2018 CMS Web Interface

PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Steward: CMS

Contents

INTRODUCTION

There are a total of 15 individual measures (including one composite consisting of two measures) included in the 2018 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The measure documents are being provided to allow group practices and Accountable Care Organizations (ACOs) an opportunity to better understand each of the 15 individual measures included in the 2018 CMS Web Interface data submission method. Each measured document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the 2018 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on 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 the positive screen

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

DENOMINATOR EXCEPTIONS:
Patient Reason(s): Patient refuses to participate
OR
Medical Reason(s): 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
OR
Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

NUMERATOR:
Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
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 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)

- 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)

- 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:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

GUIDANCE:

A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the positive screen.

Screening Tools:

- 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 in the office of the provider filing the code, on the date of the encounter
- The screening should occur during a qualified encounter
- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: “Patient referred for psychiatric evaluation due to positive depression screening.”
- Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient’s prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for reporting requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR
  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR
  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country, or was enrolled in HMO select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

***Guidance** Patient Confirmation*

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.

If "Not Qualified for Sample" is selected and the date is unknown, you may enter the last date of the measurement period (i.e., 12/31/2018).

The Measurement Period is defined as January 1 – December 31, 2018.

NOTE:

- *In Hospice: Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- *Moved out of Country: Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- *Deceased: Select this option if the patient died during the measurement period*
- *HMO Enrollment: Select this option if the patient was enrolled in an HMO at any time during the measurement period (i.e., Medicare Advantage, non-Medicare HMOs, etc.)*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure
  - If the patient is qualified for this measure select "Yes"

  OR

  - If there is a denominator exclusion for patient disqualification from the measure select "Denominator Exclusion"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Denominator Exclusion codes can be found in the 2018 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance *Denominator*

Denominator Exclusion Timing - prior to any encounter during the measurement period.

If "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected, the patient will be "skipped" and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.

CMS Approved Reason may only be selected when approved by CMS. To request a CMS Approved Reason, you would need to provide the patient rank, measure and reason for request in a Quality Payment Program Service Desk inquiry. CMS decision will be provided in the resolution of the inquiry. Patients for whom CMS Approved Reason is selected are no longer qualified for the measure. The patient will be "skipped" and another patient must be reported in their place, if available.

NOTE:

- *The term "active diagnosis" is defined as a diagnosis that is either on the patient's problem list, a diagnosis code listed on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the denominator identification measurement period*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient was screened for depression using an age appropriate standardized tool during the measurement period
  - If the patient was not screened for depression using a standardized tool select "No"

  OR

  - If the patient was documented as having been screened for depression using one of the standardized tools select "Yes"

  OR

  - If the patient was not screened for depression using a standardized tool due to a medical reason select "No - Denominator Exception – Medical Reasons"

  OR

  - If the patient was not screened for depression using a standardized tool due to a patient reason select "No - Denominator Exception – Patient Reasons"

Numerator and Denominator Exception codes can be found in the 2018 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

***Guidance** Numerator*

NOTE:

- *Use most recent screening for depression*
- *Although the patient may have access to the depression screening tool in advance of the appointment the depression screening results must be documented on the date of the encounter (date of appointment).The results must be reviewed/verified and documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of this measure*
- *Screening for depression may be completed during a telehealth encounter*
- *Denominator Exception timing is during the encounter during the measurement period*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the screen was positive for depression during the measurement period
  - If the patient's screen was not positive for depression using a standardized tool select "No"

  OR

  - If the patient's screen was positive for depression using a standardized tool select "Yes"

    IF YES

    - Determine if a follow-up plan for depression was documented on the date of the positive screen
      - If a follow-up plan for depression is not documented select "No"

      OR

      - If a follow-up plan for depression is documented select "Yes"

Numerator codes can be found in the 2018 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

***Guidance** Numerator*

NOTE:

- *Screening for Depression Documented as Negative, follow-up plan not required*
- *Documentation of recommended follow-up plan for a positive depression screen may be completed during a telehealth encounter*
- *If recommended follow-up is additional screening, the additional screening must occur at the same encounter as the positive screen*
- *If additional screening is completed during the same encounter as the positive screen, the results of the additional screening is not necessary for data abstraction*
- *Positive or Negative-Whether or not a standardized screening tool score is considered positive or negative would be determined by the eligible professional administering and reviewing the standardized tool. If the result is positive, documentation of a recommended follow-up is required.*
- *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.*

