

Preventive Care and Screening: Screening for Depression and Follow-Up Plan CMS2v13

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Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Guidance

The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter used to evaluate the numerator will be excluded from the measure regardless of whether the diagnosis is active or not.

A depression screen is completed on the date of the encounter or up to 14 calendar days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan must be documented on the date of or up to two calendar days after the date of the encounter, such as referral to a provider for additional evaluation, pharmacological interventions, or other interventions for the treatment of depression. An example to illustrate the follow-up plan documentation timing: if the encounter is on a Monday from 3-4 pm (day 0) and the patient screens positive, the clinician has through anytime on Wednesday (day 2) to complete follow-up plan documentation.

This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.

This eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters.

Screening Tools:

An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance.

The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

The depression screening must be reviewed and addressed by the provider, filing the code, on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

The screening should occur during a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar days prior to that encounter. Therefore, a clinician would not be able to complete another

screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.

Follow-Up Plan:

The follow-up plan MUST still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator. However, documentation of the follow-up plan can occur up to two calendar days after the qualifying encounter, in accordance with the policies of an eligible clinician or provider's practice or health system. All services should be documented during, or as soon as practicable, after the qualifying encounter in order to maintain an accurate medical record.

The follow-up plan must be related to a positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

Examples of a follow-up plan include but are not limited to:

- Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

Should a patient screen positive for depression, a clinician should:

- Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
- Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool will not qualify as a follow-up plan.

This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (<https://ecqi.healthit.gov/qdm>) for more information on the QDM.

Initial Population

All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period

Date of birth information can be entered in DrChrono in the patient chart under the Demographics tab with the Patient's Date of Birth.

+ Add new patient

Demographics

Appointments
Clinical Dashboard
Documents
Tasks (1)
Problem List (0)
Medication List (1)
Send eRx
Allergy List (0)
Drug Interactions (0)
CQMs
Intake Data
Lab Orders

Test Patient **Missing Sex** | 44 years old | Aug. 8, 1979

Chart ID: PATE000001
Phone: **Missing**
Email: Test@test.test
Address: Test

Primary Provider:
Date Added:
Last Scheduled Appt:
Next Scheduled Appt:

CDS: Patient must have documented allergies | Adult Immunization Schedule Age: 27-49

Flags: Peanut Allergy

BILLING WARNING: Missing Patient Sex

Important **Demographics** Insurances Eligibility Authorizations Smoking Status F

Demographics

Patient SSN
Patient Date of birth 08/08/1979 e.g. 8/8/1979

With A Qualifying Encounter During the Measurement Period

CPT Codes

HCPCS Codes

CPT and HCPCS codes can be entered into the billing section for the encounter. Below is an example from the appointment window.

Appointment **Billing** Eligibility Vitals Growthcharts Flags Log Comm. Revisions Custom Data MU Helper

Institutional Claim Patient SuperBill Clinical Note Billing Details Other Forms

Billing Status **ICD Version** ICD-10 **Patient Payment** \$ 0 Copay: \$20 **Pre Authorization Approval** **Referral #** **Payment Profile** Insurance **Billing Profile** **Billing Pick List** Choose Codes from Pick List **Diagnosis Pick List** Choose Codes from Pt Problems **Credit Card Payment** **Process Credit Card**

HCFA Box 10 - Is patient's condition related to:

Employment No
Auto Accident No
Other Accident No
Onset Date Type Onset of Current Symptoms
Onset Date
Other Date Type - Other Date Type -
Other Date

Claim Billed: \$145.00 **Adjustment: \$0.00** **Insurer Paid: \$0.00** **Patient Paid: \$0.00**

ICD-10 Codes Find Diagnosis codes **CPT Codes** Find CPT Procedure codes

#	Code	Description	Price (\$)
1	99213	OFFICE O/P EST LOW 20-29 MIN	145.00
Modifiers: --- --- --- ---			
Quantity/Minutes: 1.00			
Diagnosis Pointers: 1:0:0:0			

ICD-9 Codes to Convert Find Diagnosis codes

#	Code	Description
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NDC Codes Find NDC Codes

NDC Code	Quantity	Units	Line Item
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Custom Codes Find Custom Procedure codes

Code	Description	Price (\$)	
1	G0438	Ppps initial visit	0.00
Modifiers: --- --- --- ---			

Denominator

Equals initial population.

Denominator Exclusions

Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter.

Denominator Exceptions

Patient Reason(s) Patient refuses to participate in or complete the depression screening

OR

Medical Reason(s)

Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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)

Numerator

Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

You can enter the LOINC codes for depression screening in the CQMs tab of the patient's chart under the Risk Category/Assessment section.

- Adolescent depression screening assessment LOINC Code 73831-0
- Adult depression screening assessment LOINC Code 73832-8

Click **+New**.

Datetime	Code	Description	Value
Jan 27, 2023	LOINC: 44261-6	Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]	
May 25, 2022	LOINC: 73830-2	Fall risk assessment	Abuse of herbal medicine or folk remedy (disorder)

Risk Categ/Asst: 73831-0 [Required]

Appointment: Adolescent depression screening assessment (LOINC: 73831-0)

Datetime: Birth weight Measured (LOINC: 8339-4)

Value: Emergency department Admission history and physical note (LOINC: 78249-0)

[Create]

Risk Categ/Asst: Adolescent depression screening

Appointment: 4/06/2023 11:30AM

Datetime: 04/03/2023 12:06

LOINC: 73831-0

Value: (optional)

[Create]

If the screening is positive, a follow-up plan needs to be documented. One area to document this is in the patient's chart in the CQMs tab under the intervention section.

- Send eRx
- Allergy List 0
- Drug Interactions 13
- CQMs
- Intake Data
- Lab Orders

Intervention

Datetime	Code	Description	Value	
Mar 30, 2023	SNOMEDCT: 182922004	Dietary regime (regime/therapy)		Edit Delete
Dec 22, 2022	SNOMEDCT: 390864007	Referral for exercise therapy (procedure)		Edit Delete
Aug 26, 2022	SNOMEDCT: 413473000	Counseling about alcohol consumption (procedure)		Edit Delete
May 25, 2022	HPCPS: G8417	Bmi is documented above normal parameters and a follow-up plan is documented	Obesity (disorder)	Edit Delete

➔ + New

You can enter or search for the code. Select ordered or performed and an appointment. Click **Create** when finished.

Create Intervention

Intervention: Required

Appointment: Referral to psychiatry service (procedure)
SNOMEDCT: 183524004

Type: Abuse prevention assessment (procedure)
SNOMEDCT: 370881007

Datetime: Abuse prevention management (procedure)
SNOMEDCT: 370884004

Value: Actions to lose weight (regime/therapy)
SNOMEDCT: 248114003

Create

Create Intervention

Intervention:

Appointment: 4/06/2023 11:30AM

Type: Performed Order

Datetime:

SNOMEDCT:

Value: (optional)

Create

SNOMED Codes

If you prescribe a medication for depression, it will be documented when you complete the prescription.

Medications can be prescribed in the patient's chart in the **Send eRx** tab.

- Demographics
- Appointments
- Clinical Dashboard !
- Documents
- Eligibility
- Tasks 9
- Problem List !
- Medication List !
- Send eRx
- Allergy List 0
- Drug Interactions 13
- CQMs
- Intake Data
- Lab Orders
- Immunizations
- Growth Charts

New Prescription

Patient's Prescriptions +

Favorite medications ✕

Type* Medication Compound Supply

Medication*

N/A: U Generic RX

SIG* ⓘ Effective Date

11 / 1000

Dispense* Dispense Unit* Tablet DAW Yes No Days Supply Refills

Diagnosis Codes

Add to Favorites Add to Medication List ⓘ

Notes to Pharmacist

* Please do not enter SIG, Effective Date, Drug Name, Strength, Quantity or Dispense Unit in this field.

Numerator Exclusions

Not applicable

[Measure Information](#)
