New CPT Codes Promote Interventions

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T
e two new health care codes for substance abuse screening and brief inter-

terventions in effect Jan. 1, 2008, will “strengthen the doctor-patient relationship and incorporate a powerful preventive public health resource in America’s health care system,” according to the White House Office of National Drug Control Policy. But the medical community appears to be taking a wait-and-see approach.

Reimbursement for the new Current Procedural Terminology (CPT) codes (99408 and 99409) is a key concern among physicians informally polled about these new codes. “The existence of codes does not ensure payment for the codes, and it is unclear whether the codes will be accepted by insurers.”

The key question is whether these new CPT codes, whether insurers and Medicare will pay for them, and could they be added to other CPT codes at the same visit,” said Dr. David Spiegel, Willson Pro-
fessor and associate chair in the depart-
ment of psychiatry and behavioral services at Stanford (Calif.) University.

The potential value of these services for patients, another concern, some phys-
icians question the value of “brief inter-
ventions” for substance use.

Dr. Jon O. Eibbert, an internist at the Mayo Clinic, Rochester, Minn., said years of either inadequate or no funding at all have left limited resources for physicians to refer to. In light of that, it seems that “the government is putting the cart before the horse” with the new codes, he said.

Similarly, Dr. Lee H. Beecher, a psychi-
atrist in private practice in St. Louis Park, Minn., said it would be encouraging to see evidence that adding such codes will change clinical practice.

“We already have too many CPT codes in medicine and fewer for mental health services, because our procedures are de-
scribed as evaluation, psychotherapy, phar-
macotherapy, [electroconvulsive therapy],” and inpatient care management,” said Dr. Beecher, also an adjunct professor of psy-
chiatry at the University of Minnesota, Minneapolis.

“Psychiatrists sell time to the government. We are paid the same with no ac-
count of the patient’s responses,” he said. This drives the common denominator to its lowest level and encourages ‘upcoding’ of work [intensity].”

Dr. Beecher said physicians are cur-
rently being paid a low rate by Medicare for patient encounter time, so specifying the content of clinical interventions “will lead to the frustration of obsessive paper work, and it will rapidly become ‘an industry in itself’”

The new codes (99408 for interactions of 15-30 minutes, and 99409 for interactions of 15-30 minutes) were issued by the American Medical Association in October. The ONDCP statement says the codes will enable efficient reporting of screening services for drug and alcohol abuse (see box below), and increase the likelihood of appropriate interventions for those in need. Similar codes for tobacco use screening and intervention previously were instituted, thus tobacco use screening and cessation counseling are excluded in these codes.

The American College of Physicians, which did not create the codes but was involved in evaluating the codes and develop-


The Drug Abuse Screening Test is a tool that physicians can use to screen for drug abuse during office visits. Sample questions from the DAST include the following, according to the Office of National Drug Control Policy:

■ Can you get through the week without using drugs?
■ Are you always able to stop using drugs when you want to?
■ Do you ever feel bad or guilty about your drug use?
■ Have you neglected your family be-
cause of your use of drugs?
■ Have you been in trouble at work because of your use of drugs?
■ Have you engaged in illegal activi-
ties in order to obtain drugs?
■ Have you ever experienced with-
drawal symptoms (felt sick) when you stopped taking drugs?
■ Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?