Provider Notice

Re: Requirements for Core Data Set Depression Screening

Background:

The Center for Medicare and Medicaid Services (CMS) has established various Core Data Set Measures that states must report to CMS. The Office of Mental Health and Substance Abuse Services (OMHSAS) is therefore requiring Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) to collect depression screening data and documented follow up as a result of the depression screening from providers in scope for this requirement via claims submission using various G codes. All five PA BH-MCOs collaborated to develop a single set of specifications for this depression screening reporting. Providers should not report depression screening G codes for persons already diagnosed with depression or bipolar disorder. When a depression screen is conducted as part of diagnostic evaluation or other qualifying service, only one of the G codes for depression screening should be submitted on the claim with the qualifying service. G Codes for depression screening ***cannot*** be submitted as a standalone claim.

Magellan evaluated the results of the provider survey and is reissuing this notice. Magellan requests that providers in scope for this reporting, which are MH OP clinics, Psychologists, Psychiatrists and SUD OP clinics begin submitting G Codes for depression screening per the specification of this notice effective June 1, 2025. *If any provider in scope for this reporting can submit depression G codes prior to June 1, 2025, the provider can begin submitting these codes at any time after the issuance of this notice.*

G Codes used to report Depression Screening are:

Procedure Code	Service Description
G8431	Screening for depression is documented as being positive and a follow-up plan is documented
G8433	Screening for depression not completed documented patient or medical reason
G8510	Screening for depression is documented as negative, a follow-up plan is not required
G9717	Documentation that the patient has an active diagnosis of depression or has a diagnosis of bipolar disorder

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Magellan expects that providers submitting claims for *initial* diagnostic evaluations using procedure codes 90791 or 90792 and any applicable modifiers to these core codes *will* submit claims that also include the appropriate G Code for depression screening. In addition, there may be other services where the clinician conducts a qualifying depression screening. For a complete list of procedure codes that *could* qualify as a service where a depression screen is completed and where a G code for depression screening is reported on a claim, see Attachment 1 to this notice. All applicable modifiers to procedure codes listed in Attachment 1 are also in scope for depression screening G code reporting.

Below is guidance for depression screening G codes:

1) The Screening for Depression and Follow-Up Plan measure includes members ages 12 and older.

2) An age-appropriate, standardized, and validated depression screening tool must be used, and results documented as positive or negative. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. The screening should occur on the date of a service or up to 14 calendar days prior to the date of service. The depression screening must be reviewed and addressed by the provider on the date of service. Positive pre-screening results indicating a member is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

3) To satisfy the follow-up requirement for a member screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:
    - Referral to a provider for additional evaluation.
    - Pharmacological interventions.
    - Other interventions for the treatment of depression.

4) For members with multiple qualifying services, the member does not need to be screened at every service, only once during a year.

5) A follow-up plan must be documented on the date of the qualifying service for a positive depression screen. A clinician could opt to complete a suicide risk assessment when appropriate and based on individual member characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.

6) Providers should not report depression screening G codes for members already diagnosed with depression or bipolar disorder.

Attachment 1
Depression Screening Qualifying Procedure Codes

NOTE: This is the universe of qualifying codes and not all BH-MCO provider contracts will include the below codes. Please utilize your contracted fee schedule.

Code	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.