PREVENTIVE SERVICES AND CHRONIC DISEASE MANAGEMENT AND HEALTH TRACKS EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) POLICY

PURPOSE

Preventive care is a key component to member wellness. North Dakota Medicaid covers preventive services including many A and B grade recommendations from the United States Preventive Services Task Force (USPSTF), recommended immunizations by the Advisory Committee on Immunization Practices (ACIP), and Bright Futures/American Academy of Pediatrics (AAP) recommendations.

Preventive Services covered in this policy:

- Health Tracks/Well-Child Checks
- Adult Well Visits/Screenings
- Sports Physicals
- Standalone Immunization/Vaccine Counseling
- Diabetes Self-Management and Training Services
- «Self-Monitoring Blood Pressure for Hypertension»
- Medical Nutrition Therapy
- Tobacco Cessation Counseling
- Preventive Medicine Counseling Risk Factor Reduction
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

PREVENTIVE MEDICINE SERVICES

Staying current with recommended wellness visits is key to early prevention and treatment of health issues. Preventive medicine services are comprehensive and relate to the age of the patient.

Components of preventive medicine visits

- Comprehensive history and physical exam findings, and
- Age-appropriate
  - counseling/anticipatory guidance/risk factor reduction interventions,
  - screening labs,
  - and tests.

Preventive visits have no major complaint or illness as their focus. Providers should perform a comprehensive:

- system review
- past, family, and social history
- assessment
- history of pertinent risk factors

These components differ from a problem-focused exam because they are based on the patient's age and risk factors.

A small or unimportant problem or abnormality that comes up during a preventive medicine evaluation and management (E/M) service should not be reported unless it requires:

- additional work and
- the performance of key components of a problem-oriented E/M service.

HEALTH TRACKS BENEFIT

In North Dakota, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is known as Health Tracks. Health Tracks benefit focuses on early and periodic screening for, and treatment of, discovered conditions for youth through age 20. The benefit also ensures youth can access and use health resources.

WELL-CHILD VISITS

Well-child visits in North Dakota are included in the Health Tracks benefit.

Health Tracks uses the Bright Futures Well Child Periodicity Schedule for how often youth should have well-child visits. The Bright Futures schedule includes descriptions of recommended age-appropriate components.

Recommended Health Tracks/EPSDT Periodicity Schedule:

Newborn	2 months	9 months	18 months	Age 3 through age 20, annually
3-5 days	4 months	12 months	24 months	
1 month	6 months	15 months	30 months	

Inter-periodic Visits

Inter-periodic checkups (check-ups outside the periodicity schedule) should be billed the same as periodic check-ups.

HEALTH TRACKS/WELL-CHILD CHECKS SERVICE REQUIREMENTS

Health Tracks includes a comprehensive prevention and treatment system, to:

- Identify eligible children and provide information about the benefits of prevention and the types of assistance available.
- Help children and their families use health resources.
- Assess the child's health needs through initial and periodic check-ups; and
- Assure that discovered health problems are diagnosed and treated early, before they become complex, and their treatment becomes more costly.

All screening tools must be evidence-based. This policy contains a list of recommended screening tools.

Required components of a Health Tracks well-child visit:

- Comprehensive health and developmental history including assessment of physical and mental health development, including substance misuse disorders. See
  - Bright Futures Commonly Used Screening Tools and
  - Developmental Screenings«[1]*»
- Per federal requirements, a physical exam performed with infants unclothed, «and older children unclothed and suitably draped.»
- Appropriate immunizations«[1]» according to the Vaccine and Immunization Schedule established by the Advisory Committee on Immunization Practices (ACIP) for vaccines,
- Dental screenings are considered part of a Health Tracks/well-child visit and cannot be billed separately
- Ordering necessary laboratory tests«[1]» (including Lead Toxicity screening as appropriate for age and risk factors), and
- Health education to both children and their caregivers.
- **Lead Toxicity Screening** – The Centers for Disease Control and Prevention (CDC) recommends testing blood for lead exposure. All children are considered at risk and must be screened for lead toxicity. Federal requirements dictate that all children eligible for Medicaid have a screening blood lead test completed at 12 months and 24 months of age. Medicaid-eligible children between the ages of 36 months and 72 months of age must have a blood lead test if they have not been previously screened for lead toxicity.

