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DSF-E Frequently Asked Questions (FAQ)

This document contains questions asked prior to and during the Population Health Learning Center's (PHLC) Depression Screening and Follow up [Webinar on April 1st, 2026](#). This represents the views of subject matter experts at PHLC and their consultants and Connecting For Better Health. It is not meant to replace guidance provided by your Managed Care Plans or NCQA but, rather, augment that information to help your practice increase effectiveness of workflows and data submissions. Following the below instructions is not a guarantee that a practice will improve DSF-E measure performance however, it is informed by practice experience with improving this measure. If you have further questions, please see the [PHLC DSF-E Resource Page](#) or [Connecting For Better Health Sandbox](#) DSF-E resources.

Questions Related to Depression Screenings:

1. *For depression screening PHQ2 should only be done or always PHQ9 should be done in screening exam or both always?*

At minimum, practices should incorporate the PHQ2 for baseline depression screening. Should there be a positive screen and/or clinical judgement to further assess, practices should deploy the PHQ-9

2. *How do you ensure you are capturing all DSFs done in provider offices? How do you supplement effectively? Also, LOIN-C codes have been a barrier to capture in EMRs and impact rates. Please describe strategies to overcome this issue.*

We recommend utilizing the depression screening templates and workflows within your Electronic Health Record (EHR) for screenings conducted in your provider office. Using these EHR tools often ensures that data is captured discretely, which simplifies reporting to your Managed Care Plan or other partners. Furthermore, these tools frequently embed the specific LOINC code for each screening within the discrete data they generate.

To capture depression screenings completed by other organizations, first check if the assessments are available from one of the nine State-designated Qualified Health Information Organizations (QHIOs). If the assessment is not available via a QHIO, it may be sent to your organization via secure email and then linked to the patient's record in your Electronic Health Record (EHR).

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Note on Manual Reporting: When using the secure email method, the discrete data elements needed for automated reporting will not be available. You will need to manually upload the information to the Managed Care Plan (MCP) or your population health management tool. Providing a copy of the assessment document serves as proof of completion.

Required Document Information for Manual Upload: Ensure the document includes:

- Patient identifying information
- Date of the Assessment
- The assessment tool used
- The patient's total score

Contact your Managed Care Plan for specific guidance on the process for manually reporting assessments completed outside of your practice.

3. *If a patient needs a follow-up based on their score.. does their score determine the type of care needed?*

In our clinic, Imperial Beach Community Clinic (IBCC), the score itself doesn't dictate the level of care. Any positive PHQ-9 triggers an automatic referral to Behavioral Health. Once that referral is received, a Care Manager completes a screening and triage to determine appropriate services, taking into account the patient's social determinants of health, overall presentation, and needs. The score is one variable, but it isn't the sole driver of care decisions. Also, there is the scenario that the patient scores for example a 3 and that 3 is in response to the "I'd be better off dead" question. In this case, though the system is not designed to parse out answers and refer based on answers, only positive scores, it's critical that a whole-person care model is utilized, where the PCP reviews the answers on the PHQ9 and then has a conversation with the patient and based on clinical judgment, the patient will be referred to the appropriate services.

Questions Related to Follow up After Positive Screening:

1. *Best practices for DSF-E? How to engage follow-up?*

Imperial Beach Community Clinic's (IBCC) Best Practices for DSF-E and Automated Follow-Up: IBCC's approach centers on **whole-person care** and patient engagement. This involves building relationships, having intentional conversations, and ensuring patients feel supported and understood when discussing the next steps in their care.

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At the clinic a positive depression screening automatically initiates a process within the electronic health record (EHR).

- **Real-Time Review:** The positive score is captured and linked to the specific visit, enabling the provider to review and address it immediately.
- **Supported Follow-up:** Follow-up care is supported through referral to behavioral health services and care coordination. This maintains continuity and keeps the patient engaged.
- **Automated Referrals:** While "warm handoffs" were once considered ideal, increasing clinical demands and provider workloads have made them less consistently practical. Consequently, IBCB now relies more on an automated referral process. The Behavioral Health department is expected to apply the whole-person care approach to help patients determine the most suitable services upon receiving the automated referral.

2. *Clarification as to what counts as a follow up? Is there a checklist to review before submitting an encounter?*

- To ensure a depression screening gap is closed after a patient screens positive, you should directly contact your managed care plan (MCP) for specific guidance on the required follow-up information and coding. Many MCPs also publish this guidance on their public websites. For instance, Molina provides an example of how to code follow-up encounters [here](#).
- Below are Molina’s requirements for the diagnosis and procedure codes that need to be on a followup claim in order for it to count as a Behavioral Health encounter or Follow Up Visit encounter.:

Behavioral Health Encounter	CPT: 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 90865, 90867-90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493 HCPCS: G0155, G0176, G0177, G0409-G0411, G0511, G0512, H0002, H0004, H0031, H0034-H0037, H0039, G0040, H2000, G2001, H2010-H2020, S0201, S9480, S9484, S9485 UBREV: 0900-0905, 0907, 0911-0917, 0919
Follow Up Visit	CPT: 98960-98962, 98966-98968, 98970-98972, 98980, 98981, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99441-99443, 99457, 99458, 99483 HCPCS: G0071, G0463, G2010, G2012, G2250-G2252, T1015 UBREV: 0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0982, 0983

3. *What are some best practices or strategies to close the gap if a patient is screened positive but declines BH referral and medication?**

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It's important to validate the patient's autonomy and self-determination, and at the same time evaluate the patient's readiness for change, cultural factors, and past history related to depressive symptoms. Practices should engage in motivational interviewing, harm reduction, and trauma-informed approaches to provide brief counseling in these scenarios, and schedule a follow-up to monitor the patient's risk and progress. The patient may not be ready to engage in behavioral health or medication, but may be open to care management, peer supports, app-based CBT and mindfulness approaches, self-management and education plan or other types of interventions relevant to their readiness for change.

4. *Workflows to improve connecting back with provider after positive screen.*

Participants can reference this [toolkit](#) to develop closed loop referral tracking. Best practices include engaging MOUs with CBOs, referring via closed-loop social health systems like FindHelp, referrals to care management with closed loop reporting requirements and embedding CHWs in the workflow for comprehensive system navigation.

5. *Effective workflows to address moderate to severe cases.*

At Imperial Beach Community Clinic (IBCC), effective workflows for addressing moderate to severe depression begin with a comprehensive, multi-measure screening approach. We use tools such as the PHQ-9, GAD-7, and AUDIT to develop a more complete picture of symptom severity, co-occurring conditions, and overall clinical presentation. Our clinic is structured to effectively treat moderate levels of depression within primary care and integrated behavioral health settings. When screening and follow-up assessments indicate higher severity or more complex needs, we rely on established community partnerships with a streamlined referral process. Our care managers coordinate these referrals. The partnerships we have in the community allow us to transition patients quickly and appropriately to higher levels of care while maintaining continuity and support throughout the referral process.

Questions Related to Reporting to Health Plans:

1. *How to translate the screenings to LOINC codes for health plans.*

Each Managed Care Plan provides guidance on the LOINC codes that correspond to various depression screening tools. Reach out to your Managed Care Plan for their code list. [Here](#) is Molina's guidance:



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<i>Depression Screening Instruments</i>		
Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9) [*]	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M) [*]	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) ^{*1}	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{*1,2}	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale - Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60
¹ Brief screening instrument. All other instruments are full-length. ² Proprietary; may be cost or licensing requirement associated with use.		
Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9) [*]	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2) ^{*1}	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{*1,2}	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD) ^{*2}	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS) ¹	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	48544-1	Total score ≥10
My Mood Monitor (M-3) [*]	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31
¹ Brief screening instrument. All other instruments are full-length. ² Proprietary; may be cost or licensing requirement associated with use.		

2. Workflow of the supplemental data submission

Each Managed Care Plan (MCP) provides guidance on how to submit standard supplemental data. Reach out to your MCP representative for their specific guidance. Connecting For Better Health has compiled guidance for submitting Depression Screening Results via Standard Supplemental Data for a number of Managed Care Plans. You can find these tools on the [C4BH Sandbox](#). Here is additional guidance on how to use these tools:

Step 1: Scan the QR code to the right


Step 2: Navigate to the Community Sandbox

Step 3: Select the Use Case Library icon on the left menu

Step 3: Search for “DSF” and select the Orange County Use Case

Step 4: Scroll to the “Documents” section where you will find:

