Ensuring Solutions to Alcohol Problems
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Detailed Information About Coding for SBI Reimbursement

CPT-4: Background Information[1]

Each year, in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential.

The Health Care Procedure Code Set (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I is the CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

HCPCS: Background Information[2]

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service.

In October of 2003, the Secretary of HHS delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR Sec. 414.**40 (a)** CMS establishes uniform national

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definitions of services, codes to represent services, and payment modifiers to the codes. (http://www.cms.hhs.gov/MedHCPCSGenInfo/ accessed 1/18/06)

Alcohol and Drug Screening[3]

The use of a valid brief questionnaire about the context, frequency and amount of alcohol or other drug used by an individual. Alcohol and Drug Screening provides a quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one. Examples of valid questionnaires are: AUDIT (Alcohol Use Disorder Identification Test), MAST (Michigan Alcohol Screening test), and CAGE-AID (4 question screener about drug use), or the ASSIST. Biological assays such as blood alcohol content (BAC) or drug toxicology assessments are different from alcohol and drug screening. These routine laboratory procedures are billed by the specific biological tests conducted.

Brief Intervention[4]

The healthcare practitioner, using the results of a screening questionnaire that indicates an alcohol or drug problem, expresses concerns about the individual's drinking and advises the individual to cut down on his/her drinking or drug use. The healthcare practitioner helps the individual to develop an action plan to achieve this goal. Typically, brief interventions take place immediately following screening. Some models of brief intervention include one or more follow-up care management contacts with patients either in brief face-to-face counseling or by telephone.

V Codes: Supplementary classification of factors influencing health status and contact with health services.[5]

The V codes are provided to deal with occasions when circumstances other than a disease or injury are recorded as "diagnoses" or "problems." This can arise mainly in three ways:

- When a person who is not currently sick encounters the health services for some specific purpose, such as to discuss a problem which is in itself not a disease or injury.
- When a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change).

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- When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some current illness or injury. In this circumstance, the V code should be used only as a supplementary code and should not be the one selected for use in primary, single cause tabulations.
  - V11.3 Personal history of mental disorder: Alcoholism
  - V11.8 Personal history of mental disorder: Other mental disorders
  - V61.41 Health problems within family: Alcoholism in family
  - V65.42 Counseling on substance use and abuse
  - V67.3 Follow-up examination: Following psychotherapy and other treatment for mental disorder
  - V70.1 General psychiatric examination for persons without reported diagnosis
  - encountered during examination and investigation of individuals and populations requested by the authority (may be used as principle diagnosis on Medicare patients) for persons without reported diagnosis encountered during examination and investigation of individuals and populations.
  - V70.2 General psychiatric examination, other and unspecified for persons without reported diagnosis encountered during examination and investigation of individuals and populations.
  - V79.1 Special screening for mental disorders and developmental handicaps:
    Alcoholism
  - V79.8 Special screening for mental disorders and developmental handicaps:
    Other specified mental disorders and developmental handicaps.
  - V79.9 Special screening for mental disorders and developmental handicaps:
    Unspecified mental disorder and developmental handicap.

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Place of Service Codes:[6]

The following is a list of place-of-service codes. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with your individual payer (e.g., Medicare, Medicaid, private insurance) to determine whether a particular code will be recognized for payment purposes. Place of Service codes correspond to item 24B on the HCFA 1500. This is a required field.

Note: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Place of Service Codes

03 School
04 Homeless Shelter
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance - Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility - Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-Residential Substance Abuse Treatment Center

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60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

CPT 2006 Modifiers[7]

The following modifiers may be used to provide greater specificity about alcohol or drug screening, brief interventions, treatment, or case management, than could be provided through the CPT codes alone. The following Modifiers appear relevant to SBIRT:

21 Prolonged evaluation and management services: When the face to face or floor/unit service provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service.

32 Mandated Services: Services related to mandated consultation and/or related services (e.g., PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

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51 Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

CPT-4 Codes (Level I Codes)[8]

Alcohol and Drug Testing (Biologic Assays)

- 80100-80103 Drug testing, chromatographic procedure, confirmation, tissue preparation, each procedure
- 82055 Alcohol testing (any method other than breath)
- 82075 Alcohol testing (breath)

Psychiatric therapeutic procedures[9]

Psychiatric diagnostic interview examination includes a history, mental status, and a disposition. Psychotherapy is a treatment for mental illness and behavioral disturbances. In reporting psychotherapy, the appropriate code is chose on the basis of the type of psychotherapy, the place of service, the face-to-face time spent with the patient, and whether E/M services are furnished on the same date of service as psychotherapy. The E/M services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829.

Consultation for psychiatric evaluation of a patient (99241-99255) includes examination of a patient and exchange of information with the primary physician and other informants such as nurses or family members, and preparation of a report. These consultation services (99241-99255) are limited to initial or follow-up evaluation and do not involve psychiatric treatment.

- 90801 Psychiatric diagnostic interview examination. Psychiatric diagnostic interview examination includes a history, mental status and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

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- 90804 Office or other outpatient facility individual psychotherapy, approximately 20-30 minutes face-to-face with the patient.
- 90805 with medical evaluation and management services
- 90806 Office or other outpatient facility individual psychotherapy, approximately 45-50 minutes face-to-face with the patient.
- 90807 with medical evaluation and management services.
- 90808 Office or other outpatient facility individual psychotherapy, approximately 75-80 minutes face-to-face with the patient.
- 90809 with medical evaluation and management services.
- 90816 Inpatient hospital, partial hospital or residential care facility, individual psychotherapy, approximately 20-30 minutes face-to-face with the patient.
- 90817 with medical evaluation and management services
- 90818 Inpatient hospital, partial hospital or residential care facility individual psychotherapy, approximately 45-50 minutes face-to-face with the patient.
- 90819 with medical evaluation and management services.
- 90821 Inpatient hospital, partial hospital or residential care facility, individual psychotherapy, approximately 75-80 minutes face-to-face with the patient.
- 90822 with medical evaluation and management services.
- 90862 Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy

Health and Behavior Assessment/Intervention

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems. These codes are used to describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors

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related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

For patients that require psychiatric services (90801-90899) as well as health and behavior assessment/intervention (96150-96155), report the predominant service performed. Do not report 96150-96155 in conjunction with 90801-90899 on the same date. Evaluation and Management services codes (including Preventive Medicine, Individual Counseling codes 99401-99404) should not be reported on the same day.

Health and behavior assessment and intervention codes 96150-5 were approved in 2002. Psychologists, nurses, licensed clinical social workers, and other non-physician providers with an appropriate scope of practice can use these codes. Medicare/Medicaid reimburse for these codes except 96155 (family intervention without the patient present). Virtually all Medicare carriers reimburse for these codes. Some private insurers now reimburse these codes. Only the primary ICD-9 physical diagnosis codes should be used for these services. Alcohol-, drug- or mental health diagnoses are not allowed as primary diagnoses for this code.

- 96150 Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
- 96151 Health and behavior assessment – re-assessment
- 96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
- 96153 group (2 or more patients present)
- 96154 family (with the patient present)
- 96155 family (without the patient present)

Education and Training for Patient Self-Management

The following codes are used to report educational and training services prescribed by a physician and provided by a qualified, nonphysical health-care professional using a standardized curriculum to an individual or group of patient for the treatment of established illness(s)/disease(s) or to delay comorbidity(s). Education and training for patient self-management may be reported with these codes only when using a standardized curriculum as described below. This curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual

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patient(s). The type of education and training provided for the patient's clinical condition will be identified by the appropriate diagnosis code(s) reported.

The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association or other appropriate source. For counseling and education provided by a physician to an individual, see the appropriate Evaluation and Management codes. For counseling and/or risk factor reduction intervention provided by a physician to patient(s) without symptoms or established disease use codes 99401-99412.

- 98960 Education and training for patient self- management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.
- 98961 2-4 patients
- 98962 508 patients

Evaluation and Management: The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs. (for services provided by physicians in the emergency department, see 99281-99285. For observation or inpatient care services, use codes 99234-99236).

- 99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
  - a problem focused history;
  - a problem focused examination;
  - straightforward medical decision making

  Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
- 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
  - an expanded problem focused history;

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- an expanded problem focused examination;
- straightforward medical decision makingUsually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

- 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
  - a detailed history;
  - a detailed examination;
  - medical decision making of low complexity

  Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

- 99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
  - a comprehensive history;
  - a comprehensive examination;
  - medical decision making of moderate complexity

  Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

- 99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
  - a comprehensive history;
  - a comprehensive examination;
  - medical decision making of high complexity

  Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

- 99212-99215 Office or other outpatient visit for the evaluation and management of an established patient (in increments of 10, 15, 25, and 40 minute increments)

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Initial Hospital Care

The following codes are used to report evaluation and management services provided to hospital inpatients.

- 99221-99223 Initial hospital care, per day, for the evaluation and management of a patient which requires a comprehensive history, a comprehensive examination, and medical decision making at three levels of complexity (low [30 minutes], moderate [50 minutes], and high severity [70minutes]).

Subsequent Hospital Care

- 99231-99233 Subsequent hospital care, per day, for the evaluation and management of a patient which requires at least 2 of the following: a problem focused history, a problem-focused examination, and medical decision making at three levels of complexity (low [15 minutes], moderate [25 minutes], and high severity [35minutes]).

Consultations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. A written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

Office or other outpatient consultation for new or established patient: to report consultations, counseling and/or coordination of care with other providers or agencies.

- 99241-99245 Office consultation for a new or established patient with three key components: a problem focused history, a problem focused examination, and straightforward medical decision making (in 15 minute increments)

Initial inpatient consultations for new or established patients: to report physician consultations provided to inpatients and other residential facilities

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- 99251-99255 Initial inpatient consultation with three key components: a problem focused history, a problem focused examination, and straightforward medical decision-making (in 20 minute increments)

Emergency Department Services: used to report evaluation and management services provided in the emergency department, defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. Alcohol screening, brief intervention and treatment may increase intensity or complexity of care.

- 99281 ED visit for self-limited or minor presenting problem
- 99282 ED visit for low to moderate presenting problem
- 99283 ED visit for moderate severity presenting problem
- 99284 ED visit for high severity presenting problem, requires urgent evaluation by physician but does not pose an immediate significant threat to life or physiologic function
- 99285 ED visit for high severity problem and poses immediate significant threat to life or physiologic function

Prolonged physician services requiring direct (face-to-face) patient contact beyond the usual service

- 99354-99355 Prolonged physician service in the office or other outpatient setting requiring direct patient contact (with time increments of less than 30 minutes, 30-74 minutes, 75-104 minutes, 105-134 minutes, 135-164 minutes, 165-194 minutes.)
- 99356-99357 Prolonged physician service in the inpatient setting requiring direct patient contact beyond usual service (with time increments of less than 30 minutes, 30-74 minutes, 75-104 minutes, 105-134 minutes, 135-164 minutes, 165-194 minutes.)

Case management services

- 99361 Case management

Preventive Medicine Services

If a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem 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 99201-99215 should also be reported. Modifier 25 should

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be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. Use codes 99401-99412 for reporting those counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.

Preventive medicine codes 99381-97 are typically used for annual physical exam/preventive health visits. They do not reimburse separately for screening or counseling, unless it is prolonged or addressed as a separate problem during the visit. If this is the case, a '-25' modifier is added to the E/M code (e.g., an established 45 year old patients receiving preventive E/M and alcohol misuse counseling would be coded 99396-25). These codes would accompany appropriate diagnostic codes (e.g., V70.0 for a routine exam, and 303.00 for unspecified alcohol abuse).

- 99384 New patient, adolescent (ages 12-17 years), initial comprehensive preventive medicine evaluation and management.
- 99385 New patient, 18-39 years, initial comprehensive preventive medicine evaluation and management.
- 99386 New patient, 40-64 years, initial comprehensive preventive medicine evaluation and management.
- 99387 New patient, 65 years and over, initial comprehensive preventive medicine evaluation and management.
- 99394 Established patient, adolescent (ages 12 – 17 years), periodic comprehensive medicine reevaluation and management.
- 99395 Established patient, 18-39 years, periodic comprehensive medicine reevaluation and management.
- 99396 Established patient, 40-64 years, periodic comprehensive medicine reevaluation and management.
- 99397 Established patient, 65 years and over, periodic comprehensive medicine reevaluation and management.

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Counseling and/or Risk Factor Reduction Intervention

These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury. Preventive medicine counseling and risk factor reduction interventions provided as a separate encounter will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter. Codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling patients with symptoms or established illness, use the appropriate office, hospital or consultation or other evaluation and management codes.

These codes cannot be used for patients with established alcohol abuse or dependence, or those with alcohol-related medical problems. Therefore, using preventive counseling codes would need to accompany ICD-9 diagnosis code V65.42 (counseling on substance use and abuse). These codes generally pay less than comparable E/M codes, and many payers (e.g., Medicare, Medicaid) do not reimburse for most preventive care.

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (approximately 15 minutes).
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (approximately 30 minutes).
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (approximately 45 minutes).
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual approximately 60 minutes).
- 99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)

HCPCS Codes (Level II Medicare Codes)[10]

According to the 2004 HCPCS manual, none of these codes are reimbursed by Medicare. The H and T codes are used by those state Medicaid agencies that are mandated by state law to establish separate codes for identifyinig mental health services that include alcohol and drug treatment services. States may use these codes for reimbursement of alcohol and drug treatment services through SAMHSA block grant, state general revenue or other public funds.

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- *H0001 Alcohol and/or drug assessment*
- *H0002 Behavioral health screening to determine eligibility for admission to treatment program*
- *H0003 Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs*
- *H0004 Behavioral health counseling and therapy, per 15 minutes*
- *H0005 Alcohol and/or drug services; group counseling by a clinician*
- *H0006 Alcohol and/or drug services; case management*
- *H0008-H0014 Alcohol and/or drug services; detoxification (various settings)*
- *H0015 Alcohol and/or drug services; intensive outpatient treatment*
- *H0016 Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)*
- *H0022 Alcohol and/or drug intervention service (planned facilitation)*
- *H0048 Alcohol and/or other drug testing: collection and handling only, specimens other than blood*
- *T1012 Alcohol and/or substance abuse services, skills development*
- *T1016 Case management, each 15 minutes*

ICD-9 [11]

To code accurately, it is necessary to have a working knowledge of medical terminology and to understand the characteristics, terminology, and conventions of the ICD-9-CM. Transforming verbal descriptions of diseases, injuries, conditions, and procedures into numerical designations (coding) is a complex activity and should not be undertaken without proper training. The diagnostic codes listed below are those most commonly associated with alcohol and drug misuse.

For reimbursement purposes, if illnesses other than alcohol or drug dependence or misues are primary, those diagnoses are listed first. It may not be necessary to include an alcohol- or drug-specific diagnostic code at all. The best available diagnostic code to accompany a brief counseling intervention for non-dependent alcohol misuse is 'alcohol abuse', 305.0. For non-dependent drug misuse, the appropriate code is 305.0-305.9. Using 305.00 (i.e., adding a fifth digit code of 0) refers to unspecified alcohol abuse, which may be the most appropriate code to refer to alcohol mis-

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use in a general sense. To use procedure codes for preventive services, a diagnosis code of V65.42 (counseling for substance use and abuse) would be required.

291 Alcohol-induced mental disorders

- 291.0 Alcohol withdrawal delirium
- 291.1 Alcohol-induced persisting amnestic disorder
- 291.2 Alcohol-induced persisting dementia
- 291.3 Alcohol-induced psychotic disorder with hallucinations
- 291.4 Idiosyncratic alcohol intoxication
- 291.5 Alcohol-induced psychotic disorder with delusions
- 291.8 Other specified alcohol-induced mental disorders
  - 291.81 Alcohol withdrawal
  - 291.82 Alcohol induced sleep disorders
  - 291.89 Other
- 291.9 Unspecified alcohol-induced mental disorders

292 Drug-induced mental disorders

- 292.0 Drug withdrawal
- 292.1 Drug-induced psychotic disorders
  - 292.11 Drug-induced psychotic disorder with delusions
  - 292.12 Drug-induced psychotic disorder with hallucinations
- 292.2 Pathological drug intoxication
- 292.8 Other specified drug-induced mental disorders
  - 292.81 Drug-induced delirium
  - 292.82 Drug-induced persisting dementia
  - 292.83 Drug-induced persisting amnestic disorder
  - 292.84 Drug-induced mood disorder
  - 292.85 Drug induced sleep disorders
  - 292.89 Other
- 292.9 Unspecified drug-induced mental disorder

303 Alcohol dependence syndrome

The following fifth-digit subclassification is for use with category 303:

0 unspecified
1 continuous
2 episodic
3 in remission

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303.0 Acute alcoholic intoxication

303.9 Other and unspecified alcohol dependence

304 Drug dependence

The following fifth-digit subclassification is for use with category 304:
0 unspecified
1 continuous
2 episodic
3 in remission

304.0 Opioid type dependence

304.1 Sedative, hypnotic or anxiolytic dependence

304.2 Cocaine dependence

304.3 Cannabis dependence

304.4 Amphetamine and other psychostimulant dependence

304.5 Hallucinogen dependence

304.6 Other specified drug dependence

304.7 Combinations of opioid type drug with any other

304.8 Combinations of drug dependence excluding opioid type drug

304.9 Unspecified drug dependence

305 Nondependent abuse of drugs

Note: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative

The following fifth-digit subclassification is for use with codes 305.0, 305.2-305.9
0 unspecified
1 continuous
2 episodic
3 in remission

305.0 Alcohol abuse

305.2 Cannabis abuse

305.3 Hallucinogen abuse

305.4 Sedative, hypnotic or anxiolytic abuse

305.5 Opioid abuse

305.6 Cocaine abuse

305.7 Amphetamine or related acting sympathomimetic abuse

305.8 Antidepressant type abuse

305.9 Other, mixed, or unspecified drug abuse

357.5 Alcoholic polyneuropathy

357.6 Polyneuropathy due to drugs

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5.5 Alcoholic cardiomyopathy

