C·B·H

a division of DBHIDS

CBH SCREENING PROGRAMS

Depression Screening Program

Updated September 2025

Community Behavioral Health

1. PURPOSE

Community Behavioral Health (CBH) is implementing a depression screening program as part of the **OMHSAS** *Performance Improvement Project to Improve Suicide Prevention and Community Resilience*. Establishing a formal process of early identification and referral to treatment is essential to promoting optimal health for members included in the HealthChoices Medicaid program. This document outlines information required for all CBH-contracted providers to implement the program, including information about the screening tool, recommendations for follow-up, and submission of screening results to CBH.

2. SCIENTIFIC EVIDENCE FOR SCREENING PROGRAM

There is increasing awareness that mental health and substance use disorders (SUDs) are frequently comorbid and a growing understanding about the importance of identifying and addressing comorbid disorders (Substance Abuse and Mental Health Services Administration: Tip 42, 2020). Studies have found that up to one third of patients with depression may also have an SUD (Davis et al., 2008). Among individuals with SUDs, depression is also very common (McHugh and Weiss 2019, Grant et al., 2004). One metanalysis that reviewed comorbidity found the highest association between drug use and major depression (OR 3.80) (Lai et al., 2015). Effective screening programs can serve as an important tool to identify and ensure appropriate care for members with comorbid conditions. CBH has prioritized identification of comorbid depression and substance use as it's the focus of our adult screening program.

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** **2021 National Survey on Drug Use and Health** identified substance use, including alcohol and other drugs, throughout the past month and year, as well as any misuse identified by respondents. Among adults aged 18 or older who had a major depressive episode in the past year made up 8.3% of respondents as part of the survey. The percentage of major depressive episodes was highest among those aged 18 to 25 (18.6%), then ages 26 to 49 (9.3%), followed by adults 50 or older (4.5%). Of all participants, 19.4 million people (7.6%) had a co-occurring mental illness and an SUD. Additionally, adults aged 18 or older with SMI or AMI in the past year were more likely than those with no mental illness in the past year to be past year users of illicit drugs overall. An estimated 50.2% of adults aged 18 or older with SMI and 39.7% of adults aged 18 or older with AMI used illicit drugs in the past year compared with 17.7% of adults aged 18 or older with no mental illness.

Mental health and SUDs are associated with significant morbidity and mortality (Kessler & Bromet, 2013; Humeniuket et al., 2008). The 2010 Global Burden of Disease Study (Murray et al., 2012) ranked major depressive disorder (MDD) as the second leading cause of years lived with disability. Depression is associated with lower workplace productivity and absenteeism, which results in lower income and higher unemployment, and with higher risk for other conditions and behaviors, including smoking (Asay et al., 2016). In 2010, the economic burden of depression was estimated to be $210.5 billion. Additionally, depression is associated with an increased risk for mortality from suicide and heart disease. Similarly, the burdens of substance use are devastating and vast, only a sample of which include overdose deaths, injury/accidents, physical health consequences, financial costs, loss of workplace productivity, legal system involvement, etc. (Rhem & Shield 2019; Whiteford et al., 2013, Greenberg et al., 2021; World Health Organization, 2023).

Despite the high prevalence of depression and substance use and the morbidity and mortality associated with these disorders, only a minority of those with co-occurring disorders receive treatment for both. Analysis of the **2018 National Survey on Drug Use and Health** revealed that of the 9.2 million US adults with co-occurring disorders, 90% did not receive treatment for both disorders, and nearly half (48.6%) received no treatment at all (McCance-Katz, 2019). This finding highlights the critical importance of identifying co-occurring disorders through effective use of evidence-based screening. Early identification and referral to treatment through screening is an effective step to prevent and improve population health outcomes (SAMHSA Tip 42, U.S. Preventive Services Task Force, 2016).

3. SCREENING TOOL

CBH has identified the Patient Health Questionnaire–9 (PHQ-9) as the validated instrument for its Depression Screening Program. The PHQ-9 is a commonly utilized multipurpose instrument for screening, diagnosing, and monitoring depression. It incorporates the DSM diagnostic criteria on depressive disorders with other major depressive symptoms in a brief self-reporting tool, which rates the frequency of the symptoms yielding a severity index. The tool has been found to be both valid and reliable (Kroenke et al., 2001). The PHQ-9 is easy to use and can generally be completed in 2.5 minutes or less (Sun et al., 2020). Use of the PHQ-9 is also used in many validated metrics for quality reporting (e.g., HEDIS DFS-E and DRR-E).

The PHQ-9 is in the public domain and does not require permission for use. The **APA Report: Patient Health Questionnaire (PHQ-9 & PHQ-2)** includes a multilingual **PHQ screener generator**.

