**Depression Screening for FFS Medicare--Reimbursement Quick Guide**

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| **Covered Service** | Provide depression screening using a standardized assessment tool. | **TIP:**  • The PHQ-9 (Patient Health Questionnaire) is the validated screener most often used.  • Practitioners can choose alternative validated tools appropriate for their population or setting (Example-Geriatric Depression Screener).  • For QPP measure: *Depression Utilization of the PHQ-9 Tool,* you must use the PHQ-9 |
| **HCPCS/CPT Codes** | G0444 – Annual depression screening, 15 minutes (limited to screening only) | **TIP:**  • Bundled with G0438 (Initial Annual Wellness Visit) and the Initial Preventive Physical Exam (G0402) so do not code separately.  •Payable with G0439 (Subsequent Annual Wellness Visit)  • Modifier 25 may be used with E&M codes when services are separate, *significant* and on the same day  •Modifier 59 is dependent on the code combination—Contact <http://www.ama-assn.org/> for assistance |
| **ICD–10–CM Codes** | Diagnostic codes may vary but often used with Z13.89 (used to specify a diagnosis of encounter for screening). | **TIP:** Modifier 59 is often used in combination with G0444 and Z13.89Contact local MAC for guidance |
| **How often?** | Annually for G0444; more than 11 calendar months must pass | **TIP:** Consider using the screener to monitor treatment, though additional screeners are not billable within the same year, it will provide information on management of the condition. |
| **Where can the service be provided?** | Physician’s office  Outpatient hospital  Independent clinic  State or local public health clinic | **TIP:** Screening (G0444) can be completed by patient and scored quickly by staff during the visit. Other options include telephone, mail, e-mail, portal, e-visit, i-pad, or patient kiosk.  •Be sure to include the facility code |
| **Who can provide the service?** | Provider must have in place staff-assisted (nurse etc.) depression care supports who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. | **TIP:** Screening often happens during intake by an MA, LPN or nurse.  • More comprehensive care supports include a case manager working with the primary care physician and coordinating care with behavioral health services |
| **Who is covered?** | All **fee for service** Medicare beneficiaries are eligible for depression screening annually. | **TIP:** Once a patient has a diagnosis of depression, screening may be denied |
| **What if there is a positive screen?** | For Mild to Moderate depression, provide education, self-management support, consider meds and/or referral to a BH specialist. For severe or a positive on the suicide question, complete suicide screen and refer to BH specialist for timely assistance/intervention.  Consider building a partnership with a local BH provider or organization to ensure timely referrals and communication. | **TIP:** Use CPT code 96127 - *Brief emotional/behavioral assessment* (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale) to rescreen patients with a positive screen for treatment monitoring.  •CPT Code 96127 may be billed four times for each patient per visit, utilizing four different instruments or assessments (example: PHQ-9, GAD-7, AUDIT, Suicide Risk Assessment)  •Can be billed every time it’s medically necessary |
| **Beneficiary cost** | • Copayment/ coinsurance waived  • Deductible waived | **Tip:** Describe service to patient as a routine part of their primary care visit |
| **Documentation Requirements** | For each patient encounter, document:  • Assessment, clinical impression, and diagnosis, physical examination findings and prior diagnostic test results, risk factors, plan of care, reason for encounter and relevant history  • Document rational for ancillary services | **Tip:**  •Ensure score is captured in discreet data fields in EHR for easy extraction and reporting.  •Document total time (must be at least 8 minutes)  •Incomplete records may put you at risk for a denial |

**Codes must be validated with your local MAC. Codes are often updated and TMF Quality Innovation Network cannot verify accuracy of coding. For additional assistance contact American Medical Association at** [**http://www.ama-assn.org/**](http://www.ama-assn.org/) **or your MAC for specific coding questions.**

[**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNMattersArticles/downloads/MM7637.pdf**](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network%20MLN/MLNMattersArticles/downloads/MM7637.pdf)

**Example:** Patient comes in with sore throat, the provider asks to do depression screening, they finish the screening and the doctor feels they are depressed. If provider performed the Depression screening separately with all the criteria met to bill the screening code then it would be eligible to bill G0444 and E&M service is provided with separate documentation for work up on sore throat diagnosis then appropriate codes would be E&M code along with modifier 25 and depression screening CPT code. You can add depression diagnosis as secondary diagnosis to your E&M claim if provider document that in E&M medical record.