

# **NQF 0105: Anti-Depressant Medication Management: (a) Acute Phase Treatment, (b) Effective Continuation Phase**

## **Clinical Quality Measure Quick Reference Guide and Technical Supplement**

### **Provided By:**

The National Learning Consortium (NLC)

### **Developed By:**

Health Information Technology Research Center (HITRC)

*The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.*

## NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

## DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR).

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and denominator exclusion.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and denominator exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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## NQF 0105: Anti-Depressant Medication Management: (a) Acute Phase Treatment, (b) Effective Continuation Phase

The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> <li>Menu set measure</li> </ul>
Related to other measures?	<ul style="list-style-type: none"> <li>Not related to other Stage 1 MU clinical quality measures</li> </ul>
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> <li>Age<sup>1</sup></li> <li>Encounter codes<sup>2</sup></li> <li>Diagnosis of major depression</li> <li>Antidepressant medication (dispensed, ordered, or active)<sup>3</sup></li> </ul>
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> <li>Diagnosis of major depression<sup>4</sup></li> <li>Diagnosis of depression<sup>4</sup></li> </ul>
Data required to identify the <u>numerator 1</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> <li>Antidepressant medication dispensed<sup>5</sup></li> </ul>

**Note:** This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. <b>Confirm the patient's date of birth</b>	<ul style="list-style-type: none"> <li>Ensures only patients who are 18 years of age or older as of April 30<sup>th</sup> of the measurement year are included in the <b>denominator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of birth</li> </ul>	

<sup>1</sup> This data element(s) must be documented no more than 245 days before the end of the measurement period

<sup>2</sup> This data element(s) must be no more than 245 days before the beginning of the measurement period and no more than 245 days before the end of the measurement period.

<sup>3</sup> This data element(s) must be no more than 30 days before or 14 days after the first diagnosis of major depression

<sup>4</sup> This data element(s) must be no more than 120 days before the first diagnosis of major depression

<sup>5</sup> This data element(s) must be documented no less than 84 days after the first diagnosis of major depression for numerator 1, and no less than 120 days after the first diagnosis of major depression for numerator 2.

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
2. Check patient record for at least one emergency department, outpatient behavioral health, or inpatient encounter with a principal diagnosis of major depression.	<ul style="list-style-type: none"> <li>Ensures all patients with an active first diagnosis of major depression are captured in the <b>denominator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of encounter<sup>6</sup> with principal diagnosis of major depression<sup>7</sup></li> </ul>	
3. Check patient record for at least two emergency department or outpatient behavioral health encounters with a secondary diagnosis of major depression.	<ul style="list-style-type: none"> <li>Ensures all patients with an active first diagnosis of major depression are captured in the <b>denominator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Dates of encounters<sup>6</sup> with secondary diagnosis of major depression<sup>7</sup></li> </ul>	
4. Check patient record for dispensed, ordered, or active antidepressant medication.	<ul style="list-style-type: none"> <li>Ensures only patients who are actively on antidepressant medication, or have it dispensed or ordered, are captured in <b>denominator</b></li> </ul>	<ul style="list-style-type: none"> <li>Document date and type of antidepressant medication dispensed, ordered, or active</li> </ul>	
5. Check patient record for date of diagnosis of depression or major depression	<ul style="list-style-type: none"> <li>Ensures patients who are diagnosed less than 120 days prior to first diagnosis of major depression are captured as <b>exceptions/exclusions</b></li> </ul>	<ul style="list-style-type: none"> <li>Document date of diagnosis of depression<sup>8</sup> or major depression<sup>7</sup></li> </ul>	
6. Record the date(s) and type(s) of antidepressant medication dispensed	<ul style="list-style-type: none"> <li>Ensures all patients who were dispensed, ordered, or remained active on antidepressant medication are captured for <b>numerators</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of medication dispensation</li> <li>Type of antidepressant medication<sup>9</sup></li> </ul>	

<sup>6</sup> See the Technical Supplement of denominator inclusion details (encounter types): [pp. TS-3](#)

<sup>7</sup> See the Technical Supplement for denominator inclusion and exception/exclusion details (major depression diagnosis): [pp. TS-2](#)

<sup>8</sup> See the Technical Supplement for exception/exclusion details (depression diagnosis): [pp. TS- 7](#)

<sup>9</sup> See the Technical Supplement for numerator inclusion details (antidepressant medication): [pp. TS-11](#)

## Technical Supplement

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The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure numerator and denominator.

## DENOMINATOR INCLUSION CRITERIA

### What counts as diagnosis of major depression? (ICD-9 codes)

• Major depressive disorder, single episode, unspecified	296.20
• Major depressive disorder, single episode, mild	296.21
• Major depressive disorder, single episode, moderate	296.22
• Major depressive disorder, single episode, severe, without mention of psychotic behavior	296.23
• Major depressive disorder, single episode, severe, specified as with psychotic behavior	296.24
• Major depressive disorder, single episode, in partial or unspecified remission	296.25
• Major depressive disorder, recurrent episode, unspecified	296.30
• Major depressive disorder, recurrent episode, mild	296.31
• Major depressive disorder, recurrent episode, moderate	296.32
• Major depressive disorder, recurrent episode, severe without mention of psychotic behavior	296.33
• Major depressive disorder, recurrent episode, severe, specified as with psychotic behavior	296.34
• Major depressive disorder, recurrent episode, in partial or unspecified remission.	296.35
• Depressive type psychosis	298.0
• Dissociative, conversion, and factitious disorders	300.4
• Unspecified nonpsychotic mental disorder	309.1
• Depressive disorder not elsewhere classified	311

### What counts as diagnosis of major depression? (ICD-10 codes)

• Manic episode	F30
• Manic episode, severe with psychotic symptoms	F30.2
• Major depressive disorder, single episode	F32
• Major depressive disorder, recurrent	F33
• Major depressive disorder, recurrent, mild	F33.0
• Major depressive disorder, recurrent severe without psychotic features	F33.1
• Major depressive disorder, recurrent severe without psychotic features	F33.2
• Major depressive disorder, recurrent, severe with psychotic symptoms	F33.3
• