

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

Measure Information

General eCQM Information	
Title	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CMS eCQM ID	CMS2v14
CBE ID*	Not Applicable
MIPS Quality ID	134
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
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
Measure Scoring	Proportion measure
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rationale	Depression affects more than two hundred sixty million people across the world and is a leading cause of disability, with a variety of depressive disorders that are independent risk factors for chronic diseases, such as cardiovascular disease and diabetes, lending screening for depression as paramount to identify depressive disorders that can affect the most vulnerable populations (Costantini et al., 2021). Results from a 2018 U.S. survey indicated that 14.4 percent of adolescents (3.5 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.4 million adolescents) having one MDE with severe impairment (Substance Abuse and Mental Health Services Administration, 2019). The odds of a diagnosis of depression are believed to be 2.6 times greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed (Vibhakar et al., 2019). Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016).

The same 2018 study indicated that 7.2 percent of adults aged 18 or older (17.7 million adults) had at least one MDE with 4.7 percent of adults (11.5 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2019). Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes (Orhurhu et al., 2019).

Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). It's estimated that the global prevalence of antenatal (or perinatal) depression ranges from 15 to 65 percent, with current or previous exposure to abuse and violence, lack of social support, and family history of mental disorders being risk factors. Depressive symptoms measured during pregnancy have been shown to influence the quality of the postpartum mother-infant relationship (Hazell Raine et al., 2020). Additionally, the risk of low birth weight and preterm birth is higher among infants born from depressed mothers (Dadi, Miller, Bisetegn, & Mwanri, 2020).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Multiple social costs of depression have been identified, such as reduced educational achievements, poor financial success and role performance, higher amount of days out of role, and increased risk of job loss (Costantini et al., 2021). Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "In the United States, an estimated \$22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated \$23 billion in 2011" (Siu & USPSTF, 2016, p. 383-384).

Numerous studies have found significant disparities in depression prevalence and treatment among racial/ethnic minorities. One study revealed that Indigenous adults are at a high risk for posttraumatic stress disorder, depression, suicide, substance use disorder, and concurrent behavioral health disorders secondary to these initial health problems (Ka'apu and Burnette, 2019). Additionally, though rates of depression are lower among Blacks and Hispanics than among whites, depression among Blacks and Hispanics is likely to be more recurrent. Furthermore, 48 percent of whites receive mental health services, compared to just 31 percent of Blacks and Hispanics, and 22 percent of Asians (American Psychiatric Association, 2017). Asian Americans and Black Americans are also significantly more likely to utilize emergency rooms for depression treatment, which contributes to inconsistent follow-up care (Lee et al., 2014).

While primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 46 percent of

	depressed patients (Borner et al., 2010). "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36 percent to 44 percent of children and adolescents with depression receive treatment, suggesting that a majority of depressed youth are undiagnosed and untreated" (Siu on behalf of USPSTF, 2016). Furthermore, evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit, and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women. This measure seeks to align with USPSTF clinical guideline recommendations as well as the Healthy People 2030 recommendation to increase the proportion of adolescents and adults who are screened for depression and if positive, receive appropriate treatment (U.S. Preventive Services Task Force, 2016; U.S. Department of Health and Human Services, 2020). For patients with depression, rescreening has been shown to be an effective tool for measuring response to therapy, therefore influencing appropriate care adjustments in the treatment of depression (Anderson et al., 2002). Chen et al. noted that when patients were re-administered a screening tool after at least eight weeks after starting treatment, their "score gave primary care physicians a clear idea about the nature of patients' depressive symptoms and gave both the patient and the physician an indication of treatment progress" (Chen et al., 2006).
Clinical Recommendation Statement	Adolescent Recommendation (12-18 years): "The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu on behalf of USPSTF, 2016). Adult Recommendation (18 years and older): "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu & USPSTF, 2016). "The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions (B recommendation)" (U.S. Preventive Services Task Force, 2019). The American College of Obstetricians and Gynecologists (ACOG) provides the following recommendation: "All obstetrician–gynecologists and other obstetric care providers should complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the

	comprehensive postpartum visit for each patient" (American College of Obstetricians and Gynecologists, 2018). The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations: 1. "Clinicians should routinely screen all adults for depression using a standardized instrument." 2. "Clinicians should establish and maintain follow-up with patients." 3. "Clinicians should screen and monitor depression in pregnant and post-partum women" (Trangle et al., 2016).
Improvement Notation	Higher score indicates better quality
Definition	Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Standardized Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of standardized depression screening tools include but are not limited to: • Adolescent Screening Tools (12-17 years) • Patient Health Questionnaire for Adolescents (PHQ-A) • Beck Depression Inventory-Primary Care Version (BDI-PC) • Mood Feeling Questionnaire (MFQ) • Center for Epidemiologic Studies Depression Scale (CES-D) • Patient Health Questionnaire (PHQ-9) • Pediatric Symptom Checklist (PSC-17) • Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ-2) • Adult Screening Tools (18 years and older) • Patient Health Questionnaire (PHQ-9) • 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) • Cornell Scale for Depression in Dementia (CSDD) • PRIME MD-PHQ-2 • Hamilton Rating Scale for Depression (HAM-D) • Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)

	• Computerized Adaptive Testing Depression Inventory (CAT-DI) • Computerized Adaptive Diagnostic Screener (CAD-MDD) • Perinatal Screening Tools • Edinburgh Postnatal Depression Scale • Postpartum Depression Screening Scale • Patient Health Questionnaire 9 (PHQ-9) • Beck Depression Inventory • Beck Depression Inventory-II • Center for Epidemiologic Studies Depression Scale • Zung Self-rating Depression Scale Follow-Up Plan: Documented follow-up for a positive depression screening must include one or more of the following: • Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression
Guidance	The intent of the measure is to screen all patients for depression except those with a diagnosis of bipolar disorder. Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter 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 an 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 QDM page 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
Denominator	Equals Initial Population
Denominator Exclusions	Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter
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
Numerator Exclusions	Not Applicable
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)
Telehealth Eligible	Yes
Next Version	No Version Available
Previous Version	CMS2v13

*Verify active CBE endorsement on the CMS certified consensus-based entity's [PQM website](#)

Specifications and Measure Resources

- **Specifications:**
 - [CMS2v14.html](#)
 - [CMS2v14.zip](#)

Additional Resources for CMS2v14

- [Value Sets](#)
- [Data Elements](#)
- [eCQM Flow](#)
- [Technical Release Notes](#)
- [Jira Issue Tracker tickets](#)

*Note there may be more tickets for CMS2v14 in the [eCQM Tracker - ONC Project Tracking System \(Jira\)](#). Only tickets tagged with their associated CMS measure ID appear.

Use the eCQM Tracker to [open new issues](#) regarding eCQM implementation. [Log in](#) required.

Technical Release Notes

- [CMS2v14-TRN.xlsx](#)

Header

- Updated the [eCQM](#) version number.
Measure Section: eCQM Version Number
Source of Change: Annual Update
- Changed all references from NQF to [CBE](#) to identify the consensus-based entity role.
Measure Section: CBE Number
Source of Change: Annual Update
- Updated copyright.
Measure Section: Copyright
Source of Change: Annual Update
- Updated Rationale with new evidence aligning with intent to screen patients with depression.
Measure Section: Rationale
Source of Change: Measure Lead
- Revised the Guidance to align with the logic that intent of the measure is to screen all patients for depression except those with a diagnosis of bipolar disorder.
Measure Section: Guidance
Source of Change: Measure Lead
- Updated grammar, wording, and/or formatting to improve readability and consistency.
Measure Section: Multiple Sections
Source of Change: Annual Update
- Updated references and measure header to reflect current evidence and new or updated literature.

Measure Section: Multiple Sections

Source of Change: Measure Lead

Logic

- Updated the version number of the Measure Authoring Tool (MAT) Global Common Functions Library to v8.0.000 and the library name from 'MATGlobalCommonFunctions' to 'MATGlobalCommonFunctionsQDM.'
Measure Section: Definitions
Source of Change: Annual Update
- Updated the names of [CQL](#) definitions, functions, and/or aliases for clarification and to align with the [CQL Style Guide](#).
Measure Section: Definitions
Source of Change: Standards/Technical Update
- Renamed [value set](#) to 'Payer Type' to more accurately reflect the contents and intent of the value set.
Measure Section: Definitions
Source of Change: Standards/Technical Update
- Updated the version number of the Measure Authoring Tool (MAT) Global Common Functions Library to v8.0.000 and the library name from 'MATGlobalCommonFunctions' to 'MATGlobalCommonFunctionsQDM.'
Measure Section: Functions
Source of Change: Annual Update

Value Set

The VSAC is the source of truth for the value set content, please visit the [VSAC](#) for downloads of current value sets.

- Removed ICD-9 extensional value sets from select grouping value sets, leaving codes from active terminologies (ICD-10 and SNOMED), to reduce implementer burden.
Measure Section: Terminology
Source of Change: Standards/Technical Update
- Value set Adult Depression Medications (2.16.840.1.113883.3.526.3.1566): Added 1 RxNorm code (2605720) based on terminology update. Deleted 2 RxNorm codes (1086789, 2605719) based on terminology update. Deleted 1 RxNorm code (1298857) based on new or changed coding guidelines.
Measure Section: Terminology
Source of Change: Annual Update
- Value set Bipolar Disorder (2.16.840.1.113883.3.67.1.101.1.128): Deleted 40 ICD-9-CM codes based on applicability of value set and/or OID.
Measure Section: Terminology
Source of Change: Annual Update

- Value set Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916): Added 1 CPT code (92622) based on review by technical experts, [SMEs](#), and/or public feedback.
Measure Section: Terminology
Source of Change: Measure Lead
- Value set Follow Up for Adolescent Depression (2.16.840.1.113883.3.526.3.1569): Added 1 SNOMED CT code (768835002) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 SNOMED CT code (91310009) based on review by technical experts, SMEs, and/or public feedback.
Measure Section: Terminology
Source of Change: Measure Lead
- Value set Follow Up for Adult Depression (2.16.840.1.113883.3.526.3.1568): Added 1 SNOMED CT code (768835002) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 SNOMED CT code (91310009) based on review by technical experts, SMEs, and/or public feedback.
Measure Section: Terminology
Source of Change: Measure Lead
- Value set (2.16.840.1.114222.4.11.3591): Renamed to Payer Type based on recommended VS naming conventions.
Measure Section: Terminology
Source of Change: Annual Update
- Value set Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022): Deleted 1 SNOMED CT code (33849009) based on terminology update.
Measure Section: Terminology
Source of Change: Annual Update