▲Measure #106 (NQF 0103): Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options 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. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients with evidence that they met the DSM-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Definitions:
MDD diagnosis (DSM-5) - For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain, or decrease or increase in appetite nearly every day; fatigue or loss of energy nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer, represent a change from previous functioning, and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must:

- Not be due to the physiological effects of a substanceor to another general medical condition
- Not be better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- Never have been accompanied by a manic or hypomanic episode

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in the DSM-5 criteria, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

Severity – According to DSM-IV-TR (2000), severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. See the Rationale and Clinical Recommendation Statements Sections for Supporting Guidelines and Other References for additional information on defining severity levels. *(Note: DSM-5 does not address severity. As such, DSM-IV-TR is the most up to date resource to use for assessment of severity.)*

*NUMERATOR NOTES:*
*For clinicians who use the term relapse, generally that refers to an episode of MDD that occurs within 6 months after either response or remission, which may be a variation on the initial episode. This measure is intended to capture either an initial or recurrent episode.*

*This measure is intended for use by clinicians who are qualified to diagnose and treat depression.*

*It can be helpful to use screening tools such as the PHQ-9 in order to substantiate the need for further evaluation and accurate diagnosis of MDD; however, simply using a tool alone would not constitute making a successful MDD diagnosis. A validated depression screening tool may include the PHQ-9, which is based on the DSM criteria for MDD. Other validated tools based on the DSM criteria may be available; this list is not intended to be all-inclusive.*

*Please refer to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (version 5 as of 2013) for more information regarding diagnosing Major Depressive Disorder.*

*It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.*

*FOR PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM-5 criteria and depression severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DSM-5 Criteria for Major Depressive Disorder Documented
*(One CPT II code & one quality data code [*1040F & G8930*] are required on the claim form to submit this numerator option)*
1040F: DSM-5 criteria for major depressive disorder documented at the initial evaluation
AND
G8930: Assessment of depression severity at the initial evaluation

OR

DSM-5 Criteria for Major Depressive Disorder not Documented, Reason not Otherwise Specified
*(One CPT II code [1040F-8P] or one quality data code [*G8931*] is required on the claim form to submit this numerator option)*
1040F *with* 8P: DSM-5 criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
OR
G8931: Assessment of depression severity not documented, reason not given

RATIONALE:
Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule-out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment. As noted in clinical guidelines, treatment methods should vary by the severity of depression. A diagnostic evaluation should be instituted for all patients with major depressive disorder to determine whether a diagnosis of depression is warranted and to reveal the presence of other conditions that may have an impact on treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Patients should receive a thorough diagnostic assessment in order to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions that may require attention, and develop a comprehensive plan for treatment [I]. (APA, 2010)

Criteria for Major Depressive Episode
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly attributable to another medical condition
1. Depressed mood most of the day, nearly every day as indicated by either subjective report (eg, feels sad, empty, hopeless) or observation made by others (eg, appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The episode is not attributable to the physiological effects of a substance or to another medical condition

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self esteem is generally preserved whereas in MDE feelings of worthlessness and self loathing are common. If self derogatory ideation is present in grief, it typically involves perceived failings vis-a-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition. (DSM-5, 2013)

Major depressive disorder can alter functioning in numerous spheres of life including work, school, family, social relationships, leisure activities, or maintenance of health and hygiene. The psychiatrist (clinician) should evaluate the patient's activity in each of these domains and determine the presence, type, severity, and chronicity of any dysfunction [I]. (APA, 2010)

In developing a treatment plan, interventions should be aimed at maximizing the patient's level of functioning as well as helping the patient to set specific goals appropriate to his or her functional impairments and symptom severity [I]. (APA, 2010)

If criteria are currently met for the major depressive episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe with Psychotic Features. [The fifth digit (in the diagnostic codes for Major Depressive Disorder) indicates the severity as follows: 1 for mild severity, 2 for moderate severity, 3 for severe without psychotic features, and 4 for severe with psychotic features.] (DSM-IV-TR, 2000)

Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. (DSM-IV-TR, 2000)

- Mild episodes are characterized by the presence of only five or six depressive symptoms and either mild disability or the capacity to function normally but with substantial and unusual effort.
- Episodes that are Severe Without Psychotic Features are characterized by the presence of most of the criteria symptoms and clear-cut, observable disability (eg, inability to work or care for children).
- Moderate episodes have a severity that is intermediate between mild and severe.
- [Severe With Psychotic Features] indicates the presence of either delusions or hallucinations (typically auditory). The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features [ie, content of the delusions or hallucinations are consistent with the depressive themes] or With Mood-Incongruent Features (ie, content of the delusions or hallucinations has no apparent relationship to depressive themes).