

# Screening Codes for Tobacco Use and Suicide Safety Planning

## Provider Frequently Asked Questions (FAQ)

To support performance measure monitoring and oversight for the OMHSAS Quality Management Tobacco Recovery Quality Initiative and OMHSAS Performance Improvement Project (PIP), OMHSAS requires Magellan Behavioral Health of Pennsylvania (Magellan) to collect both tobacco use screening data (via G Codes through claims submissions) as well as suicide safety plan data (via M Codes through claims submissions). Please see reference to the December 2, 2025 Provider Notice [here](#). The FAQ document below can be used for additional guidance.

**Q. The memo states most of the codes are informational only, which suggest some of them may not be. Is there a fee associated with some of them and if so, is there a fee schedule?**

A. There are no fees associated with the tobacco screening G codes. For suicide safety codes (M codes), the list of corresponding CPT codes should be used when submitting M codes. Some of these codes may be listed on your agency's fee schedule. Please reference the correspondence linked above.

**Q. Which types and/or intervention codes would require these codes?**

A. Please refer to the CPT codes listed where an M code can be accompanied on a claim.

**Q. Are there specific programs or products that qualify?**

A. Any program that completes tobacco screenings and/or completes suicide safety plans should use the G and M codes.

**Q. Are these codes to be used in combination with regular billing codes on every claim submission or used during the treatment planning sessions or ongoing assessments?**

A. Magellan is not dictating a frequency by which these screenings, and therefore codes, should be used. We encourage that tobacco use should be a part of the regular screening process providers engage in when working with members. This may include initial engagement or upon an annual reassessment. Any follow-up screenings and/or services would be based on the outcome of the initial screening and the warranted clinical recommendations.

**Q. For the 96156 and 96160, is this the SDoH measure, or something different? I wasn't sure if there was a particular assessment suggested or expected.**

A. Please see the link [here](#) to OMHSAS' Bulletin issued on 4/15/25 regarding Screening for Tobacco Use G-Codes and Suicide Safety Plan M-Codes. Based on the bulletin these codes are Social Need Screening and Intervention Codes.

**Q. How does a provider include the G and M codes within Magellan's billing system? Do we include a separate line for the G and M codes? Should there be a new claim line with no charges?**

A. Yes, you would use a separate claim line, it would be on the same claim form as the billing code you used when the screening occurred. You will need to put .01 as the charge and 1 as the unit.

**Q. For services billed under CPT codes such as H0030, H2011, H0036, T1017 are we required to submit tobacco screening G-codes and suicide safety planning M-codes?**

A. Yes, your agency is required to submit tobacco screening G-codes and suicide safety planning M-codes if members who are receiving these services are screened for tobacco use and suicide safety planning.

**If so, please confirm the following:**

- **Whether submission of these codes is mandatory or incentive based.** Magellan is asking our provider partners to be in compliance with OMHSAS' bulletin issued on April 15, 2025 [https://www.magellanofpa.com/documents/2025/12/12225\\_providerannouncement\\_screening\\_codes.pdf/](https://www.magellanofpa.com/documents/2025/12/12225_providerannouncement_screening_codes.pdf/) regarding G and M code submissions. This is not incentive based.
- **Which programs or levels of care are subject to the requirement.** Any programs or levels of care that screen for tobacco use and suicide safety planning.
- **Whether the M and G codes must be submitted on the same date of service as the primary service code on the 837P.** Yes, the M and/or G codes must be submitted on the same date of service as the primary service code on the 837P.
- **Any specific billing instructions (e.g., separate claim line, nominal charge amount, etc.).** You would use a separate claim line for the G and M codes. The code (s) will be on the same claim form as the billing code you used when the screening occurred. You will need to put .01 as the charge and 1 as the unit.

**Q. Will you please clarify if we are required to submit via the 837P the G codes, at claim levels? If so, please advise where we can find more information related to setting up the G code in the 837P? Or are we expected to submit any other type of reporting on the G codes?**

A. You would use a separate claim line for the G and M codes. The code (s) will be on the same claim form as the billing code you used when the screening occurred. You will need to put .01 as the charge and 1 as the unit. Additional screening codes are possible and issued by the state. Magellan would communicate any new codes being added.

### **Tobacco (G-Code) Questions:**

**Q. Some items are defined by absence (e.g., “patient did not complete smoking assessment”). Does this mean every visit will require at least one and possibly multiple additional codes?**

A. Members should be screened at least once a year.

**Q. What is the guidance on tobacco screening—should this be completed once, annually, or at another interval?**

A. Tobacco screening should be completed at least once a year.

**Q. We are an IBHS provider and many of our clients are younger. What is the age expectation for use of the G codes?**

A. There is no age expectation. Please use clinical provider judgment to make this determination.

### **Suicide Safety Planning (M-Code) Questions:**

**Q. The CPT codes that are listed with the M codes all appear to be outpatient and psych testing, is this expectation not applicable to IBHS/ABA and Case Management services?**

A. The list of CPT codes should be used when submitting M codes.

**Q. When a client has died, this is typically documented in an incident note, which is non-billable and therefore not linked to a code (e.g., M1356). How should we handle this situation?**

A. The provider would notify Magellan of a member’s death through an adverse incident report.

**Q. Can more than one code be used at the same time? For example, could M1350 and M1352 both apply during the same visit?**

A. Yes, multiple M codes can be listed on a claim.

**Q. Could you help explain the difference between M1352 and M1355?**

A. M1352 states suicidal ideation and/or behavioral symptoms based on the C-SSRS or equivalent assessment and M1355 states suicide risk based on their clinician's evaluation or a clinician-rated tool.

**Q. We received the FAQ, but I’m still not certain about the difference between M1352 and M1355. The FAQ notes again the M1355 is based on the clinician’s evaluation or a clinician-rated tool. But isn’t the C-SSRS a clinician-rated tool and therefore would be the same as M1352?**

A. M1352 is when a structured suicide screening tool like the CSSRS is used, and M1355 is when the clinician assesses suicide risk based on their own clinical experience and/or uses their own “tool” they

have developed. Please see the link [here](#) to OMHSAS' Bulletin issued on 4/15/25 regarding Screening for Tobacco Use G-Codes and Suicide Safety Plan M-Codes.

**Q. IBHS rarely uses 90791, except in cases in which a member's TPL (third party liability) insurance requires it. This then only occurs once every two years. How are we to comply with this expectation?**

A. Please submit M codes, as appropriate, based on the CPT codes listed in the communication. Please note that codes do not need to be submitted if Magellan is secondary payer.

**Q. Specifically, can you please explain what it means to have a "suicide safety plan initiated?" We have an individual crisis plan for each client, but I am confused about what it means to have a safety plan initiated.**

A. A suicide safety plan is the development of a written list of coping strategies and sources of support someone can use when someone is in crisis and/or has suicidal thoughts. The suicide safety plan is like a crisis plan.

**Q. Can you please explain what is meant by "index encounter" as well as the specification that a plan needs to be updated or reviewed within 24 hours of a clinical encounter, as I am not sure how that would always fit in an outpatient setting.**

A. An index clinical encounter is the specific, documented patient visit or interaction that serves as the starting point for a study, analysis, or treatment plan. The bulletin is not specifying that a plan needs to be updated or reviewed within 24 hours of a clinical encounter. The bulletin is providing a code that can be used if this was done. For example, M1351 should be used on a claim when "Patients who had a suicide safety plan initiated, reviewed, or updated and reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation."