

## APPLICATION FOR CONSIDERATION OF A *CPT* CATEGORY II CODE

Instructions for Completing this Form:

This form plays a vital role in maintaining and increasing the efficiency of the *CPT* process and should be used to submit a coding proposal for *CPT* Category II codes. Please complete this entire form (insert additional lines and pages as needed).

Please e-mail this document or enclose a copy of this document on a 3½ inch diskette. Once the application has been completed, submit the request electronically via diskette, CD or e-mail to [ccpsubmit@ama-assn.org](mailto:ccpsubmit@ama-assn.org)

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**A. The definition or purpose of the measure is consistent with its intended use.**

**A-1.** Describe the definition of the measure, including whether it is a process or an outcome measure:

**Four codes are proposed in this application. All content applicable to Code Application #1 will appear behind Bullet #1; content for Code #2 will be associated with Bullet #2, and so forth.**

1. **Hazardous alcohol use screening:** New and established patients 15 to 75 years of age who are asked about hazardous alcohol use by means of a standardized questionnaire, the AUDIT or AUDIT-C, or CRAFFT (adolescent alcohol use) during the measurement year. This is a process measure that identifies whether a patient received an assessment of hazardous and dependent alcohol use with a valid and reliable screening instrument.
2. **Hazardous drug use screening:** New and established patients 15 to 75 years of age who are asked about use of illicit drugs or misuse of prescription medications for non-medical purposes during the measurement year. This is a process measure that identifies whether a patient received an assessment of drug use.
3. **Brief intervention: Alcohol:** Patients 15 to 75 years of age who receive an alcohol brief intervention that includes, at a minimum, 1) advice to drink less than the recommended limits or abstain from alcohol use and 2) feedback linking alcohol use to personal health. This measure is a process measure in that it identifies whether a patient who drinks in hazardous ways receives a brief intervention intended to reduce or halt use and reduce risk of unhealthy effects of alcohol use.
4. **Brief intervention: Drugs:** Patients 15 to 75 years of age who receive a brief drug use intervention that includes, at a minimum, 1) advice to abstain from drug use and 2) feedback linking drug use to personal health. This measure is a process measure in that it identifies whether a patient who uses drugs in hazardous ways receives a brief intervention intended to reduce or halt substance use and reduce risk of unhealthy effects of substance use.

**A-2.** Describe the purpose of the measure:

1. The purpose of the **hazardous alcohol use screening** measure is to identify whether a patient receives a standardized assessment of drinking patterns, as recommended by USPSTF and other professional practice standards (e.g., APA, AAP, AAFP, AACAP, ASAM, ACEP, ACS-COT, the American Medical Association, Federal government health agencies such as the VA, DOD, SAMHSA, NIAAA, CDC, NHTSA and ONDCP, and the practice standards of the major health insurance plans and employer coalitions [see appendix of consensus and evidence based practice standards]). In the absence of routine screening, providers only detect a minority of hazardous drinkers and drug users.

2. The purpose of the **hazardous drug use screening** measure is to identify patients who receive screening as new patients or annually for established patients, as recommended by professional practice standards (e.g., APA, AAP, AAFP, AACAP, ASAM, ACEP, ACS-COT, the American Medical Association, Federal government health agencies such as the VA, DOD, SAMHSA, NIAAA, CDC, NHTSA and ONDCP, and the practice standards of the major health insurance plans and employer coalitions [see appendix of consensus and evidence based practice standards]). In the absence of routine screening, providers only detect a minority of drug users.
3. The purpose of the **alcohol brief intervention** measure is to identify patients who receive a clinical brief intervention to reduce or halt hazardous alcohol use and reduce risks of unhealthy effects of alcohol use.
4. The purpose of the **drug brief intervention** measure is to identify patients who receive a clinical brief intervention to reduce or halt hazardous drug use and reduce harmful health effects of substance use.

**A-3.** Describe the intended use of the measure (e.g., quality improvement and accountability or solely quality improvement):

1. The intended use of the **hazardous alcohol use screening** measure is to document the frequency with which patients are screened with a standardized screening tool for detection of either hazardous (excessive, but not clinically dependent) or dependent alcohol use. Detection of hazardous drinking patterns is generally low and there are numerous guidelines indicating that screening should be routine. Excessive drinkers who receive screening with standardized screening instruments are more likely to be detected, reducing risk of mortality and morbidity from alcohol-related motor vehicle crashes and other types of injuries, as well as illnesses such as cirrhosis, pancreatitis, GI problems, oropharyngeal cancers and cardiovascular disorders. Providers, facilities, health plans and purchasers will use this tracking code to acquire objective data for accountability and quality improvement purposes.
2. The intended use of the **substance use screening** measure is to document the frequency that patients are screened for hazardous or dependent use of illicit drugs or non-medical prescription drug use. Assessment rates of hazardous drug use in medical settings are generally low. Among certain populations, drug use is particularly hazardous (e.g., adolescents, 18-25 year olds, pregnant women), and is increasingly at near epidemic proportions in certain populations (e.g., methamphetamine use in Western regions, oxycodone use in Southeastern regions). Therefore, there is increasing need for tracking purposes for both accountability and quality improvement purposes.
3. The intended use of the **alcohol brief intervention** measure is for both accountability and quality improvement purposes. Patients who drink in hazardous ways who receive brief interventions are significantly more likely to reduce or stop their alcohol use, thus reducing morbidity and mortality. Providers, facilities, health plans and purchasers will have objective data for both accountability and quality improvement

initiatives to increase screening and brief intervention rates.

4. The intended use of the **drug brief intervention** measure is for both accountability and quality improvement purposes. The provision of interventions will improve the quality of care delivered to patients whose use of illegal drugs or misuse of prescription drugs for non-medical purposes puts them at increased risk of mortality and morbidity. Patients who use drugs in hazardous ways who receive brief counseling from physicians or other health care providers who recommend reduction or abstinence of substance use, express concern about the health effects of continued use, assist patients to commit to take actions to change hazardous use, and refer patients to appropriate treatment or community resources are significantly more likely to reduce or stop their drug use, thereby reducing morbidity and mortality. Providers, facilities, health plans and purchasers will have objective data for accountability and quality improvement initiatives to increase screening and brief intervention rates.

**B. The aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant**

**B-1.** Describe for whom the code is relevant and why:

1. The **hazardous alcohol use screening** code is relevant for providers, hospitals and health plans that care for patients with undetected and untreated substance use problems. The code will allow them to track easily whether patients are being screened for hazardous or dependent alcohol use by means of standardized screening instruments, the AUDIT, AUDIT-C or CRAFFT. The code will be helpful in providing objective data in pay-for-performance and other quality improvement processes to identify providers, facilities and health plans that are performing at an appropriate level in screening for hazardous alcohol use.
2. The **hazardous drug use screening** code is relevant for providers, hospitals and health plans that care for patients with undetected and untreated illicit drug use problems or using prescription medications for non-medical purposes. The code will allow them to track easily whether patients are being assessed for substance use problems. The code will be helpful in providing objective data in pay-for-performance and other quality improvement processes to identify providers, facilities and health plans that are performing at an appropriate level in screening for drug use.
3. The **brief intervention: Alcohol** code is relevant for providers, hospitals and health plans that provide care for patients with otherwise undetected and untreated substance use problems. The code allows tracking whether patients are receiving effective interventions for alcohol problems. The code will provide objective data in pay-for-performance and other quality improvement processes to identify providers, facilities and health plans that are doing an appropriate job at addressing hazardous alcohol use in their patients.
4. The **brief intervention: Drug** code is relevant for providers, hospitals and health plans that provide care for patients with otherwise undetected and untreated substance use problems. The code allows tracking whether patients are receiving effective interventions for drug use problems. The code will be helpful objective data in pay-for-performance and other quality improvement processes to identify providers, facilities and health plans that are doing an appropriate job at addressing hazardous drug use in their patients.

**B-2.** Describe how the measure is substantially influenced by those described in B-1 above.

1. **Hazardous alcohol use screening** provides objective data on how effectively patients are being routinely assessed for hazardous substance use, an extremely common and under treated condition that is associated with premature mortality for every age group between age 3 and 44 through motor vehicle fatalities. Providers and health plans can greatly influence hazardous alcohol use identification rates through changes in administrative policies and procedures, training, and accountability. For example, implementing an electronic clinical reminder prompt of the 3 question AUDIT-C in the VA increased screening rates by 500% over prior un-prompted screening (Bradley et al, 2006).
2. **Hazardous drug use screening** provides objective data on how regularly patients are being assessed for illicit drug use. Providers and health plans can greatly influence substance use identification rates through changes in administrative procedures, training, and accountability.
3. **Brief intervention: Alcohol** provides objective data on how frequently patients receive feedback, advice and motivational counseling from providers to reduce hazardous drinking patterns which will reduce their health risk. Analyses of 11 studies of alcohol brief interventions in primary care suggests that amount of training, changes in administrative processes and clinical supports are associated with increased rates of brief intervention (Nilsen et al, 2006).
4. **Brief intervention: Drugs** provides objective data on how frequently patients receive feedback, advice and motivation al counseling from health care providers to reduce use or to stop use of illegal drugs or non-medical use of prescription drugs. Tracking whether brief intervention for drug use is performed provides physicians with feedback that can be used to close the gap between highly prevalent hazardous drug use and the low incidence of treatment (OAS, 2006).

**C. The code reduces burden on physicians (or other practitioner or entity), reflects the work they perform, and is useful in physicians' practice.**

**C-1.** How would a code reduce data collection burden on physicians (or other practitioner or entity)?

1. Having a code that indicates performance of **hazardous alcohol use screening** using a standardized screening tool (the AUDIT, the AUDIT-C or CRAFFT) could reduce the burden on providers and health plans when documenting compliance with HEDIS indicators, PCPI, and trauma center requirements. Currently, in order to document compliance, providers must access medical records and look for documentation that screening took place. Such efforts are frustrated by inadequate documentation in the medical or administrative records.
2. Having a code that indicates performance of **hazardous drug use screening** using a standardized screening tool (e.g., the DAST) could reduce the burden on providers and

health plans when documenting compliance with HEDIS indicators, PCPI, and trauma center requirements. Currently, in order to document compliance, providers must access medical records and look for documentation that screening took place. Such efforts are often frustrated by inadequate documentation of screening in the medical or administrative records.

3. Having a code that indicates **brief intervention for alcohol** occurred will reduce the burden on providers and health plans that have to pull medical records to report on brief intervention for accreditation (e.g., ACS-COT trauma center accreditation) or performance measurement (e.g., NCQA HEDIS chemical dependency identification and initiation measures).
4. Having a code that indicates **brief intervention for drugs** occurred will reduce the burden on providers and health plans that have to pull medical records to report on brief intervention for accreditation or performance measurement.

**C-2.** Describe how a code would reflect the work of physicians (or other practitioner or entity) for the measure described in A.

1. A code for **hazardous alcohol use screening** would reflect that the provider is administering an objective, validated clinical tool that can identify quantity, frequency, consequences, and risky or dependent use of alcohol.
2. A code for **hazardous drug use screening** would reflect that the provider is doing well at assessing illegal drug use and misuse of prescription drugs.
3. A code for **brief intervention for alcohol** would reflect that the provider is providing specific feedback, and using methods to increase patient motivation to reduce hazardous alcohol use or to engage in available treatments.
4. A code for **brief intervention for drugs** would reflect that the provider is providing specific feedback and using methods to increase patient motivation to stop hazardous drug use, or to accept a referral for appropriate treatment.

**C-3.** How would the use of a code and corresponding data it provides as feedback be useful in physicians' practice?

1. If providers, hospitals and health plans are able to identify the percentage of patients that have this code (**hazardous alcohol use screening**) and are able to compare their rates with others with similar practices or settings, they will know if they need to be more aggressive in their screening strategies, or they are on target and need to continue their current practices.
2. If providers, hospitals and health plans are able to identify the percentage of patients that have this code (**hazardous drug use screening**) and are able to compare their rates with others with similar practices or settings, they will know if they need to be more aggressive in their screening strategies, or they are on target and need to continue their current practices.

3. If providers, hospitals and health plans are able to identify the percentage of their patients that have this code (**brief intervention for alcohol**), they can determine if they need to be more aggressive in counseling patients to reduce or abstain from use, to express concern about the health consequences, and to link those with more severe or complicated alcohol use conditions to specialty treatment and ongoing monitoring. The code will give providers objective data to know whether changes are needed or if they are on target and need to continue their current practices.
4. If providers, hospitals and health plans are able to identify the percentage of their patients that have this code (**brief intervention for drugs**), they can determine if they need to be more aggressive in counseling patients to reduce or abstain from use, to express concern about the health consequences, and to link those with more severe or complicated substance use conditions to specialty treatment and ongoing monitoring. The code will give providers objective data to know whether changes are needed or if they are on target and need to continue their current practices.

**D. The measure upon which this code is based is significant.**

**D-1. How does the measure affect a large segment of the health care community?**

1. Approximately 18.9 million Americans drink in hazardous or dependent ways (OAS, 2006). The prevalence of hazardous alcohol use in primary care practices is much more common: as high as 30% in primary care (Saitz, 2005; Whitlock et al, 2004) and 40% to 60% in hospital emergency services and trauma centers (Rockett et al, 2003; 2005). Yet, physicians and other health care providers identify less than one patient in ten who have an alcohol use disorder (NCQA, 2006; OAS, 2006). Many drinkers seek out or require medical treatment for health problems attributable to their alcohol use without their hazardous use ever being detected. There is a dose-response relationship between average daily alcohol consumption and elevations in blood pressure and risk of cirrhosis, hemorrhagic stroke, trauma and cancers of the oropharynx, larynx, esophagus, and liver (Rehm et al., 2003). Medical problems due to heavy and prolonged alcohol use include alcohol withdrawal syndrome, psychosis, hepatitis, cirrhosis, pancreatitis, thiamine deficiency, neuropathy, dementia, and cardiomyopathy. Screening is not aimed just at substance use dependent individuals, but also at the far larger population of patients at risk for problems due to hazardous alcohol use. If their alcohol problems are detected, hazardous users and alcohol dependent patients benefit from brief primary care counseling (Babor & Kadden, 2005; D'Onofrio & Degutis, 2002; Miller & Willbourne, 2002; Saitz, 2005; Moyer et al., 2002).
2. Of the 7.6 million Americans who need treatment due to their drug dependence or drug abuse disorder, only 1.3 million report receiving any treatment for their condition (17% of those in need: OAS, 2006). More than one-fourth of emergency department patients (Rockett et al, 2003, 2005), and as many as 65% of trauma center patients have illicit drugs in their systems or report recent drug use on questionnaires (Dischinger, Mitchell, Kufera, Soderstrom, & Lowenfels 2001; Walsh, 2004; Walsh et



al., 2005). Less than 5 percent of primary care patients use drugs in hazardous or dependent ways (Mertens et al, 2005). Low screening rates for drug use in emergency departments, trauma centers and ambulatory practices are associated with low rates of detection and treatment. Screening is aimed at detecting patients with diagnosable substance use disorders and the far larger population of patients at risk for problems due to drug use. Both groups of patients benefit from brief counseling interventions delivered in general medical settings such as emergency departments, trauma centers, and ambulatory primary care (Babor & Kadden, 2005; Burke, Arkowitz, & Menchola, 2003; Miller et al, 2003).

3. **Brief intervention for alcohol** is important because screening alone has been found repeatedly to have no impact on health outcomes in hazardous or dependent alcohol users (USPFT, 2005). Nor does screening alone increase alcohol-related counseling (Nilsen et al, 2006). Brief alcohol interventions for patients who drink excessively has been designated one of the top 10 prevention priorities for the US (Maciosek et al, 2006). The low rates of screening and intervention in many health care settings are associated with increased risk of injury, illness, disability and death. Brief interventions following an initial positive substance use screen, on the other hand, are associated with reductions in drinking, reductions in hazardous patterns of substance use, reductions in traffic fatalities and DUIs (driving under the influence of alcohol or other drugs), reduced injuries and illnesses, and reductions in use of emergency services and hospital inpatient services (Cydulka, Harmody, Barnoski, Fallon, & Emerman, 1998; Blondell, Looney, Hottman, & Boaz, 2002). Both the hazardous alcohol use screening and brief intervention measures have the potential for tremendous impact across many health care settings, including primary care and specialty care ambulatory practice, hospital emergency services, and inpatient, and on the health care and disability costs of employers and public purchasers of health care.
4. **Brief intervention for drugs** is important for the reasons stated above (Babor & Kadden, 2005; Dunn et al, 2001; Bernstein et al, 2005).

**D-2.** Describe how the measure is tied to health outcomes.

1. Nearly 19 adolescents and adults in the U.S. drink in hazardous or dependent ways, but only 7% are identified and receive treatments that can reduce their risk of health problems and premature mortality (OAS, 2006). Reliance on clinical judgment results in low identification rates and low rates of engaging patients in treatment (Gentilello et al, 1999). When the Veterans Administration initiated use of a standardized screening tool for risky and dependent substance use, the AUDIT-C, rates of identification of problem drinking increased from 4.5% to 25% in a 15 month trial involving 1.5 million administrations of the brief screen (Bradley et al, 2006).
2. 7.6 million adolescents and adults in the U.S. use drugs in hazardous or dependent ways, but fewer than 17% are identified and receive treatments that can reduce their risk of health problems and premature mortality (OAS, 2006). Reliance on clinical judgment results in low identification rates and low rates of engaging patients in treatment (Rockett et al, 2003, 2005; Babor & Kadden, 2005; Dunn et al, 2001).
3. **Brief intervention for alcohol** is the crucial step following screening and identification of alcohol use problems that can facilitate patients' decisions to reduce use. In 2004, the U.S. Preventive Services Task Force recommended routine, annual

screening for hazardous alcohol use and brief interventions for those screening positive as an effective public health intervention. Persons with untreated alcohol use problems are at increased risk of injury, illness and premature death. Persons who receive brief interventions are less likely to be injured, require emergency services and inpatient treatment, be arrested for driving under the influence, and become involved in motor vehicle crashes (Dunn et al, 2000; Gentilello et al, 1999; Babor & Kadden, 2005). Several recent effectiveness trials have found a beneficial effect of brief alcohol counseling for alcohol dependent patients and hazardous drinkers (Horton et al, 2003; Ockene et al, 1999; Babor et al, 2006).

4. **Brief intervention for drugs** is the crucial step following screening and identification of substance use problems that can facilitate patients' decisions to reduce or halt drug use. Persons with untreated drug use problems are at increased risk of injury, illness and premature death. Brief interventions can assist patients to reduce use and facilitate entrance into specialty treatment for those with more complicated and severe substance use disorders (Bernstein et al, 2005; McCambridge & Strang, 2004; White et al, 2006; Stotts et al, 2001; Babor & Kadden, 2005).

**D-3.** Describe how the measure addresses clinical conditions of high prevalence, high costs, high risks?

1. As stated above, there is a high prevalence of problematic substance use among adolescents and adults in the US. But most people who are high risk substance users are never identified and never receive effective care. The total annual economic burden of alcohol use problems in the U.S. is estimated at \$186 billion annually. The health care costs associated with substance use tops \$26 billion, but only one-fifth of that amount is spent on the actual treatment of substance use problems (Hon, 2003; Harwood, 2000). Four out of five alcohol use-related treatment dollars are spent on treatment of the illnesses and injuries that are caused or complicated by alcohol use. Persons with hazardous alcohol use patterns who are not identified in the health care system are at high risk developing alcohol dependence, injuring themselves and others in vehicle crashes, and severe illnesses and death. The measure of **hazardous alcohol use screening** helps to identify where providers and health plans can improve the care of their patients with hazardous substance use and thus reduce the risk of these poor outcomes. The measure of brief intervention for hazardous alcohol use enables tracking of clinicians' efforts directed at positive screens for this prevalent, costly, high-risk condition.
2. The prevalence of problem use of illegal drugs and misuse of prescription drugs for non-medical purposes is substantial. But most people (5 out of 6) who are high risk substance users are never identified and never receive effective care (OAS, 2006). The burden of illicit drug use and misuse of prescription medications is \$166 billion. The health care costs associated with drug use is \$16 billion, but only one-third of that amount is spent on the actual treatment of drug problems (Harwood, 2000). The other two-thirds of health expenditures are spent on treatment of the illnesses and injuries that are caused or complicated by drug use. Persons with hazardous drug use patterns who are not identified in the health care system are at high risk developing drug dependence, injuring themselves and others in vehicle crashes, and severe illnesses and death. The measure of **hazardous drug use screening** helps to identify where providers and health plans can improve the care of their patients with hazardous

substance use and thus reduce the risk of these poor outcomes. The measure of brief intervention for hazardous drug use enables tracking of clinicians' efforts directed at positive screens for this prevalent, costly, high-risk condition.

3. Screening is the necessary first step, but is insufficient in itself, in producing the behavioral changes to reduce mortality and morbidity risk associated with hazardous alcohol use. **Brief interventions for alcohol** that follow substance use screening are the most effective alcohol treatment technique identified in a study of 361 controlled clinical alcohol trials (Miller & Willbourne, 2002). Meta-analyses of substance use treatment using motivational interviewing, the core technology of substance use brief intervention, found moderate effect sizes for reductions in alcohol consumption (Moyer et al, 2002).
4. **Brief interventions for drug use** that follow hazardous drug use screening are effective at reducing drug use and improving such social outcomes as drug use-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems ( Moyer et al, 2002).

#### **E. The measure is evidence-based.**

**E-1.** Describe the evidence-base from which this measure was derived.

1. **Hazardous alcohol use screening** using standardized screening questionnaires such as the ten item AUDIT or the three item AUDIT-C is recommended as the most effective way of identifying patients who drink in hazardous ways by the clinical guidelines of 8 medical societies (APA, AAP, AAFP, AACAP, ASAM, ACEP, ACS-COT), the American Medical Association, Federal government health agencies such as the VA, DOD, SAMHSA, NIAAA, CDC, NHTSA and ONDCP, and the practice standards of the major health insurance plans and employer coalitions. Studies in emergency settings, trauma care, inpatient and ambulatory settings have shown the superior reliability, sensitivity and specificity of standardized alcohol screening questionnaires compared to clinical judgment, and better guidance for treatment. Implementation of routine, electronic medical system-prompted alcohol problem screening in the Veterans Health Administration (using the AUDIT-C) increased rates of identification of hazardous alcohol use by more than 500% (Bradley et al, 2006; Babor & Kadden, 2005; NIAAA, 2003; Fiellan, Reid, & O'Connor, 2000).
2. **Hazardous drug use screening** is recommended as the an essential first step to identifying patients who use drugs according to the clinical guidelines of several medical societies (APA, AAP, AAFP, AACAP, ASAM, ACEP), Federal government health agencies such as the VA, DOD, SAMHSA, NIDA, CDC and ONDCP, and the practice standards of the major health insurance plans and employer coalitions. Standardized brief questionnaires, such as the 10-item DAST and the online DAPA-PC (Drug Abuse Problem Assessment for Primary Care), can improve sensitivity and reliability of detecting drug use in general medical practice (Zeiler et al, 2002; Nemes et al, 2004; Babor & Kadden, 2005).
3. Many professional medical societies, Federal health agencies, health plans and

employers recommend **brief intervention** for patients who drink in hazardous ways. These recommendations are based on more than 20 controlled trials involving more than 15,000 patients, including 8 randomized, prospective trials, that document efficacy and effectiveness of brief intervention. Brief intervention (BI) is a specific set of behavioral counseling techniques with proven effectiveness in reducing risky drinking, and preventing or reducing subsequent health consequences when delivered by trained providers who apply the techniques with fidelity. Comparisons between BI and routine medical advice or non-specific alcohol counseling provided by medical practitioners consistently find greater clinical effect for screening and intervention across a broad range of clinical populations, providers, and outcomes. Indeed, a combined analysis of 361 clinical trials of different types of alcohol counseling methods found BI to be the most effective of the 40 different methods studied. Non-specific, generalized medical counseling without use of BI techniques ranked 39th out of the 40 treatments studied (Hester & Miller, 2003). More than 30 controlled clinical trials, including over a dozen randomized, controlled clinical trials, have shown the efficacy and effectiveness of BI techniques as delivered by physicians and other health care providers across a wide range of settings and patient populations. The US Preventive Services Task Force (Whitlock et al, 2004) recommended routine use of screening and intervention for all adults, including pregnant women, in the primary care setting.

4. Several medical specialties recommend brief substance abuse interventions for patients who use drugs in hazardous ways. Federal health agencies such as the Substance Abuse and Mental Health Services Administration and the Office of National Drug Control Strategy, along with the largest health plans in the country and employer coalitions recommend brief intervention for patients who use substances in hazardous ways. The effectiveness of brief interventions for patients who use drugs has been extensively demonstrated (Babor & Kadden, 2005; Burke, Arkowitz, & Menchola, 2003; Miller et al, 2003; Booth, Kwiattkowski, Iguchi, Pinto, & John, 1998; Martino, Grilo, & Fehon, 2000; Saunders, Wilkinson, & Phillips, 1995; Schneider, Casey, & Kohn, 2000; Stephens, Roffman, & Curtin, 2000; Copeland, Swift, Roffman, & Stephens 2001; Marijuana Treatment Project Research Group, 2004; Lang et al, 2000; Baker et al., 2002; Miller et al. 2003).

