BEHAVIORAL HEALTH SKILLS TRAINING

DEPRESSION SCREEN DOCUMENTATION AND BILLING

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PHQ SCREENING

EXAMPLES OF STANDARDIZED DEPRESSION SCREENING TOOLS

Adolescent screening tools (ages 12 to 17)

Patient Health Questionnaire Modified for Adolescents (PHQ-A), Beck Depression Inventory for Primary Care (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CESD), and PRIME MD-PHQ2.

Adult screening tools (ages 18 and older)

Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CESD), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, Hospital Anxiety and Depression Scale (HADS), and PRIME MD-PHQ2.

Special populations

Pregnancy and Postpartum:

Edinburgh Postnatal Depression Scale (EPDS)

Geriatric:

Geriatric Depression Scale (GDS)

Dementia:

Cornell Scale for Depression in Dementia (CSDD)

CODING FOR DEPRESSION SCREENING

Screening – G0444 (Medicare, Medicare Advantage, Medicaid)

Screening – 96127 (Commercial, Self-Pay, Sliding Fee)

Negative Screening – G8510

Positive Screening – G8431

Diagnosis Code – Z13.31

OTHER SCREENING CODES

- 96110, “Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument,”
- 96160, “Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument,”
- 96161, “Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.”

Codes 96110, 96160, and 96161 are typically limited to developmental screening and the health risk assessment (HRA). However, code 96127 should be reported for both screening and follow-up of emotional and behavioral health conditions

Diagnosis Code Z13.89

CLINICAL DOCUMENTATION

Documentation of a structured screening or assessment should include the date, patient's name, name and relationship of the informant (when information is provided by someone other than the patient), name of the instrument, score, and name and credentials of the individual administering the instrument. In addition, the physician must document that he or she reviewed the score in the context of the patient presentation and discussed the results with the patient/family as part of the related E/M service. A few payers do indicate that a report (separate from the E/M service documentation) is required. This is based on CPT guidance for central nervous system assessments that states, “It is expected that the administration of these tests will generate material that will be formulated into a report.” Verify your payers' documentation requirements prior to providing these services.

QUICK REFERENCE: SCREENING AND ASSESSMENT CODES

Code	Purpose	Examples (not all inclusive)	Notes
96110	Childhood instrument-based screening for failure to develop and/or achieve skills according to the expected time frame (e.g., expressive and receptive language, motor skills)	Ages & Stages Questionnaires Third Edition, Parents' Evaluation of Developmental Status, and Modified Checklist for Autism in Toddlers Revised With Follow-Up	Use for developmental and autism screening.
96127	Instrument-based assessment of potential emotional and/or behavioral problems (e.g., depression, attention-deficit)	Patient Health Questionnaire-9, Edinburgh Postnatal Depression Scale (administered for the benefit of the mother), and NICHQ Vanderbilt Assessment Scales	Use for both screening and follow-up of emotional and behavioral health conditions. Report HCPCS code G0444 for depression screening in lieu of code 96127 for Medicare Part B patients.
96160	Instrument-based assessment of the patient's risk for certain health conditions, behaviors that may negatively impact health, and pros and cons for initiating behavior change	Mini Nutritional Assessment - Short Form, Acute Concussion Evaluation, Alcohol Use Disorders Identification Test, CRAFFT (Care, Relax, Alone, Forget, Friends, Trouble), and HEEADSSS (Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety)	Some payers require reporting 96127 for HEEADSSS and CRAFFT screenings. If brief intervention for alcohol or substance abuse (at least 15 minutes) is also provided, report codes 99408 – 99409 based on time.
96161	Instrument-based assessment of the caregiver's risk for certain health conditions that may impact his or her ability to care for the patient	Safe Environment for Every Kid, Caregiver Strain Index, and Edinburgh Postnatal Depression Scale (administered for benefit of the child)	Report code 96161 for a health risk assessment when focused on caregiver risk that may impact the patient's health (e.g., postpartum depression).

DOCUMENTING A FOLLOW-UP STRATEGY

Using a screening tool to identify patients who might have depression is only the first step and must lead to a follow-up strategy to help patients with depression reach remission. To get credit for this work under PQRS, the physician needs to document on the date of the positive screen a follow-up plan that includes at least one of the following:

- Additional evaluation for depression,
- Suicide risk assessment,
- Referral to a practitioner who is qualified to diagnose and treat depression,
- Pharmacological interventions,
- Other interventions or follow-up for the diagnosis or treatment of depression.

Those in our community routinely document a follow-up strategy using a built-in template that is triggered by or associated with the screening documentation. For example, a Health Clinic system has a space for documenting the follow-up strategy near the field where the provider would see the results of a positive screen. The Health Clinic uses electronic tools to pull screening test results directly into the EHR, making it easier for the physician to see and manage chronic medical issues over time.

PARTNERING WITH BH PROVIDERS

- In the event the patient has a positive screening outcome, patient-centered care teams, to include a BH/MH provider can be a great asset. Performing a Warm-Handoff to a BH/MH provider, to join the Medical visit when a positive screening has been performed allows the BH/MH provider the opportunity for further mental health assessment to determine further needs of the patient.

