Centers for Medicare & Medicaid Services
Medicare Preventive Services National Provider Call:
Five New Medicare Preventive Services
Moderator: Leah Nguyen
August 15, 2012
2:00 p.m. ET

Podcast 2 of 5: Screening for Depression in Adults

Disclaimers

Presentation 2

Amanda Barnes: Welcome to the second of five podcasts from the New Medicare Preventive Services National Provider Call, brought to you by the Medicare Learning Network — your source for official CMS information for Medicare Fee-For-Service providers. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, August 15, 2012.

In this second podcast, Michelle Issa from the Center for Clinical Standards & Quality, Kathy Bryant from the Hospital and Ambulatory Policy Group, and Wil Gehne from the Provider Billing Group discuss Screening for Depression in Adults.

Leah: And now I would like to turn the call back over to Michelle Issa, with our presentation on Screening for Depression in Adults.

Michelle Issa: Thanks, Leah.

Effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting that have staff-assisted depression care

supports in place to assure accurate diagnosis, effective treatment, and followup.

Next slide, number 29. Screening – up to 15 minutes for depression screening for Medicare beneficiaries in a primary care setting when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and followup. At a minimum level, staff-assisted supports consist of a clinical staff – for example, a nurse or physician assistant in a 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 a primary care setting. Next slide, number 30. For the purposes of this benefit, a primary care setting is a setting where there is provision of integrated, accessible healthcare services by clinicians who are accountable for addressing large majority of personal health care needs, development of sustained partnership with patients, and practicing in the context of family and community.

Next slide, Coverage Limitations, slide 31. Screening for depression is not covered when performed more than one time in a 12-month period. It 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 pharmacotherapy, combination therapy, counseling and medications, or other interventions for depression. Self-help materials, telephone calls, and Web-based counseling are not separately reimbursable by Medicare and are not part of this national coverage determination.

Thank you. Now I'd like to turn it over to Kathy.

Kathy Bryant: Thank you.

For HCPCS code G0444 – is the code used for annual depression screening. The national payment rates, again, starting with the physician nonfacility rate is $17.36. For the physician providing a service in the facility, $9.19. The

hospital outpatient rate is $35.69. And there is no beneficiary co-insurance or deductible for this service.

Now, I'll turn it over to Wil.

Wil Gehne: Thanks, Kathy.

For coding of depression screening on professional claims, you would use HCPCS Code G0444, and in this case the associated place of service code list is a little bit more limited – limited to physician's office, outpatient hospital, independent clinic, or public health clinic. Similar to the other benefits, the Medicare system is going to edit to ensure that the correct place of service is reported, and if it's not, the remittance advice will show that with reason code 58 and the remark code N428. And for the place of service edits, the remittance advice coding is consistent across all five of these benefits. We'll move through that a little bit more quickly as we go along.

Regarding coding institutional claims, the same HCPCS would be used, and the same list of type of bills is allowable that we had seen in the previous benefits and Medicare systems (turning to slide 36) and, again, edit to ensure that. In this case, we have slightly different remittance advice coding for those denials using reason code 170, which is that "payment is denied when performed or billed by this type of provider," and remark code N428, "not covered when performed in this place of service." So for the institutional claim edits, the remittance advice coding varies slightly between the benefits.

Once again, the payment basis on slide 37 varies by facility type. This is consistent across all five of the benefits. We'll move through that a little bit more quickly as we go along as well.

Turning to all claims again on slide 38: Medicare systems enforce that annual depression screening is billed no more than once within a 12-month period. Whenever there are time limitations like that it's important to get the specific definition of how that's enforced, and we're using 11 full months that must elapse following the month in which the last annual depression screening took place.

On slide 39, you can see that when that edit is applied, the remittance advice will indicate it with reason code 119, "benefit maximum for this time period or occurrence has been reached," and remark code N362, "the number of days or units of service exceeds our acceptable maximum." And once again, professional and facility fees can be billed separately for the services just as we defined them back on slide 22.

Amanda Barnes: Thank you for listening to this Medicare Preventive Services educational podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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