  The CDC recommends health care providers use either a capillary or venous sample for the initial blood level. If the capillary results are equal to or greater than 3.5 ug/dl, a venous sample should be collected. All blood lead level results are included in the mandatory reportable conditions per ND Administrative Code § 33-06-01-01 Reportable Conditions. The Childhood Lead Poisoning Evaluation Questionnaire (SFN 59322) can be utilized for children screened at ages outside the ranges noted above. Additional information available on testing for Blood Lead Levels in Children and Childhood Lead Poisoning Prevention.

[1] *«Note: ND Medicaid allows for this service to be billed under a separate CPT® code when provided in conjunction with a wellness visit.»*

The following services may be billed separately from a well-child visit and are encouraged as appropriate:

- Fluoride Varnish
- Maternal Depression Screenings
- Other necessary diagnostic services.
- «As of 01/01/2025, vision, and hearing screenings will be separately reimbursed when billed in conjunction with an E/M service or S0302.»

Health Tracks/Well-Child Checks codes

Provider Type	Revenue Code	Procedure Code
FQHC	0521	S0302 or 9938X / 9939X
RHC	0521	S0302 or 9938X / 9939X
IHS	0519	S0302 or 9938X / 9939X
LPHU	N/A	S0302
All other providers	N/A	S0302 or 9938X / 9939X

S0302 - Health Tracks screenings

9938X/9939X - new or established well child exam – comprehensive preventive medicine evaluation and management service

SPORTS PHYSICALS

«Sports physicals should be coded as CPT® code 99429-unlisted preventive service along with ICD-10-CM code Z02.5. If the child has not had a well-child visit in the last year a well-child visit should be performed along with the sports physical. When a well child visit and a sports physical occur at the same visit the provider should bill the well-child visit only.»

DIAGNOSIS

When a Health Tracks/well-child visit indicates the need for further evaluation of a child's health, appropriate diagnostic services must be provided, and a referral should be made without delay. Appropriate follow-up must also occur to make sure that the member receives a complete diagnostic evaluation.

TREATMENT

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening or diagnostic procedure.

DOCUMENTATION REQUIREMENTS

Documentation must capture all Bright Futures visit components, including:

- Comprehensive health and developmental history, to include social/behavioral/mental health screenings;
- Health education/anticipatory guidance;
- Comprehensive physical examination;
- Immunizations received;
- Lead screening;
- Hearing screening;
- Vision screening;
- Dental screening including fluoride varnish; and
- Laboratory tests and results.

Please see Documentation Guidelines section in the Provider Requirements policy.

DEVELOPMENTAL SCREENINGS AND BREIF BEHAVIORAL ASSESSMENTS

ND Medicaid covers the following developmental screenings and behavioral assessments when billed in conjunction with a preventive medicine service, E/M service, or a Health Tracks service.

CPT ® code 96110 - Developmental screens (e.g., developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument

Instrument	Abbreviation
Ages and Stages Questionnaire - Third Edition	ASQ-3
Modified Checklist for Autism in Toddlers	M-CHAT or M-CHAT-R/F
Parents' Evaluation of Developmental Status	PEDS
Survey of Well-being of Young Children	SWYC

*Use KX modifier for M-CHAT screenings.

CPT ® code 96127 - Brief emotional/behavioral assessments (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Ages and Stages Questionnaire: Social-Emotional 2nd Edition	ASQ:SE-2
Ask Suicide-Screening Questions	ASQ
Baby Pediatric Symptoms Checklist	BBSC

Columbia -Suicide Severity Rating Scale	C-SSRS
Patient Health Questionnaire	PHQ-2, PHQ-9 or PHQ-A
Patient Safety Screener	PSS-3
Pediatric Symptom Checklist	PSC, PSC-Y or PSC-17
Preschool Pediatric Symptoms Checklist	PPSC
Strength and Difficulties Questionnaire	SDQ

«Note: Screening to Brief Intervention (S2BI), Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT), and Brief Screener for Alcohol, Tobacco, and Other Drugs are SBIRT (Screening, Brief Intervention, Referral to Treatment) screenings and may only occur if services meet SBIRT requirements. See SBIRT section of this policy for more information.»

