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Screening Your Adult Patients for Depression



Family physicians are well-placed to catch depression in patients early – and get reimbursed for it.

Although depression screening is not new for many family physicians, the United States Preventive Services Task Force (USPSTF) in January recommended expanding those screens to most adult patients, with a particular focus on women in the peripartum period.¹ Prior recommendations had suggested screening only when staff resources were sufficient to provide support and treatment; however, the USPSTF has concluded that mental health supports are now more widely available than in 2009 when the previous recommendation was made.

The USPSTF is an independent, volunteer panel of national experts that makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Following a review of the available evidence, the USPSTF assigns one of five letter grades (A, B, C, D, or I) to a recommendation. Grade A and B recommendations represent services with high or moderate evidence to support their use. Depression screening in adults and adolescents is a grade B recommendation, meaning there is high certainty that the net benefit of depression screening is moderate

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or there is moderate certainty that the net benefit is moderate to substantial.²

Family physicians should be aware of this grading system, as evidence-based screenings with USPSTF A or B grades are covered services under the Patient Protection and Affordable Care Act.¹ In addition, an increasing number of physician quality programs, including the Centers for Medicare & Medicaid Services' (CMS) Physician Quality Reporting System (PQRS), now use depression screening as a quality indicator. In 2015, Medicare's PQRS program expanded the depression quality metric to include treatment and remission.³

Why screen for depression?

Depression is very common in the United States. Between 2009 and 2012, 8 percent of people 12 years of age and older reported having depression for a two-week period.⁴ Major depressive disorder is listed as the primary diagnosis for 8 million ambulatory visits to physician offices, hospital outpatient clinics, and emergency departments and for 395,000 inpatient visits.⁵ Yet we know that the effect of depression on chronic medical disease management is grossly underestimated. Patients with depression experience a higher incidence of premature death related to cardiovascular disease and are 4.5 times more likely to suffer a myocardial infarction than those without depression.⁶ The costs of depression extend past the obvious emotional, mental, and physical burden on an individual person.

In 2000, the total economic burden of depression was an estimated \$83 billion, and the majority was related to lost workplace productivity.⁷ In addition to the burden on employer-sponsored health plans, the cost to employers for work days lost to depression is as great or greater than that generated by heart disease, diabetes, or back problems.⁸

Diagnosing depression can be difficult as non-specific comorbid symptoms may overlap with a wide range of other psychiatric and medical illnesses. Correct diagnosis of major depression is especially critical because medication therapies are ineffective for minor depression. Though some believe major depression remains underdiagnosed, other studies have indicated that depression may be actually be overdiagnosed.^{9,10} Many experienced clinicians will use their clinical judgment and mnemonics like "SIGECAPS"¹¹ to diagnosis major depression; however,

completing such an extensive history can be time-consuming for routine screening. Fortunately, evidence-based screening tools have been developed and validated for primary care physicians to appropriately identify and diagnose depression.

Screening tools

The USPSTF does not list a preferred screening tool in its recommendation but notes that the Patient Health Questionnaire (PHQ) is the most commonly used instrument for depression screening in the United States. CMS does not list a preferred tool either but does say that to meet the PQRS measure you must use a "normalized and validated depression screening tool developed for the patient population in which it is being utilized and that tool name should be documented in your medical record."³ (See "Examples of standardized depression screening tools" on page 18.)

Many practices are choosing to do a two-step screening process using the PHQ-2 and PHQ-9. Both PHQ-2 and PHQ-9 are subsets of the longer PHQ screening tool. The PHQ combines DSM-IV depression criteria and major depressive symptoms into a brief self-report instrument that can be used for screening, diagnosis, and treatment. The diagnostic validity of the PHQ-9 was confirmed through studies based in eight primary care and seven obstetric clinics. In those studies, PHQ-9 scores of 10 or higher had a sensitivity of 88 percent and a specificity of 88 percent for major depressive disorder. The PHQ-2 is simply the first two questions of the PHQ-9:

- Over the past month, have you felt down, depressed, or hopeless?
- Over the past month, have you felt little interest or pleasure in doing things?

If a patient has a positive screen on the PHQ-2, this triggers the practice to proceed to completing the full PHQ-9. In primary care offices, the PHQ-2 has a sensitivity of 97 percent and a specificity of 67 percent.¹² The full PHQ-9 is available at multiple websites, including the USPSTF website, which offers a printer-ready version at <http://bit.ly/1PRy0JQ>.

It is important to note that the PHQ tools were developed to be self-administered; the test was never validated for staff or other care providers to ask the patients the questions directly. ►

Identifying and screening patients

Although you may agree that screening for depression across age groups is a good idea, doing so in a busy practice can pose some significant challenges. Figuring out who needs to be screened has gotten much easier with age-based recommendations that do not require identifying other risk factors. Practices have been successful implementing screening strategies in a wide variety of ways.

Leverage information technology. There are numerous ways to use information technology to support depression screening. Once your practice identifies your preferred screening tools and workflow, you can build them into your system. The primary care practices in our systems, Christiana Care Health System and Temple University Health System, have incorporated depression screening into the routine rooming process. Some practices use a report that indicates if a patient is due for screening and automatically prints the blank screening tool along with the patient's registration paperwork. Other practices prefer on-demand printing during the rooming process. The entry form for the screening tool

is embedded within the vital sign documentation, and staff enter the patient's answers into the electronic health record (EHR). A care gap tool notifies staff and providers if a patient is overdue for screening and allows staff to quickly flag a provider to follow up with the patient during a visit about a positive screen. Practices can even ask patients to complete the screening tools through the patient portal before a visit. For providers in rural locations, Medicare pays for telehealth screening using staff or clinicians if the practice meets the specified requirements.^{13,14}

Empower your staff. Because patients complete many of the standardized screening tools independently, office staff can initiate the screening process. Providing preprinted copies of the screening tool at check-in lets patients complete the screen before being taken back to the exam room. Rooming staff can then enter the information into the EHR so that it is available to the clinician for the visit.

