<table>
<thead>
<tr>
<th>Client</th>
<th>HMSA: PQSR 2007</th>
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<tr>
<td>Measure Title</td>
<td>TREATMENT OF MAJOR DEPRESSION: OPTIMAL PRACTITIONER CONTACTS</td>
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<tr>
<td>Disease State</td>
<td>Major Depression</td>
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<tr>
<td>Indicator Class</td>
<td>Disease Management</td>
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<tr>
<td>Strength of Rec</td>
<td>A</td>
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<tr>
<td>Clinical Intent</td>
<td>The intent of the measure is to ensure that all members diagnosed with major depression who received medication have (or are given ) appropriate follow-up treatment and/or services.</td>
</tr>
<tr>
<td>Physician Specialties</td>
<td>Refer to PQSR 2007 Specialty Matrix</td>
</tr>
</tbody>
</table>

**Clinical Rationale**

- Major depression is a common and very disabling disorder with extensive social, medical, and economic impact. Of the estimated 17.5 million Americans who are affected by some form of depression, 9.2 million have major or clinical depression.[1]
- The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease.[2]
- In 2001-02, more than one in ten non-institutionalized adult Americans were estimated to have had a major depressive disorder at some point in their lifetime, with 6.6% having a major depressive disorder during the past 12 months.[3]
- Despite the potential risks and widely available evidence-based clinical guidelines, data suggest that many patients are not being managed optimally. For example, only about 65% of all adults diagnosed with depression receive treatment.[4, 5], and the mean HEDIS benchmark for optimal practitioner contacts is only 20.3%.[6]

**Reason for Indicated Intervention or Treatment**

- Despite the importance of sustained intervention for depressed patients, the rates of maintaining continuity of treatment are low. For instance, evidence shows that only 1 in 5 patients sees a health care provider for the recommended number of visits following a diagnosis of a new episode of depression.[7]

**Evidence supporting Intervention or Treatment**

- Randomized, controlled trials have shown that active outreach and follow-up lead to improved outcomes for major depression.[8-11]
- Other studies have demonstrated the feasibility of this type of intervention.[12-14]
- Randomized, controlled trials have shown that collaborative care programs that involve enhanced patient education (via pamphlets and videotapes) and integration of several psychiatric visits into the primary care treatment of patients with depression significantly enhanced outcomes compared with usual care.[15, 16]
Clinical Recommendations

- The Institute for Clinical Systems Improvement (ICSI) guideline for major depression in adults gives a grade A recommendation for establishing and maintaining initial follow-up contact intervals (office, phone, other) during the acute phase of illness. The guideline states “If symptoms are severe, weekly contacts are appropriate. Contact should be every 2-4 weeks if mild or moderate symptoms are present. This protocol should be in place until remission or best possible response is achieved, then treatment should be spaced out as clinically warranted. Office visits for maintenance medication can occur every 3-12 months if everything else is stable.”[17]

- The American Psychiatric Association recommends that during the acute phase, “Visits should be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.”[18]

- The Veterans Health Association / Department of Defense Guideline for the treatment of MDD recommends that “Patients should be seen to monitor clinical status and side effects at one week (optimally) and no later than 2 weeks after antidepressant is started. If there is a response to a particular antidepressant after two weeks of treatment, the patient should be re-assessed at four weeks and at six weeks after initiation of antidepressant treatment. Thereafter, the patient should ideally be monitored monthly throughout the acute phase of treatment.”[19]

Source

Adapted from the Health Plan Employer Data and Information Set (HEDIS®) 2007 Technical Specification adapted for HMSA:

Removed because HMSA does not receive phone consultation codes

[C] A diagnosis of major depression:

ICD-9-CM Dx codes: 290.xx, 293.xx-302.xx, 306.xx-316.xx

AND

A phone consultation:

CPT-4 codes: 99371-99373

Numerator changed to require two visits at request of HMSA instead of 3 per HEDIS

Denominator

Members ages 18 years or older as of the 120th day of the measurement year, who were newly diagnosed with major depression and who began antidepressant therapy during the one year period beginning 245 days before the measurement year, and who were continuously enrolled for 120 days prior to 245 days after their diagnosis date.

Relevant Billing Codes:

ICD-9-CM codes: 296.2x, 296.3x, 298.0x, 300.4x, 309.1x, 311.xx

UB-92 revenue codes: 0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x, 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 045x, 0513, 072x, 080x, 0900, 0901, 0905-0907, 0909-0916, 0961, 0981, 0987, 118, 128, 138, 148, 158, 19x, 55x, 66x, 10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 45x, 513, 72x, 80x, 900, 901, 905-907, 909-916, 961, 981, 987

Denominator Exclusion

Members with a prior history of depression, antidepressant medication, or an acute mental health/substance abuse inpatient stay during the 120 days before the index date.

Relevant Billing Codes:

306.xx – 316.xx

CPT-4 codes: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291

UB-92 revenue codes: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987 10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 80x, 987

Numerator

- Members who had two or more outpatient visits (not including the index diagnosis date) with a mental or non-mental health practitioner 1-84 days after the index date. All follow-up visits are to be for mental health and at least one visit must be with the prescribing physician (i.e., physician who prescribed denominator [D] antidepressant).

- Additionally, one of the two visits must be with the prescribing physician (i.e., physician who prescribed denominator [D] antidepressant).

An office visits with a mental or non-mental health practitioner with a diagnosis of major depression defined as:

Relevant Billing Codes:

ICD-9-CM Dx codes: 290.xx, 293.xx-302.xx, 306.xx-316.xx

CPT codes: 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404


UB-92 revenue codes: 0513, 0900, 0901, 0905-0907, 0909-0916, 0961, 513, 900, 901, 905-907, 909-916, 961
Interpretation of Score
High score implies better performance

Physician Attribution
Score the prescribing physician (i.e., physician who prescribed denominator [D] antidepressant) and all physicians (in the selected specialties) who came in contact with the member 0 - 84 days after the index date.

External Files
antidepressants_medlist_2007.xls
Source: NCQA website
Updated Annually

References
17. ICSI. *Major Depression in Adults for Mental Health Care.* 2004 [cited 2006 January 23].


### Indicator Classification
(Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g., evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)</td>
</tr>
<tr>
<td><strong>Effectiveness of Care</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g., immunizations).</td>
</tr>
<tr>
<td>Screening</td>
<td>Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g., pap smears; screening for elevated blood pressure).</td>
</tr>
<tr>
<td>Disease Management</td>
<td>Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g., cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).</td>
</tr>
<tr>
<td>Medication Monitoring</td>
<td>Measures applicable to patients taking medications with narrow therapeutic windows and/or potential preventable significant side effects or adverse reactions (e.g., thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy).</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g., adherence to lipid lowering medication).</td>
</tr>
<tr>
<td>Utilization</td>
<td>Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g., conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).</td>
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Strength of Recommendation Based on a Body of Evidence

**FIGURE 2.** Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)