# Provider Bulletin 25-23: Screening for Tobacco Use G-Codes and Suicide Safety Plan M-Codes

1. **Can you provide guidance as to the scope of this screening requirement? Is the pediatric behavioral health population included in the scope? Are the screening requirement and coding focused on inpatient, outpatient, or both?**

   The tobacco screening requirements apply to patients ages 12 and older or school-aged, whichever comes first, and must be completed at least once yearly. Screening is required for all levels.

   The suicide safety plan requirements for submission of M codes apply to patients ages 18 and older with suicidal ideation or behavior symptoms based on the results of a standardized screening tool or assessment. Safety planning M-codes should be submitted for all members over 18 years old (See relevant CPT codes in CBH Provider Bulletin 25-23). Although M codes submission is only accepted for these CPT codes, suicide screening and safety planning should be performed for all members in all levels of care. Additional information will be forthcoming in the CBH Suicide Prevention Clinical Practice Guidelines.

2. **Can you provide guidance on how an organization can receive the OMHSAS bulletins when issued?**

   OMHSAS Systems Notices are posted on the Commonwealth of Pennsylvania's website.

3. **Can you advise on which visit types and/or intervention codes would trigger the use of these?**

   As outlined in CBH Bulletin 25-23, M codes related to Suicide Screening, Assessment, and Safety Planning can be submitted with the CPT encounters outlined. Triggers to Suicide Screening, Assessment, and Safety Planning may occur during intake or clinician assessment during a clinical encounter. The "index clinical encounter" does not always mean intake (although completing at intake is a great practice to ensure you provide adequate assessment for all individuals when developing a case formulation). It could also mean when a person indicates that they are having suicidal thoughts, at any time during treatment, that results in a completed suicide screening event. The "index clinical encounter" is when the suicide screening was completed.

4. **Would we use more than one code at a time? For example, M1350 and 1352 could definitely occur at the same visit.**

   Yes. It is possible to submit more than one code at a time. For example, code M1352 for suicidal ideation may be submitted at the same time as M1350 for completion of a suicide safety plan within 24 hours of the index clinical encounter.

5. **Can you help explain the difference between M1352 and M1355?**

   M1352 will be utilized if the Columbia-Suicide Severity Rating Scale (C-SSRS) or similar evidence-based tool is utilized for the assessment. However, if a C-SSRS was not used but a clinician assessment was completed to assess suicide, and the individual was positive for suicidal ideation, M1355 should be submitted.

6. **Do you have guidance regarding the implementation and frequency of when codes must be submitted? I know that for Depression Screenings, there are guidelines for submitting initial and updated screenings. Is there something like that for the Screening for Tobacco Use G-Codes and Suicide Safety Plan M-Codes?**

   Screening for tobacco use should be done at intake and at least once annually.

   Screening for suicide safety should be completed at intake, at least once annually, and as clinical need arises. More information about screening frequency will be forthcoming in a Suicide Prevention Clinical Practice Guideline.

7. **Because some of these items are defined by absence (e.g., "patient did not complete smoking assessment"), does this mean every visit will need at least one and likely multiple additional locations?**

   G9905 "Patient not screened for tobacco use" should be used in place of codes G9902 "Patient screened for tobacco use AND identified as a tobacco user" or G9903 "Patient screened for tobacco use AND identified as a tobacco non-user." Code G9905 would only need to be used at the same interval as screening occurs – so at intake or at least a routine annual interval.

8. **Do you have recommendations for screening tools to use?**

   Please see the **Treatment of Tobacco Use Disorder Clinical Practice Guideline** and our **Tobacco Recovery and Wellness Initiative (TRWI) webpage** for suggested tobacco use screening tools.

   As outlined in **CBH Bulletin 25-26**, CBH recommends that providers utilize the C-SSRS.

**9. Do electronic cigarettes and chewing tobacco products count as tobacco?**

Any non-prescribed product with nicotine, including but not limited to cigarettes, blunts, chew, snus, snuff, hookah, and electronic devices of any kind, is considered a "tobacco product" and should be considered during screening and treatment. Please see the **Treatment of Tobacco Use Disorder Clinical Practice Guideline** and our **Tobacco Recovery and Wellness Initiative (TRWI) webpage** for a comprehensive list of tobacco product types.