**E-2.** Describe the evidence-based process used for development of the measure.

1. Extensive review of the literature, clinical practice standards, and consensus development processes were used for development of the **hazardous alcohol screening measure** by the Veterans Health Administration, the Physicians Consortium for Performance Improvement, and the Joint Commission for Accreditation of Healthcare Organizations.
2. Extensive review of the literature, clinical practice standards, and consensus development processes were used for development of the proposed **hazardous drug screening measure**. The proposed measure developers received input from SAMHSA, ONDCP, VA, IHS, CDC, PLNDP, and physicians across a wide spectrum of specialties.
3. Extensive review of the research literature and clinical practice standards were used for

the development of the **brief intervention for alcohol measure**. The proposed measure developers received input from SAMHSA, ONDCP, VA, CDC, Indian Health Service, PLNDP, and physicians across a wide spectrum of specialties.

4. Extensive review of the research literature and clinical practice standards were used for the development of the **brief intervention for drugs measure**. The proposed measure developers received input from SAMHSA, ONDCP, VA, IHS, CDC, PLNDP, and physicians across a wide spectrum of specialties.

**F. Risk adjustment instructions and specifications for all outcome measures are included or compelling evidence as to why risk adjustment is not relevant is explained.**

**F-1.** Describe the risk adjustment instructions and specifications for use of the measure or cite compelling evidence why risk adjustment is not relevant for this measure.

1. **Screening for hazardous alcohol use** is a process measure. Guidelines from professional associations and government health agencies suggest that administration of alcohol screening should be routine (e.g., USPSTF, 2005). The measure is not an outcome, so no risk adjustment is needed.
2. **Screening for hazardous drug use** is a process measure. Guidelines from professional associations and government health agencies suggest that drug screening should be routine. The measure is not an outcome, so no risk adjustment is needed.
3. Although the prevalence of hazardous use of alcohol will vary substantially from setting to setting, depending on the socio-demographic characteristics of patient populations and type of practice, the tracking measure, **brief intervention for alcohol**, indicates only whether the service was performed. The measure is not an outcome, so no risk adjustment is needed.
4. Although the prevalence of drug use will vary substantially from setting to setting, depending on the socio-demographic characteristics of patient populations and type of practice, the tracking measure, **brief intervention for drug use**, indicates only whether the service was performed. The measure is not an outcome, so no risk adjustment is needed.

**G. The measure contains data elements sufficiently detailed to make it useful for multiple purposes.**

**G-1.** Describe how the data elements included in this measure may be used for multiple purposes.

1. The **hazardous alcohol use screening** measure can provide information about the prevalence of hazardous and dependent alcohol use in a broad variety of practices, including inpatient and outpatient, and across different ages, genders, and medical conditions, enabling its use for multiple purposes. It can be combined with other administrative record information to develop predictive models of the types of co-occurring illnesses and injuries, and patient characteristics most likely to be associated with hazardous alcohol use. It can be used to determine the impact of policy changes, such as changes in mandatory health insurance coverage for alcohol treatment, changes in underage drinking laws, and impact of payer reward programs such as pay for performance.
2. The **hazardous drug use screening** measure can provide information about the prevalence of hazardous substance use in a broad variety of practices, including inpatient and outpatient, and across different ages, genders, and medical conditions, enabling its use for multiple purposes. It can be combined with other administrative record information to develop predictive models of the types of co-occurring illnesses and injuries, and patient characteristics most likely to be associated with hazardous substance use. It can be used to determine the impact of policy changes, such as changes in mandatory health insurance coverage for substance use treatment, and impact of payer reward programs such as pay for performance.
3. The **brief intervention for alcohol** measure can provide information on whether patients are receiving effective and prompt brief treatment. In conjunction with administrative records data on subsequent specialty alcohol treatment procedures, it can be useful in assessing the effectiveness of brief interventions in motivating patients with serious alcohol use disorders to engage in specialty treatment. The brief intervention code could be valuable to providers, facilities and health plans that are working to improve their low rates on the NCQA HEDIS chemical dependency identification, initiation and engagement measures.
4. The **brief intervention for drugs** measure can provide information on whether patients are receiving effective and prompt substance use brief treatment. In conjunction with administrative records data on subsequent substance use treatment procedures, it can be useful in assessing the effectiveness of brief interventions in motivating patients with drug use disorders to engage in specialty treatment. The brief intervention code could be valuable to providers, facilities and health plans that are working to improve their low rates on the NCQA HEDIS chemical dependency identification, initiation and engagement measures.

**H. The proposed tracking code facilitates reporting of performance measure(s).**

**H-1.** How would the use of a tracking code facilitate reporting of the measure described in criterion A above?

Tracking codes would make it easier for providers, facilities (hospitals, emergency departments, clinics), and plans to identify their overall effectiveness in identifying patients with hazardous substance use and who are at risk of adverse health outcomes associated with substance use by employing administrative data rather than searching through medical records for notations of clinical impressions or through patient surveys. These two latter methods are used by the Veterans Health Administration to measure hazardous alcohol use screening, for example. Both methods require considerable expense and time to collect, and both are subject to serious threats to validity and reliability from sampling error and power, response biases, and provider and coder error. Information will be more rapidly and objectively available for quality improvement and accountability. Objective administrative data can be more readily and reliably accessed to demonstrate performance of screening and brief intervention for accreditation purposes (e.g., American College of Surgeons -- Committee on Trauma accreditation standards for level I and II trauma centers, the JCAHO pilot BHIG accreditation measures for inpatient psychiatric services).

**I. The proposed tracking code includes select patient history, testing (e.g., hemoglobin A1C), other process measures, cognitive or procedure services within CPT, or physiologic measures (e.g., blood pressure, etc.) to support performance measurement.**

**I-1.** Describe how a tracking code would include the necessary data elements to support performance measurement.

1. The tracking code **hazardous alcohol use screening** would identify persons who have received a standardized assessment of hazardous use, and can be viewed as an extension of a select portion of the patient history. The information acquired by the screening questionnaire alone provides all needed data elements to support performance measurement.
2. The tracking code **hazardous drug use screening** would identify persons who have received an assessment of their use of illegal drugs and misuse of prescription medications, and can be viewed as an extension of a select portion of the patient history. The information acquired by the screening questionnaire or clinical interview alone provides all needed data elements to support performance measurement.
3. The tracking code **brief intervention for hazardous alcohol use** would identify persons who receive feedback about their hazardous drinking, expressed clinical concern about the health consequences of their alcohol use patterns, and efforts to increase motivation to choose options to modify their behaviors. It is a cognitive procedure that alone provides all needed data elements to support performance measurement.
4. The tracking code **brief intervention for drug use** would identify persons who receive feedback, expressed clinical concern about the health consequences of their substance use patterns, and efforts to increase motivation to choose options to modify their behaviors. This is a cognitive procedure that alone provides all needed data elements to support performance measurement.

**J. The performance measure development process includes a nationally recognized expert panel with multidisciplinary representation and appropriate vetting.**

**J-1.** Describe the nationally recognized expert panel that developed the measure.

1. The **hazardous alcohol use screening** measure is currently included in the Physicians Consortium for Performance Improvement preventive measure set, and the JCAHO's pilot Hospital-Based Inpatient Psychiatric Services core measure set. In addition, all level I and II Trauma Centers in the US must screen for hazardous alcohol use to retain accreditation by the American College of Surgeons. The measure is currently included as a required element for grantees of the Center for Substance Abuse Treatment, an agency within the Department of Health and Human Services, in 17 states.
2. The **hazardous drug use screening** measure is currently included in the JCAHO's pilot Hospital-Based Inpatient Psychiatric Services core measure set. The measure is currently included as a required element for grantees of the Center for Substance Abuse Treatment, an agency within the Department of Health and Human Services, in 17 states.
3. The **brief intervention for alcohol** measure is used by the Center for Substance Abuse Treatment as a required element for grantees in 17 states that routinely report rates of screening and brief interventions performed, accumulating data on 449,000 screenings and more than 67,000 brief interventions over the last two years.
4. The **brief intervention for drugs** measure is used by the Center for Substance Abuse Treatment as a required element for grantees in 17 states that routinely report rates of screening and brief interventions performed, accumulating data on 449,000 screenings and more than 67,000 brief interventions over the last two years.

**J-2.** Describe the multidisciplinary review process used to achieve consensus on the measure among all constituents of the respective organizations, including internal and public comment processes.

1. The **hazardous alcohol use screening** measure has been adopted by multiple organizations, and, thus, the process varies. For example, in the VHA, it was subject to internal and external public and professional review and comment (the VHA alcohol screening measure is derived from medical record review and patient survey, not from administrative records). The JCAHO measure was developed by a multidisciplinary group of performance measure experts representing public and private behavioral health care providers, and is presently undergoing pilot testing. The PCPI screening measure has been reviewed by all member professional associations, accrediting organizations and the public.
2. The **hazardous drug use screening** measure in the JCAHO inpatient psychiatric hospital measure set was developed by a multidisciplinary group of performance measure experts representing public and private behavioral health care providers, and is



presently undergoing pilot testing. The proposed measure developers received input from SAMHSA, ONDCP, VA, CDC, Indian Health Service, PLNDP, and physicians across a wide spectrum of specialties.

3. The **brief intervention for alcohol** measure is included in clinical practice standards by 7 professional medical societies, the AMA, Federal health agencies and health plans which recommend routine brief intervention for persons with hazardous substance use, all of which have been developed with considerable internal and public review. The proposed measure developers received input from SAMHSA, ONDCP, VA, CDC, Indian Health Service, PLNDP, and physicians across a wide spectrum of specialties.
4. The **brief intervention for drugs** measure is included in the clinical practice standards by several professional medical societies, the AMA, Federal health agencies and health plans which recommend routine brief intervention for persons with hazardous drug use, all of which have been developed with considerable internal and public review. The proposed measure developers received input from SAMHSA, ONDCP, VA, CDC, Indian Health Service, PLNDP, and physicians across a wide spectrum of specialties.

**J-3.** Describe how the testing for validity and feasibility for the measure was accomplished.

1. The validity, reliability of the **hazardous alcohol use screening** measures, using the AUDIT, AUDIT-C and CRAFFT, have been extensively tested in a variety of settings (emergency departments, ambulatory care, inpatient, trauma care) and across a wide range of populations (age, sex, ethnicity, primary language, presenting problems). Comparison with other screening instruments and structured research diagnostic interviews find the AUDIT is superior in sensitivity and specificity for hazardous alcohol use to other screening measures.
2. The **hazardous drug use screening** measures, indicates screening for use of illicit drugs or use of prescription drugs for non-medical use. Unlike alcohol, the variety of drugs available is extensive, and there is no short list of available screening tools that cover all possibilities. This measure seeks to document that physicians obtaining a medical history have inquired about the use of drugs for psychotropic, as opposed to medicinal, purposes. Abundant data have documented that patients do not routinely volunteer such data, and information about use of drugs is more likely to be successfully obtained when physicians include such inquiries when obtaining a routine history.
3. The **brief intervention for alcohol** measure captures use of a set of well-studied counseling techniques. The feasibility and validity of coding brief interventions have been established through multiple prospective randomized trials (Babor et al, 2005; Gentilello et al, 1999; Dunn et al, 2000; Babor & Kadden, 2005).
4. The **brief intervention for drugs** measure captures use of a set of well-studied counseling techniques. The feasibility and validity of coding brief interventions have been established through multiple prospective randomized trials (Bernstein et al, 2005; Babor & Kadden, 2005; Dunn et al, 2000).

**K. The performance measure for which a tracking code is sought is not currently coded using existing code sets designated under HIPAA (e.g., CPT Category I, ICD-9-CM, or HCPCS codes).**

**K-1.** Describe any specific code(s) that with modification might serve as a tracking code.

Screening and brief intervention are discrete and definable processes. For each, there are specific work elements. Although there are many procedure codes providers may use the may include screening and brief intervention elements, there are no unique, discrete codes in the current CPT Category I that cover all of the work elements involved in screening and intervention for alcohol or for drugs. For example, providers may use any of the following codes which could include elements of alcohol or drug screening: 90801, 99201, 99212, 99222, 99241, 99251, 99281, H0001, H0049. Brief intervention may be included in any of the following procedure codes: 90804, 90816, 99202, 99221, 99241-99242, 99251-99252, 99281, 99282, 994012, H0004, H0050. Some procedure codes that, on the surface, appear particularly relevant as alternatives to the proposed tracking codes, such as the HCPCS Level II codes H00049 and H0050, can only be used with certain payers (Medicaid), so would be inadequate for measuring general medical performance on screening and intervention. Other codes, such as the E&M CPT Category I codes, cover so many procedures in addition to substance use screening and intervention that it would be impossible to distinguish screening and brief intervention.

