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Primary care — the first step for treatment of depression

Aetna Depression in Primary Care Program

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23.03.859.1 I (1/17)

The Aetna Depression in Primary Care Program is designed to support the screening for and treatment of depression at the primary care level.

Background — depression quick facts

- Depression often coexists with other serious medical illnesses, such as heart disease, stroke, cancer, HIV/AIDS, diabetes and Parkinson's disease. Most people do not seek treatment due to the stigma associated with depression.
- A high percentage of those treated don't receive appropriate treatment or continue their treatment for a sufficient period of time.
- Medical associations are recognizing the critical role that practices like yours play in identifying and treating patients.

Challenges facing primary care physicians

- **No time** — Diagnosing and monitoring patients with depression is time intensive.
- **No tools** — Many primary care physicians have no evaluation/screening tools. Patients often come in complaining of physical symptoms. Because the symptoms of depression can mimic other illnesses, recognizing them may not be obvious for the patient and physician.
- **No support** — There is a lack of a well-organized mental health system for physician support and patient treatment in the primary care setting.

Program benefits

Our Aetna Depression in Primary Care Program offers your practice:

- A tool to screen for depression as well as monitor response to treatment
- Reimbursement for depression screening and follow-up monitoring
- Patient health questionnaire (PHQ-9) — specifically developed for use in primary care
  - Self-administered, quick and easy
  - Specific for depression
  - Available in English and Spanish
- PHQ-9 reimbursement
  - Submit claim with the following billing combination: CPT code 96127 (brief emotional/behavioral assessment) in conjunction with diagnosis code Z13.89 (screening for depression)

Getting started

Ready to join us in the Aetna Depression in Primary Care Program? To get started, you simply need to:

- Be a participating provider
- Use the PHQ-9 tool to screen/monitor your patients
- Submit your claims using the combination coding

Learn more **here**.

Beacon Health Options
Depression Screening Program Description

Purpose

The purpose of Beacon's *Depression Screening Program* is to establish a formal process of assessing and ensuring early detection and treatment of depressive disorders to promote optimal health for its members. This screening program is grounded in the elements established by Beacon's depression health management program (DHM), launched in 2008, aimed at improving the health outcomes of people with depression. The DHM program uses a multi-pronged approach to achieve the best possible outcomes based on early identification, timely and personalized practitioner interventions, and ongoing care monitoring and evaluation.

Background/Rationale

The National Alliance on Mental Illness (NAMI) reports that 5-8 percent of adults in the United States, or 25 million people, are affected by depression each year.[1] NAMI's findings additionally reveal that only half of this population receives treatment. Without treatment, the frequency and severity of depression symptoms worsen over time. Major depression that remains untreated has increased potential to result in decline in overall quality of life, in addition to severe consequences, such as, suicide[2]. Depression is also a mental illness that spans globally serving as the leading cause of disability worldwide, as reported by the World Health Organization (WHO)[3].

According to the Center for Disease Control (CDC), depression can adversely affect the course and outcome of common chronic conditions, such as arthritis, asthma, cancer and diabetes. Not only is depression a standalone chronic disease, it is also proven to be associated with behaviors linked to other chronic diseases. For example, studies conclude that depression is associated with an increased risk for smoking, which is a leading cause for lung disease, and can furthermore, impede smoking cessation efforts. Also as evidence of this, research shows that physical inactivity is a risk factor for depression and, strongly correlated to obesity. Depression can additionally result in work absenteeism, short-term disability, and decreased productivity.

Depression not only affects the person suffering from the illness, but also those who are around them. Interpersonal relationships tend to suffer for those experiencing symptoms of depression. Very few families or friend groups are not affected by their loved one's depression. Relationships outside of the home, such as at school or in the workplace, can also

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[1] *What is Depression?* . (n.d.). Retrieved on August 6, 2014 from National Alliance on Mental Illness: http://www.nami.org/template.cfm?section=Depression
[2] *Depression.* (n.d.). Retrieved on August 6, 2014 from Center for Disease Control and Prevention: http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm
[3] *Depression Key Facts.* (n.d.). Retrieved on August 6, 2014 from the World Health Organization: http://www.who.int/mediacentre/factsheets/fs369/en/

be affected.[4] Effective treatment of depression can help to improve the health of someone who is suffering, as well as repair broken interpersonal relationships.

