Incorporating Mental Health Screening Into Adolescent Office Visits | PHQ-9

Administering and Scoring the PHQ-9 Screening Questionnaire

Administering

- The Patient Health Questionnaire Modified for Teens (PHQ-9 Modified) can be used with patients between the ages of 12 and 18 and takes less than five minutes to complete and score.

- The PHQ-9 Modified can be administered and scored by a nurse, medical technician, physician assistant, physician or other office staff.

- Patients should be left alone to complete the PHQ-9 Modified in a private area, such as an exam room or a private area of the waiting room.

- Patients should be informed of their confidentiality rights before the PHQ-9 Modified is administered.

- The American Academy of Pediatrics and the U.S. Preventive Services Task Force recommends that depression screening be conducted annually.

Scoring

- For every X:
  - Not at all = 0
  - Several days = 1
  - More than half the days = 2
  - Nearly every day = 3
  - Add up all “X” ed boxes on the screen.

Defining a Positive Screen on the PHQ-9 Modified:

- Total scores ≥ 11 are positive

Suicidality:

Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (questions 12 and 13 on the screen) should be considered a positive screen.
Interpreting the Screening Results

- Patients that score positive on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.

- It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.

- For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as “more than half days” and “nearly every day” with the patient.

- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Depression Severity

- The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.

- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.

- Additional questions on the PHQ-9 Modified also explore dysthymia, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.

**Total Score: Depression Severity**

- 1–4: Minimal depression
- 5–9: Mild depression
- 10–14: Moderate depression (≥ 11 = Positive Score)
- 15–19: Moderately severe depression
- 20–27: Severe depression

Engaging and Informing Parents

- Inform parents of the screening results (positive or negative), recent suicidal thinking, past suicide attempts and recommendations for referral, treatment or follow-up.

- Provide parents with information about the next steps and offer support and assistance with finding or making an appointment with a mental health professional.

- Compile a list of mental health referral resources in the community and share that list with families of patients that receive a referral.

- Work with the patient’s existing insurance benefit to determine the mental health resources that are available to them.

- Obtain written permission from parents to allow the transfer of information between the PCP and the mental health professional who accepts the referral.

Coding and Payment

The following is a comprehensive list of relevant codes that may be used to bill for mental health checkups. These codes are not guaranteed to work with all payers.

**Mental Health Screening**

96110 – Standardized, developmental and mental health testing/screening; limited with interpretation and report.

**Health Risk Assessment Code**

99420 – This code may be used for the administration and interpretation of a health risk assessment instrument.

**Evaluation and Management Codes (E/M)**

PCPs may report an office or outpatient E/M code using time as the key factor when a limited screening test is administered along with an E/M service.

**Modifier 25**

Modifier 25 tells insurers that the particular visit is different; it should be added to the office/outpatient visit to indicate that a significant, separately identifiable E/M service was performed in addition to the preventive medicine visit. Note that many insurers do not reimburse for modifier 25.

**Corresponding ICD-9 (Diagnosis) Codes**

V20.2 – Well-child, preventative health visits

V79.8 – Special screening exam for mental disorders and developmental handicaps

V40.0 – Mental and behavioral health problems

For more information about making a referral, please refer to our Guide to Referral, available upon request.

<table>
<thead>
<tr>
<th>Established Patients</th>
<th>New Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211 (5 minutes)</td>
<td>99201 (10 minutes)</td>
</tr>
<tr>
<td>99212 (10 minutes)</td>
<td>99202 (20 minutes)</td>
</tr>
<tr>
<td>99213 (15 minutes)</td>
<td>99203 (30 minutes)</td>
</tr>
<tr>
<td>99214 (25 minutes)</td>
<td>99204 (45 minutes)</td>
</tr>
<tr>
<td>99215 (40 minutes)</td>
<td>99205 (60 minutes)</td>
</tr>
</tbody>
</table>

For more information about coding and payment for mental health issues, please refer to our Guide to Coding and Payment, available upon request.
Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>(0)</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Feeling down, depressed, irritable, or hopeless?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>2</td>
<td>Little interest or pleasure in doing things?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>3</td>
<td>Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>4</td>
<td>Poor appetite, weight loss, or overeating?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>5</td>
<td>Feeling tired, or having little energy?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>6</td>
<td>Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>7</td>
<td>Trouble concentrating on things like school work, reading, or watching TV?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>8</td>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
<tr>
<td>9</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td>Not At All</td>
<td>Several Days</td>
<td>More Than Half the Days</td>
</tr>
</tbody>
</table>

10. In the past year have you felt depressed or sad most days, even if you felt okay sometimes?  
   [ ] Yes  [ ] No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?  
   [ ] Not difficult at all  [ ] Somewhat difficult  [ ] Very difficult  [ ] Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life?  
   [ ] Yes  [ ] No

13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?  
   [ ] Yes  [ ] No

FOR OFFICE USE ONLY Score ____________________  
Q. 12 and Q. 13 = Y or TS =≥11