Using procedure and diagnostic codes together to identify hazardous alcohol and drug screening and brief intervention for tracking purposes is also problematic. Screening and brief interventions are generally provided to patients whose hazardous alcohol and drug use do not meet the full DSM IV-R or ICD-9 diagnostic criteria of substance use disorder. One of the justifications for tracking hazardous alcohol and drug screening and brief intervention is that brief physician counseling of patients with hazardous substance use patterns will prevent progression to diagnosable substance use disorders. The appropriate application of hazardous alcohol and drug screening and brief intervention with patients whose alcohol or drug use does not reach the diagnostic thresholds of substance dependence on DSM IVR or ICD-9 makes it impossible to derive the tracking measures from diagnostic codes in administrative records. Consequently there are no existing procedure code sets or proposed procedure codes that could be used to track more than a fraction of screening and brief intervention.

**L. Code language addition, deletion, and/or revisions requested.**

**L-1.** If this is a new code, specify the recommended terminology (code descriptor) for the proposed CPT Category II code. Specify the placement of the proposed code in the current text of CPT (list section, subsection). Also list abbreviations or other technical names for the Clinical Condition or topic that is being addressed. A footnote should be created to identify the measure organization or other origin of the measure from which the suggested code is to be derived. The footnote should include the measure organization's name, and website address, if any. Underline the footnote listing if it is new to the Category II coding section.

**Category II**

**Patient History**

1XXXXF     *Hazardous alcohol use screen*  
1XXXXF     *Hazardous drug use screen*

**Therapeutic, Preventive or Other Interventions**

4XXXXF     *Alcohol brief intervention*  
4XXXXF     *Drug brief intervention*

**Footnotes:**

*JCAHO Hospital- Based, Inpatient Psychiatric Services (HBIPS) Candidate Core Measure Set*

<http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Hospital+Based+Inpatient+Psychiatric+Services.htm>

*Substance use screening: percent of patients annually screened for substance use misuse. Office of Quality and Performance (10Q). FY 2005 VHA executive career field network director performance measurement system and JCAHO hospital core measures. Technical manual. Washington (DC): Veterans Health Administration (VHA); 2005 Mar 9. Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01.*

<http://www.oqp.med.va.gov/general/uploads/FINAL%20FY05%20TM%20SUD%2010%2018%2004.doc>

*Physician Consortium on Performance Improvement, Preventive Care and Screening Measurement Sets* <http://www.ama-assn.org/ama1/pub/upload/mm/370/preventiveset-12-05.pdf>

**L-2.** If this code is proposed for revision, specify the recommended terminology (code descriptor) for the proposed revised code. Use the conventional techniques of strike-outs for deletions and underlining for additions/revisions. Also, indicate the revision(s) in context with the current code descriptor (list the complete family of codes related to your request).

NA

**L-3.** If you are recommending a code deletion, please provide the recommended cross-reference (i.e., how is the deleted service now to be coded?) Include the conventional technique of strike-outs for deletions.

NA

**M. Appendix H Listing.**

**M-2. Hazardous Alcohol Use Screening**

Brief Description of Performance Measure & Source	CPT Code(s)	Brief Code Descriptor
<p><b>Hazardous alcohol use screening</b></p> <p>Whether or not new patients were screened using a standardized substance use screening instrument (the AUDIT-C, AUDIT or CRAFFT) and established patients were screened at least once in the past year with one of the standardized substance use screening instrument.</p> <p><b>Numerator:</b> Patients screened using one or more of the standardized screening tests.</p> <p><b>Denominator:</b> All new patients and established patients.</p> <p><b>Exclusion(s) (If any):</b> Patients younger than 15 and older than 75 years of age and cognitively impaired and terminally ill patients.</p> <p><b>REPORTING INSTRUCTIONS:</b>            Patients with consistent documentation of not using alcohol in the prior 12 months are included in both the numerator and denominator as indicative of screening            Patients already enrolled and actively receiving treatment for alcohol use are included in the numerator and denominator as indicative of screening.</p>	<p><b>1XXXF</b></p>	<p>Hazardous alcohol use screening</p>

**M-2. Hazardous Drug Use Screening**

Brief Description of Performance Measure & Source	CPT Code(s)	Brief Code Descriptor
<p><b>Hazardous Drug Use Screening</b></p> <p>Whether or not new patients were screened for illegal drug use and misuse of prescription drugs. May use a standardized drug use screening instrument (the DAST) and established patients were screened at least once in the past year.</p> <p><b>Numerator:</b> Patients screened.</p> <p><b>Denominator:</b> All new patients and established patients.</p>	<p><b>1XXXF</b></p>	<p>Hazardous Drug Use Screening</p>

<p><b>Exclusion(s) (If any):</b> Patients younger than 15 and older than 75 years of age and cognitively impaired and terminally ill patients.</p> <p><b>REPORTING INSTRUCTIONS:</b>  Patients with consistent documentation of not using drugs in the prior 12 months are included in both the numerator and denominator as indicative of screening  Patients already enrolled and actively receiving treatment for drug use are included in the numerator and denominator as indicative of screening.</p>		
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**M-2. Brief Intervention: Alcohol**

Brief Description of Performance Measure & Source	CPT Code(s)	Brief Code Descriptor
<p><b>Brief Intervention: Alcohol</b></p> <p>Whether or not a patient receives, brief intervention.</p> <p><b>Numerator:</b> Patients who receive a brief intervention for alcohol.</p> <p><b>Denominator:</b> All new patients and established patients.</p> <p><b>Exclusion(s) (If any):</b> Patients younger than 15 and older than 75 years of age and cognitively impaired and terminally ill patients.</p> <p><b>REPORTING INSTRUCTIONS:</b></p> <p>.</p>	4XXXF	Brief Intervention: Alcohol

**M-2. Brief Intervention: Drugs**

Brief Description of Performance Measure & Source	CPT Code(s)	Brief Code Descriptor
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<p><b>Brief Intervention: Drugs</b></p> <p>Whether or not a patient receives a brief intervention for drug use.</p> <p><b>Numerator:</b> Patients who receive a brief intervention.</p> <p><b>Denominator:</b> All new patients and established patients.</p> <p><b>Exclusion(s) (If any):</b> Patients younger than 15 and older than 75 years of age and cognitively impaired and terminally ill patients.</p> <p><b>REPORTING INSTRUCTIONS:</b></p> <p>.</p>	<p><b>4XXXF</b></p>	<p>Brief Intervention: Drugs</p>
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Please note any comments or observations you have regarding the code or measure here:

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## **Screening and Brief Intervention for Hazardous Alcohol and Drug Use: Consensus and Evidence-Based Practice Guidelines**

SBI manuals, training and continuing medical education programs, and clinical support systems for physicians are widely available from the Federal Substance Abuse Mental Health Services Administration (SAMHSA), Veterans Health Administration (VHA), National Highway Transportation Safety Administration (NHTSA), Centers for Disease Control and Prevention (CDC), specialty medical societies such as (ACEP, ACS-COT), and clinical program developers (e.g., Boston City Hospital, Yale-New Haven, Harborview, Center on Alcohol, Substance Abuse and Addiction). The Accreditation Council for Continuing Medical Education (ACCME) chose SBI as the 2007 demonstration continuing medical education program. ACCME will assist all specialty medical societies to implement CME programs for SBI during the coming year. The Centers for Disease Control, Substance Abuse and Mental Health Services Administration, National Highway Traffic Safety Administration, and National Institute of Alcohol Abuse and Alcoholism recently collaborated and funded publication of guidelines for SBI for use in all American College of Surgeons accredited Level 1 Trauma Centers in the United States.

### **Professional medical societies that recommend SBI:**

- American Psychiatric Association (APA, 1994)
- American Academy of Pediatrics (Kulig, 2005; AAP, 2005)
- American Academy of Family Physicians (Leawood, 2005)
- American Academy of Child and Adolescent Psychiatry (Bukstein, 2004)
- American Society of Addiction Medicine (ASAM, 1997)

- American College of Emergency Physicians (ACEP, 2005, 2006)
- American College of Surgeons ó Committee on Trauma (ACS 2006)
- American College of Obstetricians and Gynecologists (<http://acog.org/>)
- AMA (1999, 2001)

**Federal and state health agencies that have promulgated practice guidelines that include strong recommendations for SBI:**

- The Veterans Administration and Department of Defense joint guidelines for substance use treatment (VA/DOD, 2002).
- National Institute on Alcohol Abuse and Alcoholism ([www.niaaa.nih.gov](http://www.niaaa.nih.gov))
- The Substance Abuse and Mental Health Services Administration Treatment Improvement Protocols numbers 35, 34, 32, 32, 24, 16, 11 and 3 (CSAT, various dates).
- New York State Department of Health (2005).
- The Michigan Quality Improvement Consortium (2005).
- National Quality Forum (2005)

**Major payers that have developed practice standards that include specific recommendations to use SBIs:**

- Magellan and ValueOptions, the largest managed behavioral healthcare companies, published guidelines (Magellan, 2005; ValueOptions, 2006).
- WellPoint and United Healthcare, the largest and second largest healthcare companies recommend primary care SBI (UHC, 2005, MAMSI, 2005);
- National Business Coalition on Health and the National Business Group on Health recommend and monitor health plansøSBI (NBCH, 2006; NBGH, 2006).

**International health organizations and national health ministries that have developed practice standards that incorporate SBI:**

- World Health Organization (Babor, Higgins-Biddle, 2001a,b)
- United Kingdom (2004)
- Scotland (2003)
- Australia (2004)
- Canada (2005)
- European Union 17-country collaborative guideline (Anderson et al, 2005)

**The federal agencies responsible for public health and public safety recommend routine SBI:**

- The White House Office of National Drug Control Policy ( 2006)
- NHTSA (2006) identifies SBI as one of its three strategies for reducing impaired driving
- CDC convened two conferences on SBI, and is assisting businesses to implement SBI
- NIAAA released a guide for primary care clinicians on SBI (NIAAA, 2005).

**Seventeen medical professions recommend SBI training and the demonstration of clinical competency in SBI for professional education (AMERSA, Project MAINSTREAM).**

**Federal health services and major foundations are investing substantial resources in developing SBI demonstration programs:**

- SAMHSA, CSAT has invested more than \$175 million in SBI demonstrations, and supports more than 40 courses and training programs on SBI.
- NIAAA and CDC jointly awarded SBI grants to 10 academic medical centers.
- The Robert Wood Johnson Foundation has invested more than \$1 billion to reduce the harm caused by alcohol and other drug misuse in America. SBI has been a major RWJF emphasis.

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Every code change proposal applicant shall disclose his or her financial and other potential interest as described below in the course of submitting the code change proposal application.

Interests required to be disclosed:

- 1) Applicant may benefit financially from the code change proposal; and/or
- 2) Applicant is a consultant, agent or employee, and applicant should reasonably be aware that applicant's client or employer may benefit financially from the code change proposal.

*This does not include any interest that is limited to providing clinical services to patients (including the service(s) for which a code change proposal is being submitted).*

This disclosure does not restrict or limit the ability of the code change proposal applicant to submit the proposal or to advocate for the CPT changes before the Panel or in writing.

Please complete and sign the following Statement of Compliance. The Statement of Compliance will be disclosed to all individuals reviewing/considering the code change proposal.

**Statement of Compliance with the CPT Code Change Proposal Conflict of Interest Policy**

I understand that I am expected to comply with the CPT Code Change Proposal Conflict of Interest Policy. I will disclose any financial interests or other interest as described in the Conflict of Interest Policy in the above CPT Code Change Proposal. I understand that, should I choose to present the above CPT Code Change Proposal to the CPT Editorial Panel, I have a continuing responsibility to comply with the Conflict of Interest Policy, and I will promptly disclose my interests required to be disclosed under the Policy.

Please check as appropriate:

I have no conflicts as described in the CPT Code Change Proposal Conflict of Interest Policy.

I may benefit financially from the code change proposal; and/or

If checked, please describe: \_\_\_\_\_  
\_\_\_\_\_

I am a consultant, agent or employee, and my client or employer may benefit financially from the code change proposal.

If checked, please describe: \_\_\_\_\_  
\_\_\_\_\_

Signature     *Dan Jensen MD*     Date     December 15, 2006

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Agreed:

Signature: David C. Lewis, MD  
Print Name: David C. Lewis, MD  
Organization: Physicians and Lawyers for National Drug Policy  
Date: December 15, 2006

**Submit your request to:**

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