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

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.
**Integrating 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), 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 behavioral health specialist.
- Give information to parents about why the referral is being made, how the services you are referring can help, and details about where you are sending them.
- Compile a list of appropriate 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 referral resources that are available to them.
- Obtain written permission from parents to allow the transfer of information between the PCP and the behavioral health specialist 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

<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.
Una Encuesta de Parte de su Proveedor de Cuidados de Salud — PHQ-9 Modified for Teens

Nombre

Clinico

Fecha

Instrucciones: ¿Qué tan a menudo ha sentido cada uno de los siguientes síntomas durante las dos ultimas semanas? Por cada síntoma escriba una “X” en el cuadro que mejor describe como se siente.

<table>
<thead>
<tr>
<th>(0) Ninguno</th>
<th>(1) Varios Días</th>
<th>(2) Más de la Mitad de los Días</th>
<th>(3) Casi Todos los Días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Se siente deprimido, irritado, o sin esperanza?</td>
<td></td>
<td></td>
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<tr>
<td>2. ¿Poco interés o placer para hacer cosas?</td>
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<td>3. ¿Tiene dificultad para dormirse, quedarse dormido, o duerme demasiado?</td>
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<td>4. ¿Poco apetito, perdida de peso, o come demasiado?</td>
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<td>5. ¿Se siente cansado o tiene poca energía?</td>
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<tr>
<td>6. ¿Se siente mal por usted mismo-o siente que es un fracasado, o que le ha fallado a su familia y a usted mismo?</td>
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<tr>
<td>7. ¿Tiene problema para concentrarse en cosas tales como tareas escolares, leer, o ver televisión?</td>
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<tr>
<td>8. ¿Se mueve o habla tan lentamente que las otras personas pueden notarlo? ¿O al contrario—esta tan inquieto que se mueve más de lo usual?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. ¿Pensamientos que estaría mejor muerto o de hacerse daño usted mismo de alguna manera?</td>
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</tbody>
</table>

10. ¿En el año pasado se ha sentido deprimido o triste la mayoría de los días, aun cuando se siente bien algunas veces?  
    [ ] Si  [ ] No

11. Si usted esta pasando por cualquiera de los problemas mencionados en este formulario, ¿qué tan difícil estos problemas le causan para hacer su trabajo, hacer las cosas de la casa, o relacionarse con las demás personas?  
    [ ] No dificil  [ ] Un poco dificil  [ ] Muy dificil  [ ] Sumamente dificil

12. ¿En el mes pasado hubo algún momento donde usted pensó seriamente en terminar con su vida?  
    [ ] Si  [ ] No

13. ¿Alguna vez en su vida, trato de matarse o trato de suicidarse?  
    [ ] Si  [ ] No

PARA USO DE LA OFICINA SOLAMENTE Score __________________________

Q. 12 and Q. 13 = Y or Screen = ≥11

Used with Permission of the GLAD-PC Steering Group: www.GLAD-PC.org
Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)