

Depression Screening and Follow-Up Plan Guidance Document

Oregon Health Plan

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Introduction

The purpose of this document is to provide Coordinated Care Organizations (CCOs), Oregon clinics and administrative staff with guidance on implementing screening for depressive disorders and follow up planning in primary care settings and details on the CCO Incentive Measure. This document will be updated as appropriate to reflect the ongoing changes in policy and regulation.

Executive Summary

Major depression is a serious mental illness affecting millions of adults and children each year. Depressive disorders are highly prevalent, chronic and costly, affecting medical outcomes, economic productivity, and quality of life.¹

Comprehensive screening in primary care may help clinicians identify undiagnosed depression and initiate appropriate treatment. Additionally, screening may help primary care clinicians identify patients earlier in their course of depression. In both cases, it is presumed that the use of standard evidenced-based and effective treatment would improve these patients' depression and alleviate their suffering sooner or more thoroughly than if they had not been screened.

The CCO incentive measure will follow the Meaningful Use specifications for NQF 0418, which look at the percentage of patients aged 12 years and older who were screened for clinical depression using an age appropriate standardized depression screening tool AND if positive, have a follow-up plan documented on the date of the positive screen.

Note that the Metrics and Scoring Committee originally intended to measure depression screening for adults aged 18 years and older, to align with the alcohol and drug misuse (SBIRT) measure, but the Meaningful Use specifications for electronic reporting of clinical quality data include patients ages 12 and up.

Quality pool payment for CCO performance on this measure in CY 2013 and CY 2014 is tied to OHA's acceptance of a technology plan for collecting and reporting this measure using electronic health record data and Meaningful Use specifications, and CCO submission of EHR-based clinical quality data. CY 2015 is the first year of pay for performance on this measure. CCOs must submit their EHR-based clinical quality data according to the year three guidance, as well as meet the benchmark to earn quality pool funds in 2015 for this measure.

The CCO incentive measure does not rely on claims data or chart review conducted for a CCO's entire member population. Quality pool funding is not tied to administrative data.

As this CCO incentive measure is not dependent on correct coding or encounter data submission, this guidance document provides clarification on evidence based AMH-approved screening tools for

¹ National Research Council and Institute of Medicine (2009). Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington, DC: The National Academies Press.

depression; provider types to conduct depression screening; Meaningful Use measure specifications; and recommended resources.

Background

Depression causes noticeable disruptions in daily life, such as work, school or social activities. It can affect people of any age or sex, including children. It isn't the same as depression caused by a loss (such as the death of a loved one), substance abuse or a medical condition such as a thyroid disorder.

Individuals are at risk for depression across their entire life span. Consistently identified high-risk groups include:

- Women;
- People with other psychiatric disorders, including substance misuse;
- People with a family history of depression;
- People with a chronic medical disease; and
- People who are unemployed or of a lower socio-economic status.

Approximately 15 percent of adults over the age of 65 are affected by depression; in nursing facilities and hospitals the numbers are higher. Depression is associated with common life events in older adults, including mental illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.^{2,3}

Depression is the leading cause of disease-related disability in women, and the most common complication of childbirth. In Oregon, nearly one in four new mothers (24 percent) report symptoms of depression either during or after pregnancy. Forty-eight percent of these women were still depressed when their child was two years old. American Indian/Alaska Native and African American women were significantly more likely than women of other race/ethnic groups to report that they were always or often depressed since the birth of their baby.^{4,5}

Comprehensive screening in primary care may help clinicians identify undiagnosed depression and initiate appropriate treatment. Additionally, screening may help primary care clinicians identify patients earlier in their course of depression. In both cases, it is presumed that the use of standard evidenced-

² O'Connor EA, Whitlock EP, Gaynes B, et al. Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review. 2009. <http://www.ncbi.nlm.nih.gov/books/NBK36406/>

³ Geriatric Mental Health Foundation, Initiative on Depression in Late Life, "Depression in Late Life: A Natural Part of Aging" http://www.gmhfonline.org/gmhf/consumer/factsheets/depression_latelife.html

⁴ Oregon Perinatal Data Book, 2007.
http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Documents/databook_2007.pdf

⁵ Maternal Depression in Oregon, 2010
<https://public.health.oregon.gov/HealthyPeopleFamilies/Women/MaternalMentalHealth/Documents/peri-depression-fact-sheet.pdf>

based and effective treatment would improve these patients' depression and alleviate their suffering sooner or more thoroughly than if they had not been screened.

Unlike other screening tests, screening all patients for depression, including those previously identified as depressed, may be useful since it might help identify ineffectively treated patients whose treatment needs modification.⁶

Standardized evidence-based screening instruments are available and most have good sensitivity and provide reliable detection of depressed patients. See the full list of evidence-based AMH-approved depression screening tools in Appendix A.

According to the U. S. Preventive Services Task Force (USPSTF), prevalence estimates of Major Depression Disorder in primary care settings range from 5 to 13 percent in all adults.⁷ Even those patients with "false" positives may have depressive symptoms or a diagnosis of dysthymia. Therefore a positive screen warrants follow up with more detailed mental health evaluation by a clinician to determine whether or not ongoing treatment is needed.

The substantial numbers of adults with depression who are untreated, along with the under recognition of depression by primary care providers, has led to examination of the use of brief screening procedures for depressive symptoms to address this problem.

⁶ O'Connor EA, Whitlock EP, Gaynes B, et al. Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review. 2009. <http://www.ncbi.nlm.nih.gov/books/NBK36406/>

⁷ Ibid.

Screening Recommendations

- ➔ The U.S. Preventive Service Taskforce (USPSTF) recommends screening adults, including older adults, for depression in outpatient primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. They have found adequate evidence that screening improves the accurate identification of depressed patients in primary care settings, and that treatment of depressed adults identified in primary care settings decreases clinical morbidity.

Recommendation available online at:

www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm

- ➔ The USPSTF also recommends screening of adolescents (12 – 18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow up.

Recommendation available online at:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm>

- ➔ The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at baby's one-, two-, and four-month visits.

Recommendation available online at:

<http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.abstract>

- ➔ The American Medical Association recommends screening for depression among adolescents who may be at risk due to family problems, drug or alcohol use, or other indicators of risk.

Recommendation available online at:

<http://www.amaassn.org/ama1/pub/upload/mm/39/gapsmono.pdf>

- ➔ The American Academy of Pediatrics recommends that pediatricians ask questions about depression in routine history-taking throughout adolescence.

Recommendation available online at: <http://www.ncbi.nlm.nih.gov/pubmed/10742340>

Definitions

This section provides an overview of the key definitions integral to depression screening and follow-up planning.

Depression is not a specific term for a single diagnostic condition. Depressive disorders generally consist of Major Depressive Disorder (MDD), dysthymia, and minor depression, but not other conditions that include depressive features, such as bipolar disorder.⁸

DSM –IV Criteria for Major Depressive Disorder

Depressed mood and/or loss of interest or pleasure in daily activities for at least two weeks, and at least five of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

- Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
- Decreased interest or pleasure in most activities, most of each day.
- Significant weight change (5 percent) or change in appetite.
- Change in sleep: insomnia or hypersomnia.
- Change in activity: psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or inappropriate guilt.
- Diminished ability to think or concentrate, or more indecisiveness.
- Thoughts of death or suicide, or has suicide plan.

DSM – IV Criteria for Dysthymia

Depressed mood most of the day for more days than not, for at least two years (at least one year for children and adolescents), and at least two of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

- Poor appetite or overeating.
- Insomnia or sleeping too much.
- Low energy or fatigue.
- Low self-esteem.
- Poor concentration or difficulty making decisions.
- Feelings of hopelessness.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive

⁸ <http://www.uspreventiveservicestaskforce.org/uspstf09/adultdepression/addepres.pdf>

disorder, single or recurrent episode, severity/psychotic/remission specifies, followed by as many specifics that apply to the current episode.

Follow-Up Plan is the proposed outline of treatment to be conducted as a result of positive depression screening. Follow-up for a positive depression screening *must* include one or more of the following:

- Additional evaluation.
- 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.

