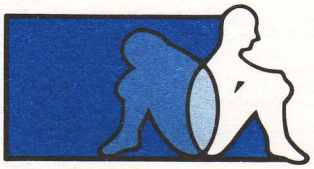
Prime·MD

PRIMARY CARE EVALUATION OF MENTAL DISORDERS



CLINICIAN EVALUATION GUIDE

INSTRUCTIONS

1. **Instructions to you are printed in blue. Questions that you ask or statements that you make to the patient are printed in plain black type.**
2. **Within each module, proceed sequentially from question to question unless instructed either to skip to another question or to EXIT from the module. Remember: always proceed to the next question unless you are instructed to go elsewhere.**
3. **Diagnoses are boxed and shaded in red.**
4. **EXIT means to exit from the module you are in. Then proceed either to the next module that needs to be evaluated or to the Summary Sheet on the last page.**

PATIENT NAME _____

INTRODUCTION TO PATIENT

Let me look at your answers to the questionnaire. I'll be asking you some questions to help me understand some of the symptoms that you checked off. I'll be making some notes as we go along.

ENTERING CLINICIAN EVALUATION GUIDE (CEG) MODULE

Enter modules triggered by the Patient Questionnaire (PQ) as follows:

At least three of #1 to #16 Somatoform, p. 9	#17 Eating, p. 7	#18 or #19 Mood, p. 1	#20, #21, or #22 Anxiety, p. 3	At least one of #23 to #26 Alcohol, p. 5

Any module not triggered by the Patient Questionnaire can be entered if you have other reasons to suspect a diagnosis in that module.

Enter modules in the order in which they appear in the Clinician Evaluation Guide (ie, Mood first, Anxiety second, Somatoform last).

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MOOD MODULE

MAJOR DEPRESSION

For the last 2 weeks, have you had any of the following problems nearly every day?

1.	Trouble falling or staying asleep, or sleeping too much?	**Yes**	**No**
2.	Feeling tired or having little energy?	**Yes**	**No**
3.	Poor appetite or overeating?	**Yes**	**No**
4.	Little interest or pleasure in doing things?	**Yes**	**No**
5.	Feeling down, depressed, or hopeless?	**Yes**	**No**
6.	Feeling bad about yourself — or that you are a failure — or have let yourself or your family down?	**Yes**	**No**
7.	Trouble concentrating on things, such as reading the newspaper or watching television?	**Yes**	**No**
8.	Being so fidgety or restless that you were moving around a lot more than usual? **If No:** What about the opposite — moving or speaking so slowly that other people could have noticed? **Count as Yes if Yes to either question, or if psychomotor agitation or retardation observed during interview.**	**Yes**	**No**
9.	In the last 2 weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way? **If Yes:** Tell me about it.	**Yes**	**No**
10.	**Are answers to five or more of #1 to #9 Yes?**	**Yes** – ***Major Depressive Disorder*** **Go to #12**	**No**

PARTIAL REMISSION OR RECURRENCE OF MAJOR DEPRESSION

11. Have you ever had a time when you were either much more down or depressed, or had even less interest or pleasure in doing things?
    If Yes: At that time, did you have many of the problems that I just asked you about, like trouble sleeping, concentrating, feeling tired, poor appetite, little interest in things?
    Count as Yes only if, in the past, patient probably had five of symptoms #1 to #9 and acknowledges some current depressed mood or little interest or pleasure.

    Yes → *Partial Remission or Recurrence of Major Depressive Disorder* | No

DYSTHYMIA

12. Over the last 2 years, have you often felt down or depressed, or had little interest or pleasure in doing things?
    Count as Yes only if also Yes to: Was that on more than half the days over the last 2 years?

    Yes | No → Go to #14

13. In the last 2 years, has that often made it hard for you to do your work, take care of things at home, or get along with other people?

    Yes → *Dysthymia* / Go to #16 | No

MINOR DEPRESSION

14. **Was Major Depression (including partial remission or recurrence) diagnosed at #10 or #11?**

    Yes → Go to #16 | No

15. **Are answers to two or more of #1 to #9 Yes?**

    Yes → *Minor Depressive Disorder* | No → EXIT

BIPOLAR

16. Did a doctor ever say you were manic-depressive or give you lithium?
    If Yes: When was that? Do you know why?

    Yes → *Add R/O Bipolar Disorder* | No

DEPRESSION DUE TO PHYSICAL DISORDER, MEDICATION, OR OTHER DRUG

17. **Are current depressed symptoms probably due to the biological effects of a physical disorder, medication, or other drug?**

    Yes → *Add R/O Depressive Disorder Due to Physical Disorder, Medication, or Other Drug* | No → EXIT

    Not Sure → *Add R/O Depressive Disorder Due to Physical Disorder, Medication, or Other Drug* / EXIT

ANXIETY MODULE

PANIC

If Patient Questionnaire #22 (anxiety attack) checked No, go to #34.

18. You indicated that you had an anxiety attack this month. Have you ever had four attacks in a 4-week period?
If No: Are you afraid of having another attack?
Count as Yes if Yes to either question. **Yes** **No** – Go to #34

19. Does the attack sometimes come suddenly out of the blue? **Yes** **No** – Go to #34
If unclear: In situations where you don't expect to be nervous or uncomfortable?

Think about the last really bad time this happened.

Go to #33 as soon as you have checked four symptoms that occurred during the patient's last attack.

20. ☐ Were you short of breath?

21. ☐ Did your heart race, pound, or skip?

22. ☐ Did you have chest pain or pressure?

23. ☐ Did you sweat?

24. ☐ Did you feel as if you were choking?

25. ☐ Did you have hot flashes or chills?

26. ☐ Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?

27. ☐ Did you feel dizzy, unsteady, or faint?

28. ☐ Did you have tingling or numbness in parts of your body?

29. ☐ Did you tremble or shake?

30. ☐ Did things around you seem unreal?

31. ☐ Were you afraid you were dying?

32. ☐ Were you afraid you were going crazy or might do something uncontrolled, like shout or run?

33. **Are four or more of #20 to #32 checked?** **Yes** – *Panic Disorder* **No** – *Anxiety Disorder NOS*

GENERALIZED ANXIETY

34. Have you felt nervous, anxious, or on edge on more than half the days in the last month? — **Yes** — **No** → Go to #45

In the last month, have you often been bothered by any of these problems?

35. ☐ Feeling restless so that it is hard to sit still?

36. ☐ Getting tired very easily?

37. ☐ Muscle tension, aches, or soreness?

38. ☐ Trouble falling asleep or staying asleep?

39. ☐ Trouble concentrating on things, such as reading a book or watching TV?

40. ☐ Becoming easily annoyed or irritated?

41. **Are two or more of #35 to #40 checked?** — **Yes** — **No** → Go to #45

42. In the last month, have these problems made it hard for you to do your work, take care of things at home, or get along with other people? — **Yes** — **No** → *Anxiety Disorder NOS* → Go to #46

43. In the last month, have you been worrying a great deal about different things?
Count as Yes only if also Yes to: Has this been on more than half the days in the last month? — **Yes** — **No** → *Anxiety Disorder NOS* → Go to #46

44. Have you had all of these problems, like feeling nervous, anxious, or on edge, and **(#35 to #40 that were checked)** for as long as 6 months? — **Yes** → *Generalized Anxiety Disorder* → Go to #46 — **No** → *Anxiety Disorder NOS* → Go to #46

45. **Has Panic Disorder or Anxiety Disorder NOS been diagnosed?** — **Yes** — **No** → EXIT

ANXIETY DUE TO PHYSICAL DISORDER, MEDICATION, OR OTHER DRUG

46. **Are current anxiety symptoms probably due to the biological effects of a physical disorder, medication, or other drug?** — **Yes** / **Not Sure** → *Add R/O Anxiety Disorder Due to Physical Disorder, Medication, or Other Drug* → EXIT — **No** → EXIT

ALCOHOL MODULE

ALCOHOL ABUSE/DEPENDENCE

Section A

On the questionnaire you said that...

If Patient Questionnaire #23 checked Yes: ...you thought you should cut down on your drinking. Why?

If Patient Questionnaire #24 checked Yes: ...someone has complained about your drinking. Who? Why?

If Patient Questionnaire #25 checked Yes: ...you have felt guilty or upset about your drinking. Why?

If Patient Questionnaire #26 checked Yes: ...you had five or more drinks on a single day in the past month. How often have you had that much to drink in the past 6 months? Has that caused any problems?

Section B

Assess #47 to #51 by any of the following: 1) asking the patient each question; 2) considering the responses given above; or 3) considering other information known about the patient, such as information obtained from a family member.

47. Has a doctor ever suggested that you stop drinking because of a problem with your health?
Count as Yes if has continued to drink in the last 6 months after doctor suggested stopping. — **Yes** **No**

Have any of the following happened to you more than one time in the last 6 months?

48. Were you drinking, high from alcohol, or hung over while you were working, going to school, or taking care of other responsibilities? — **Yes** **No**

49. What about missing or being late for work, school, or other responsibilities because you were drinking or hung over? — **Yes** **No**

50. What about having a problem getting along with other people while you were drinking? — **Yes** **No**

51. What about driving a car after having several drinks or after drinking too much? — **Yes** **No**

52. **Is at least one of #47 to #51 Yes — OR — do responses in Section A indicate patient has probably had a significant problem with alcohol within the past 6 months?** — **Yes** → ***Probable Alcohol Abuse/ Dependence*** → **EXIT**; **No** → **EXIT**

EATING MODULE

BULIMIA NERVOSA, BINGE EATING

53. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food? **Yes** **No-** EXIT

54. When you eat this way, do you often feel that you can't control what or how much you eat? **Yes** **No-** EXIT

55. Does this happen as often, on average, as twice a week? **Yes** **No-** EXIT

56. Has this been occurring for as long as 6 months? **Yes** **No-** EXIT

57. Do you often make yourself vomit or take laxatives to lose or avoid gaining weight? **Yes** **No-** *Binge Eating Disorder* EXIT

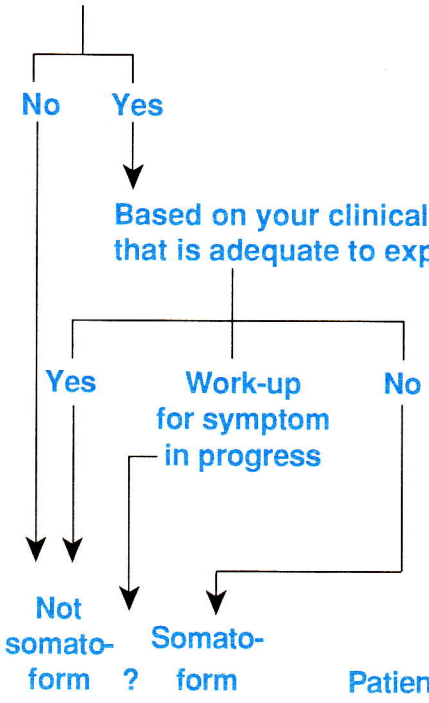
58. Do you do this as often, on average, as twice a week? **Yes** **No-** *Eating Disorder NOS* EXIT

59. Has this been occurring for as long as 3 months? **Yes-** *Bulimia Nervosa* EXIT **No-** *Eating Disorder NOS* EXIT

SOMATOFORM MODULE

Count each symptom checked Yes on Patient Questionnaire items #1 to #15 as follows:

Has (symptom) bothered you a lot in the past month?



Not somato-form	?	Somato-form	Patient Questionnaire Item	
☐	☐	☐	#1	stomach pain
☐	☐	☐	#2	back pain
☐	☐	☐	#3	pain in your arms, legs, or joints (knees, hips, etc)
☐	☐	☐	#4	menstrual pain or problems
☐	☐	☐	#5	pain or problems during sexual intercourse
☐	☐	☐	#6	headaches
☐	☐	☐	#7	chest pain
☐	☐	☐	#8	dizziness
☐	☐	☐	#9	fainting spells
☐	☐	☐	#10	feeling your heart pound or race
☐	☐	☐	#11	shortness of breath
☐	☐	☐	#12	constipation, loose bowels, or diarrhea
☐	☐	☐	#13	nausea, gas, or indigestion
☐	☐	☐	#14	feeling tired or having low energy
☐	☐	☐	#15	trouble sleeping

Check "Not somatoform" if symptom occurs only during panic attacks

Check "Not somatoform" if symptom is due to a mood or anxiety disorder

If no symptoms are checked "Somatoform," go to Disease Concern on next page.

MULTISOMATOFORM

60. **Are there three or more symptoms checked "Somatoform"?** — **Yes** — **No** → **Go to #62**

61. Over the past several years, have you had these or other symptoms or complaints that your doctors couldn't fully explain?
Count as Yes also if explanation was nerves or stress.
Yes → ***Multisomatoform Disorder*** / **Go to Disease Concern**
No → ***Somatoform Disorder NOS*** / **Go to Disease Concern**

SOMATOFORM PAIN

62. **Is there at least one symptom involving pain (items #1 to #7) checked "Somatoform"?** — **Yes** — **No** → **Go to Disease Concern**

63. Has (have) the(se) pain(s) interfered with your life or activities <u>on more than half the days in the past 6 months</u>?
Yes → ***Chronic Pain Disorder*** — **No**

DISEASE CONCERN

Check here ☐ and EXIT if no concern with disease (Patient Questionnaire #16 is No).

64. You've been bothered by the thought that you may have a serious disease. What do you think you might have?
Check here ☐ and EXIT if concern with disease is realistic.

65. Is this something you <u>keep</u> thinking about and that bothers you <u>a lot</u>? — **Yes** — **No** → **EXIT**

66. Have doctors ever explained the cause of this problem or tried to reassure you about it? — **Yes** — **No** → **EXIT**

67. What did they tell you?

68. **Is patient preoccupied with, and distressed by, an unrealistic thought of having a serious physical disease, even after previous attempts at appropriate reassurance by physician?**
Count as No if patient's concern may be appropriate or reaction to reassurance is unclear.
Yes — **No** → **EXIT**

69. Have you been worried about this for as long as 6 months?
Yes → ***Hypochondriasis*** / **EXIT**
No → **EXIT**

SUMMARY SHEET

Patient Name: _____ **Record Number:** _____

Physician Name: _____ **Date:** _____

SUMMARY DIAGNOSES

Check all diagnoses made in the modules. ICD-9-CM codes appear in parentheses.

- ☐ No diagnoses made in any module

Mood

- ☐ Major Depressive Disorder (296.20)
- ☐ Partial Remission or Recurrence of Major Depressive Disorder (296.25)
- ☐ Dysthymia (300.4)
- ☐ Minor Depressive Disorder (311)
- ☐ R/O Bipolar Disorder (If confirmed: 296.50)
- ☐ R/O Depressive Disorder Due to Physical Disorder, Medication, or Other Drug
  (If confirmed and due to physical disorder: 293.83)
  (If confirmed and due to medication or other drug: 292.84)

Anxiety

- ☐ Panic Disorder (300.01)
- ☐ Generalized Anxiety Disorder (300.02)
- ☐ Anxiety Disorder NOS (300.00)
- ☐ R/O Anxiety Disorder Due to Physical Disorder, Medication, or Other Drug
  (If confirmed and due to physical disorder: 293.89)
  (If confirmed and due to medication or other drug: 292.89)

Alcohol

- ☐ Probable Alcohol Abuse/Dependence
  (If confirmed Alcohol Abuse: 305.00)
  (If confirmed Alcohol Dependence: 303.90)

Eating

- ☐ Binge Eating Disorder (307.59)
- ☐ Bulimia Nervosa (307.51)
- ☐ Eating Disorder NOS (307.50)

Somatoform

- ☐ Multisomatoform Disorder (300.7)
- ☐ Somatoform Disorder NOS (300.7)
- ☐ Chronic Pain Disorder (307.80)
- ☐ Hypochondriasis (300.7)

CPT CODES FOR PRIME-MD AS A DIAGNOSTIC PROCEDURE

- ☐ Psychiatric diagnostic interview examination (90801)
- ☐ Psychological testing by physician (90830)

REIMBURSEMENT

Patient coverage, billing requirements, and reimbursement vary among payers in each state. Many payers will accept the following CPT codes for reimbursement. Several payers may require the following higher level Evaluation and Management (E/M) codes. You should verify the appropriate codes with the payer prior to submitting the claim.

CPT Codes	Code Numbers
Psychiatric diagnostic examination	90801
Psychological testing by physician	90830
E/M Codes	
Office or Other Outpatient Services	
New patient	99201-99205*
Established patient	99211-99215*

* When selecting E/M level, consult American Medical Association Physicians' Current Procedural Terminology, 1993, E/M Services Guidelines.

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