3.3 Alcoholic gastritis

571 Chronic liver disease and cirrhosis

- 571.0 Alcoholic fatty liver
- 571.1 Acute alcoholic hepatitis
- 571.2 Alcoholic cirrhosis of liver

3.3 Alcoholic liver damage, unspecified

- 790.3 Excessive blood level of alcohol

980 Toxic effect of alcohol

- 980.0 Ethyl alcohol
- 980.9 Unspecified alcohol

Alcohol-related illnesses and injuries[12]

Alcohol has been implicated by many research studies as a causal or complicating factor for numerous illnesses and injuries. Below are the ICD-9 codes and diagnoses associated with alcohol use, and E-codes or external cause of trauma episode codes associated with alcohol use.

ICD 9	Illness/Injury
141,143-146, 148, 149	Oropharyngeal cancer
150	Esophageal cancer
155	Liver cancer
161	Laryngeal cancer
174	Female breast cancer
291	Alcohol psychosis
292	Drug
303	Alcohol dependence
305	Alcohol abuse
309, 311	Depressive reaction
345	Epilepsy
357.5	Alcoholic poly neuropathy
401-405	Hypertension
410-414	Ischemic heart disease
425.5	Alcoholic cardiomyopathy
427.0, 427.2, 427.3	Supraventricular cardiac dysrhythmias
433x1, 434x1, 436	Ischemic stroke
430-432	Hemorrhagic stroke
456.0 - 456.2	Esophogeal varices
530.7	Gastro-esophageal hemorrhage
535.3	Alcoholic gastritis

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ICD 9	Illness/Injury
571	All liver cirrhosis
574	Cholelithiasis
577.0, 577.1	Acute & chronic pancreatitis
634	Spontaneous abortion
656.5, 764, 765	Low birth weight
696.1	Psoriasis
980	Ethanol toxicity
E810-E819	Road injuries
E860.0	Alcoholic beverage poisoning
E860.1	Other ethanol and methanol poisoning
E880- E888	Fall injuries
E890 - E899	Fire injuries
E910	Drowning
E911	Aspiration
E919, E920	Occupational and machine injuries
E950 - E959	Suicide
E960, E965, E966, E968, E969	Assault
E967	Child abuse

Endnotes

[1]http://www.cms.hhs.gov/MedHCPCSGenInfo/ accessed 1/18/06.

[2] http://www.cms.hhs.gov/MedHCPCSGenInfo/02_HCPCS_LEVEL_II_CODES.asp#TopOfPage, (http://www.cms.hhs.gov/MedHCPCSGenInfo/ accessed 1/18/06)

[3] http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=328506&cat_id=964

[4] http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=329150&cat_id=964

[5] American Medical Association (2006) CPT 2006: Current Procedural Terminology Professional Edition. Chicago: AMA.

[6] American Medical Association (2006) CPT 2006: Current Procedural Terminology Professional Edition. Chicago: AMA.

[7] American Medical Association (2006) CPT 2006: Current Procedural Terminology Professional Edition. Chicago: AMA.

[8] American Medical Association (2006) CPT 2006: Current Procedural Terminology Professional Edition. Chicago: AMA.

[9] In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy, the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy.

[10] American Medical Association (2004) HCPCS 2004: Healthcare Common Procedure Coding System: Medicare's National Level II Codes. Chicago: AMA. According to the

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HCPCS 2004 manual, none of the substance use assessment and treatment codes are reimbursed by Medicare.

[11] AMA (2006) The International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1,2,3, Chicago, IL. AMA. The ICD-9-CM is maintained jointly by the National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS). http://www.cdc.gov/nchs/icd9.htm#RTF accessed 4/3/06

[12] Ridolfo, B., Stevenson, C. (February 2001) The quantification of drug-caused mortality and morbidity in Australia, 1998. Canberra, AU. Australian Institute of Health and Welfare (AIHW cat. No. PHE 29). Drug Statistics Series Number 7. http://www.aihw.gov.au. English, DR, Holman, CD, Milne E, Hulse, G, Winter MG (1995). The quantification of morbidity and mortality caused by substance abuse. Prepared for the Second International Symposium on the Social and Economic Costs of Substance Abuse. 2-5 October, 1995. http://www.ccsa.ca/costs/morbmort.htm. English DR, Holman CDJ, Milne E, Winter MG, Hulse GK Coddle JP, Bower CI, Corti B, de Klerk N, Knuiman MW, Kurinczuk JJ, Lewin GF, Ryan GA. The quantification of drug caused morbidity and mortality in Australia, 1995 edition. Commonwealth Department of Health Services and health, Canberra, 1995).

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