Primary Care Setting is defined as one in which there is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with beneficiaries, and practicing in the context of family and community. A primary care setting may be:

- An office,
- An outpatient hospital,
- An independent clinic, or
- A state or local public health clinic.

Screening is the completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Depression screening tests do not diagnose depression, but rather indicate severity of depression symptoms within a given time period, i.e., the past several days, past week, or past two weeks including today.⁹

Depression screening often occurs in two stages:

- 1) A brief initial or pre-screen (such as the PHQ-2) can be used to determine if a more comprehensive screening is warranted. The brief initial is not used to establish a diagnosis or monitor depression severity, only as a first step to determine if additional screening is needed. Brief screening is not required as part of the depression screening measure, but is often clinical practice to pre-screen individuals before using a more detailed screening tool.

Note that the OHA-approved brief screening tool for alcohol and drug misuse (SBIRT) also includes a question about mood and would qualify as an initial or pre-screen for depression.¹⁰

- 2) A secondary or full screen (such as the PHQ-9) is used to provide more detailed information about the severity of the depression or other mental health symptoms. The full screen can guide

⁹ CMS' Decision Memo for Screening for Depression in Adults (CAG-00425N). October 2011. Available online at: <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251>

¹⁰ Additions and Mental Health Approved Evidence-Based Screening Tools for SBIRT. Available online at: <http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx>

a professional to better identify whether further intervention and treatment is necessary, and what form that should take after a discussion with the patient concerning the results of the screening.

Standardized Depression Screening Tool is a normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include, but are not limited to:

- Beck Depression Inventory
- Patient Health Questionnaire (PHQ-9); and
- Center for Epidemiologic Studies Depression Scale (CES-D)

See the full list of AMH approved, evidence-based screening tools in Appendix A.

In general, billable services include administration of a full screen, or full screen and follow-up planning services. Administering a brief initial screen is not a billable service.

Staff-Assisted Depression Care Supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care setting who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment.¹¹

¹¹ Ibid.

Depression Screening and Follow-Up Planning Services

Depression screening and follow-up planning services apply to all age-groups. This section provides guidance on who can conduct and bill for depression screening and follow up planning services.

Note: the CCO incentive measure is not claims based. The CCO incentive measure follows Meaningful Use specifications for the data submission. See Measure Specifications section below.

Who can administer and interpret the initial or pre-screen (e.g., PHQ-2)?

The initial or pre-screen for depressive disorders can be done by front desk staff or any other appropriate professional. The initial screen may be administered in writing, orally, or via various technologies. The initial screen may be mailed to the individual prior to the visit, given over the phone, online or in person.

Note that the OHA-approved brief screening tool for alcohol and drug misuse (SBIRT) also includes a question about mood and would qualify as an initial or pre-screen for depression.¹²

Who can administer and interpret the secondary or full screen (e.g., PHQ-9)?

A full, or secondary screen for depression disorders must be administered and interpreted by a licensed provider or an ancillary provider working under the general supervision of the licensed provider (see list of provider types below). The full billable depression screening services must be provided face-to-face (in-person or via simultaneous audio and video transmission) with the individual. A physician prescription is not required for screening or follow-up planning.

See the full list of AMH approved, evidence-based screening tools in Appendix A.

Who can conduct follow-up planning?

Follow-up planning must be provided by a licensed provider or an ancillary provider working under the general supervision of the licensed provider (see list of provider types below).

Provider Types

Licensed providers who can independently conduct and bill for depression screening and follow up planning services using their provider number:

- Physicians
- Physician's Assistants
- Nurse Practitioners
- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

¹² Additions and Mental Health Approved Evidence-Based Screening Tools for SBIRT. Available online at:
<http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx>

Auxiliary providers or personnel who can conduct depression screening and follow up planning services under the general supervision of a licensed provider or entity listed above:

These provider types would bill “incident to” a licensed professional. This is not an exhaustive list.

- Nurses, Clinical Nurse Specialists, and Registered Nurses
- Health Educators, Community Health Workers, and Wellness Coaches
- Certified Alcohol and Drug Counselors (CADC)
- Qualified Mental Health Professionals
- Students or graduates entering medical profession in areas such as medical, physician assistant, nursing, counseling, social work, and psychology.

Qualified Mental Health Professionals are defined in Oregon Administrative Rule 309-032-1505:(105) as a Licensed Medical Practitioners (LMPs) or any other person meeting one or more of the following minimum qualifications as authorized by the Local Mental Health Authority (LMHA) or designee:

- Bachelor’s degree in nursing and licensed by the State of Oregon;
- Bachelor’s degree in occupational therapy and licensed by the State of Oregon;
- Graduate degree in psychology;
- Graduate degree in social work;
- Graduate degree in recreational, art, or music therapy; or
- Graduate degree in a behavioral science field.

Additionally, OAR 309-032-1520(2)(f) defines minimum competencies for qualified mental health professionals: “QMHPs must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, alcohol and other drug use, past mental health services and criminal justice contacts, assessment family, cultural, social, and work relationships.”

More information about Qualified Mental Health Professionals available online here:
<http://www.oregon.gov/oha/amh/docs/qmha-qmhp-faq.pdf>

Note: while qualified mental health professionals **can** conduct depression screening and follow up planning services as auxiliary providers or personnel under the general supervision of a licensed provider or entity, the intent of the CCO incentive measure is to focus on depression screening and follow up planning services occurring in physical health / primary care settings, or co-located settings.

Licensed Medical Practitioners are defined in Oregon Administrative Rule as a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

- Physician licensed to practice in the State of Oregon,
- Nurse practitioner licensed to practice in the State of Oregon,
- Physician’s Assistant licensed to practice in the State of Oregon; and
- Whose training, experience, and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

Incident To Guidance

- **Location:** Incident to billing applies in outpatient Physician's office or clinic settings, but not outpatient hospital clinic settings. Incident to billing does not apply in an "institutional setting", such as a hospital or skilled nursing facility.

If a physician's office is located within an "institution", it must be confined to a separately identified part of the facility used solely as the physician's office and cannot be construed to extend throughout the entire institution.
- **Employment:** Both the supervising physician and the auxiliary provider or personnel furnishing the service must be a part-time, full-time or leased employee or independent contractor.
- **Initial Service Requirement:** To bill incident-to, there must have been a direct service furnished by the supervising physician to initiate the course of treatment of which the service being performed by the auxiliary provider or personnel is an incidental part, and there must be subsequent services by the physician of a frequency that reflects their continuing active participation in the management of the treatment.

The auxiliary provider or personnel needs to document the "link" between their face to face service and the preceding physician service to which their service is incidental.

- **Direct Supervision Requirement:** The licensed provider who is supervising the auxiliary provider or personnel must be present in the office and immediately available to provide assistance and direction throughout the time the auxiliary provider or personnel is providing the service(s).

Oregon Health Authority and the CCO Incentive Measure

Intent

Depression screening and follow-up planning are an essential part of the detection, treatment, and referral to mental health professionals for persons with depressive disorders. These services are intended to identify people at risk of developing depression or early detection of depression. These services are not intended to treat members already diagnosed with a depressive disorder, or those members already receiving treatment for depression.

OHA presented measure specifications to the Metrics and Scoring Committee in June 2013, using CMS Adult Quality Measure guidance¹³ and administrative data. As this would require OHA internal changes in billing processing and require providing extensive education and training on billing for providers, the Metrics and Scoring Committee agreed to treat depression screening as a clinical measure and follow the proposed approach for other clinical CCO incentive measures.

OHA is interested in building CCO and state level capacity to report e-clinical measures, or the ability to extract clinical data from electronic health records. Recognizing that CCOs may need to develop the infrastructure to collect e-clinical data from their provider network, OHA has proposed that CCOs will meet these incentive measures by submitting a technology plan that describes how the CCO will build the capacity to collect and report on the information electronically. In Year One, CCOs submitted “proof of concept” data to OHA, demonstrating they have the ability to report on EHR-based clinical quality data for this measure (as well as diabetes control and hypertension control).

In Year Two (CY 2014), CCOs will build additional capacity towards electronic reporting of these three clinical measures. CCOs will be required to submit a technology plan and clinical data to meet this measure and earn quality pool funds. However, challenge pool funds (that is, funds left over after the initial distribution of quality pool funds) tied to the depression screening measure will only be distributed to those CCOs who meet the established benchmark in their submitted clinical data.

Year Three (CY 2015) is the first year of pay for performance on this measure. CCOs must submit their data according to the year three guidance, which will be published online by June 2015, as well as meet the established benchmark to earn quality pool funds in 2015 for this measure.

¹³ Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>

Measure Specifications

Data submitted for this measure will follow Meaningful Use specifications for electronic reporting of clinical quality data: Preventive Care and Screening – Screening for Clinical Depression and Follow-Up Plan (NQF 0418).

Meaningful Use 2014 specifications are used for Year Two (CY 2014) and Meaningful Use 2015 specifications, July 2014 release, are used for Year Three (CY 2015).

Meaningful Use measure specifications are available online at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIincentivePrograms/eCQM_Library.html

Oregon Health Authority's Year Two Technology Plan and Data Submission Guidance Documents are posted online: <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>. Year Three guidance will be posted online no later than June 2015.

Numerator: Patients screened for depression on the date of the encounter, using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

See the full list of AMH approved, evidence-based screening tools in Appendix A.

Required Exclusions for Numerator: n/a

Denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Required Exclusions for Denominator: Patients with an active diagnosis for depression or bipolar disorder

Exceptions to the Denominator:

- Patient refuses to participate; or
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression screening tools. For example: certain court appointed cases or cases of delirium.

Measurement Period:

OHA's preferred measurement period for Year Three (CY 2015) data submission is calendar year 2015. OHA will provide clarification on which measurement periods will be accepted in January 2015. OHA will also publish the Year Three guidance by June 2015.

Benchmark

2013 benchmark: n/a

2014 benchmark: 25 percent, Metrics & Scoring Committee consensus. For challenge pool only.

2015 benchmark: 25 percent, Metrics & Scoring Committee consensus.

Limitations

As this measure is under development, data collection and/or reporting may change for subsequent measurement years.

Eligibility

Depression screening and follow-up planning services are a benefit available to all OHP eligible individuals ten years of age or older on the date of service.

Please note that while the Metrics and Scoring Committee originally agreed to focus on depression screening for the adult population 18 years of age or older, the Meaningful Use specifications focus on depression screening for individuals 12 years of age or older on the date of service.

For members enrolled in a Medicaid CCO or Fully Capitated Health Plan (FCHP), depression screening and follow-up planning services are to be coordinated with those organizations for reimbursement.

Depression screening and follow-up planning services do not require a prior authorization (PA) for Fee For Service (FFS) members.

Screening Frequency

For members enrolled in Medicaid, the screening benefit is limited to medical appropriateness. Usually one screen per rolling 12 months is sufficient; however, there may be clinical indication that an additional screen is needed.

Documentation Requirements

A depression screen is complete on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. The documented follow up plan must be related to positive depression screening, for example: “patient referred for psychiatric evaluation due to positive depression screening.”

In addition, providers should document what screening tool was used and the member’s responses to the screening questions. The completed screening tools should be available for review in the case of an audit.

To support coding and claim submission, the medical record must:

- Be complete and legible;
- Denote start/stop time or total face-to-face time with the patient (because some codes are time-based);
- Document the patient’s progress, response to changes in treatment, and revisions of diagnosis;
- Document the rationale for ordering diagnostic and other ancillary services, or ensure that it can be easily inferred;
- For each patient encounter, document:
 - Assessment, clinical impression, and diagnosis;
 - Date and legible identity of observer / provider;
 - Physical examination findings and prior diagnostic test results;
 - Plan of care; and
 - Reason for encounter and relevant history.
- Include documentation to support all CPT and ICD diagnosis codes reported on the health insurance claim;

- Make past and present diagnoses accessible for the treating and/or consulting physician; and
- Sign all services provided / ordered.

Medicaid documentation requirements are outlined in OAR General 410-120-1360 and can be found online here: <http://www.dhs.state.or.us/policy/healthplan/guides/mail.html>

The medical record must support that the coding for the services reported on the health insurance claim are correct and accurate.

Resources

OHA-recommended resources are listed below. Additional resources are available through the Patient Centered Primary Care Home Institute (PCPCI), <http://www.pcpci.org/>, and through the CCO Learning Collaborative, <http://transformationcenter.org/>

Guidelines:

- US Preventive Services Task Force's recommendation for depression screening
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm>

The USPSTF Community Guide's recommendations for collaborative care for the management of depressive disorders <http://www.thecommunityguide.org/mentalhealth/collab-care.html>

Care Models and Toolkits:

- IMPACT – evidence-based depression care for older adults. University of Washington.
<http://impact-uw.org/>
- PEARLS – evidence-based depression treatment program for older adults. University of Washington. www.pearlsprogram.org
- The MacArthur Foundation's Initiative on Depression and Primary Care
<http://www.macfound.org/networks/initiative-on-depression-primary-care/details>
<http://prevention.mt.gov/suicideprevention/13macarthurtoolkit.pdf>

Oregon Initiatives:

- **Oregon's HB 2666 Maternal Mental Health work group** conducted a year-long review of state and national systems and policies to address maternal mental health, and developed a set of findings and recommendations, which were presented to the Oregon Legislature in 2010.
<http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Documents/HB2666-mmh-report.pdf>
- Prenatal and postpartum depression screening in Oregon is being carried out in a wide variety of settings, including obstetric and primary care practices, as well as early childhood services, home visiting programs, and other settings that serve pregnant women and young families.

For more information about **perinatal depression screening initiatives in Oregon**, see the Oregon Health Authority's Maternal Mental Health website at:
www.healthoregon.org/perinatalmentalhealth/

- **The Oregon Pediatric Society's START project** trains primary care providers to implement depression screening and management in their practices for maternal depression and also

adolescent depression. Information online at: <http://oregonpediatricsociety.org/programs/ops-programs/start/>

- **Postpartum Support International** supports prenatal and postpartum depression screening, assessment, and support in Oregon through a toll-free warm line, trained volunteers, and training a wide variety of providers on skills and knowledge for assessment, care and treatment of perinatal mood and anxiety disorders. <http://www.postpartum.net/>

Other:

- National Research Council and Institute of Medicine, “Depression in Parents, Parenting, and Children: Opportunities to improve identification, treatment, and prevention”
http://www.nap.edu/catalog.php?record_id=12565
- Parental Depression Screening for Pediatric Clinicians: An implementation manual
<http://www.commonwealthfund.org/Publications/Fund-Manuals/2007/Apr/Parental-Depression-Screening-for-Pediatric-Clinicians--An-Implementation-Manual.aspx>

For More Information

For questions related to the CCO incentive measure, please contact: Metrics.Questions@state.or.us

For questions related to prenatal and postpartum depression, please contact:
Dana Hargunani at dana.hargunani@state.or.us and Nurit Fischler at nurit.r.fischler@state.or.us

For questions related to Medicaid billing, please contact: Provider Services at 1.800.336.6016

Appendix A: AMH Approved Evidence-Based Screening Tools

OHA does not require use of a specific screening tool or tools to qualify for the CCO incentive metric, only that the screening tool be a normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Implementation of one or multiple screening tools is at the provider or clinic's discretion, although health plans may have their own requirements related to screening tools.

Brief Annual Screen, All Patients

- **Annual SBIRT Questionnaire¹⁴**
3 questions.
- **PRIME MD-PHQ2**
2 questions.

Full Health Risk Assessment Screen, Adults

- **Global Appraisal of Individual Needs – Short Screener (GAIN-SS)**
20 questions, co-occurring screen.
- **Patient Health Questionnaire (PHQ9)**
9 questions.
- **Beck Depression Inventory (BDI or BDI-II)**
21 questions.
- **Center for Epidemiologic Studies Depression Scale (CES-D)**
20 questions.
- **Depression Scale (DEPS)**
- **Duke Anxiety-Depression Scale (DADS)**
7 questions.
- **Geriatric Depression Scale (GDS)**
Short and long forms.