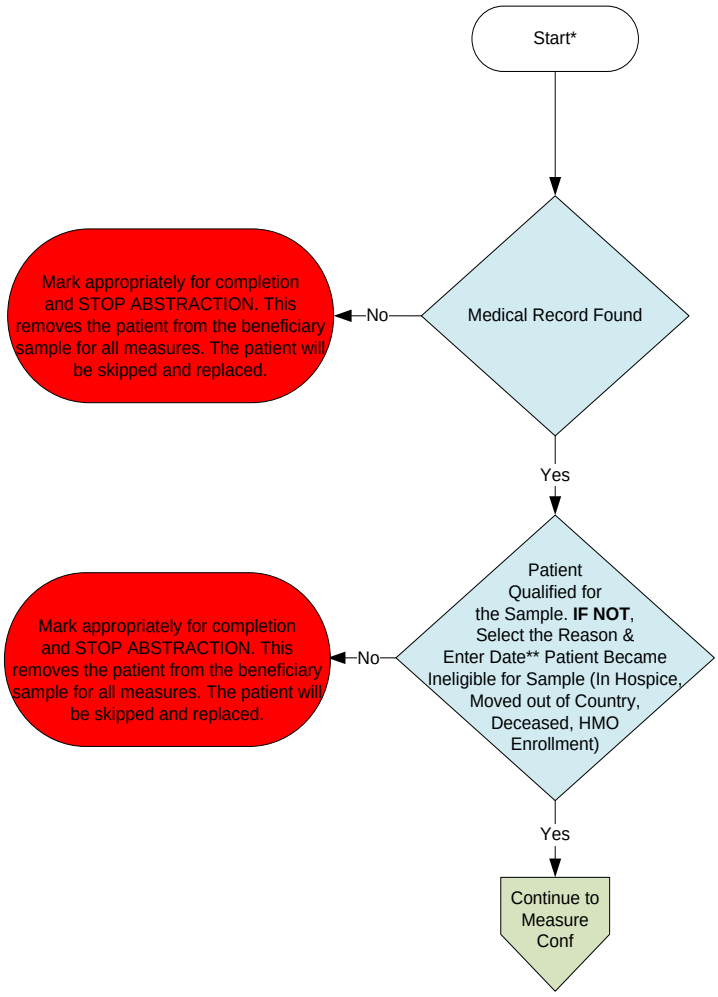
DOCUMENTATION REQUIREMENTS

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Patient Confirmation Flow

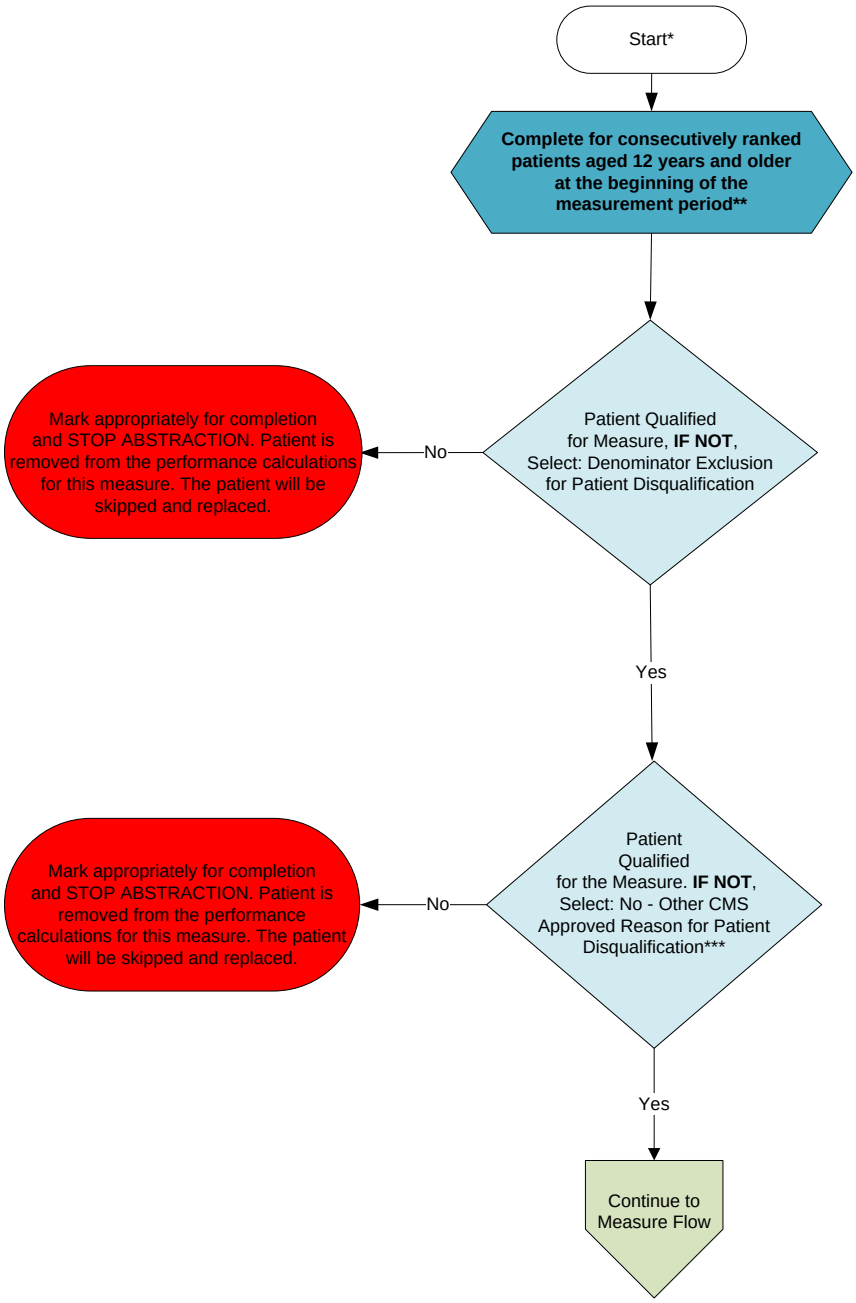
For 2018, confirmation of the “Medical Record Found”, or indicating the patient is “Not Qualified for Sample” with a reason of "In Hospice", "Moved out of Country", "Deceased", or "HMO Enrollment", will only need to be done once per patient.



*See the Measure Submission Document for further instructions on how to submit this measure
**If date is unknown, enter 12/31/2018

