

Medicare Reimbursement for Depression Screening in Adults

Medicare Benefit	Reimbursed screening for depression in adults once-a-year under Fee-for-Service Medicare available since October 14, 2011. No coinsurance; no deductible for patient <ul style="list-style-type: none"> • Medicare and Medicaid Services Memo - Screening for Depression • Depression Screening - Medicare.gov
Value to you and your patients	Depression screening and depression care support improves clinical outcomes in adults and older adults and is recommended by the US Preventive Services Task Force (USPSTF) Treating adults and older adults diagnosed with depression through screening in primary care settings with antidepressant medications, psychotherapy or both, results in improved clinical outcomes and overall enhanced morbidity
Procedure Code	G0444 (Depression Screen – 15 minutes)
Eligibility	Primary care settings with depression care supports in place (e.g., staff to report results to PCP and coordinate referrals). Sites screening for depression should also offer physician feedback to patients, on-site treatment, or staff support for successful referrals to appropriate treatment Points of care eligible for reimbursement: primary care office, outpatient hospital, independent clinic, FQHC (federally qualified health center) state and local health clinic and RHC (Rural health clinic).
Referral Options	If Behavioral Health specialist referral options are not available in your practice, consider consulting local community mental health center, local chapters of the American Psychiatric Association, the American Psychological Association or National Association of Social Work
Recommended evidence-based screening tool with no license fee PHQ-9	Patient Health Questionnaire (called the PHQ-9) can be completed by patient and quickly scored by staff during the visit. A depression severity score of 5 or more reflects evidence of depression and an intervention should be considered (see here). Alternatively, staff or physician can orally present the first 2 questions (PHQ-2) as an initial screen. If the patient scores a 2 (more than half the days) or 3 (nearly every day) on either item, the full PHQ-9 be should completed by the patient.

Provisional Diagnoses* and Treatment Guidelines based on PHQ-9 score

PHQ-9 Score	Severity: Provisional Diagnoses*	Proposed Actions/Treatment Considerations
0-4	None: Minimal	None
5 - 9	Mild: Minimal Depressive Symptoms Depression diagnosis may not be appropriate.	<ul style="list-style-type: none"> • Watchful waiting - provide support (e.g., educate patient to call if symptoms worsen; Offer self- help recommendations (books, websites) • Have patient return in 1 month to repeat screening and reassess

10-14	Moderate: Minor Depression, or Dysthymia	<ul style="list-style-type: none"> • Develop treatment plan with consideration of counseling/psychotherapy, antidepressant medication and follow-up. • Monitor with continued screenings over time
15-19	Moderately Severe: Depression	<ul style="list-style-type: none"> • Consider initiating anti-depressant medication and/or refer for psychotherapy and/or antidepressant medication • Monitor with continued screenings over time
20 or greater	Severe: Major Depression	<ul style="list-style-type: none"> • Expedited referral to a mental health specialist for psychotherapy and/or antidepressant medication and collaborative management • Consider Immediate initiation of anti-depressant medication • Monitor with continued screenings over time

Adapted with modification from: Kroenke K, Spitzer RL, The PHQ-9: A new depression and diagnostic severity measure *Psychiatric Annals* 2002; 32:509-521

*A screening tool should not be the sole basis for a diagnosis. A more thorough evaluation is recommended.

Assessment of Suicidal Risk/Severity

If patient responds positively to question 9 of the PHQ-9 indicating the potential for suicidal actions, here are a set of questions you can use to help determine the severity (lethality) of the condition; and need for immediate hospitalization, expedited referral to behavioral healthcare professional and/or immediate initiation of anti-depressant medication.

1. Have you ever attempted to harm yourself in the past?
2. Have you thought about how you might actually hurt yourself?
3. There is a big difference between having a thought and acting on a thought. On a scale from 1-5, 1 being unlikely and 5 being most likely;” How likely are you to act on these thoughts about hurting yourself or ending your life during the next month?”
4. Is there anything that would prevent or keep you from harming yourself?

Adapted from: Dube P, Kroenke K, Bair MJ, Theobald D, Williams LS. The p4 screener: evaluation of a brief measure for assessing potential suicide risk in 2 randomized effectiveness trials of primary care and oncology patients. *Prim Care Companion J Clin Psychiatry*. 2010;12(6):PCC. 10m00978

Additional Resources:

- [HealthTeamWorks Depression Guidelines](#)
- [The American College of Physician Depression Care Guide](#)