

♣ Measure #134: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

**2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:**  
**CLAIMS, REGISTRY**

**DESCRIPTION:**

Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate 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 12 years and older

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 12$  years on date of encounter

**AND**

**Patient encounter during the reporting period (CPT):** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90862, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439

**NUMERATOR:**

Patient's screening for clinical depression using an age appropriate 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 examples of depression screening tools include but are not limited to:

- Adult Screening Tools (18 years and older)  
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 Depression Scale (SDS), 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) and PRIME MD-PHQ2
- Adolescent Screening Tools (12-17 years)  
Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2

**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 an age appropriate standardized tool and a follow-up plan documented

**OR**

**Negative Screen for Clinical Depression Documented, Follow-Up Plan not Required**

**G8510:** Negative screen for clinical depression using an age appropriate standardized tool, follow-up not required

**OR**

**Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate**

**G8433:** Screening for clinical depression using an age appropriate 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 an age appropriate standardized tool

**OR**

**Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Specified**

**G8511:** Positive Screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified

**RATIONALE:**

The World Health Organization, as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, rates of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) reported that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care

physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is even more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. In 2000, Healthy People 2010 recommended routine screening for mental health problems as a part of primary care for both children and adults.

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Gil Zalsman et al., (2006), as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated \$83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

### **CLINICAL RECOMMENDATION STATEMENTS:**

#### **Adult Recommendation (18 years and older)**

The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (2009).

Routine depression screening should be performed for adult patients (including older adults) but only if the practice has staff-assisted "systems in place to ensure that positive results are followed by accurate diagnosis, effective treatment, and careful follow-up" (ICSI, 2010).

#### **Adolescent Recommendation (12-18 years)**

The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (2009).

Level II Child Preventive Services should be assessed and offered to each patient; as such services have been shown to be effective. Such Level II services include: Screening adolescents ages 12-18 for major depressive disorder when systems are in place for accurate diagnosis, treatment, and follow-up (ICSI, 2010).