



## SBIRT Services



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## What's Changed?

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- Added examples of locations where Medicare-eligible providers can perform SBIRT services (page 6)
- Updated the eligible providers information with coverage requirements and payment information (pages 6–23)
- Added marriage and family therapists (MFTs) and mental health counselors (MHCs) to list of eligible providers (page 15)
- Added information about telehealth flexibilities (page 17)
- Added information about evaluation and management (E/M) for medication management (page 17)

Substantive content changes are in dark red.

Medicare and Medicaid cover screening, brief intervention, and referral to treatment (SBIRT) services. [SBIRT](#) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders (SUDs) and people who are at risk of developing these disorders.

- We cover [alcohol misuse screening and counseling](#) (a preventive screening once per year for adults who use alcohol but don't meet criteria for alcohol use disorder (AUD); if you detect misuse, we cover up to 4 brief face-to-face counseling sessions per year if the Medicare patient is alert and competent during counseling).
- We cover an [annual depression screen](#) in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.
- We also cover [wellness visits](#). During these visits, physicians or other health care professionals review the patient's medical and social history related to their health, education, and counseling about preventive services. These include an SUD screening.
- We also cover several mental health services for SUD. [Medicare & Mental Health Coverage](#) explains qualifications, coverage, and payment guidelines, including inpatient treatment and the intensive outpatient treatment program (IOP).

[Medicare & Medicaid Basics](#) explores the Medicare- and Medicaid-covered service requirements.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Throughout this booklet, **we** refers to **CMS**.

### SBIRT Benefits

In primary care settings, systematically screen people who may not seek SUD help and offer SBIRT treatment services access to:

- Reduce health care costs
- Decrease drug and alcohol use severity
- Reduce physical trauma risks
- Reduce the percentage of patients who go without specialized treatment

## What's SBIRT?

SBIRT is an evidence-based, early detection and intervention approach for people with non-dependent substance use before they need more extensive or specialized treatment. This approach is different for people who are already diagnosed with an SUD.

**SBIRT has 3 major components:**



# 1

### **Screening:**

Screen or assess a patient for risky substance use behaviors with standardized assessment tools (known as Medicare Structured Assessment) to identify the appropriate level of care. Screening quickly assesses a patient's substance use severity and identifies the appropriate treatment level.



# 2

### **Brief Intervention:**

Brief intervention increases substance use insight and awareness and motivates behavioral change. Engage the patient in a short conversation to increase their awareness of risky substance use behaviors and provide feedback, motivation, and advice. We cover 1 preventive screening per year and up to 4 brief face-to-face counseling sessions per year at no cost to patients.



# 3

### **Referral to Treatment:**

Refer patients whose assessment or screening shows a need for additional services to brief therapy or specialty care treatment.

### **SBIRT Assessment & Screening Tools**

The first SBIRT element is assessment or screening. You may use tools, including the World Health Organization's [Alcohol Use Disorders Identification Test \(AUDIT\) Manual](#) and the [Drug Abuse Screening Test \(DAST\)](#). [SAMHSA Resources for SBIRT](#) has more SBIRT assessment and screening tools information.

The [Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition \(DSM-5\)](#) no longer uses the terms "substance abuse" and "substance dependence." Instead, it refers to "substance use disorders" (SUDs), classified as mild, moderate, or severe. The number of diagnostic criteria a person meets determines their severity level. [SAMHSA's Mental Health and SUDs](#) has common SUD facts. [SAMHSA's Behavioral Health Treatment Locator](#) helps you find mental health treatment facilities and programs around the country.

## Medicare-Eligible Providers

We pay for medically reasonable and necessary SBIRT services in both [physicians' offices and outpatient hospital settings](#), including public health centers, emergency departments, and primary and specialty care physicians' offices.

In these settings, assess and identify people with, or at risk for, substance use-related issues and provide limited interventions or treatment.

The following sections list individual SBIRT provider-type required qualifications, coverage, and payment criteria. Each provider type must meet all qualifications and coverage requirements.

### Physician

#### Required Qualifications

- [Legally authorized](#) to practice medicine in the state where you provide services
- Act within the scope of your license

#### Coverage Requirements

- We don't statutorily preclude the services, and they're reasonable and necessary
- Generally, in addition to performing tests, you may also supervise the performance of diagnostic psychological and neuropsychological tests
- You may have services and supplies provided incident to your personal professional services

#### Payment

Paid at 100% under the [Medicare Physician Fee Schedule \(PFS\)](#)



## Physician Assistant (PA)

### Required Qualifications

- [Licensed](#) by the state where you practice and 1 of these criteria apply:
  - Graduated from a PA educational program accredited by the [Accreditation Review Commission on Education for the Physician Assistant](#) (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation)
  - Passed a national certification exam administered by the [National Commission on Certification of Physician Assistants](#)



### Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if provided by a medical doctor (MD) or a doctor of osteopathy (DO)
- Someone who meets all PA qualifications provides the services
- You provide services under an MD or a DO's supervision
- You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under the PA benefit category and as authorized by state law; we authorize PAs to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

### Payment

- We pay only on assignment
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under [42 CFR 424.55](#)
  - If a patient paid for a service over these limits, refund their payment
- We pay for your professional services, including services and supplies provided incident to your services
- We pay for your professional services provided in all rural and non-rural settings and areas
- We pay only if no facility or other provider charges or we didn't pay any other service amount they provided

- We pay for services at 80% of the lesser of the actual charge or at 85% of the amount a physician gets under the [Medicare PFS](#)
- We pay for services provided incident to a PA outside a hospital at 85% of the amount a physician gets under the Medicare PFS
- When you bill a hospital inpatient and outpatient service directly, we unbundle the payment and pay you directly
- You can bill Medicare and we pay for your services directly like we do NPs and clinical nurse specialists (CNSs)
- You may reassign your service payment rights and incorporate as a group of practitioners only in your specialty and bill Medicare like NPs and CNSs
- Bill under your NPI

## Nurse Practitioner (NP)

### Required Qualifications

- Be a registered nurse (RN) [licensed](#) and authorized by the state where you provide NP services according to state law
- Be a registered professional nurse who's authorized by the state where you provide services to practice as an NP by December 31, 2000
- Got Medicare NP billing privileges for the first time since January 1, 2003, and:
  - NP certified by a recognized [national certifying body](#) with established NP standards
  - Master's degree in nursing or a Doctor of Nursing Practice Doctoral degree
- Got Medicare NP billing privileges for the first time before January 1, 2003, and meet certification requirements
- Got Medicare NP billing privileges for the first time before January 1, 2001



### Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services while working in collaboration with a physician

- You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under the NP benefit; we authorize NPs to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

## Payment

- We pay only on assignment
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under [42 CFR 424.55](#)
  - If a patient paid for a service over these limits, refund their payment
- We pay for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the [Medicare PFS](#)

## Clinical Nurse Specialist (CNS)

### Required Qualifications

- Be an RN currently [licensed](#) in the state where you practice and authorized to provide CNS services according to state law
- Doctor of Nursing Practice or master's degree in a defined clinical nursing area from an accredited educational institution
- Certified as a CNS by a recognized [national certifying body](#) with established CNS standards



### Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services while working in collaboration with a physician
- You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under the CNS benefit; we authorize CNSs to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

## Payment

- We pay only on assignment
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under [42 CFR 424.55](#)
  - If a patient paid for a service over these limits, refund their payment
- We pay for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the [Medicare PFS](#)

## Clinical Psychologist (CP)

### Required Qualifications

- Psychology doctoral degree
- [Licensed](#) or certified in the state where you practice at the independent level and directly provide diagnostic, assessment, preventive, and therapeutic patient services

### Coverage Requirements

- Legally authorized to practice psychology in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- If the patient consents, attempt to consult their attending or primary care physician about provided services and either:
  - Document the date the patient consented or declined consultation and the consultation dates in the patient's medical record
  - Document in the patient's medical record if consultations are unsuccessful with the date and the physician notification method (doesn't apply if the physician referred the patient to a CP)
- Generally, in addition to personally performing diagnostic psychological and neuropsychological tests, you may supervise the performance of diagnostic psychological and neuropsychological tests
- You may have services and supplies provided incident to your personal professional services



## Payment

- We pay only on assignment
- Paid at 100% of assigned services under the [Medicare PFS](#)

## Clinical Social Worker (CSW)

### Required Qualifications

- Social work master's or doctoral degree
- At least 2 years of supervised clinical social work
- [Licensed](#) or certified CSW by the state where you provide services
- If you practice in a state that doesn't have licensure or certification and you completed at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in social work practice in an appropriate setting (for example, a hospital, skilled nursing facility (SNF), or clinic)



### Coverage Requirements

- Legally authorized to practice clinical social work in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- You provide mental health services for diagnosing and treating a mental illness and you're legally authorized to perform them under state law
- We cover CSW hospital outpatient services and pay for CSW services under the CSW benefit category when hospitals bill under the CSW's NPI
- We don't pay under the CSW benefit category for CSW services to patients under a partial hospitalization program (PHP) or an IOP by a hospital outpatient department or community mental health center (CMHC)
- We may cover ancillary CSW services when provided as auxiliary personnel incident to the personal professional services of a physician, CP, CNS, NP, PA, or CNM
- We don't cover services provided incident to your personal professional services

### Payment

- We pay only on assignment
- Paid at 80% of the lesser of the actual charge for the service or 75% of the CP's [Medicare PFS](#)

## Certified Nurse-Midwife (CNM)

### Required Qualifications

- Be a RN [legally authorized](#) to practice as a nurse-midwife in the state where you provide services
- Successfully completed a nurse-midwives program of study and got clinical experience accredited by an accrediting body the U.S. Department of Education approves
- Certified as a nurse-midwife by the [American College of Nurse-Midwives](#) or the [American College of Nurse-Midwives Certification Council](#)

### Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services without physician supervision and without association with a physician or other health care provider, unless otherwise required under state law
- You may personally perform diagnostic psychological and neuropsychological tests without physician supervision or oversight as required under the CNM benefit category and as authorized under state law; we authorize CNMs to supervise diagnostic tests performed according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

### Payment

- We pay only on assignment
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under [42 CFR 424.55](#)
  - If a patient paid for a service over these limits, refund their payment
- We pay for services at 80% of the lesser of the actual charge, or 100% of the amount a physician gets under the [Medicare PFS](#)



## Independently Practicing Psychologist (IPP)

### Required Qualifications

- Psychologist who isn't a CP
- Meets 1 of these criteria:
  - Practices independent of an institution, agency, or physician's office and is licensed or certified to practice psychology in the state or jurisdiction where you provide the services
  - Practicing psychologist who [provides services](#) in a jurisdiction that doesn't issue licenses



### Coverage Requirements

- We don't statutorily preclude the services, and they're reasonable and necessary
- Provide services on your own responsibility, free of administrative and professional control of an employer (for example, physician, institution, or agency)
- You treat your own patients
- When you practice in an office in an institution:
  - The office is confined to a separately identified part of the facility used solely as an office and not confused as extending throughout the entire institution
  - You operate a private practice (patients outside an institution and non-institutional patients)
- You may perform diagnostic psychological and neuropsychological tests when a physician or certain non-physician practitioners (NPPs) order them
- You can bill directly and collect and retain service fees

### Payment

- We don't subject diagnostic psychological and neuropsychological tests to assignment; however, on the claim, include the name and address of the physician or NPP who orders the tests
- Paid at 100% of [Medicare PFS](#) for diagnostic tests

## Marriage and Family Therapist (MFT)

### Required Qualifications

- Master's or doctor's degree that qualifies for licensure or certification as an MFT according to the state law where you provide services
- [Licensed](#) or certified as an MFT in the state where you provide services
- After getting your degree, you complete at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in marriage and family therapy in an appropriate setting (for example, a hospital, SNF, or clinic)



### Coverage Requirements

- Legally authorized to practice as an MFT in the state where you provide services
- You may enroll in Medicare and bill Medicare independently beginning January 1, 2024
- You may also still provide services and supplies as auxiliary personnel incident to a physician's or certain NPP's personal professional service

### Payment

- We pay only on assignment
- We pay for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the [Medicare PFS](#)
- We don't pay under the MFT benefit category for MFT services to patients under a PHP or an IOP by a hospital outpatient department or CMHC

## Mental Health Counselor (MHC)

### Required Qualifications

- Master's or doctor's degree that qualifies for licensure or certification as an MHC according to the state law where you provide MHC services
- [Licensed](#) or certified as an MHC; a clinical professional counselor; an addiction, alcohol, or drug counselor; or a professional counselor in the state where you provide services
- After getting your degree and you complete at least 2 years or 3,000 hours of clinical supervised experience in mental health counseling

### Coverage Requirements

- Legally authorized to practice as an MHC in the state where you provide services
- You may enroll in Medicare and bill Medicare independently beginning January 1, 2024
- You may also still provide services and supplies as auxiliary personnel incident to a physician's or certain NPP's personal professional service

### Payment

- We pay only on assignment
- We pay for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the [Medicare PFS](#)
- We don't pay under the MHC benefit category for MHC services to patients under a PHP or an IOP by a hospital outpatient department or CMHC



## Medicare-Covered SBIRT Services

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We cover reasonable and necessary SBIRT services you provide to evaluate or treat patients with signs or symptoms of illness or injury, according to Section 1862(a)(1)(A) of the [Social Security Act](#).

We pay for these services under the Medicare PFS and the Hospital Outpatient Prospective Payment System. Section 200.6 of the [Medicare Claims Processing Manual, Chapter 4](#) has more Medicare SBIRT payment services information.

## Documenting Medicare SBIRT Services

The patient's medical record must support all Medicare claims. Incomplete records place you at risk for partial or full Medicare payment denial. The patient's medical record must:

- Be complete and legible
- Record start and stop times or total face-to-face time with the patient (some SBIRT HCPCS codes are time based)
- Document the patient's progress, response to treatment changes, and diagnosis revision
- Document the rationale for ordering diagnostic and other ancillary services, or ensure it's easily inferred
- For each patient encounter, document:
  - Assessment, clinical impression, and diagnosis
  - Date and legible provider identity
  - Physical exam findings and prior diagnostic test results
  - Plan of care
  - Encounter reason and relevant history
- Identify appropriate health risk factors
- Make past and present diagnoses accessible for treating and consulting physicians
- Have signatures for all services provided or ordered

Physicians, certified registered nurse anesthetists (CRNAs), PAs, CNMs, CNSs, NPs, **MFTs**, and **MHCs** may review and verify (sign and date), rather than re-document, notes in a patient's medical record from physicians; residents; nurses; medical, PA, and advanced practice registered nurse (APRN) students; or other medical team members, including, as applicable, notes documenting the physician's, CRNA's, PA's, CNM's, CNS's, NP's, **MFT's**, or **MHC's** presence and service participation.

### Medicare Telehealth Includes SBIRT Services

You can provide SBIRT services via [telehealth](#) if you meet all requirements.

We cover interactive telecommunications, including 2-way, interactive, audio-only technology, to diagnose, evaluate, or treat certain SUDs using telehealth services if the patient is in their home. You can provide telehealth using 2-way, interactive, audio-only technology through December 31, 2024. We'll pay telehealth services you provide to people in their homes at the non-facility PFS rate through December 31, 2024.

## Billing Medicare SBIRT Services

Bill alcohol and substance use (other than tobacco) SBIRT services with these HCPCS codes:

<b>G2011</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 5-14 minutes	
<b>G0396</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	
<b>G0397</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	

If you diagnose your patient with opioid use disorder (OUD), we cover these treatment services:

- Evaluation & management (E/M) visits for medication management
- Office-based SUD treatment services
- Comprehensive treatment provided by an opioid treatment program (OTP)

## E/M Visit for Medication Management

CPT codes 99202–99499 represent visits and services for evaluating and managing patient health. You can use E/M visits to provide medication management to ensure patients take medications properly, for example, in their recovery process. Medications prescribed for patients with OUD in the office setting could include buprenorphine and naltrexone. If your patient has Medicare Part D coverage, their plan must cover these medications.

The [Evaluation and Management Services Guide](#) has more information.

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## Office-Based SUD Treatment Services

[Office-based SUD treatment services](#) give you a way to bill for a group of services in the office setting. We cover a monthly bundle of services (for patients who are prescribed buprenorphine or naltrexone in the office setting) for treating an OUD and/or other SUDs.

Bill office-based SUD treatment services with these HCPCS codes:

<b>G2086</b>	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	
<b>G2087</b>	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	
<b>G2088</b>	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	

**Note:** Don't bill HCPCS codes G2086–G2088 more than once per month per patient. These codes describe treatment for 1 or more SUDs.



## Opioid Treatment Programs

We pay certified OTPs through bundled OUD Medicare Part B treatment services payments. Covered services include FDA-approved opioid agonist and antagonist medication (including methadone, buprenorphine, and naltrexone) and their administration (if applicable), substance use counseling, individual and group therapy, toxicology testing, intake activities, periodic assessments, take-home supplies of naloxone, and intensive outpatient program services.

[Opioid Treatment Program Directory](#) and [OTPs Billing & Payment](#) have more information.

These add-on codes cover the cost of naloxone:

**G2215**

Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 ml nasal spray (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

**G2216**

Take-home supply of injectable naloxone (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

**G1028**

Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 ml nasal spray (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

**Note:** We limit payment for HCPCS codes G1028, G2215, and G2216 to once every 30 days unless an additional take-home supply of the medication is medically reasonable and necessary.

OTPs can provide substance use counseling and individual and group therapy services through audio-only interaction (for example, phone calls) when audio and video communication isn't available to the patient, including circumstances where the patient isn't capable of, or doesn't consent to, using devices that permit a 2-way audio or video interaction, provided the OTP meets all other applicable requirements.

There's no copayment for OTP services for patients with Medicare.

View a list of [Medicare-enrolled OTPs](#).

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that expired at the end of the PHE.

## Opioid Use Disorder: Part D Treatment Drugs

Medicare drug plan (Part D) sponsors must cover OUD Part D treatment drugs, when medically necessary, by including them on the formulary or by exception. Coverage isn't limited to single entity products (for example, buprenorphine) but must include combination products when medically necessary (for example, buprenorphine naloxone and long-acting naltrexone).

Part D sponsors must have a transition policy to prevent interruptions in Part D therapeutic treatment drugs when new patients transition into the benefit. This transition policy, along with CMS's non-formulary exceptions and appeals requirements, helps ensure all patients have timely access to their medically necessary OUD Part D drug therapies.

A pharmacy can dispense a Part D drug only upon a prescription if the drug is helping treat a medically accepted indication. Section 10.6 of the [Medicare Prescription Drug Benefit Manual, Chapter 6](#) has more information.

You can prescribe a Medicare Part D Schedule II, III, IV, or V controlled substance electronically according to the electronic prescription drug program requirements.

Methadone isn't an OUD Part D drug when used for treating opioid dependence because it can't be dispensed for this purpose through a prescription at a retail pharmacy. Methadone is a Part D drug when used for pain. [42 CFR 8.12\(h\)\(2\)](#) has more FDA-authorized OUD investigational use medication information, and [42 CFR 8.1](#) has more OUD medication information.

**Note:** State Medicaid Programs may include the methadone costs in their bundled payment to qualified OTPs or hospitals dispensing methadone for OUD. Section 10.8 of the [Medicare Prescription Drug Benefit Manual, Chapter 6](#) has more information.



## Medicaid-Covered SBIRT

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States may cover SBIRT as a Medicaid state plan service. Several Medicaid statutory authorities may cover SBIRT, including, but not limited to:

- [42 CFR 440.50](#): Physicians' services
- [42 CFR 440.60](#): Services of other licensed practitioners
- [42 CFR 440.130\(c\)](#): Preventive services
- [42 CFR 440.130\(d\)](#): Rehabilitative services

Section 1905(r) of the [Social Security Act](#) states that the early and periodic screening, diagnostic, and treatment benefit provides a comprehensive selection of preventive, diagnostic, and treatment services for eligible children under age 21. Medicaid includes this mandatory benefit to ensure children get early detection and care to treat or avoid health issues.

A physician or other licensed practitioner must recommend preventive and rehabilitative services.

When state Medicaid plans cover SBIRT, the states establish which practitioners may provide services and their qualifications. Practitioner qualifications for offering SUD treatment include, but aren't limited to those:

- Licensed or certified to perform SUD services by the state where they perform the services
- Qualified to perform specific SUD services
- Supervised by a licensed practitioner (in some instances when a qualified unlicensed professional provided the services)
- Working within their state scope-of-practice act

## Documenting Medicaid SBIRT Services

Comply with your state's Medicaid SBIRT documentation policy. See your state's documentation policy in your Medicaid Provider Manual. Your [state Medicaid agency](#) has more documentation information.

## Billing Medicaid SBIRT Services

If a state chooses to cover SBIRT under its Medicaid Program, the state may choose which codes to bill brief intervention services; for example, HCPCS codes:

<b>G2011</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 5-14 minutes	
<b>G0396</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	
<b>G0397</b>	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	
<b>G0442</b>	Annual alcohol misuse screening, 5 to 15 minutes	
<b>G0443</b>	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	
<b>G0444</b>	Annual depression screening, 5 to 15 minutes	
<b>H0049</b>	Alcohol and/or drug screening	
<b>H0050</b>	Alcohol and/or drug services, brief intervention, per 15 minutes	

Check with your state Medicaid agency about which billing codes to use.

Section C (14) of the [Medicaid National Correct Coding Initiative Policy Manual, Chapter 12](#) has information about billing codes G0396 and G0397 with evaluation and management and behavioral health codes.

### Medicaid Telemedicine Includes SBIRT

If your state allows it, you may provide SBIRT via [telemedicine](#).

## Dually Eligible Medicare-Medicaid Beneficiaries

For people enrolled in both Medicare and Medicaid Programs (dually eligible), Medicare-participating providers should bill Medicare and their Medicare Administrative Contractor (MAC) will transfer the claim to Medicaid after paying the Medicare-approved amount. Medicare providers must enroll in their state Medicaid Program to get paid. States must accept the claim and decide if they'll pay the cost-sharing amounts.

States accept claims for all Medicare-covered services for certain dually eligible beneficiaries and pay cost-sharing amounts according to the state plan's payment method.

**Note:** Nominal Medicaid cost-sharing may apply for certain [dually eligible beneficiaries](#). State Medicaid Programs pay some cost-sharing. However, you can't balance-bill dually eligible beneficiaries when Medicare and Medicaid payments fall below the approved Medicare rate.

Find your [MAC's website](#) for more information.

## Resources

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- [CMS Opioid Treatment Programs](#)
- [Medicare Benefit Policy Manual, Chapter 15](#)
- [Opioid Treatment Programs \(OTPs\) Medicare Enrollment](#)

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