Provider Implementation of Core Data Set Depression Screening – Frequently Asked Questions

This Frequently Asked Questions document serves as a follow up to CBH Provider Bulletin 25-11, released March 11, 2025. Please contact your assigned provider relations representative with any questions and/or concerns.

1) Are the depression screening codes mentioned in the attached bulletin going to be reimbursable? If so, will they be added to our Schedule A on the effective date of 6/1/25 with a reimbursement amount and a Blanket Auth Number?

The depression screening codes are not reimbursable. As noted in Provider Bulletin 25-11 Provider Implementation of Core Data Set Depression Screening, "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."

2) Providers should not report depression screening G codes for members already diagnosed with depression or bipolar disorder. However, there is a G code listed which says: "Procedure Code Service Description."

G9717 Documentation that the patient has an active diagnosis of depression or has a diagnosis of bipolar disorder. Should they be using the G code?

G Code for depression screening should be reported with each "intake" represented by claims submitted with procedure code 90791 or 90792. Providers should select the appropriate G-code among the four choices for each intake If a member presents for intake with a known or active diagnosis for Depression or Bipolar Disorder as a result of some documentation, (such as IP discharge or other acceptable documentation to the provider), report code G9717.

Clinicians may conduct a depression screen at other times during the course of treatment and if subsequent depression screens are conducted, the provider can report the appropriate

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G code based on the outcome of the screen with any of the acceptable procedure codes listed in notice.

3) I'm unclear as to how to handle initial evaluations – let's say an individual comes in for the first time. They score positively on the screening tool and are diagnosed with Major Depressive Disorder during the evaluation. Do we use G8431 (screened positively and a follow up plan is documented) or G9717 (documentation that the patient has an active diagnosis of depression)?

G8431 would be used in this case indicating screened positively and a follow up plan is documented.

4) The bulletin notes that providers should not report depression screening G codes for members already diagnosed with depression or bipolar disorder. However, G9717 is specifically for individuals that have an active diagnosis of depression or bipolar disorder. When do we use G9717 versus not reporting a code?

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Clinicians may conduct a depression screen at other times during the course of treatment and if subsequent depression screens are conducted, the provider can report the appropriate G code based on the outcome of the screen with any of the acceptable procedure codes listed in notice.

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5) Only primary diagnosis is submitted with claims data. Thus, there may be individuals who have a primary diagnosis of PTSD, etc. and a secondary diagnosis of depression, with depression documented in their medical record but not submitted to CBH systematically as primary diagnoses are. Does the G9717 code apply to individuals with a secondary diagnosis of depression?

Yes. The G9717 code applies to individuals with a secondary diagnosis of depression.

6) Does the bulletin apply to CIRC, as there is an OP component?

Yes, this applies to CIRC providers. As indicated in Provider Bulletin 25-11 Provider Implementation of Core Data Set Depression Screening all mental health outpatient (MH OP) clinics, psychologists, psychiatrists, and substance use disorder outpatient (SUD OP) clinics must complete these screenings.

7) It says for members with multiple qualifying services the member does not need to be screened at every service, only once a year. Does this mean that all applicable individuals must be re-screened annually, or that if someone has two evaluations within a year or two different outpatient programs (e.g. MHOP and SUD OP) they only need to do it once, rather than in both programs?

All applicable individuals should be screened annually. The screening does not need to be completed for each service provided. In this example, a screening does not need to be completed by both the MHOP and SUD OP providers in the same year.