

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days (MSSP only – the same day or within 2 days) of a positive depression screen finding.

Exclusions

- Active diagnosis for depression (not applicable to Medicare).
- Active diagnosis for bipolar disorder.

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
G8431	Depression screening positive with follow-up plan
G8510	Depression screening negative follow-up not required

When supporting medical documentation is available for depression screening, submit this information to the ACN Quality Data Abstractor assigned to the practice in order to close the quality gap if coding is unavailable.

Documentation Requirements

- Screening may occur on the date of the encounter or up to 14 days prior to the date of the encounter.
- Clinician interpretation of “positive” or “negative” must be documented on the date of the encounter. A score alone is not sufficient.
- The name of the age-appropriate standardized depression screening tool must be documented.
- If positive, a follow-up plan must be documented. A follow-up plan includes at least one of the following:
 - Additional evaluation or assessment for depression; suicide risk assessment; referral to a practitioner who is qualified to diagnose and treat depression; pharmacological interventions; or other interventions or follow-up for the diagnosis or treatment of depression.
- Screening and follow-up plan documentation may be completed during a telehealth encounter

Common Documentation Insufficiencies

- Failing to include a clinician interpretation such as “positive” or “negative.”
- Utilizing PHQ-9 forms that do not include patient first and last name, date of birth, and encounter date.
- Failing to document the name of the screening tool.

Best Practices

- Utilize a PHQ-9 screening form, labeled as such, which includes a prompt for clinician interpretation (positive or negative) and signature. Ensure this form contains the patient's first and last name, date of birth, and encounter date, and upload to the EMR, labeled clearly for easy identification.
- Ensure workflows are in place to notify and remind providers when a patient's next screening or follow-up is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Utilize care gap lists to identify non-compliant patients.