BlueCross BlueShield of New Mexico

Depression Screening and Outpatient Provider Incentive Overview

Behavioral Health Quality

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Depression Screening

- Major Depressive Disorder (MDD) remains a treatable cause of pain, suffering, disability and death.
- Primary Care Clinicians detect MDD in one-third to one-half of their patients and about half of these go untreated.
- Additionally, more than 80% of patients with depression have a medical comorbidity.
- Who should be screened for purposes of this incentive?

  - Members who are 12 years of age and older

  - Members without an active diagnosis of depression, bipolar disorder or other mood symptoms.

- Patients should be screened with an age-appropriate, standardized depression screening tool. For example, the PHQ-9 can be completed by patients in your office and is easily accessible in multiple languages at www.phqscreeners.com.

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Depression Screening

- Patients who are not eligible or may not be clinically indicated for the depression screening measurement:
  - Patients for who a screening is not clinically indicated.
  - Patients whose functional capacity or motivation to improve may impact the accuracy of results (e.g., certain court-appointed cases or cases of delirium).
  - Patients who already have an active diagnosis of depression or bipolar disorder.

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Depression Screening

• BCBSNM reimburses providers that participate in the Blue Cross Community Centennial network for administering an annual depression screening tool using procedure code G0444 this can be reimbursed up to 4 times a year.

• Results are reported simultaneously with procedure code G0444 or any other qualifying CPT/HCPCS code along with either G8431 (positive screen with plan) or G8510 (negative screen) result code. Currently, an additional $10 reimbursement is provided for G8431 and G8510.

• A follow-up plan related to a positive screen includes one or more of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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Behavioral Health Outpatient Provider Incentive Initiative

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Outpatient Provider Incentive Initiative

- Purpose:

❖ To improve follow-up visits within 30 days of discharge after an acute mental health admission.

- How:

✓ When a Blue Cross member is seen in-office or via telehealth for psychotherapy or pharmacologic management within 30 days post-discharge:

✓ Add the procedure code G9002, then U9 in the modifier section on the CMS 1500.

✓ Receive an additional $30 per qualifying claim.

✓ The additional payment began March 4, 2020.

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Outpatient Provider Incentive Initiative

- Important

– Only one provider may use the code and modifier for the same member within the same 30-day period.

– Any reimbursement will be made according to medical/reimbursement policies for services and other billing and reimbursement practices.

VISIT CAN BE A TELEHEALTH VISIT.

- Questions can be emailed to **BHQualityImprovement@bcbstx.com**

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Enhanced Payment for Initiation of Substance Use Treatment

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Initiation of Alcohol and Other Drug Dependence Treatment (IET)

- IET Enhanced Payment for Blue Cross Community Centennial members

  –**Eligible visit -** You will be eligible to earn an additional $75 per claim if:

- You diagnose a new (194 days without a substance abuse claim) substance use disorder and provide an initial follow-up visit related to substance use disorder previously diagnosed.
- The follow-up service is within 14 days of the initial appointment in which the diagnosis of a new substance use disorder is made.
- Member is a Blue Cross Community Centennial (Medicaid) member.
- This enhanced payment program began September 1, 2021.

How to submit a claim for an eligible follow-up visit using CMS 1500

–Add **procedure code H0006** to your standard code(s) for the visit.

–Use the **modifier U9** in the modifier section.

–Use the code and modifier only once for the same member annually.

–Only one provider may use the code and modifier for the same member annually.

–**VISITS CAN BE A TELEHEALTH VISIT.**

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