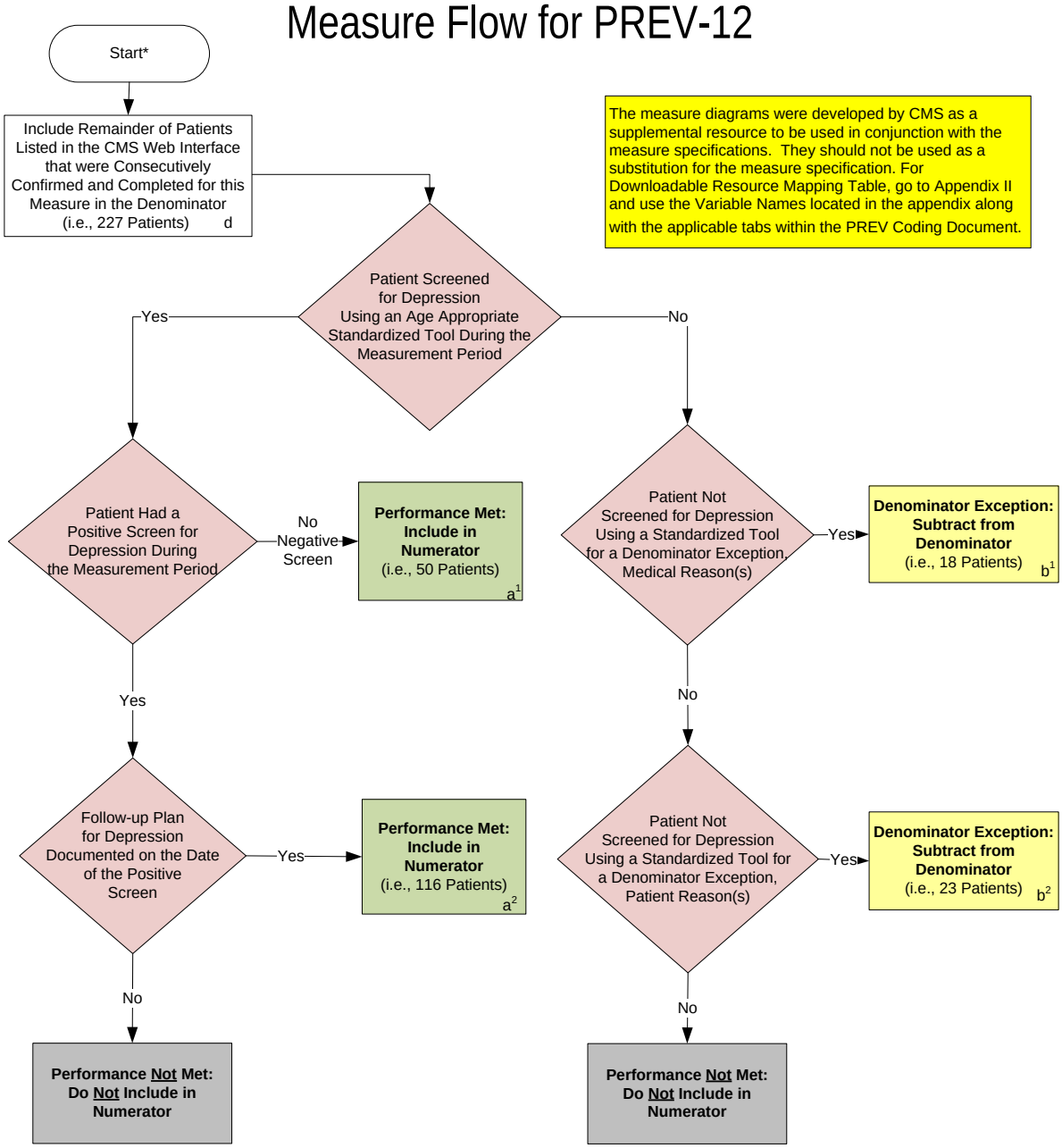
Measure Confirmation Flow for PREV-12

For 2018, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.



*See the Measure Submission Document for further instructions on how to submit this measure
**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-12 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
***"Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at qpp@cms.hhs.gov

Measure Flow for PREV-12



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a^1=50 Patients + a^2=116 Patients) / Denominator (d=227 Patients) - Denominator Exception (b^1=18 Patients + b^2=23 Patients) = 166 Patients / 186 Patients = 89.25%

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

*See the Measure Submission Document for further instructions on how to submit this measure

Patient Confirmation Flow

For 2018, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "HMO Enrollment", will only need to be done once per patient. Refer to the Measure Submission Document for further instructions.

1. Start Patient Confirmation Flow.

2. Check to determine if Medical Record can be found.
    a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, Medical Record found, continue processing.

3. Check to determine if Patient Qualified for the sample.
    a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2018) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, HMO Enrollment. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for PREV-12.

Measure Confirmation Flow for PREV-12

For 2018, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears. Refer to the Measure Submission Document for further instructions.

1. Start Measure Confirmation Flow for PREV-12. Complete for consecutively ranked patients aged 12 years and older at the beginning of the measurement period. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-12 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient qualifies for the measure (Denominator Exclusion).
    a. If no, the patient does not qualify for the measure select: Denominator Exclusion for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the measure, continue processing.

3. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).
    a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. "Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at QPP@cms.hhs.gov . Stop processing.
    b. If yes, the patient does qualify for the measure, continue to the PREV-12 measure flow.

Measure Flow for PREV-12

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used as a substitution for the measure specifications. For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the PREV Coding Document.

1. Start processing 2018 PREV-12 (NQF 0418) Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for PREV-12. Note: Include remainder of patients listed in the CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (eligible denominator, i.e. 227 patients).

2. Check to determine if the patient was screened for depression using an age appropriate standardized tool during the measurement period.
    a. If no, the patient was not screened for depression using an age appropriate standardized tool during the measurement period, continue processing and proceed to step 5.
    b. If yes, the patient was screened for depression using an age appropriate standardized tool during the measurement period, continue processing.

3. Check to determine if the patient had a positive screen for depression during the measurement period.
    a. If no, the patient did not have a positive screen for depression during the measurement period, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a^{1}' category (numerator, i.e. 50 patients). Stop processing.
    b. If yes, patient had a positive screen for depression during the measurement period, continue processing.

4. Check to determine if the patient had a follow-up plan for depression documented on the date of the positive screen.
    a. If no, the patient did not have a follow-up plan for depression documented on the date of the positive screen, performance is not met and the patient should not be included in the numerator. Stop processing.
    b. If yes, the patient had a follow-up plan for depression documented on the date of the positive screen, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a^{2}' category (numerator, i.e. 116 patients). Stop processing.

5. Check to determine if the patient was Not screened for depression using a standardized tool for a denominator exception, medical reason(s).
    a. If no, the patient was Not screened for depression using a standardized tool for a denominator exception, medical reason(s), continue processing.
    b. If yes, the patient was Not screened for depression using a standardized tool for a denominator exception, medical reason(s), this is a denominator exception and the case should be subtracted from the denominator. For the sample calculation in the flow these patients would fall into the 'b^{1}' category (denominator exception, i.e. 18 patients). Stop processing.

6. Check to determine if the patient was Not screened for depression using a standardized tool for a denominator exception, patient reason(s).

a. If no, the patient Not screened for depression using a standardized tool for a denominator exception, patient reason(s), performance is not met and the patient should not be included in the numerator. Stop processing.
b. If yes, the patient was Not screened for depression using a standardized tool for a denominator exception, patient reason(s), this is a denominator exception and the case should be subtracted from the denominator. For the sample calculation in the flow these patients would fall into the 'b²' category (denominator exception, i.e. 23 patients). Stop processing.

Sample Calculation
Performance Rate Equals
Performance Met is category 'a¹ plus a²' in the measure flow (166 patients)
Denominator is category 'd' in the measure flow (227 patients)
Denominator Exception is category 'b¹ plus b²' in the measure flow (41 patients)
166 (Performance Met) divided by 186 (Denominator minus Denominator Exception) equals a performance rate of 89.25 percent
Calculation May Change Pending Performance Met

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2018 CMS Web Interface PREV Coding Document.

*PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator Exclusion/ Denominator Exclusion Codes	Exclusion	BIPOLAR_DX_CODE	I9 I10 SNM
		DEPRESSION_DX_CODE	I9 I10 SNM
Numerator/Numerator Codes/Numerator Drug Codes	Depression Screen	SCREENING_CODE	LN
		NEG_SCREENING_CODE	SNM
		POS_SCREENING_CODE	SNM
	Positive Screen	POS_SCREENING_CODE	SNM
	Follow-up Plan	ADDITIONAL_EVAL_CODE	SNM
		FOLLOW_UP_CODE	SNM
		REFERRAL_CODE	SNM
		SUICIDE_RISK_CODE	SNM
		DEP_DRUG_CODE	RxNorm (Drug EX=N)
Denominator Exception/ Denominator Exception Codes	Medical Reason	MEDICAL_OTHER_REASON	SNM
	Patient Reason	PATIENT_REASON_REFUSED	SNM

** For EHR mapping, the coding within PREV-12 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

2014 U.S. survey data indicate that 2.8 million (11.4 percent) adolescents aged 12 to 17 had a major depressive episode (MDE) in the past year and that 15.7 million (6.6 percent) adults aged 18 or older had at least one MDE in the past year, with 10.2 million adults (4.3 percent) having one MDE with severe impairment in the past year (Center for Behavioral Health Statistics and Quality, 2015). The World Health Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Data indicate that approximately 80% of people diagnosed with depression report some level of difficulty in functioning because of their depressive symptoms. For example, 35% of males and 22% of females with depression reported that their depressive symptoms make it extremely difficult for them to work, get things done at home, or get along with other people. Additionally, more than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their depressive symptoms (Pratt & Brody, 2008). In young adulthood, major depressive disorder (MDD) has been found to be associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning (Williams et al., 2009, p. e716). In the perinatal period, depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families. Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. 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 50% of depressed patients (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). “In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated” (Sui, A. and USPSTF, 2016). 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.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. “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” (Sui, A. and USPSTF, 2016). This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

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)” (Sui, A. and USPSTF, 2016, p. 360).

“Clinicians and health care systems should try to consistently screen adolescents, ages 12-18, for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up” (ICSI, 2013, p. 16).

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)" (Sui, A. and USPSTF, 2016, p. 380).

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, 2016 p.p. 9 – 10)

Appendix IV: Use Notices, Copyrights, and Disclaimers