

Screening for Clinical Depression

*This measure is to be reported for all patients aged 18 years and older seen by the clinician — a minimum of **once** per reporting period.*

Measure description

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool

What will you need to report for each patient aged 18 and older?

If you select this measure for reporting, you will report:

- Whether or not the patient was screened for depression using a standardized tool¹

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to screen for depression, due to:

- Documented reasons (eg, patient refuses to participate, patient is in urgent or emergent situation and to delay treatment would jeopardize the patient's health status, patient's motivation to improve may impact the accuracy of results, patient was referred with a diagnosis of depression, patient has been participating in on-going treatment with screening of clinical depression in a previous reporting period, severe mental and/or physical incapacity)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

¹An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS — Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

Preventive Care and Screening

Screening for Clinical Depression

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	No	Code Required on Claim Form
Patient is aged 18 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT Service Code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes.
If No is checked for any of the above, STOP. Do not report a G-code.			
Step 2 Does patient meet or have an acceptable reason for not meeting the measure?			
Clinical Depression Screening Using a Standardized Tool¹	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Documented	<input type="checkbox"/>	<input type="checkbox"/>	G8431
Not documented for the following reason: • Documented reasons (eg, patient not eligible/ not appropriate for clinical depression screening ²)	<input type="checkbox"/>	<input type="checkbox"/>	G8433
Document reason here and in medical chart. _____ _____			If No is checked for all of the above, report G8432 (No documentation using a standardized clinical tool.)

¹An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS — Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

²Patients may be considered not eligible/not appropriate in the following situations: patient refuses to participate, patient is in urgent or emergent situation and to delay treatment would jeopardize the patient's health status, patient's motivation to improve may impact the accuracy of results, patient was referred with a diagnosis of depression, patient has been participating in on-going treatment with screening of clinical depression in a previous reporting period, severe mental and/or physical incapacity.

Screening for Clinical Depression

Coding Specifications

Codes required to document a visit occurred:

A CPT service code is required to identify patients to be included in this measure.

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 97003 (physical medicine and rehabilitation)

Quality codes for this measure (one of the following for every eligible patient):

G-Code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8431:** Documentation of clinical depression screening using a standardized tool
- **G8433:** Patient not eligible/not appropriate for clinical depression screening
- **G8432:** No documentation of clinical depression screening using a standardized tool