- **Use Case Overview:** Detailed workflows for improving data exchange for the Depression Screening and Follow Up measure
- **DSF-E Implementation Playbook:** How to implement these improvements within your workflow
- **Synthetic Data:** Health Plan Standard Supplemental Data Submission Guides specifically for submission of DSF-E data



C4BH Sandbox

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Questions Related to Data Issues:

1. *How to integrate data into system*

At Imperial Beach Community Clinic (IBCC), collaboration with our data analyst was essential in identifying and building a claim structure that included the appropriate coding to ensure our work was accurately captured and credited. I also recommend reaching out directly to payers whenever possible. While they may not always provide immediate or complete answers, these conversations can clarify payer-specific expectations and help build rapport. Often, you may learn what works best for your specific site, which can inform how data and workflows are structured moving forward.

2. *How to track without a robust EHR*

For practices without a robust Electronic Health Record (EHR) system, it is recommended to use a manual tracking tool, such as an Excel file, to record each depression screening. This file should, at minimum, include:

- Patient identifying information
- Date of assessment
- Type of assessment tool used
- Associated LOINC code
- Total score

The completed depression screening assessments should be securely scanned and stored. This ensures they are accessible for verification purposes when needed.

Practices have two options for submitting this data:

1. Manually enter the data using a population health tool provided by the managed care plan.
2. Work with the Managed Care Plan to submit the data using standard supplemental data methods.

Questions Asked by Webinar Participants:

1. *Is the billing code all that needs to be done to get credit by payors? (Anish Dhamija)*

Fabiola: For Care Management (CM) encounters, submission of the appropriate billing code is sufficient to receive credit. For Behavioral Health (BH) provider encounters,

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credit requires documentation of an ICD-10 diagnosis code, a CPT code, and that the service was delivered by a licensed Behavioral Health provider.

2. *If a patient screens positive on the PHQ-9. Based on the score they get is there a recommended follow up? Or like earlier stated is it best to meet the patient where they are at and discuss what they feel they need (Jaylin Bell)*

Fabiola: Yes, Jaylin, you're absolutely correct. While a positive score is the only variable that automatically triggers a referral, this does not diminish the importance of lower scores, which may be equally valid and warrant follow-up. A whole-person approach is recommended, in which the PCP initiates a thoughtful conversation with the patient about care recommendations and then incorporates the patient's perspectives and preferences when determining next steps.

3. *Are most pediatric practices doing the PHQ2? We are doing the PHQ9 from the start. Would like some feedback. (Ada Arevalo)*

Our practice, Imperial Beach Community Clinic (IBCC), is using PHQ9 throughout, both for pediatrics and adults.

4. *If the patient's PHQ-9 is positive but the PCP wants to follow up with the patient within 30 days and not refer to BH will we get credit? (Erika Patino)*

The recommended intervention will be depended on the patient's risk level assessment. Brief counseling with a planned follow up in 30 days can be a sufficient intervention based on clinical judgement and the patient's needs/goals. Not all positive screens automatically require a referral; the goal is take a relational approach to build trust with the patient and develop a collaborative care plan.

5. *Does it matter really to do PHQ2 first then if the answer is Positive, then goto PHQ9,. Or can we practice straight asking Pts to answer PHQ9 (Bong Tiamson)*

Practices may choose to use the PHQ-2 as the minimum necessary brief universal screen & apply the PHQ-9 for all positive screens. Some clinics prefer to bypass the PHQ-2 and use the PHQ-9 as the universal screening tool. This is practice-specific preference of what works best within the workflow.

6. *This is amazing work to operationalize a screening measure that is inherently poorly designed despite the best of intentions. Ideally this measure should be 2 separate measures. The measure as designed disincentivizes positive screens, since positive screens then require extra work in the measure. The incentive actually may suppress*

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reporting of positive screens. There should be one screening compliance measure so that screens are administered consistently. And then a separate measure that assesses whether patients with positive scores did follow up for an intervention. I think that could allow better operationalization and measure the 2 separate important dimensions of depression identification and care. Again, great work on this. (Henry Chung)

Fabiola: Henry, that's a very astute observation, and I agree. I've long believed that the PHQ-9 would benefit from a meaningful update to better reflect current generations, incorporate broader cultural sensitivity, and move away from overly rigid scoring thresholds. There is often significant nuance and "in-between" experience in how patients interpret and respond to these questions. Thank you for raising this important point and for sharing your perspective.