Preventive Care and Screening: Screening for Depression and Follow-Up Plan eCQM CMS2v12

07/08/2024 7:20 pm EDT

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 measure intends to screen for new cases of depression in patients who have never had a diagnosis of depression or bipolar disorder. Patients who have ever been diagnosed with depression or 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 guides 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 the 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, per 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 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:

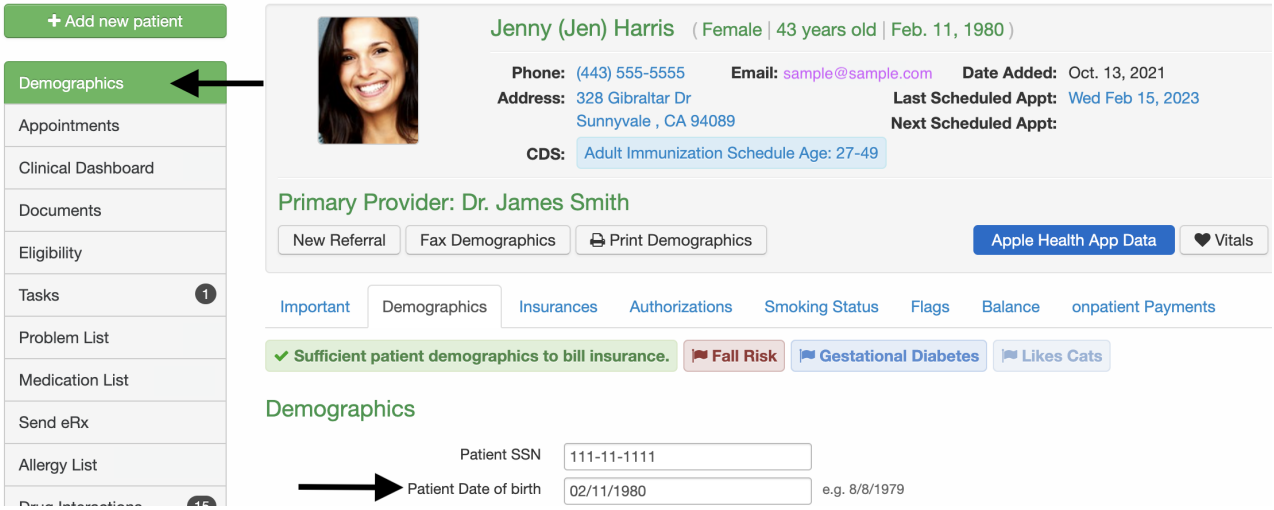
- Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
- Opt to complete a suicide risk assessment when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



