations for health services. This policy change will result in increased capacity to deliver both prevention and treatment services to persons who report levels of alcohol consumption that place them at-risk for health problems.

Alcohol Use Prevalence and Attributable Harm

Alcohol-attributable harm occurs across the continuum of alcohol use. At-risk alcohol use is defined as drinking alcohol above recommended National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommendations; these are no more than three drinks in a day AND no more than seven drinks per week for healthy adult women and for men and women aged >64 years and no more than four drinks in a day AND not >14 drinks per week for healthy adult men aged <65 years. For pregnant women and those ages younger than 21 years, any alcohol use is considered at-risk. Binge drinking is defined as drinking five or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days, whereas heavy drinking is defined as drinking five or more alcoholic drinks on the same occasion on each of five or more days in the past 30 days (NIAAA, 2015b). Alcohol use disorder is a diagnostic term that applies once a clinician has determined that a patient meets the criteria as specified by the Diagnostic Statistical Manual V (American Psychiatric Association, 2015). According to National Institute on Alcohol Abuse and Alcoholism, slightly >7% of the population has an alcohol use disorder. Yet, alcohol is the third leading cause of preventable death in the United States with almost 88,000 alcohol-related deaths per year attributable to alcohol (CDC, 2014; NIAAA, 2015a). In 2013, 52.2% of Americans aged 12 years or older reported current alcohol use, and almost one quarter engaged in binge drinking (22.9%), and 6.9% reported heavy drinking (Substance Abuse and Mental Health Services Administration, 2014). However, there is little public awareness of the negative impact of alcohol use on health even without an alcohol use disorder (WHO, 2014). Those who engage in at-risk drinking are at increased risk for multiple adverse health outcomes such as cancer, injury, stroke, and communicable diseases (WHO, 2014). The economic effects of heavy or binge drinking cost the U.S. $223.5 billion a year in health care costs, lost productivity, burden to the justice system, and property losses (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). Thus, identification and early intervention with individuals who consume alcohol above the recommended limits has the potential to reduce the burden of disease attributable to at-risk alcohol use.

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SBIRT Definition

SBIRT is promoted by the Substance Abuse and Mental Health Services Administration as an evidence-based and reimbursable intervention that can be successfully implemented for the purposes of large-scale community-based primary care screening. The intervention is structured to be a brief intervention focusing on motivating individuals' toward behavioral change and identification of the appropriate level of treatment. More than 180 independent studies demonstrated that SBIRT procedures significantly reduced at-risk alcohol use and alcohol-related problems for adolescents and adults (Tanner-Smith & Lipsey, 2015). The United States Preventative Task Force Services (USPTF) provide a B rating for SBIRT, indicating that there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial (U.S. Preventive Services Task Force, 2013). The Affordable Care Act includes SBIRT and related brief interventions, such as motivational interviewing, as preventive health services for all insured individuals aged 11 years and older. However, the uptake and implementation of SBIRT has been slow because of a series of barriers, one of which is reimbursement.

Reimbursement Barriers

SBIRT could be more rapidly adopted and implemented by changing policies that restrict the use of the SBIRT HCPCS codes. SBIRT is a well-established, effective, evidence-based approach that can be delivered in 5 to 15 min (Babor et al., 2007). The range of barriers that have slowed adoption of SBIRT includes many associated with the existing operational guidelines for using the Current Procedural Terminology (CPT) billing codes. These include the following:

- For commercial insurers (Level 1 HCPCS/CPT codes) and Medicare codes ("G" codes), the minimum time documentation for SBIRT delivery is 15 min, delivered by licensed independent practitioners who are not psychiatric or mental health specialists (LIP; e.g., primary care MDs, nurse practitioners, physician assistants).
  - There is a mismatch between SBIRT and the billing code criteria for reimbursement of SBIRT. An SBIRT procedure takes 5 to 15 min to complete, but Level 1 HCPCS/CPT codes require clinical documentation of an SBIRT procedure lasting at least 15 min for reimbursement by private payers and Medicare.
  - Level 1 HCPCS/CPT codes for SBIRT allow only reimbursement for primary care LIPs. Registered nurses are not included as LIPs, thus the largest component of the frontline primary care health workforce is eliminated from reimbursement for SBIRT. SBIRT is designed and has been studied however, as being administered by generic nonpsychiatric specialist providers such as generalist, registered nurses. The requirement that only primary care LIPs administer SBIRT to bill for the procedure is neither cost nor time effective for most practice settings.
  - Not all commercial payers reimburse nonphysician LIPs (e.g., nurse practitioners, nurse midwives, physician assistants) for SBIRT.
- Medicaid uses either HCPCS Level 1 and/or Level 2 codes for reimbursement.
  - Only 23 states have assigned reimbursement to SBIRT HCPCS Level 1 or Level 2 codes.
  - Under Level 1 code, no minimum time exists for screening, but only nine states currently offer reimbursement using this code.
  - Thirteen states have activated either HCPCS Level 1 or Level 2 codes for Medicaid but have not assigned any reimbursement to the codes.
  - Some nonphysician clinical psychologists in primary care settings may use Health Behavior Assessment and Intervention (HBAI) codes that require documentation of at least 15 min of SBIRT procedure for Medicaid reimbursement in 23 states.
  - There are "same-day restrictions" on HBAI codes in some states. Thus, authorized HBAI providers cannot bill for SBIRT on the same day that a different provider bills for other health service(s). This policy discourages providers from adding SBIRT to their current screening batteries.

Nursing Can Be Part of the Solution

Research literature demonstrates that completion of SBIRT education programs results in generalist registered nurses effectively delivering SBIRT (Broyles et al., 2013a; Broyles, Kraemer, Kengor, & Gordon, 2013b; Puskar et al., 2013; Strobbe, Perhats, & Broyles, 2013). Registered nurses are the largest qualified health care workforce (more than three million RNs) available to implement SBIRT processes in primary care (Finnell et al., 2014). In addition, registered nurses practice in settings that have great potential for risk reduction and injury prevention; examples include outpatient settings, collegiate and school-based clinics, and emergency departments. Nursing organization support and collaboration in expanding education and taking action to reduce barriers can directly influence the adoption of SBIRT as the need for a broader scope of SBIRT implementation is substantial. If health care providers are to meet the WHO recommendation for expanded capacity of health care services for delivery of prevention services such as SBIRT, the following actions and policies will potentially reduce the harm associated with risky alcohol use.

Recommendations for organizations that regulate or provide reimbursement to remove barriers to SBIRT implementation, including commercial insurance carriers, national-level third-party reimbursement insurers, state health insurance commissioners, state

health insurance advisory boards, and CMS and State Medicaid administrators:

- Allow reimbursement to agencies for SBIRT delivered by registered nurses. Reimburse the facilities or institutions for nurse-delivered SBIRT using the appropriate additional CPT codes versus including this in the evaluation and management CPT code reimbursement.
- Include primary care advanced practice registered nurses and all registered nurses as qualified for direct SBIRT reimbursement by private and public payers.
- Allow same-day billing for SBIRT screens by nonphysician clinicians using HBAI codes across all 50 states.
- Alter the current billing code requirements to accurately reflect the time required to administer the SBIRT intervention.
  - Set the billing code criteria to 5 to 15 min at a maximum for SBIRT administration and allow use of "incident to" billing codes.
- The states (13) using at least one HCPCS SBIRT code should assign reimbursement value to the codes. States should be encouraged to set a reimbursement amount for the SBIRT codes reflective of the time and expertise required for SBIRT.
- States that have not activated any HCPCS SBIRT codes for Medicaid reimbursement should activate codes and assign appropriate reimbursement values.

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REFERENCES

American Psychiatric Association. (2015). *Diagnostic and statistical manual of mental disorders*. DSM-5 (5th ed.).

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K., & Bray, J. (2007). Screening, brief intervention, and referral to treatment (SBIRT). *Substance Abuse, 28*(3), 7–30.

Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon, C. J., & Brewer, R. D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine, 41*(5), 516–524.

Broyles, L. M., Gordon, A. J., Rodriguez, K. L., Hanusa, B. H., Kengor, C., & Kraemer, K. L. (2013a). Evaluation of a pilot training program in alcohol screening, brief intervention, and referral to treatment for nurses in inpatient settings. *Journal of Addictions Nursing, 24*(1), 8–19.

Broyles, L. M., Kraemer, K. L., Kengor, C., & Gordon, A. J. (2013b). A tailored curriculum of alcohol screening, brief intervention, and referral to treatment (SBIRT) for nurses in inpatient settings. *Journal of Addictions Nursing, 24*(3), 130–141.

Centers for Disease Control and Prevention (CDC). (2014). *Vital signs: Alcohol screening and counseling*. Retrieved from http://www.cdc.gov/vitalsigns/alcohol-screening-counseling/index.html.

Finnell, D. S., Nowzari, S., Reimann, B., Fischer, L., Pace, E., & Goplerud, E. (2014). Screening, brief intervention, and referral to treatment (SBIRT) as an integral part of nursing practice. *Substance Abuse, 35*(2), 114–118.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2015a). *Alcohol facts and statistics*. Retrieved from http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2015b). *Drinking levels defined*. Retrieved from http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking.

Puskar, K., Gotham, H. J., Terhorst, L., Hagle, H., Mitchell, A. M., Braxter, B., & …, Burns, H. K. (2013). Effects of screening, brief intervention, and referral to treatment (SBIRT) education and training on nursing students' attitudes toward working with patients who use alcohol and drugs. *Substance Abuse, 34*(2), 122–128.

Strobbe, S., Perhats, C., & Broyles, L. M. (2013). Expanded roles and responsibilities for nurses in screening, brief intervention, and referral to treatment (SBIRT) for alcohol use. *Journal of Addictions Nursing, 24*(3), 203–204.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *The NSDUH report: substance use and mental health estimates from the 2013 National Survey on Drug Use and Health: Overview of findings*. Rockville, MD: Author.

Tanner-Smith, E. E., & Lipsey, M. W. (2015). Brief alcohol interventions for adolescents and young adults: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment, 51*, 1–18.

U.S. Preventive Services Task Force. (2013). *Recommendation summary*. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care?ds=1&s=Alcohol.

World Health Organization (WHO). (2014). *Global status report on alcohol and health 2014*. Retrieved from http://www.who.int/substance_abuse/publications/global_alcohol_report/en/.