3.1. Scoring

- The total PHQ-9 score can range from 0 to 27.
- Each of the 9 items can be rated on a four-point scale from (0 = Not at All; 1= Several Days; 2= More than Half the Days; 3 = Nearly Every Day).
- Higher scores indicate greater severity of depression (0-4= None; 5-9 = Mild Depression; 10-14 = Moderate Depression; 15-19=Moderately Severe Depression; 20-27= Severe Depression).

3.2. Target Population:

All CBH-eligible members, age 12 and older, shall be screened for depression in all CBH contracted levels of care, including treatment settings for SUD.

3.3. Mode of Administration:

The PHQ-9 can be administered by a clinician (in person or by telephone) or self-administered. The clinician should calculate the total score and document the results in the electronic health record in both the embedded screening tool and in the progress notes. All screening results, and any recommended next steps, should be discussed with the member.

Please note, the administering clinician should always review the response to item 9 on the PHQ-9 (which assesses thoughts of self-harm or suicide). Positive answers (score of 1-3) to item 9 should trigger additional assessment (per provider protocols) and requires the completion of a **Columbia Suicide Severity Rating Scale (C-SSRS)**.

3.4. Frequency

- Screening is recommended at the onset of treatment, as a part of the intake process.
- Screening is recommended annually for individuals who score 9 or less.
- Screening is recommended at least every four months for individuals who score 10 or more.

3.5. Follow-up

- Screening PHQ-9 scores of 9 or less do not require a follow-up with a clinician, unless clinically indicated by assessor. These members should continue to have ongoing annual screening.
- Screening PHQ-9 scores of 10 or more (positive screening) require a follow-up activity within 30 days at minimum (See **Appendix C** for allowable CPT codes).
  - Appropriate follow up activities may include:
    - Outpatient, telephonic, e-visit follow-up with a diagnosis of depression or other health condition
    - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
    - A behavioral health encounter, including assessment, therapy, collaborative care, or medication management
    - A dispensed antidepressant medication
  - These members should have ongoing PHQ-9 every four months (at minimum) to assess progress in treatment.
- Individuals who score as moderate (15-19) or severe depression (20-27) should receive immediate intervention, as clinically appropriate (i.e., referral to mental health provider, collaboration with mental health provider, crisis evaluation, etc.). CBH recommends these individuals should receive suicide risk assessment, such as the C-SSRS.
- Positive answers (score of 1-3) to item 9 should trigger additional assessment (per provider protocols) and requires the completion of a C-SSRS.

- Follow-up activities for members who screen positive must occur within 30 days of the positive screening.
  - Appropriate follow up activities may include:
    - Outpatient, telephonic, e-visit follow-up with a diagnosis of depression or other health condition
    - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition
    - A behavioral health encounter, including assessment, therapy, collaborative care, or medication management
    - A dispensed antidepressant medication
  - Members who need assistance identifying a provider should be given the phone number for CBH Member Services (888-545-2600).

3.6. Training

CBH recommends that providers offer training to staff on administration of the screening tool, as well as provider policy and protocols regarding follow-up on positive screening. Potential resources for training include:

- University of Washington Aims Center PHQ-9 Resource
- Pfizer PHQ Screener Generator

3.6.1. Additional Resources

- CBH Clinical Practice Guidelines

4. REPORTING SCREENING RESULTS

All screening results will be reported to CBH via HL7 messaging each time a PHQ-9 screening is completed. Please follow the CBH HL7 Submission Guide. The following codes will be utilized when reporting PHQ-9 screening:

Performance Measure	LOINC Code	Description
DSF-E DRR-E PDS-E	44261-6	Code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'

5. REFERENCES

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APPENDIX A: ICD-10CM CODES FOR DEPRESSION

Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.41	Major depressive disorder, recurrent, in partial remission
F33.9	Major depressive disorder, recurrent, unspecified
F32.5	Major depressive disorder, single episode, in full remission
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.42	Major depressive disorder, recurrent, in full remission
F34.1	Dysthymic disorder

APPENDIX B: ICD-10CM CODES FOR BIPOLAR DISORDER

Code	Description
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features

Code	Description
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

APPENDIX C: ALLOWABLE CPT CODES FOR FOLLOW-UP SERVICES

The following CPT codes will count as a follow-up visit:

90791	99211	H0004
90792	99212	H0031
90832	99213	H0034
90834	99214	H0035
90837	99215	H0036
90846	99242	H0037
90847	99243	H0039
90853	99244	H2010
90867	99245	H2011

90868	99341	H2014
90869	99342	H2019
90870	99344	S9480
90875	99345	S9484
99202	99484	S9485
99203	99492	T1015
99204	99493	T1016
99205	99494	T1017