¹⁴ Additions and Mental Health Approved Evidence-Based Screening Tools for SBIRT. Available online at:
<http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx>

- **Hopkins Symptom Checklist (HSCL)**
Short and long forms.
- **The Zung Self-Rating Depression Scale (SDS)**
20 questions.
- **Cornell Scale Screening**
This is a screening tool which is used in situations when the patient has cognitive impairment and is administered through the caregiver. 19 questions.
- **Edinburgh Postnatal Scale**
10 questions.

Full Health Risk Assessment Screen, Adolescents (age 12-17)

- **Global Appraisal of Individual Needs – Short Screener (GAIN-SS)**
20 questions, co-occurring screen.
- **Beck Youth Depression Inventory**
- **Weinberg Depression Scale**
56 questions.
- **Center for Epidemiologic Studies Depression Scale (CES-D)**
20 questions.

Appendix B: Frequently Asked Questions

Who is supposed to complete (“fill out”) the depression screening tool?

The initial screen may be conducted by a variety of health professionals or any other clinic staff member (e.g., front desk staff). The full screen may be conducted and interpreted by a variety of health professionals.

Who can be reimbursed for depression screening?

See pages 10-11 above.

Does the initial screen count for the CCO incentive metric?

Yes, a brief screen such as the PHQ2 does count as depression screening for the CCO incentive metric.

Can the initial screen be conducted over the phone (i.e., prior to a clinic visit)?

Yes. We know that some clinics are conducting initial screenings over the phone. Depending on the results, when the client comes in for their appointment, they are asked to fill out the appropriate full screen and the results are then reviewed with the client.

Is the CCO incentive measure counting depression screening services for ages 12 years and older or ages 18 Years and older?

While the Metrics and Scoring Committee initially agreed upon ages 18 years and older to align with the Alcohol and Drug Misuse (SBIRT) measure, the Meaningful Use measure specifications that will be used for electronic clinical quality reporting include ages 12 Years and older. CCOs will be asked to submit data for ages 12 years and older.

Depression screening is a covered service for members ages 10 years and older and OHA encourages providers and practices to screen all members ages 10 years and older for depression.

How should CCOs submit the data to OHA for this measure?

For 2014, Year Two technology plan and data submission guidance documents are available online at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>.

OHA will publish Year Three guidance by June 2015.

Can combined screening tools be used (e.g., depression and SBIRT)?

Yes. As long as the combined screening tool for the initial screening incorporates the PHQ-2 (or similar questions), other questions can be added, such as tobacco use, alcohol and drug use, or domestic

violence. Note that the OHA-approved brief screening tool for alcohol and drug misuse (SBIRT) also includes a question about mood and would qualify as an initial or pre-screen for depression.¹⁵ As long as the combined screening tool for the full screening incorporates the full, standardized screening tool (see Appendix A) and does not modify the standardized screening tool, other questions can be added. OHA recommends caution when combining full screening tools, as this may make the screening tool(s) less reliable.

Note that the GAIN-SS tool is an evidence-based screening tool that addresses both mental health and substance use and could be used for both depression screening and SBIRT.

Do combined screening tools still qualify for the CCO incentive metrics?

Yes, however a brief screening tool such as the PHQ-2 for depression that does not also include alcohol and drug use is not appropriate for use as a brief annual screening tool *for the SBIRT incentive measure*. Likewise, a brief screening tool that only asks about alcohol and drug use is not appropriate as a brief screening tool *for the depression screening measure*.

¹⁵ Additions and Mental Health Approved Evidence-Based Screening Tools for SBIRT. Available online at: <http://www.oregon.gov/oha/amh/Pages/eb-tools.aspx>

Appendix C: Reimbursable Codes

This appendix includes reimbursable diagnosis, CPT, and HCPCS codes that **can** be used to document depression screening and follow-up planning services.

Please note that for CY 2014 and CY 2015, the CCO incentive measure follows Meaningful Use specifications for electronic reporting of clinical quality data: none of these codes will “count” toward the incentive measure.

