♠ Measure #134: Screening for Clinical Depression and Follow-Up Plan

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92590, 92625, 92626, 96150, 96151, 97003

NUMERATOR:
Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented

Definitions:

Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS – Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Positive Screen for Clinical Depression, Follow-up Plan Documented

G8431: Positive screen for clinical depression using a standardized tool and a follow-up plan documented

OR

Negative Screen for Clinical Depression Documented, Follow-up Plan not Indicated

G8510: Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

OR

Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate
G8433: Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate

OR

Screening for Clinical Depression not Documented, Reason not Specified
G8432: No documentation of clinical depression screening using a standardized tool
OR
Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Specified
G8511: Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified

RATIONALE:
The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease. In primary care settings, the point prevalence of major depression ranges from 5 to 9 percent among adults, and up to 50 percent of depressed patients are not recognized. Depressive disorders are also relatively common in younger persons, with estimated prevalence of 0.8 to 2.0 percent in children and 4.5 percent in adolescents.

U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with "usual care" in community primary care practices. Results showed significantly improved patient outcomes.

The National Center for Policy Analysis and the U.S. Surgeons General, among others, estimate the direct and indirect costs of depression to American businesses ranging from $36.2 billion to $80 billion annually.

Major depression is " ranked second only to ischemic heart disease in magnitude of disease burden in established market economies" and "is the leading cause of *disability* (measured by the number of years *lived* with a disabling condition) worldwide among persons age 5 and older." Murray CJL, Lopez AD, eds. The Global Burden Of Disease And Injury Series, Volume 1: A Comprehensive Assessment Of Mortality And Disability From Diseases, Injuries, And Risk Factors In 1990 And Projected To 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression.

Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.

A search of the literature in PubMed concerning social workers and depression screening showed nothing to indicate that these practitioners are routinely screening their patients for depression.

A search of the National Quality Measures Clearinghouse database found no depression screening measures that address Medicare eligible patients and there was only one measure from the Physician Consortium for Performance Improvement addressing screening for patients aged 18 years and older with suspected major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF.