

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



Official Information Health Care
Professionals Can Trust

Screening for Depression

Medicare Fee-For-Service
PREVENTIVE SERVICES



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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:

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

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

Coverage Information

Medicare Part B covers **annual** (that is, 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 (for example, 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 not covered when performed more than one time in a 12-month period (that is, at least 11 months after the most recent screening for depression). Additionally, self-help materials, telephone calls, and web-based counseling are not paid separately by Medicare and are not part of this benefit.

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.

Telehealth Services

CMS added annual depression screening as a covered Medicare telehealth service effective January 1, 2013. For more information, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/telehealthsvcsfctst.pdf> on the CMS website.

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 2013. The count starts February 2013. The beneficiary may get another screening for depression in January 2014.

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 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 and review the following documents:

- ▶ “Revised and Clarified Place of Service (POS) Coding Instructions” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf> on the CMS website; and
- ▶ “The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1104.pdf> 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.

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.

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. 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.

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- **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.

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.

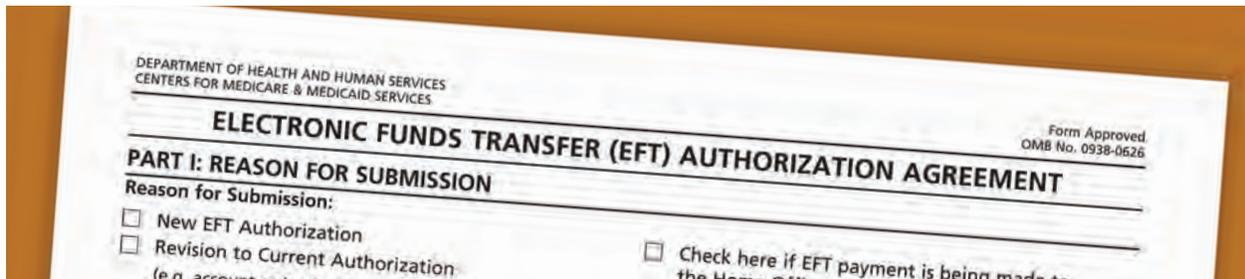
Institutional Claims

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 on the same day as an Initial Preventive Physical Examination (IPPE) or a first Annual Wellness Visit (AWV).
- ▶ 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/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map> 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
“Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Medicare Fee-For-Service (FFS) 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
MLN Guided Pathways to Medicare Resources	<p>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.</p> <p>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.</p>
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf

Table 4. Provider Resources (cont.)

Resource	Website
MPFS	http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched
MPFS Search Tool	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf
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/coverage/preventive-and-screening-services.html
“Medicare & You: Stay Healthy with Medicare’s Preventive Benefits” Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=plcp
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/coverage/depression-screenings.html
“Publications for Medicare Beneficiaries”	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf



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