

## Provider Implementation of Core Data Set Depression Screening

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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 Community Behavioral Health (CBH) 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 people already diagnosed with depression or bipolar disorder. When a depression screening is conducted as part of a 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.

CBH evaluated the results of the provider survey and is reissuing this notice. CBH 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:

<i>Procedure Code</i>	<i>Service Description</i>
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

CBH expects that providers submitting claims for initial diagnostic evaluations using procedure codes 90791 or 90792 and any applicable modifiers to these core codes will

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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 [Section 1.2: Depression Screening Qualifying Procedure Codes](#). All applicable modifiers to procedure codes listed in [Section 1.2: Depression Screening Qualifying Procedure Codes](#) are also in scope for depression screening G code reporting.

Below is guidance for depression screening G codes:

- ➔ The Screening for Depression and Follow-Up Plan measure includes members ages 12 and older.
- ➔ 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 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.
- ➔ 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 an additional evaluation
  - » Pharmacological interventions
  - » Other interventions for the treatment of depression
- ➔ For members with multiple qualifying services, the member does not need to be screened at every service, only once during a year.

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

Please contact your assigned provider relations representative with any questions and/or concerns.