CPT Codes Promote Substance Abuse Screening

BY SHARON WORCESTER
Southeast Bureau

Two new health care codes for substance abuse screening and brief intervention set to take effect Jan. 1, 2008, will "strengthen the doctor-patient relationship and incorporate a powerful preventive public health resource in America's health care system," according to the White House Office of National Drug Control Policy. But the medical community appears to be taking a wait-and-see approach.

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

"The key issue is not whether there are new CPT codes, but whether insurers and Medicare will pay for them, and could they be added to other CPT codes at the same visit," said Dr. David Spiegel, Willson professor and associate chair in the department of psychiatry and behavioral sciences at Stanford (Calif.) University.

The potential value of these services for patients is another concern; some physicians question the value of "brief interventions" for substance use.

"My immediate response is that the government is putting the cart before the horse insofar as years of inadequate or no funding for drug treatment have left limited resources for physicians to refer to if patients screen positive," said Dr. Jon O. Ebbert, an internist at the Mayo Clinic, Rochester, Minn. "Furthermore, I have concerns about the utility of 'brief interventions' for substance use and whether physicians who bill for these are adequately trained to deliver them."

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

"We already have too many CPT codes in medicine and fewer for mental health services, because our procedures are described as evaluation, psychotherapy, pharmacotherapy, [electroconvulsive therapy], and inpatient care management," said Dr. Beecher, also an adjunct professor of psychiatry at the University of Minnesota, Minneapolis. "Psychiatrists sell time to the government. We are paid the same with no account of the patient's responses. This drives the common denominator to its lowest level and encourages 'upcoding' of work [intensity]."

Dr. Beecher said psychiatrists are currently being paid a low rate by Medicare for patient encounter time, so specifying the content of clinical interventions "will lead to the frustration of obsessive paperwork and whip cracking from clinic managers for 'productivity.' "

The new codes (99408 for interactions of 15-30 minutes, and 99409 for interactions over 30 minutes) were issued by the American Medical Association in October. According to the White House statement, they will enable efficient screening services for subtance abuse (see sidebar), and increase the likelihood of interventions. Similar codes for tobacco use screening and intervention previously were instituted, thus tobacco use screening and cessation counseling are excluded in these codes.

The codes provide medical professionals a means to "communicate concisely and reliably with colleagues, patients and insurers about screening for substance use and appropriate interventions," according to the statement.

If physicians are reimbursed, use of the codes among members will be promoted, said Brian Whitman, a senior analyst for regulatory and insurer affairs with the American College of Physicians. The new codes are important because unlike with tobacco use screening and interventions, substance and alcohol use screening is less common and typically more time-consuming, he said in an interview.

"[Substance use screening] is a bit more specialized," he said. "But to the extent that payers will accept them—and we hope they do—we would encourage members to use them," he said of the codes.

The American Academy of Family Physicians will be "watching closely to see what payers will do," Cindy Hughes, a coding and compliance specialist with the AAFP, said in an interview.

The AAFP's stance on the codes largely will depend on whether payers accept the codes and on the value that is assigned, Ms. Hughes said.

Nonetheless, some see potential benefits with the use of these codes.

"They implicitly acknowledge that screening and short intervention for substance abuse are practical and effective," said Dr. Rodrigo A. Muñoz, of the University of California, San Diego. The codes are a reminder that substance abuse problems are "common, costly, diagnosable, treatable, and often associated with other diagnoses in many medical specialties," he said.

Although Dr. William E. Golden, professor of medicine and public health at the University of Arkansas, Little Rock, said that he agrees with Dr. Ebbert that referral options are limited for those who screen positive, he noted that there is potential value in screening because "understanding patients' habits can alter primary care prescribing even if there are limited options for effective interventions. ■

Questions to ID Substance Abuse

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

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

Most PTSD Therapies Lack Substantive Evidence, IOM Says

BY ALICIA AULT
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Evidence is insufficient to support most of the therapies and medications now in use for posttraumatic stress disorder, concludes an Institute of Medicine panel report issued in October after 9 months of investigation.

"This result was unexpected and may surprise [Veterans Affairs] and others interested in this disorder," the committee wrote in the preface to its report, "Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence."

Among the therapies found to be lacking evidence of effectiveness were cognitive restructuring, coping skills training, individual psychotherapy, and group therapy. In addition, not a single drug therapy has sufficient evidence to say it has utility in treating PTSD, said panel chairman Dr. Alfred O. Berg, professor of family medicine at the University of Washington, Seattle, in a telebriefing with reporters.

Only exposure therapy—in which the patient is exposed to a real or surrogate threat in a safe environment—had enough evidence to warrant a conclusion that it is effective, the panel said.

Dr. Berg pointed out that the aim of the report is to spur more sophisticated research into PTSD's causes, diagnosis, and treatment. It is not meant to provide guidelines for clinicians. "Many of the studies that have looked into the effectiveness of PTSD therapies have limitations and therefore do not provide a clear picture of what works and what doesn't."

The panel was not in complete consensus on all the recommendations. Only two of the eight committee members were psychiatrists, and one—Dr. Thomas A. Mellman of Howard University, Washington—disagreed with the conclusions that selective serotonin reuptake inhibitors were not useful in the general PTSD population and that newer-generation antipsychotics might not be effective.

The Department of Veterans Affairs (VA) requested the IOM study, but its findings have much broader implications, said Dr. Berg, noting that PTSD affects some 12-20 million Americans, only several hundred thousand of whom are veterans. Dr. Berg estimated a lifetime prevalence of 7% in the U.S. population and a current prevalence of 3.6%. In addition, data indicate that 13% of those who have served in Iraq and 6% of those who have served in Afghanistan have experienced PTSD.

Only 90 studies met the committee's criteria for inclusion in its review of the available data. The majority—53—were of pharmaceuticals, and 37 were psychotherapy studies. Many studies had high dropout rates, from 20% to 50%, and statistical analyses used to adjust for that factor weakened results, he said. Studies also had lack of blinding or missing data.

Finally, most of the drug studies were funded by the manufacturers, and most psychotherapies were investigated by their inventors or close collaborators, noted the panel. The IOM committee urged replication of these trials by a broader range of investigators.

The panel reviewed 24 randomized, controlled trials of exposure therapy, some of which had cognitive restructuring or coping skills added as adjunctive therapies.

The evidence also did not address the effects of comorbidities in veterans, including major depression, traumatic brain injury, and substance abuse. So the panel's conclusions might not apply to "the substantial proportion of veterans with one or more important comorbidities," the report said.

The panel recommended that the VA and other organizations that fund research help identify methods to improve the internal validity of research, to encourage broader investigations into more subgroups of veterans and to find ways to fund comparative effectiveness research. There should also be longer follow-up in trials said the panel, noting that no good data exist on optimal duration of drug or psychotherapy treatment.

One of the report's reviewers, Dr. Arthur S. Blank Jr., agreed higher-quality trials of PTSD interventions are needed, but he differed on how those trials should be carried out.

Those studies should be more naturalistic, said Dr. Blank, who served as an Army psychiatrist in Vietnam and as the national director of war veterans counseling centers at the VA headquarters. Most PTSD patients are receiving multiple interventions simultaneously. Studies should be conducted to examine therapies in the way they are administered, said Dr. Blank of the department of psychiatry at George Washington University, Washington.

He also criticized the committee's approach to reviewing the evidence, arguing that randomized, controlled trials cannot truly document the effectiveness of interpersonal psychotherapy. ■