It is the responsibility of each provider to select the most appropriate diagnosis and procedure codes when billing for services. It is the providers' responsibility to comply with the CCO's prior authorization requirements or other policies necessary for reimbursement, before providing services to any Medicaid client enrolled in a CCO. It is the providers' responsibility to be compliant with federal and state laws (see OAR 410-120-1160).

Reimbursement

Depression screening services are reimbursed through E&M visit codes, which include the time spent on the screening or using G0444 as a separately identified service that is not included in the E&M level of service. Use of a modifier is required for National Correct Coding Initiative (NCCI) edits.

HCPCS codes

Healthcare Common Procedure Coding System (HCPCS) codes that can be used to report screening for depression in adults include:

- G0444 – annual depression screening, 15 minutes.

The following group of codes are valid for use reporting the results of the screening (G0444) for depression and what documentation exist. These codes are intended for reporting purposes only and are **not** separately reimbursable. These codes would be included on a claim with charges of \$0.00.

G8431	Positive screen for clinical depression documented, follow-up plan documented.
G8511	Positive screen for clinical depression documented, follow up plan not documented, reason not given
G8510	Negative screen for clinical depression documented, follow-up not required
G8940	Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate
G8433	Screening for clinical depression not documented, patient not eligible/appropriate
G8432	Clinical depression screening not documented, reason not given

This measure is also a PQRS measure and CMS has published PQRS measure specifications including these HPCDP codes. Guidelines for reporting are available online here:

- <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>
- <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.

Other codes that are available to report depression screening results include:

- 3725F – Screening for depression performed (DEM)
- 3351F – Negative screen for depressive symptoms
- 3353F – Mild to moderate depressive symptoms
- 3354F – Clinically significant depressive symptoms

The following list of codes is intended for informational purposes only and is provided to identify CPT and HCPC codes currently available that would be appropriate for coding depression screenings in claims data.

CPT	Office/Outpatient Visits for the evaluation and management of a new patient
99201	10 minutes are spent face-to-face with the patient and/or family.
99202	20 minutes are spent face-to-face with the patient and/or family.
99203	30 minutes are spent face-to-face with the patient and/or family.
99204	45 minutes are spent face-to-face with the patient and/or family.
99205	60 minutes are spent face-to-face with the patient and/or family.

Billable with G0444 only with modifier.

CPT	Office/Outpatient Visits for the evaluation and management of an established patient
99212	10 minutes are spent face-to-face with the patient and/or family.
99213	15 minutes are spent face-to-face with the patient and/or family.
99214	25 minutes are spent face-to-face with the patient and/or family.
99215	40 minutes are spent face-to-face with the patient and/or family.

Billable with G0444 only with modifier.

CPT	Health and Behavior Assessment and Intervention
96150	Health and behavior assessment; each 15 minutes face-to-face with the patient; initial assessment.
96151	Health and behavior assessment; each 15 minutes face-to-face with the patient; re-assessment.

Subject to list pairing.

CPT	Psychiatric Evaluations
90791	Psychiatric diagnostic evaluation.
90792	Psychiatric diagnostic evaluation with medical services.

Billable with G0444 only with modifier.

CPT	Psychotherapy
90832	Psychotherapy, 30 minutes with patient and/or family member.
90834	Psychotherapy, 45 minutes with patient and/or family member.
90837	Psychotherapy, 60 minutes with patient and/or family member.
90839	Psychotherapy for crisis; first 60 minutes.

Billable with G0444 only with modifier. Subject to list pairing.

CPT	Initial comprehensive preventive medicine evaluation and management
99385	New patient; 18-39 years.
99386	New patient; 40-64 years.
99387	New patient; 65 years and older.

Billable with G0444 only with modifier.

CPT	Periodic comprehensive preventive medicine re-evaluation and management
99395	Established patient; 18-39 years.
99396	Established patient; 40-64 years.
99397	Established patient; 65 years and older.

Billable with G0444 only with modifier.

HCPC	
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit.
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit.

Equivalent to preventive medicine E&M codes listed above.

Eligible for reimbursement for DMAP/FFS, subject to list pairing.