H0031 — Mental health assessment by a non-physician

ENC

HE (SP)
HK (Residential)
U4 (ICM)
TM (ACT)

Place of Service

- 03 School
- 04 Shelter
- 11 Office
- 12 Home
- 13 ALF
- 14 Grp Home
- 15 Mobile Unit
- 21 Inpt Hosp
- 22 Outpt Hosp
- 23 ER
- 31 SNF
- 32 NF
- 33 Cust Care
- 50 FQHC
- 51 Inpt PF
- 52 PF-PHP
- 53 CMHC
- 54 ICF-MR
- 56 PRTC
- 72 RHC
- 99 Other

Child (0-11), Adol (12-17), Young Adult (18-20), Adult (21-64), Geriatric (65+)

Service Description: (Including example activities)
A clinical assessment that identifies factors of mental illness, functional capacity, and other additional information used for the treatment of mental illness. Information may be obtained from collaterals. This assessment results in the identification of the member's Behavioral Health service needs and recommendations for treatment. The service can also be used by any MHP when an update of the assessment is necessary, for example a referral to a different Level of Care or program

- Meeting with the member in order to assess his/her needs
- Meeting with the member/member's family to collect social history information
- With the member's permission, meetings/ telephone contact with family members, collateral sources of pertinent information (educational, medical, social services, etc.)
- Administering acceptable instruments to the member to document substantial impairment in role functioning

Notes: (Including specific documentation and/or diagnosis requirements)
* Licensed MHPs, when completing a full assessment with mental status and diagnosis should use procedure code 90791

If a Mental Status Exam and Diagnosis evaluation is completed, it needs to be completed by staff with at least the minimum requirements for a 90791. Otherwise a deferred diagnosis should be used.

H0031 is used in lieu of individual psychotherapy procedure codes when the focus of the session is on assessment and not psychotherapy (insight-oriented, behavior modifying and/or supportive) has occurred during the session. (See psychotherapy procedure codes.) Outside assessment information may be used in lieu of some assessment criteria/new assessment, with a corresponding statement as to what information/documentation was reviewed with the member and is still current.

Documentation details in addition to the guidance found in Section X. Service Documentation Standards:

Review of psychosocial and family history, member functioning and other assessment information

Min: N/A
Max: N/A

Service Provider

- Bach Level
- Intern
- Unlicensed Master's Level
- Unlicensed EdD/ PhD/PsyD
- LCSW
- LPC
- LMFT
- Licensed EdD/PhD/PsyD
- LAC
- RN

Provider Types That Can Bill:

01, 02, 05, 16, 24, 25, 26, 30, 32, 35, 36, 37, 38, 39, 41, 45, 51, 52, 63, 64

H0032 — Mental health service plan development by non-physician

ENC

HE (SP)
HK (Residential)
U4 (ICM)
TM (ACT)
HM (Respite)
HJ (Voc)
TT (Recovery)
HT (Prev/EI)

Place of Service

- 03 School
- 04 Shelter
- 11 Office
- 12 Home
- 13 ALF
- 14 Grp Home
- 15 Mobile Unit
- 22 Outpt Hosp
- 31 SNF
- 32 NF
- 33 Cust Care
- 50 FQHC
- 53 CMHC
- 54 ICF-MR
- 72 RHC
- 99 Other

Child (0-11), Adol (12-17), Young Adult (18-20), Adult (21-64), Geriatric (65+)

Service Description: (Including example activities)
Activities to develop, evaluate, or modify a member's treatment/ service plan, including the statement of individualized treatment/ service goals, clinical interventions designed to achieve goals, and an evaluation of progress toward goals. The treatment/ service plan is reviewed by the clinician and clinical supervisor and revised with the member as necessary or when a major change in the member's condition/service needs occurs.

Notes: (Including specific documentation and/or diagnosis requirements)

H0032 is used in lieu of individual psychotherapy procedure codes (see psychotherapy procedure codes) when the focus of the session is on treatment/service planning and no psychotherapy occurs during the session. Use a psychotherapy code if more than 50% of the session is psychotherapy.

Documentation details in addition to the guidance found in Section X. Service Documentation Standards:

- Description of the service (should include discussion of treatment/service plan development)
- Completion of or substantial progress toward plan development including required signatures according to agency policies
- Treatment/service plan revisions should include progress and/or completion of goals

Min: N/A
Max: N/A

Service Provider

- Bach Level
- Intern
- Unlicensed Master's Level
- Unlicensed EdD/ PhD/PsyD
- LCSW
- LPC
- LMFT
- Licensed EdD/PhD/PsyD
- LAC
- CAS
- LPN/LVN
- RN
- APN
- PA

Provider Types That Can Bill:

01, 02, 05, 16, 24, 25, 26, 30, 32, 35, 36, 37, 38, 39, 41, 45, 51, 52, 63, 64

AUTOMATING CODES

- It is best practice to set up your screening templates in your EMR to automate dropping of these codes, based on service performed and payor attached to the patient.
- This will alleviate the need for manual entry of the noted CPT codes and Diagnosis, and will ensure correct coding on the claim side

QUESTIONS?

THANK YOU

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