

# Preventive Care and Screening

## Screening for Clinical Depression and Follow Up Plan

### PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
<b>Step 1 Is patient eligible for this measure?</b>			
	<b>Yes</b>	<b>No</b>	<b>Code Required on Claim Form</b>
Patient is aged 18 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT Code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
If <b>No</b> is checked for any of the above, STOP. Do not report a G-code.			
<b>Step 2 Does patient meet or have an acceptable reason for not meeting the measure?</b>			
<b>Clinical Depression Screening Using a Standardized Tool<sup>1</sup> AND Follow Up Plan<sup>2</sup></b>			<b>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</b>
Performed — Positive screen AND follow up plan documented	<input type="checkbox"/>	<input type="checkbox"/>	G8431
Performed — Negative screen AND follow up plan not appropriate	<input type="checkbox"/>	<input type="checkbox"/>	G8510
Not performed for the following reason: • Documented reasons (eg, patient not eligible/ not appropriate for clinical depression screening <sup>3</sup> )	<input type="checkbox"/>	<input type="checkbox"/>	G8433
Document reason here and in medical chart. _____ _____ _____			If <b>No</b> is checked for <b>all</b> of the above, report G8432 (No documentation using a standardized clinical tool.) <b>OR</b> G8511 (Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified.)

<sup>1</sup>An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS — Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

<sup>2</sup>Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

<sup>3</sup>Patients may be considered not eligible/not appropriate in the following situations: patient refuses to participate, patient is in urgent or emergent situation and to delay treatment would jeopardize the patient's health status, patient's motivation to improve may impact the accuracy of results, patient was referred with a diagnosis of depression, patient has been participating in on-going treatment with screening of clinical depression in a previous reporting period, severe mental and/or physical incapacity.