Screening at wellness visits. Some providers may find it easier to align the screening with their standard wellness visit workflows. This method ensures that physicians raise the topic with patients at least once a year. For younger adults, some of our local physicians have found screening for depression during adolescent well-child visits or gynecological care to be effective. For older patients, consider pairing the depression screening with the Medicare Annual Wellness Visit (AWV). (For information on efficient delivery of the AWV, see *FPM's* collection of articles on the topic at <http://www.aafp.org/fpm/annualwellnessvisit>.)

Partnering with behavioral health and psychiatry

Screening for depression is an example of how a patient-centered care team can be a great asset, especially if they have internal resources that can improve not only screening rates but also a wide range of chronic conditions.

At Christiana Care, physicians have embedded behavioral health consultants (BHCs) who can provide clinical support and care for their populations. The system's workflow notifies the BHCs of patients with a positive screen, allowing for a warm hand-off from clinician to consultant. Physicians have

■ The U.S. Preventive Services Task Force recommends that physicians screen most adult patients for depression.

■ The Patient Health Questionnaire is the most commonly used depression screening tool.

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)

found that patients are much more likely to follow up when they can meet the BHC in person at the time the referral is made. In addition, the physicians have found that sharing a medical record has been invaluable in easing communication between providers. The physicians were able to collaborate to establish clear practice guidelines regarding when to escalate care to a psychiatrist, which has reduced misunderstandings and unintentional delays in care.

At Temple University Health System, the physicians rely on behavioral health colleagues both within the system and within the community as part of the medical neighborhood. It is critical to identify local sites available to the population and develop a working relationship with these community partners. If you are unsure what mental health resources are available, use the phone number on the back of the patient's insurance card, contact the patient's employee assistance program, or dial 2-1-1 to locate additional co-management options. (For more suggestions on approaching and working with community resources, see "Caring for Seniors: How Community-Based Organizations Can Help," *FPM*, September/October 2014, <http://www.aafp.org/fpm/2014/0900/p13.html>.)

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, Christiana Care's system has a space for documenting the follow-up strategy near the field where the provider would see the results of

a positive screen. Temple University Health System 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.

The Institute for Clinical Systems Improvement has developed an Adult Depression in Primary Care Guideline (<http://bit.ly/IT8DZt>) that includes strategies to improve the overall management of depression.

Coding for depression

Primary care physicians have struggled in the past to receive payment for providing mental health services in their offices. Fortunately, screening for depression is now covered under the ACA by both CMS and private payers.

For Medicare, annual depression screening is a 15-minute time-based code that is covered using HCPCS code G0444 and ICD-10 code Z13.89, "Encounter for screening for other disorder." Depression screening services are not bundled and could be provided on the same day as a problem-oriented visit.¹⁵ However, claims for depression screening will be denied when reported with a "Welcome to Medicare" visit or initial Medicare Annual Wellness Visit. Another common reason for claims denials is when depression screening is billed more than once in a 12-month period.

Aetna will reimburse for PHQ-9 if a provider submits CPT 99420, "Administration and interpretation of a health risk assessment instrument (e.g., health hazard appraisal)," in conjunction with diagnosis code Z13.89.¹⁶ Some plans provided by Blue Cross Blue

■ Busy practices can use information technology, staff advocacy, and wellness visits to stay on top of screening.

■ Any positive screening for depression requires a follow-up plan or additional evaluation and treatment.

■ Screening for depression is now covered for reimbursement under the Affordable Care Act.

CODING FOR DEPRESSION SCREENING

Codes for Medicare payment

G0444: Annual depression screening, 15 minutes

Z13.89: Encounter for screening for other disorder

Codes for Medicare PQRS reporting

G8431: Positive screen for clinical depression with a documented follow-up plan

G8510: Negative screen for clinical depression, follow up not required

G8433: Screening for clinical depression not documented, patient not eligible/appropriate

G8940: Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate

Practices can even ask patients to complete the screening tools through the patient portal before a visit.



Shield and United Healthcare also cover depression screening as a preventive service.

Payment rates vary across the country, but private insurers typically pay around \$15 for 99420 and Medicare pays around \$18 for G0444.

Payment for *managing* patients with depression in primary care offices is less straightforward. Improper or incomplete documentation can lead to payment denials. Common mistakes include failing to record the amount of time spent providing the service, not documenting in the office note the service provided, and failing to sign the documentation.

You can use the EHR to your advantage by building populated order sets that can be customized to each patient, providing appropriate documentation, appropriate coding, and other coordinated service recommendations.

Codes for billing depression screening, as well as codes for registry reporting of PQRS quality measures, are listed in “Coding for depression screening,” page 19.

A systematic approach

Depression is a widespread problem with far-reaching implications. Physicians can be paid for providing depression screening, which is a grade B USPSTF recommendation. Systematize and streamline your workflow and consider partnering with behavioral health professionals or adding them to your practice team to make the process efficient. Use templates to ensure adequate documentation and choose the correct code, and you will be prepared to provide this important service to your patients. **FPM**

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