With A Qualifying Encounter During the Measurement Period

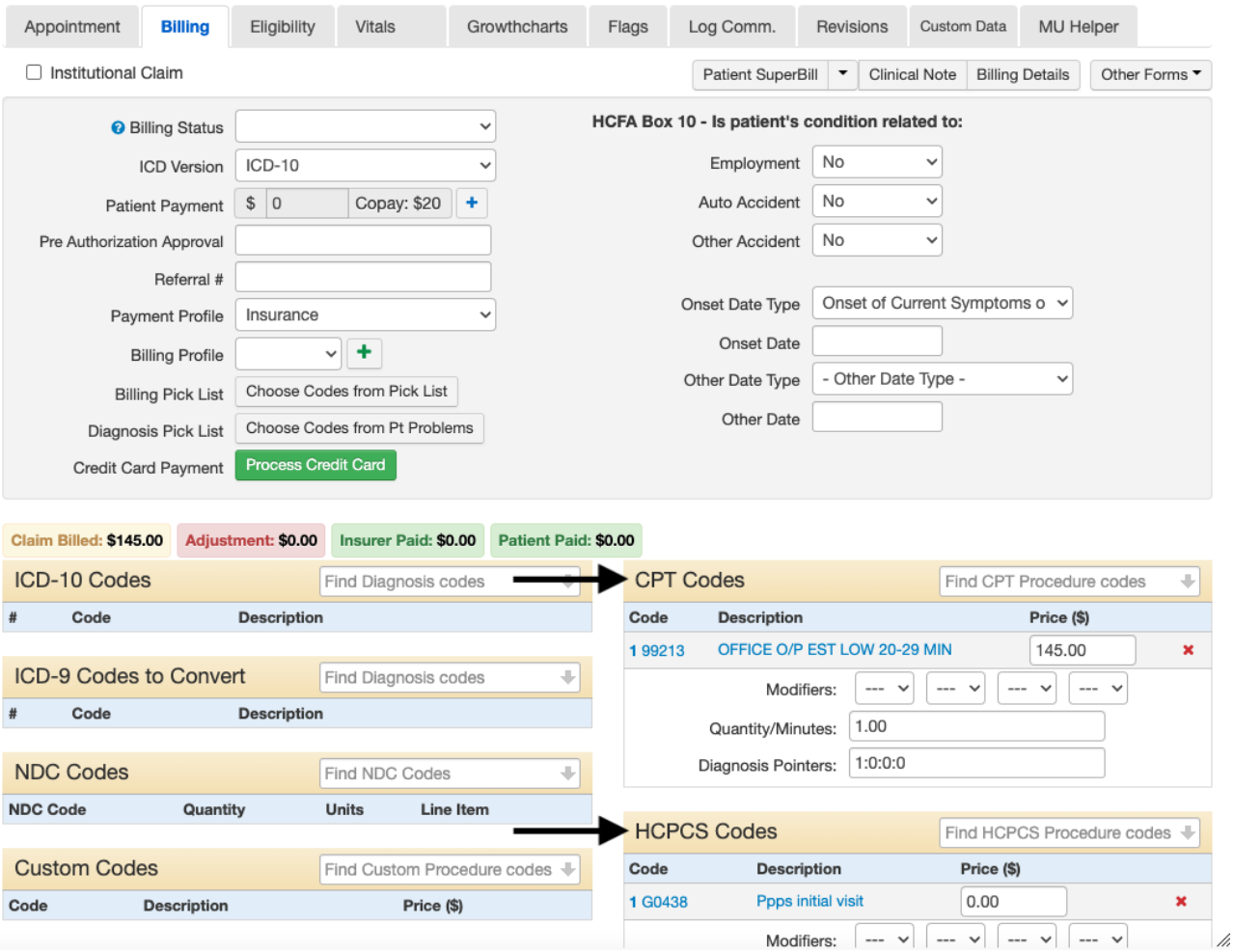
CPT Codes

59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 98966, 98967, 98968, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401, 99402, 99403, 99424, 99441, 99442, 99443, 99483, 99484, 99491, 99492, 99493, 99384,, 99385, 99386, 99387, 99394, 99395, 99396, 99397

HPCS Codes

G0101, G0402, G0438, G0439, G0444

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



Denominator

Equals initial population.

Denominator Exclusions

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

Denominator Exceptions

Patient Reason(s) Patient refuses to participate

OR

Medical Reason(s)

Documentation of medical reason for not screening a patient for depression (e.g., cognitive, functional, or motivational limitations that may impact the accuracy of results; the patient is in an urgent or emergent situation where time is of the essence and delay treatment would jeopardize the patient's health status)

Numerator

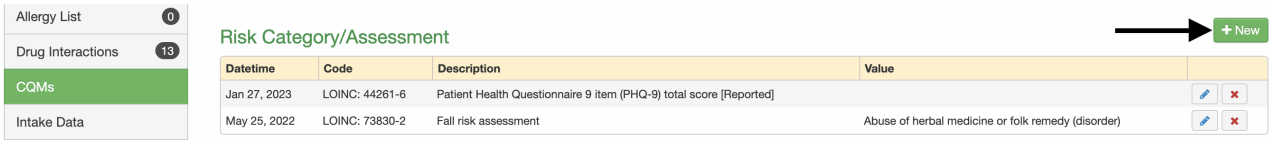
Patients screened for depression on the date of the encounter or up to 14 days before the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to

two days after the date of the qualifying encounter.

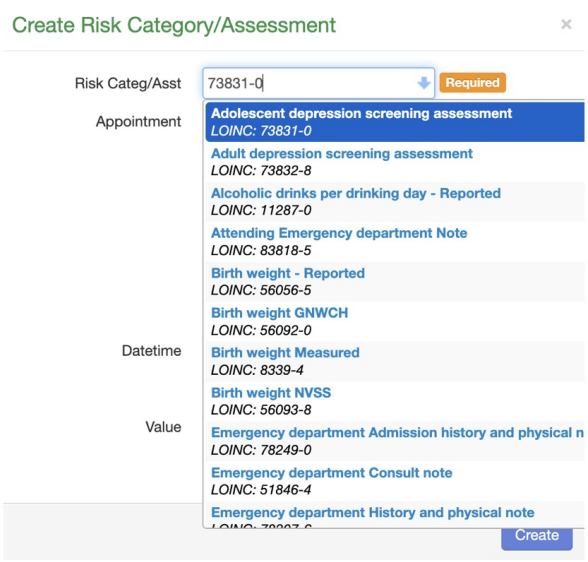
You can enter the LOINC codes for depression screening in the CQMs tab of the patient's chart under the Risk Category/Assessment section.

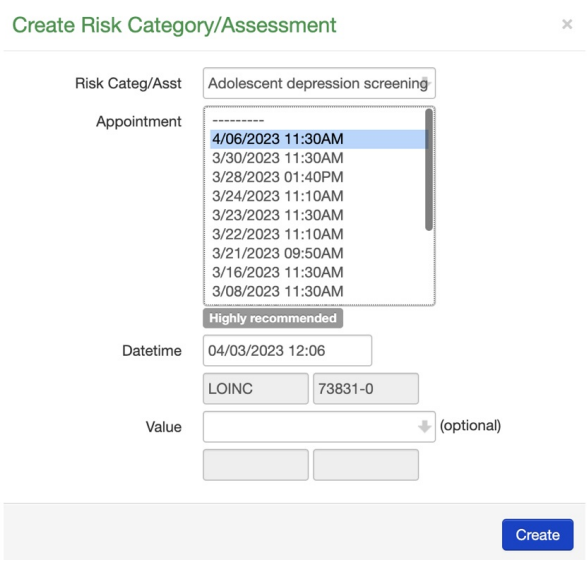
- Adolescent depression screening assessment LOINC Code 73831-0
- Adult depression screening assessment LOINC Code 73832-8

Click **+New**.

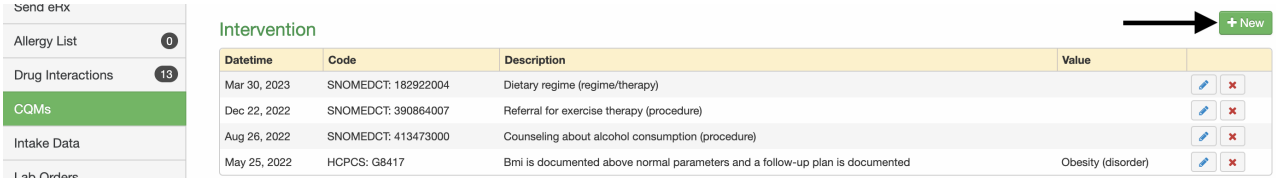


Enter the code or search for it. Select an appointment and click **Create**.

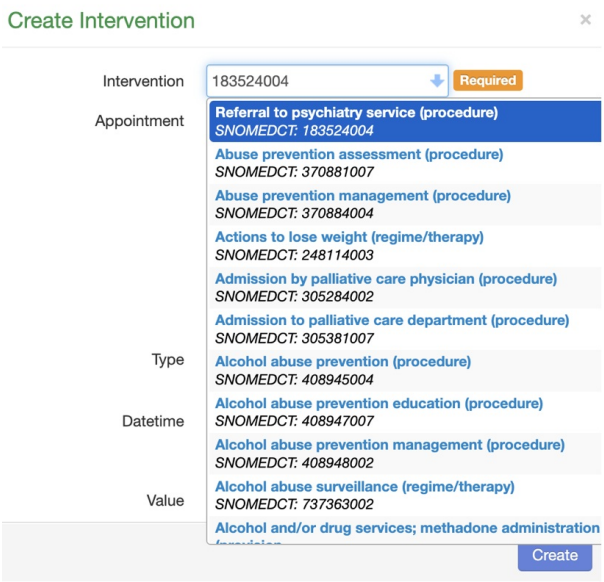


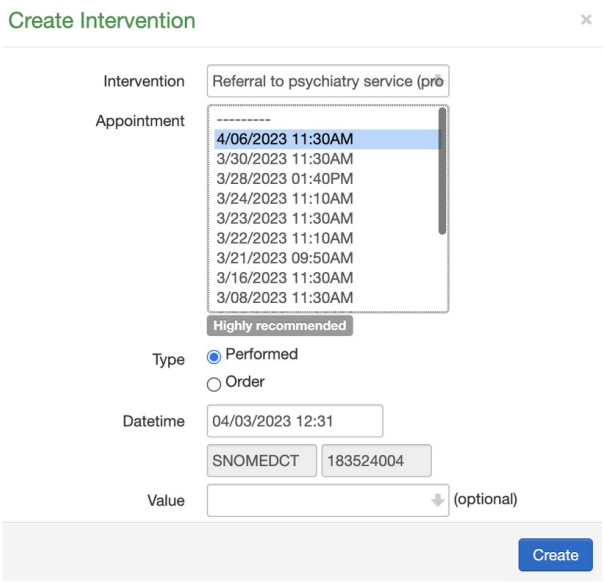


If the screening is positive, a follow-up plan needs to be documented. One area to document this is in the patient's chart in the CQMs tab under the intervention section.



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





SNOMED Codes

108313002	Family psychotherapy procedure (regime/therapy)
1555005	Brief group psychotherapy (regime/therapy)
15558000	Expressive psychotherapy (regime/therapy)
18512000	Individual psychotherapy (regime/therapy)
228557008	Cognitive and behavioral therapy (regime/therapy)
229065009	Exercise therapy (regime/therapy)
28868002	Interactive group medical psychotherapy (regime/therapy)
372067001	Implementation of measures to provide psychological support (regime/therapy)
385721005	Coping support assessment (procedure)
385724002	Coping support management (procedure)
385725001	Emotional support assessment (procedure)
385726000	Emotional support education (procedure)
385727009	Emotional support management (procedure)
385887004	Mental health history taking assessment (procedure)
385889001	Mental health history taking education (procedure)
385890005	Mental health history taking management (procedure)
386472008	Telephone consultation (procedure)
401277000	Completion of mental health crisis plan (procedure)
405780009	Dialectical behavior therapy (regime/therapy)
410223002	Mental health care assessment (procedure)
410224008	Mental health care education (procedure)
410225009	Mental health care management (procedure)
410226005	Mental health promotion assessment (procedure)
410227001	Mental health promotion education (procedure)
410228006	Mental health promotion management (procedure)
410229003	Mental health screening assessment (procedure)
410230008	Mental health screening education (procedure)
410231007	Mental health screening management (procedure)
410232000	Mental health treatment assessment (procedure)
410233005	Mental health treatment education (procedure)
410234004	Management of mental health treatment (procedure)
425604002	Case management follow up (procedure)
439141002	Discharge by mental health primary care worker (procedure)

5694008	Crisis intervention with follow-up (regime/therapy)
75516001	Psychotherapy (regime/therapy)
76168009	Group psychotherapy (regime/therapy)
76740001	Psychiatric telephone consultation or therapy with patient (procedure)
81294000	Patient referral for psychotherapy (procedure)
88848003	Psychiatric follow-up (procedure)
91310009	Patient follow-up to return when and if necessary (procedure)
108313002	Family psychotherapy procedure (regime/therapy)
1555005	Brief group psychotherapy (regime/therapy)
15558000	Expressive psychotherapy (regime/therapy)
18512000	Individual psychotherapy (regime/therapy)
228557008	Cognitive and behavioral therapy (regime/therapy)
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385890005	Mental health history taking management (procedure)
386472008	Telephone consultation (procedure)
401277000	Completion of mental health crisis plan (procedure)
405780009	Dialectical behavior therapy (regime/therapy)
410223002	Mental health care assessment (procedure)
410224008	Mental health care education (procedure)
410225009	Mental health care management (procedure)
410226005	Mental health promotion assessment (procedure)
410227001	Mental health promotion education (procedure)
410228006	Mental health promotion management (procedure)
410229003	Mental health screening assessment (procedure)
410230008	Mental health screening education (procedure)
410231007	Mental health screening management (procedure)
410232000	Mental health treatment assessment (procedure)
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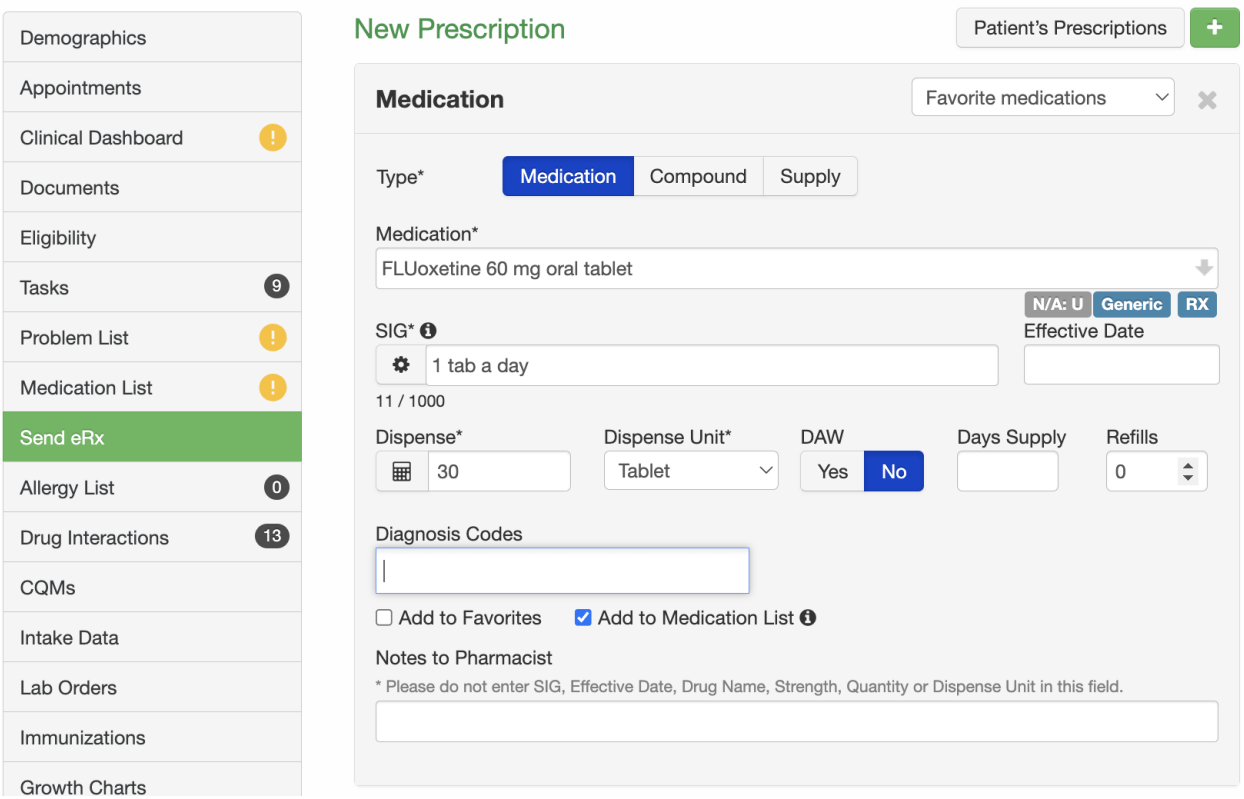
75516001	Psychotherapy (regime/therapy)
76168009	Group psychotherapy (regime/therapy)
76740001	Psychiatric telephone consultation or therapy with patient (procedure)
81294000	Patient referral for psychotherapy (procedure)
88848003	Psychiatric follow-up (procedure)
91310009	Patient follow-up to return when and if necessary (procedure)
183524004	Referral to psychiatry service (procedure)
183583007	Refer to mental health worker (procedure)
183866009	Referral to emergency clinic (procedure)

306136006 Referral to liaison psychiatry service (procedure)

306137002 Referral to mental handicap psychiatry service (procedure)
306226009 Referral to mental health counseling service (procedure)
306227000 Referral for mental health counseling (procedure)
306252003 Referral to mental health counselor (procedure)
306291008 Referral to child and adolescent psychiatrist (procedure)
306294000 Referral to psychiatrist for mental handicap (procedure)
308459004 Referral to psychologist (procedure)
308477009 Referral to psychiatrist (procedure)
309627007 Child referral - clinical psychologist (procedure)
390866009 Referral to mental health team (procedure)
703978000 Referral to primary care service (procedure)
710914003 Referral to family therapy (procedure)
711281004 Referral to support group (procedure)
183524004 Referral to psychiatry service (procedure)
183528001 Referral to psychiatrist for the elderly mentally ill (procedure)
183583007 Refer to mental health worker (procedure)
183866009 Referral to emergency clinic (procedure)
306136006 Referral to liaison psychiatry service (procedure)
306137002 Referral to mental handicap psychiatry service (procedure)
306138007 Referral to psychogeriatric service (procedure)
306204008 Referral to psychogeriatric day hospital (procedure)
306226009 Referral to mental health counseling service (procedure)
306227000 Referral for mental health counseling (procedure)
306252003 Referral to mental health counselor (procedure)
306294000 Referral to psychiatrist for mental handicap (procedure)
308459004 Referral to psychologist (procedure)
308477009 Referral to psychiatrist (procedure)
390866009 Referral to mental health team (procedure)
703978000 Referral to primary care service (procedure)
710914003 Referral to family therapy (procedure)
711281004 Referral to support group (procedure)

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.



Numerator Exclusions

Not applicable

Measure Information