Beacon's annual BH diagnosis prevalence data demonstrates depressive disorders are consistently the top Behavioral Health (BH) diagnoses each year. The prevalence of depression, along with the cited scientific research regarding the adverse affects of this mental illness, are evidence that a comprehensive screening program is necessary to yield positive health outcomes and reduce costs, by providing timely and effective treatment.

Eligible Members

- All Beacon members (13 years of age and older) receiving BH treatment under the following conditions:
    - Members with a diagnosis of a depressive disorder
    - Members assessed to be at high risk for depression, to include, but not limited to the following[5]:
        - Presence of other psychiatric disorders, to include substance use disorders
        - Presence of a chronic medical disease and/or terminal illness
        - Genetic history
        - Unemployment or lower socioeconomic status
        - Significant life event (stress, injury, trauma, death of a loved one, homelessness, loss of support network)

Planned Screenings

Beacon recognizes that screening is the first step in identifying the appropriate treatment and level of care for members with depression. Screening must be conducted during the initial patient interview, repeated at regular intervals as clinically indicated, and also when depression management programs are in place to ensure effective monitoring and follow-up with the patient. Beacon utilizes clinically validated screening tools within its network. Patient Health Questionnaire (PHQ)-2 and PHQ-9/PHQ-A are brief, multipurpose, self-administered tools for assessing depression, endorsed by the National Quality Forum (NQF). The diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) depression criteria are incorporated with other leading major depressive symptoms into a brief self-report instrument that are commonly used for screening and diagnosis, as well as selecting and monitoring treatment.[6]

[4] *An Estimated 1 in 10 U.S. Adults Report Depression*. (n.d.). Retrieved on August 18, 2014 from Centers for Disease Control and Prevention : http://www.cdc.gov/Features/dsDepression/

[5] Guidelines to Clinical Preventative Services: Depression in Adults (n.d.). Retrieved on August 18, 2014 from the Agency for Healthcare Research and Quality: Patients who screen positive with the PHQ-2 should be further evaluated with the PHQ-9 tool[5].

- **PHQ-2**: The sole purpose of PHQ-2 is to screen for depression, encompassing only the first two questions of the PHQ9, identifying the degree to which an individual experienced depressed mood and anhedonia over the past two weeks. To access the PHQ-2 screening tool, click here.
- **PHQ-9**: The PHQ-9 is used to screen for depression, but is also valid for the assessment of depression severity. Thus, when used successively during a treatment episode, the PHQ-9 is a practical means to quantitatively monitor the patient's response to depression treatment[7]. To access the PHQ-9 screening tool and available in over 30 languages, click here.
- **PHQ-A**: The PHQ-A is a modified version of the PHQ-9 sensitive to the adolescent experience of depression that is an acceptable and efficient tool for early detection and recognition of mental disorders in this high-risk group.[8] To access the PHQ-A screening tool, click here.
- **Screening Frequency**: The Agency for Healthcare Research and Quality (AHRQ) reports that there is no known optimal screening interval and the tool can be administered repeatedly to measure treatment progress. The frequency of readministration should be determined by the treatment BH clinician. In those instances where the primary care provider is administering, the PHQ9/PHQ-A the Point of Care Guidelines of the American Family Physician recommends that the PHQ-2 be used as a screening instrument for use during a routine intake or annual examination[9]. Patients who screen positive with the PHQ-2 should be further evaluated with the PHQ-9/PHQ-A tool[10]. For all treaters, the PHQ-9/PHQ-A tool should also be utilized at the discretion of the provider when the member meets any of the criteria in the eligible members section above.

Conditions Required for Screening

A screening must be performed when the following condition(s) or circumstance(s) exist:

- All adolescents and adults in BH treatment that meet the depressive diagnosis or members at high risk as defined in the eligible members section above.
- Members who self-identify.
- Members identified by the health plan.

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[6] *Patient Health Questionnaire* (PHQ-9 & PHQ-2). (n.d.). Retrieved on August 11, 2014 from the American Psychological Association: http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx.

[7] Pinto-Meza A, Serrano-Blanco A, Peñarrubia M.T, Blanco E, Haro JM (2005) Assessing Depression in Primary Care with the PHQ-9: Can It Be Carried Out over the Telephone? Journal of General Internal Medicine, 20, 8, 738–742. Retrieved 5/21/14.

[8] Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002 Mar;30(3):196-204.

[9] *Point of Care Guidelines: Screening Instruments for Depression.* (n.d.). Retrieved on August 14, 2014 from American Family Physician: http://www.aafp.org/afp/2008/0715/p244.html

[10] *Patient Health Questionnaire* (PHQ-2): Description. (n.d.). Retrieved on August 11, 2014 from U.S. Department of Health and Human Services: http://www.innovations.ahrq.gov/content.aspx?id=2280.

Beacon Health Options
Depression Screening Program Description

Input for Program Design

a) Provider/Practitioner Input:

- Elicitation of feedback at Provider Advisory Council and via provider surveys.
- Beacon Expert Panel feedback
- Feedback from Beacon's team of board certified and actively practicing psychiatrists

b) Beacon Clinical Input:

- Clinician literature reviews on current clinical practice guidelines for screening and treatment of substance use disorders.
- Annual review of program and screening tools at Beacon's Clinical Quality Improvement Committee.
- Oversight and approval of revisions to program and use of screening tools at Beacon's Quality Improvement Committee.

Screening Promotion

Beacon encourages and promotes the importance of screening using a variety of interventions to include:

- Online access to Beacon's Member Depression Treatment Tool (MDTT) which is a resource for prescribers to use in assisting members in understanding depression treatment, and letters emphasizing the importance of members' follow-up appointments and medication management.
- Provider Bulletin mailed or faxed to providers annually promoting Beacon's depression screening recommendations.
- Distribution of annual provider postcards that list educational and screening materials posted on Beacon's website.
- Education and feedback during provider events, such as expert panels, provider breakfasts, site visits and chart reviews by Beacon clinicians.
- Collaborate with our interested health plan partners on dissemination of the Depression Screening program to primary care sites.
- Targeted questions in chart audit tool around depression screening to include:
  1. If the member is age 13-18, was there member assessed for depression?
  2. If the member is age 13-18 and screened for depression, was a suicide risk assessment conducted?
  3. If the member is age 13-18 and screened for depression, was there family involved in treatment?

4. For members age 18 or older diagnosed with depression or dysthymia: Was the PHQ-9 tool used to monitor progress of treatment? If yes, was the tool utilized once every four months to monitor progress? If no, select the reason: 1) Member was not diagnosed with depression or the member was under the age of 18; 2) The tool was used once, but the chart audit took place prior to the member's next appointment with the provider/plan; 3) other reason.

Screening for Suicide

There is an increased risk of suicide associated with the presence of a mental health disorder, to include depression. According to the U.S. Preventative Task Force (USPSTF), the majority of people who die by suicide have a psychiatric disorder, many of which have recently been seen in primary care[11]. The USPSTF endorses depression screening in adolescents, adults and older adults in primary care settings when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up. Beacon encourages providers to consider suicide screening for patients diagnosed with depression, and also to focus on patients during periods of high suicide risk, such as post psychiatric hospitalization, to reduce related deaths. To access the USPSTF report on suicide screening, click here.

[11] National Guideline Clearinghouse: Screening for suicide risk. (n.d.). Retrieved from the Agency for Healthcare Research and Quality on September 2, 2014, http://www.guideline.gov/content.aspx?f=rss&id=48193&osrc=12

BlueCross BlueShield of New Mexico

Blue Cross Community Centennial℠

CENTENNIALCARE

Screening for Clinical Depression Initiative

Although many patients may present to their provider's office with nonspecific physical symptoms consistent with depression such as pain, poor sleep or poor appetite, their comorbid diagnosis of depression may go unrecognized.

Providers may not have the tools or the time needed to screen or treat such patients. Blue Cross and Blue Shield of New Mexico (BCBSNM) understands these challenges and wants to help.

Did you know?

- Major Depressive Disorder (MDD) remains a treatable cause of pain, suffering, disability and death.
- Primary Care Clinicians detect MDD in one-third to one-half of their patients and about half of these go untreated.
- Additionally, more than 80% of patients with depression have a medical comorbidity.

For questions, you may contact your Provider Representative or email Behavioral Health Quality Improvement at BHQualityImprovement@bcbstx.com.

What will you need to know and how may we help?

- BCBSNM reimburses providers that participate in the Blue Cross Community Centennial network for administering an annual depression screening tool using procedure code G0444 (administration).
- **Results are reported simultaneously with either G8431 (positive screen with plan) or G8510 (negative screen) result code. Starting July 1, 2017, and through December 31, 2018, additional reimbursement will be provided for G8431 and G8510.**
  - **Add the modifier, U8, in the modifier section on the CMS 1500 when submitting the claim that includes G0444 with the addition of either G8431 or G8510.** ***Any reimbursement will be made according to Blue Cross Community Centennial medical/reimbursement policies for services and other billing and reimbursement practices.***
- This tool kit includes a sample Patient Health Questionnaire (PHQ-9), tips for administering the screening test, contact information and much more.
- The PHQ-9 is completed by patients in your office and is easily accessible in multiple languages at www.phqscreeners.com.
- The purpose of the PHQ-9 is to screen for depression.

Who should I screen?

- Blue Cross Community Centennial members who are 18 years of age and older
- Blue Cross Community Centennial members without an active diagnosis of depression, bipolar disorder or other mood symptoms.

Patients who are not eligible or may not be clinically indicated for the depression screening measurement:

- Patients who have had an annual depression screen or refuse to participate
- Patients who are in an urgent or emergent situation where a delay in treatment may jeopardize the patient's health status
- Patients whose functional capacity or motivation to improve may impact the accuracy of results (e.g., certain court-appointed cases or cases of delirium)
- Patients who already have an active diagnosis of depression or bipolar disorder

Williams Jr JW, Noel PH, Cordes JA, et al. Is this patient clinically depressed? JAMA 2002;287:1160-70.

Schonfeld WH, Verboncoeur CJ, Fifer SK, et al. The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. J Affect Disord 1997;43:105-19.

Klinkman MS. The role of algorithms in the detection and treatment of depression in primary care. J Clin Psychiatry 2003;64[suppl 2]:19-23.

Practice guidelines are meant to serve as general guidelines and are not intended to substitute for clinical judgment in individual cases.

The Patient Health Questionnaire (PHQ-9) is a publicly available screening tool available from Pfizer Inc.

All providers referenced in this document are not employed by and are independent from BCBSNM.

Such services are funded in part with the State of New Mexico.

Patient Health Questionnaire - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For office coding:	0	+_____	+_____	+_____
Total Score:				

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

Screening for Depression

Medicare | PREVENTIVE SERVICES

ICN 907799 June 2012

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The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

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Table of Contents

The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare beneficiaries understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your beneficiaries about Medicare-covered screening for depression in adults, as well as assist you in correctly billing for these services.

Overview

Among persons older than 65 years, one in six individuals suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illnesses, including:

- Cancer,
- Arthritis,
- Stroke,
- Chronic lung disease, and
- Cardiovascular disease.

Removal of Barriers to Preventive Services Under the Affordable Care Act

Medicare waives the coinsurance or copayment and deductible for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population, and that are appropriate for the individual.

Older adults have the highest risk of suicide of all age groups. These beneficiaries are important in the primary care setting because 50 to 75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that beneficiaries feel nearly every day include, but are not limited to:

- Feeling sad or empty,
- Less interest in daily activities,
- Weight loss or gain when not dieting,
- Less ability to think or concentrate,
- Tearfulness,
- Feelings of worthlessness, and
- Thoughts of death or suicide.

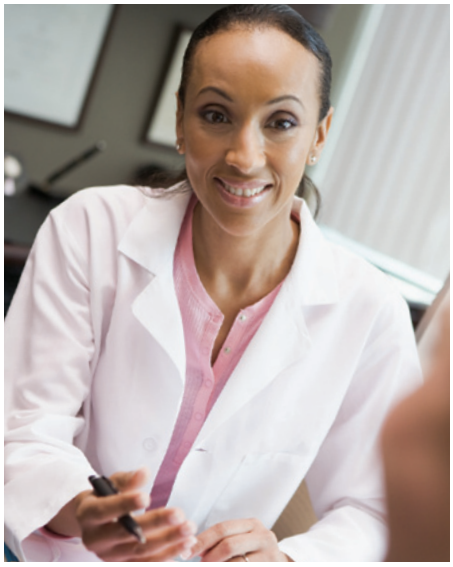
Stand Alone Benefit

The screening for depression in adults benefit covered by Medicare is a stand alone billable service. It is a separate service from the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit (AWV), although it can be provided at the same time as the IPPE or AWV.

Coverage Information

Effective for dates of service on or after October 14, 2011, Medicare Part B covers **annual** (i.e., at least 11 months after the most recent screening for depression) screening up to 15 minutes for depression screening for Medicare beneficiaries in primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. At a minimum level, staff-assisted 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.

Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.



Screening for depression is non-covered when performed more than one time in a 12-month period (i.e., at least 11 months after the most recent screening for depression). In addition, self-help materials, telephone calls, and web-based counseling are not paid separately by Medicare and are not part of this national coverage determination.

Primary Care Setting Defined

For purposes of this covered service, a 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. CMS does not consider the following as primary care settings under this definition:

- Ambulatory surgical centers,
- Emergency departments,
- Hospices,
- Independent diagnostic testing facilities,
- Inpatient hospital settings,
- Inpatient rehabilitation facilities, and
- Skilled nursing facilities.

Medicare covers screening for depression when services are furnished in the following places of service:

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

Frequency

When calculating frequency to determine the annual period, 11 full months must elapse following the month in which the last annual depression screening took place.

EXAMPLE: A beneficiary gets a screening for depression in January 2012. The count starts February 2012. The beneficiary may get another screening for depression in January 2013.

Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for this screening service if conditions of coverage are met. However, if a beneficiary sees a non-participating physician, there could be a charge.

Documentation

Medical records must document that all coverage requirements are met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) code, listed in Table 1, to report screening for depression in adults.

Table 1. HCPCS Code for Screening for Depression in Adults

HCPCS Code	Code Descriptor
G0444	Annual depression screening, 15 minutes

Diagnosis Requirements

Although you must report a diagnosis code on the claim, Medicare does not require a specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code for screening for depression in adults. Contact your local Medicare Contractor for further guidance.

Coming Soon!
International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

For more information, visit http://www.cms.gov/Medicare/Coding/ICD10 on the CMS website.

Billing Requirements

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code

in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims, to indicate where you provided the service. For more information on POS codes, visit http://www.cms.gov/Medicare/Coding/place-of-service-codes on the CMS website.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report the appropriate HCPCS code, revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.

Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for screening for depression in adults when submitted on the following TOBs, listed in Table 2. For further guidance on the appropriate revenue code, contact your local Medicare Contractor.

Table 2. Facility Types and TOBs for Screening for Depression in Adults

Facility Type	TOB
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician's interpretation of the results of an examination. For instructions on billing the professional component, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf on the CMS website.

The technical component is services rendered outside the scope of the physician's interpretation of the results of an examination. If you perform technical components or services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:

- **For Provider-Based FQHCs or RHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website and choose the appropriate chapter based on your facility type.
- **For Independent FQHCs or RHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the CMS website.


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Form Approved
OMB No. 0938-0626

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization
☐ Revision to Current Authorization

☐ Check here if EFT payment is being made to

Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for screening for depression in adults under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screenings for depression.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data, or revalidating enrollment must use Electronic Funds Transfer (EFT) to get payments. For more information about EFT, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html on the CMS website.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for screening for depression in adults depends on the type of facility providing the service. Table 3 lists the type of payment that facilities get.

Table 3. Facility Payment Methods for Screening for Depression in Adults

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

Reasons for Claim Denial

Medicare may deny coverage of screening for depression in adults in several situations, including:

- The beneficiary got more than one screening for depression in the last 12 months.
- The beneficiary got the screening for depression outside of the primary care setting.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit http://www.wpc-edi.com/reference on the Internet. You can obtain additional information about claims from your carrier, FI, or A/B MAC.

Medicare Contractor Contact Information

For carrier, FI, or A/B MAC contact information, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

RA Information

For more information about the RA, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html on the CMS website.

Resources

For more information about screening for depression in adults, refer to the resources listed in Tables 4 and 5. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.

Table 4. Provider Resources

Resource	Website
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/Medicare/Medicare-General-Information/BNI
"CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 190	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Medicare Learning Network (MLN) Matters® Article MM7637, "Screening for Depression in Adults"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7637.pdf
"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.9	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo

Table 4. Provider Resources (cont.)

Resource	Website
MLN Guided Pathways to Medicare Resources	The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the "Coverage of Preventive Services" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
MPFS	http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched
OPPS	http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientPPS
USPSTF Screening for Depression in Adults Recommendations	For a summary of the USPSTF written recommendations on screening for depression in adults, visit http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm on the Internet.

Table 5. Beneficiary Resources

Resource	Website/Contact Information
Manage Your Health – Preventive Services	http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx
"Medicare & You: Stay Healthy with Medicare's Preventive Benefits" Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=relmfu
Medicare Beneficiary Help Line and Website	Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
Medicare Depression Screenings	http://www.medicare.gov/navigation/manage-your-health/preventive-services/depression-screenings.aspx
"Publications for Medicare Beneficiaries"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf

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The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo on the CMS website.

SCREENING FOR DEPRESSION IN ADULTS (NCD 210.9)

Guideline Number: MPG274.04 **Approval Date**: August 8, 2018

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Related Medicare Advantage Coverage Summaries

- Preventive Health Services and Procedures
- Telemedicine/Telehealth Services

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®**), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.
**CPT® is a registered trademark of the American Medical Association.

PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

POLICY SUMMARY

Overview

Persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, chronic lung disease, arthritis, stroke, and cardiovascular disease. Stressful events, such as the loss of friends and loved ones, are also risk factors for depression.

Symptoms of major depression that are felt nearly every day include, but are limited to, feeling sad or empty; less ability to think or concentrate; less interest in daily activities; weight loss or gain when not dieting; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Based upon authority to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on screening for depression in adults. Screening for depression in adults is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Part A and Part B.

CMS will cover annual screening for depression for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. The decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as combination therapy (medications and counseling), pharmacotherapy, or other interventions for depression.

Guidelines

Nationally Covered Indications

CMS will cover annual screening up to 15 minutes for Medicare beneficiaries when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. At a minimum level, staff-assisted supports consist of clinical staff (e.g., physician assistant, nurse) in the primary care setting who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. Services covered under this NCD must be provided by a primary care provider.

Nationally Non-Covered Indications

Screening for depression is non-covered when performed more than one time in a 12-month period. Also self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.

Other

Medicare coinsurance and Part B deductible are waived for this preventive service.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
G0444	Annual depression screening, 15 minutes

Place of Service Code	Description
11	Physician's office
19	Off Campus-Outpatient hospital

Place of Service Code	Description
22	On Campus-Outpatient hospital
49	Independent clinic
71	State or local public health clinic

REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 210.9 Screening for Depression in Adults

CMS Benefit Policy Manual
Chapter 15; § 270.2 List of Medicare Telehealth Services

CMS Claims Processing Manual
Chapter 1; § 190 Medicare Payment for Telehealth Services
Chapter 18; § 190 Screening for Depression in Adults

Transmittals
Transmittal 139, Change Request 7637, Dated 11/23/2011 (Screening for Depression in Adults)
Transmittal 2359, Change Request 7637, Dated 11/23/2011 (Screening for Depression in Adults)
Transmittal 2431, Change Request 7637, Dated 03/23/2012 (Screening for Depression in Adults)

MLN Matters
Article MM7637, Screening for Depression in Adults
Article MM7637 Revised, Screening for Depression in Adults

UnitedHealthcare Commercial Policies
Preventive Care Services

Others
Dept of Health and Human Services (Centers for Medicare and Medicaid Services) Preventative Services (IBT for Cardiovascular Disease), CMS Website
Medicare Preventive Services, ICN 006559, August 2018

GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Action/Description
08/08/2018	• Annual review, no changes

PREVENTIVE MEDICINE AND SCREENING POLICY

Policy Number: ADMINISTRATIVE 238.19 T0 **Effective Date**: July 1, 2018

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Related Policy

- Add-On Policy
- Preventive Care Services
- Prolonged Services

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

Note: Please refer to the policy titled Preventive Care Services for additional information regarding preventive health services.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

OVERVIEW

Preventive Medicine Services [Current Procedural Terminology (CPT®) codes 99381-99387, 99391-99397, Healthcare Common Procedure Coding System (HCPCS) code G0402] are comprehensive in nature, reflect an age and gender appropriate history and examination, and include counseling, anticipatory guidance, and risk factor reduction interventions, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, Oxford will reimburse the

Preventive Medicine service plus 50% the Problem-Oriented E/M service code when that code is appended with modifier 25. If the Problem-Oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed.

When a Preventive Medicine service and Other E/M services are provided during the same visit, only the Preventive Medicine service will be reimbursed.

Screening services include cervical cancer screening; pelvic and breast examination; prostate cancer screening/digital rectal examination; and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory. These Screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day.

Prolonged services are included in (and not separately reimbursed from) Preventive Medicine codes.

Counseling services are included in (and not separately reimbursed from) Preventive Medicine codes.

Medical Nutrition Therapy services are included in (and not separately reimbursed from) Preventive Medicine codes.

Visual function screening and Visual Acuity screening are included in (and not separately reimbursed from) Preventive Medicine services.

For a list of specific codes that are included in (and not separately reimbursed from) Preventive Medicine Services see the Applicable Codes section below.

For the purposes of this policy, Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional is defined as a physician, hospital, ambulatory surgical center, and/or other health care professional of the same group and Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional reporting the same Federal Tax Identification number.

REIMBURSEMENT GUIDELINES

Preventive Medicine Service and Problem Oriented E/M Service

A Preventive Medicine CPT or HCPCS code and a Problem-Oriented E/M CPT code may both be submitted for the same patient by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional on the same date of service. If the E/M code represents a significant, separately identifiable service and is submitted with modifier 25 appended, Oxford will reimburse the Preventive Medicine code plus 50% of the Problem-Oriented E/M code. Oxford will not reimburse a Problem-Oriented E/M code that does not represent a significant, separately identifiable service and that is not submitted with modifier 25 appended.

Preventive Medicine Service and Other E/M Service

A Preventive Medicine CPT or HCPCS code and Other E/M CPT or HCPCS codes may both be submitted for the same patient by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional on the same date of service. However, Oxford will only reimburse the Preventive Medicine CPT or HCPCS code.

Screening Services

The comprehensive nature of a Preventive Medicine code reflects an age and gender appropriate examination. When a screening code is billed with a Preventive Medicine code on the same date of service by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional, only the Preventive Medicine code is reimbursed.

Prolonged Services

Prolonged services codes represent add-on services that are reimbursed when reported in addition to an appropriate primary service. Preventive medicine services are not designated as appropriate primary codes for the Prolonged services codes. When Prolonged service add-on codes are billed with a Preventive Medicine code on the same date of service by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional, only the Preventive Medicine code is reimbursed.

According to CPT and HCPCS, prolonged preventive service codes G0513-G0514 are considered add-on codes and should not be reported without the appropriate primary code. Refer to the Add-On Policy for details.

Counseling Services

Preventive Medicine Services include counseling. When counseling service codes are billed with a Preventive Medicine code on the same date of service by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional, only the Preventive Medicine code is reimbursed.

Medical Nutrition Therapy Services

According to CPT, for Medical Nutrition Therapy assessment and/or intervention performed by a physician, report Evaluation and Management or Preventive Medicine service codes. When Medical Nutrition Therapy codes are billed with a Preventive Medicine code on the same date of service by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional, only the Preventive Medicine code is reimbursed.

Visual Function and Visual Acuity Screening

The comprehensive nature of a Preventive Medicine code reflects an age and gender appropriate examination. When Visual Function Screening or Visual Acuity Screening is billed with a Preventive Medicine code on the same date of service by the Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional, only the Preventive Medicine code is reimbursed.

Modifier	Description
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

DEFINITIONS

Preventive Medicine Services: Includes annual physical and well-child examinations, usually in the absence of a disease-related diagnosis.

Same Specialty Physician, Hospital, Ambulatory Surgical Center or Other Health Care Professional: Physicians, hospitals, ambulatory surgical centers and/or other health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

Preventive Medicine Services

CPT Code	Description
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)

CPT Code	Description
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older

HCPCS Code	Description
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Codes Included in Preventive Medicine Services

CPT Code	Description
Problem Oriented E/M Services	
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

CPT Code	Description
Problem Oriented E/M Services	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Other E/M Services	
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99251	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT Code	Description
Other E/M Services	
99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

CPT Code	Description
Other E/M Services	
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
Prolonged Services	
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
Counseling Services	
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
Medical Nutrition Therapy Services	
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

CPT Code	Description
Medical Nutrition Therapy Services	
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
Visual Function and Visual Acuity Screening	
0333T	Visual evoked potential, screening of visual acuity, automated, with report
99172	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for contrast sensitivity, vision under glare)
99173	Screening test of visual acuity, quantitative, bilateral

HCPCS Code	Description
Problem Oriented E/M Services	
G0463	Hospital outpatient clinic visit for assessment and management of a patient
Other E/M Services	
G0245	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (4) patient education
G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education
S0285	Colonoscopy consultation performed prior to a screening colonoscopy procedure
Screening Services	
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0102	Prostate cancer screening; digital rectal examination
G0442	Annual alcohol misuse screening, 15 minutes
G0444	Annual depression screening, 15 minutes
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
Counseling Services	
G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0445	Semiannual High Intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0446	Biannual face-to-face intensive behavioral therapy to reduce cardiovascular disease risk individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes

HCPCS Code	Description
Counseling Services	
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
S0265	Genetic counseling, under physician supervision, each 15 minutes
S9470	Nutritional counseling, dietitian visit
T1006	Alcohol and/or substance abuse services, family/couple counseling
T1027	Family training and counseling for child development, per 15 minutes
Medical Nutrition Therapy Services	
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

QUESTIONS AND ANSWERS

1	**Q:**	Why does Oxford reduce reimbursement to 50% for an evaluation and management (E/M) service (99201-99205 or 99212-99215 with modifier 25) billed for the same person on the same date of service as a Preventive Medicine service?
	A:	Oxford recognizes that a visit may begin as a Preventive Medicine service, and in the process of the examination it may be determined that a disease related condition exists (evaluation and management). When this occurs, the level of decision-making during such a visit may be more complex than the decision-making during a Preventive Medicine visit. However, there are elements of the Preventive Medicine service (e.g., making the appointment, obtaining vital signs, maintaining and stocking the exam room, etc.) that are duplicated in the reimbursement for an E/M code; these duplicated practice expense services are 50% of the E/M cost.
2	**Q:**	In what situation is CPT code 96110 reimbursable?
	A:	As defined, CPT code 96110 represents developmental screening with interpretation and report. In the introduction to the section in which this code appears, the CPT book states that "it is expected that the administration of these tests will generate material that will be formulated into a report." Because a physician obtains developmental information as an intrinsic part of a preventive medicine service for an infant or child and because this information is sometimes obtained in the form of a questionnaire completed by the parents, it is expected that this code will be reported in addition to the preventive medicine visit only if the screening meets the code description. Physicians should report CPT code, for developmental screening or other similar screening or testing, separate and distinct from the Preventive medicine service only when the testing or screening results in an interpretation and report by the physician being entered into the medical record.
3	**Q:**	Why is Q0091 not separately reimbursable when billed with a Preventive Medicine code?
	A:	Oxford considers Q0091 (obtaining, preparing and conveying a cervical or vaginal smear to the laboratory) to be an integral part of a Preventive Health Care service. Therefore, this component of a Preventive visit is not separately reimbursable.
4	**Q:**	Why is 99173 (screening test of visual acuity) not separately reimbursable when billed with a Preventive Medicine code?
	A:	Oxford considers vision screening using an eye chart to be integral to a Preventive Medicine examination in the same way that measurements of height, weight and blood pressure are integral to a Preventive Medicine examination. Therefore, vision screening using an eye chart is not reimbursed separately from a Preventive Medicine examination.
5	**Q:**	Why is 99172 (visual function screening) not separately reimbursable when billed with a Preventive Medicine code?
	A:	The CPT Book clearly states that this service should not be reported in addition to an E/M code.

6	Q:	How does Oxford reimburse for screening tests based on a questionnaire completed by the patient or a family member when done in conjunction with a Preventive Medicine service?
	A:	Counseling, anticipatory guidance and risk factor reduction interventions are integral to a Preventive Medicine visit. Historical information may be obtained either through direct questioning or through completion of a written questionnaire. The responses on a questionnaire often identify areas for more focused interventions or treatments. Since this screening is part of a Preventive Medicine service, it is not reimbursed separately. Occasionally, a screening instrument requires interpretation, scoring, and the development of a report separate from the Preventive Medicine encounter. In those situations, where a CPT code exists for that service, screening, interpretation and development of a report is reimbursed separately from a Preventive Medicine service.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2018R0013B*]

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

07/01/2018	• Updated list of related policies; added reference link to the policy titled:
	  ○ *Add-On Policy*
	  ○ *Prolonged Services*
	• Updated reimbursement guidelines; added language to indicate:
	  ○ According to CPT and HCPCS, prolonged preventive service codes G0513-G0514 are considered add-on codes and should not be reported without the appropriate primary code; refer to the *Add-On Policy* for details
	• Archived previous policy version ADMINISTRATIVE 238.18 T0