

Screening for Clinical Depression and Follow Up Plan

*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 AND documentation of follow up plan

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 AND documentation of a follow up plan²

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 ongoing 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).

²Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

Preventive Care and Screening

Screening for Clinical Depression and Follow Up Plan

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 on date of encounter.	<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. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
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 AND Follow Up Plan²			Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Performed — Positive screen AND follow up plan documented	<input type="checkbox"/>	<input type="checkbox"/>	G8431
Performed — Negative screen AND follow up plan not appropriate	<input type="checkbox"/>	<input type="checkbox"/>	G8510
Not performed for the following reason: • Documented reasons (eg, patient not eligible/ not appropriate for clinical depression screening ³)	<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.) OR G8511 (Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified.)

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²Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

³Patients 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.

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Coding Specifications

Codes required to document a visit occurred:

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

All measure-specific coding should be reported ON THE SAME CLAIM.

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 92557 (comprehensive audiometry threshold evaluation and speech recognition),
- 92567 (tympanometry [impedance testing]),
- 92568 (acoustic reflex testing),
- 92625 (assessment of tinnitus),
- 97003 (physical medicine and rehabilitation)

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **G8431:** Positive screen for of clinical depression using a standardized tool and a follow up plan documented
- **G8510:** Negative screen for clinical depression using a standardized tool, patient not eligible/appropriate for follow up plan documented
- **G8433:** Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate
- **G8432:** No documentation of clinical depression screening using a standardized tool
- **G8511:** Screen for clinical depression using a standardized tool documented, follow up plan not documented, reason not specified