ND Medicaid aligns with the American Academy of Pediatrics (AAP) Bright Futures guidelines which recommends universal screening for developmental concerns, behavioral/social/emotional concerns, maternal depression, adolescent depression and suicide risk, substance use, or oral health concerns. The table above provides a list of tools for use at specific Bright Futures visits as well as screening and assessment tools for use at the discretion of the health care professional. For more information refer to Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools | AAP Toolkits | American Academy of Pediatrics

MATERNAL DEPRESSION SCREEING

ND Medicaid reimburses maternal depression screenings as a separate service when performed in conjunction with a Health Tracks visit/well-child check, or any other pediatric visit, as a risk assessment for the child. All mothers with a ND Medicaid-eligible child under the age of one should be screened for maternal depression.

Coverage Criteria

Screen any time within the child's first year. American Academy of Pediatrics – Bright Futures guidelines recommend screening at the 1-month visit, 2-month visit, 4-month visit, and 6-month visit. For more information refer to Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools

Providers must use one of the following standardized screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire - 9 (PHQ-9) Screener

Billing Requirements

When a Maternal Depression Screening occurs during a Health Tracks visit/well-child check or other pediatric office visit for an eligible child under one year of age, the following guidelines apply:

- Bill using the child's North Dakota Medicaid member ID number.

CPT Code
96161 - Administration of a caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.

ICD10-CM Covered Diagnosis
Z00.110 Health Examination for a newborn under 8 days old
Z00.111 Health Examination for a newborn 8 to 28 days old
Z00.121 Encounter for routine child health exam with abnormal findings
Z00.129 Encounter for routine child health exam w/out abnormal findings

Limits
Up to four (4) Maternal Depression Screenings for a child up to age one.

FLUORIDE VARNISH
Dental Office

Application of fluoride varnish is covered for members ages 6 months through 20 years old. There is a maximum of three (3) applications^ (of either D1206 or D1208 or a combination) per year, per member when performed in a dental office.

CDT® Codes	Code Description
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride – excluding varnish

Outside of a Dental Office

Application of fluoride varnish performed in a non-dental clinic or facility setting is covered for members ages 6 months through 20 years old. A maximum of two (2) applications^ per year, per member is covered. It is recommended the fluoride varnish be applied at the time of a Health Tracks/well-child check.

CPT® Code	Code Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional when performed in a non-dental clinic or facility setting

^Dental office and non-dental office service limits are separate, meaning a child can get up to five (5) fluoride varnish applications per year (three (3) in a dental office and two (2) outside of a dental office).

Dentists, physicians, and physician assistants may bill ND Medicaid for the application of fluoride varnish in accordance with their scope of practice and any rules adopted by their respective licensing boards.

The following practitioners may bill ND Medicaid for the application of fluoride varnish after receiving training approved by the North Dakota Board of Dental Examiners:

- Nurse Practitioners
- Registered Nurses and Licensed Practical Nurses under the supervision* of a physician, family nurse practitioner, or physician assistant
- Registered Dental Hygienist or Registered Dental Assistant under the supervision* of a licensed dentist.

*Supervision requirements are dictated by state law, administrative rules, and the applicable licensing boards.

ICD-10-CM Covered Diagnosis

Z00.121 Encounter for routine child health examination with abnormal findings

Z00.129 Encounter for routine child health examination without abnormal findings

Z29.3 Encounter for prophylactic fluoride administration.

Z41.8 Encounter for other procedures for purposes other than remedying health state

Additional Resources

Benefits of Fluoride Varnish FAQ

Information Sheet: Dental Fluoride Varnish Comparison

STAND-ALONE IMMUNIZATION/VACCINE COUNSELING

Stand-alone visits for vaccine counseling visits related to all pediatric vaccines for all members under the age of 21 are covered when provided by a qualified health professional. *See* the Immunizations «policy» for more information.

WELL ADULT VISITS

Preventive Services

Preventive services performed at adult annual wellness visits vary based on the patient's age and risk factors. Visits may include:

Cancer

- Breast cancer screening (mammogram)
- Cervical cancer screening (women ages 21-65)
- Colorectal cancer screening (adults ages 45-75)
- Lung cancer screening (adults ages 50-80 with history of smoking)
- Skin cancer prevention

Chronic Conditions

- Abdominal aortic aneurysm screening (men 65-75 who have ever smoked)
- Depression screening and follow-up plan
- Hepatitis B infection screening (adults at risk of increased infection)
- Hepatitis C screening (adults ages 18-79)
- Hypertension/High blood pressure screening
- Latent Tuberculosis (TB) infection screening (adults at increased risk)
- Osteoporosis screening (women ages 65+, high risk women <60)
- Prediabetes and Type 2 Diabetes screening (adults 35-70 who are overweight or obese)
- Statin use for prevention of cardiovascular disease (adults ages 40-75)

Health Promotion

- Fall prevention in older adults (ages 65+)
- Healthful diet and physical activity for cardiovascular disease counseling
- Tobacco use cessation interventions
- Intimate partner violence screening and counseling
- Unhealthy drug and/or alcohol use screening and behavioral counseling interventions
- Screening for anxiety

Reproductive Health

- Chlamydia and Gonorrhea screening (sexually active women 24 and younger, older women at risk)
- Contraceptive services and counseling, including postpartum women
- Human immunodeficiency virus (HIV) screening (adults ages 21-65 and others at increased risk)
- Sexually Transmitted Infections (STI) counseling (adults at high risk; all sexually active women)
- Syphilis screening (adults at increased risk)

Pregnancy & Postpartum

- Breastfeeding services and supplies
- Breastfeeding primary care interventions
- Folic acid supplement to prevent neural tube defects
- Healthy weight and weight gain in pregnancy, behavioral counseling interventions
- Interventions for tobacco smoking cessation
- Screenings
    - Asymptomatic bacteriuria
    - Depression
        - Maternal depression screening (CPT© code 96161) performed in conjunction with a child's Health Tracks screening, Well-Child, or any other pediatric visit, as a risk assessment for the child anytime within the child's first year.
    - Gestational diabetes and diabetes mellitus after pregnancy
    - Hepatitis B
    - HIV
    - Preeclampsia
    - Rh(D) incompatibility
    - Syphilis

Well-Woman Care

Recommendations for preventive health care screenings and services for well-woman visits can be found at the Women's Preventive Services Initiative (WPSI).

Coverage for Colorectal Cancer Screening Services

Description of Service	Age, Frequency and Risk Criteria
Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) 82270, 82272, 82274, or G0328	Ages 45 to 85; once every 12 months
Multi-target stool DNA test - Cologuard™ 81528 and G0464	Ages 45 to 85; once every 3 years for asymptomatic, average risk individuals

Screening Colonoscopy, Sigmoidoscopy or Barium Enema G0105, G0104 or G0120 45378, 45380, 45381, 45382, 45384, 45385, 45388, 45389, 45390, 45391, 45392, 45393, 45398	High-risk individuals*: No minimum age requirement; once every 24 months
Screening Colonoscopy, Sigmoidoscopy or Barium Enema G0121 or G0104 45378, 45380, 45381, 45382, 45384, 45385, 45388, 45389, 45390, 45391, 45392, 45393, 45398	Average risk individuals: ages 45 to 85; once every 10 years

Note to providers: If during a screening colonoscopy or sigmoidoscopy, a lesion/growth is detected which results in biopsy/removal of growth, the appropriate diagnostic procedure classified as colonoscopy with biopsy/removal should be billed rather than the screening procedure. Diagnostic and therapeutic colonoscopies are also covered by ND Medicaid.

If the results of a stool test are positive or abnormal, the member's follow-up colonoscopy is part of the screening process and not a diagnostic procedure.

*According to the Centers for Medicare and Medicaid Services, a patient is high-risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps; or
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

«Billing guidance applicable to all well-checks
Screenings with identified CPT® codes are separately billable from the well-check visit.»

Per CPT® "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99202-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

The provider's electronic signature on the claim is the attestation of the medical necessity of both services, including an assurance that the following requirements are met.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

- Provider documentation must support billing of both services. Providers must create separate notes for each service rendered in order to document medical necessity.
- In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during a Health Tracks/adult wellness visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.
- All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.
- The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph that clearly describes the specific condition requiring evaluation and management.
- The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

LIMITATIONS

- ND Medicaid will not reimburse HCPCS code S0302 – EPSDT screening, and CPT code 9938x/9939x – Preventive Medicine Services on the same date of service.
- Adult wellness screenings are limited to one per calendar year.

DIABETES SELF-MANAGEMENT AND TRAINING (DSMT) SERVICES

Diabetes self-management and training (DSMT) services may be provided by pharmacists, and licensed registered dieticians and registered nurses with diabetic educator credentialing.

BILLING GUIDELINES

- G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes.
- G0109 – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Diabetic educator credentialed registered nurses are not ND Medicaid-enrollable providers for these services. This service is billed incident-to the licensed supervising practitioner.

«SELF-MONITORING BLOOD PRESSURE FOR HYPERTENSION

Blood pressure self-monitoring may be ordered by a member's physician, pharmacist or Other Licensed Practitioner.

At-home self-monitored blood pressure monitoring may be medically necessary to:

- Differentiate between hypertension occurring due to being in the doctor's office for the measurement (i.e. "white coat hypertension") and
- to help monitor variation in blood pressure measurements and appropriately adjust treatment protocols to avoid "overtreatment". The second reason also can result in more adherence to treatment.

Covered Services

Members must use a validated blood pressure device (CPT® A4670) from the Validated Device List – Blood Pressure Devices for blood pressure self-monitoring.

Patient Education and Training

Members may receive a one-time per monitor education and training on the set-up (CPT® code 99473) and use of a self-monitoring blood pressure (SMBP) measurement device, which includes device calibration.

SMBP Data Collection and Interpretation

CPT® code 99474 is used for members who self-measure their blood pressure twice daily for a one-month period. Members are to take their blood pressure four times daily. Twice in the morning and twice in the evening, with a minute between each blood pressure reading.

Measurements must be communicated from the member to their treating provider's practice and can be recorded and transmitted manually or electronically. Treating

providers must then create or modify the member's hypertension treatment plan based on the documented average of the submitted readings. The new or modified treatment plan must be in the member's medical record and communicated back to the member. If this communication takes place during an E/M visit, this service is not separately billable.

COVERAGE LIMITATIONS
99473 – billed once per blood pressure measurement device. Cannot be billed separately if there is an E/M service billed by the same rendering provider on the same date of service.

99474 – may not be separately reimbursed when billed with an E/M service when performed on the same date of service by the same rendering provider. Member must have a minimum of twelve (12) readings in a calendar month to bill for this CPT code. Code may only be used once per calendar month per member.»

MEDICAL NUTRITION THERAPY
Medical nutrition therapy consists of counseling for individuals in relation to the nutritive and metabolic processes of the body. Medical nutrition therapy may be provided by Medicaid-enrolled licensed registered dieticians. If a licensed registered dietitian does not enroll with ND Medicaid, they may provide medical nutrition therapy under the supervision of a practitioner enrolled with ND Medicaid. Licensed registered dietitians rendering medical nutrition therapy under the supervision of a practitioner must follow "incident to" requirements.

COVERAGE LIMITATIONS
To receive payment, a licensed registered dietician must enroll as an independent Medicaid provider or be part of a clinic or FQHC.

Nutritional services are allowed up to four (4) hours per calendar year without service authorization. Additional services may be authorized if determined to be medically necessary.

COVERED SERVICES

HCPCS/ CPT Code	Description
G0270	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97804	Medical nutrition therapy, group (2 or more individuals), each 30 minutes

NONCOVERED SERVICES

- Exercise classes
- Nutritional supplements for the purpose of weight reduction
- Instructional materials and books

TOBACCO CESSATION COUNSELING

Tobacco cessation counseling is covered for all North Dakota Medicaid members.

SERVICE REQUIREMENTS

Counseling must be provided face-to-face by, or under, the supervision of a physician or other health care professional who is

- legally authorized to furnish such services under state law within their scope of practice, and
- enrolled as a ND Medicaid provider.

CPT© Code: 99406 – Smoking and tobacco cessation counseling visit; intermediate, greater than three minutes up to 10 minutes.

CPT© Code: 99407 - Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes.

PREVENTIVE MEDICINE COUNSELING RISK FACTOR REDUCTION

Counseling risk factor reduction services are for the purpose of promoting health and preventing illness or injury.

COVERED SERVICES & LIMITS

Preventive medicine counseling risk factor reduction services are face-to-face, time-based, and separate from E/M services. These are separate visits from preventive medicine visits (CPT® 99381-99397) which include counseling, anticipatory guidance, and risk-factor reduction interventions.

Prevention medicine counseling risk factor reduction services are for people without specific illnesses where the counseling might otherwise be part of the treatment.

Preventive medicine counseling and risk factor reduction interventions provided outside of a preventive medicine visit to promote health and illness/injury prevention may be reported using the codes in this policy. Services will vary with age and patient circumstances such as: family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory results available at the time of the encounter.

The following types of counseling and risk factor reductions are covered:

- Prevention of cavities in children younger than 5
- Healthy weight and weight gain in pregnancy
- Healthy diet and physical activity for cardiovascular disease prevention in adults with risk factors
- Sexually transmitted infections for adolescents and adults
- Tobacco use in adolescents and children
- BRCA-related cancer, risk assessment
- Perinatal depression
- Weight loss to prevent obesity and related morbidity and mortality in adults
- Falls prevention in community-dwelling older adults
- Skin cancer prevention – all ages
- Obesity in children and adolescents
- Breastfeeding

TELEHEALTH

Preventive medicine counseling and risk factor reduction may be rendered via telehealth. See Telehealth policy for telehealth requirements.

NONCOVERED SERVICES

- Cannot be billed as part of a preventive medicine visit (CPT® 99381-99395)
- Services lasting less than 8 minutes

BILLING AND REIMBURSEMENT

99401	15 minutes
99402	30 minutes

E/M services may be reported separately with a 25 modifier when performed with preventive medicine counseling risk factor reduction services.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is meant to prevent or reduce substance use through early intervention. This can prevent health-related consequences, diseases, accidents, and injuries related to substance use. SBIRT is an evidence-based, early intervention for people with substance use disorders and those at risk of developing those disorders.

COVERED SERVICES & LIMITS

Pre-Screening patients for substance use should occur as part of preventive and E/M visits. This screening is not separately billable but must precede SBIRT services. Screen all patients using this Brief Health Screen and follow the interpretation instructions. Patients with answers of "yes" or "1 or more" should receive full screens using validated, approved screening instruments listed in this policy.

SBIRT Components

SBIRT has three parts:

1) Screening:
   To assess a patient for risky substance use behaviors with standardized assessment tools. This shows a patient's substance use severity and identifies the appropriate treatment level.
2) Brief intervention:
   This allows a patient to be more aware and understanding of their substance use and motivates behavioral change. It is a short conversation between patient and provider to increase the patient's awareness of risky substance use behaviors. The provider gives feedback, motivation, and advice.
3) Referral to treatment:
   Refer patients who screen as needing additional services to brief therapy or specialty care treatment.

Approved SBIRT screening tools:

- World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- Opioid Risk Tool – OUD (ORT-OUD)

Tools specifically for Youth

- Screening to Brief Intervention (S2BI)
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)
- CRAFFT (ages 12-21)

Resource: SBIRT Toolkit (SBIRT (Early Intervention) | Health and Human Services North Dakota)

SBIRT Providers and Training
Providers must be trained and qualified to render SBIRT services within their scope of practice. Providers can complete an online SBIRT training if they have not received training on SBIRT.

Services may be rendered by health care professionals supervised by one of the below-listed licensed practitioners if trained and qualified to render SBIRT services within the scope of practice applicable to their profession, while following all applicable laws, rules, and board of practice regulations. Services must be billed by physicians, dentists, or providers considered Other Licensed Practitioners (currently LCSWs, LPCCs, LPCs, LMFTs, LACs, Licensed Psychologists, Nurse Practitioners, Physicians Assistants, and Clinical Nurse Specialists).

Limits
Members are limited to 4 SBIRTs per calendar year. Medically necessary SBIRTs beyond this limit require service authorizations.

Screening and counseling services are included in the comprehensive nature of preventive medicine visits (CPT® 99381-99397) and will not be separately reimbursed.

SERVICE AUTHORIZATION
Service authorization is required for SBIRTs exceeding the 4 per calendar year limit.

TELEHEALTH
SBIRT may be rendered via telehealth if providers document member pre-screening and the member's score which indicates the need for a full screen. Providers must also document the member's standardized assessment score. See Telehealth policy for telehealth requirements.

NON-COVERED SERVICES

- Pre-screens conducted as a part of preventive and E/M visits are not separately billable.
- SBIRT services lasting less than 15 minutes are not separately billable.

DOCUMENTATION REQUIREMENTS
Documentation must include:

- Screening instrument used and screening results;
- Brief intervention delivered; and
- Referral for further treatment if appropriate.

Documentation must support the time spent on this service, either the start and stop time or total time spent with the member.

BILLING AND REIMBURSEMENT

99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

INDIAN HEALTH SERVICES, TRIBAL HEALTH PROGRAMS, RURAL HEALTH CLINICS, AND FEDERALLY QUALIFIED HEALTH CENTERS

SBIRT is not a separately reimbursable service outside the all-inclusive rate/encounter rate.

RELATED POLICIES:

Immunizations
Telehealth

Updated: October 2024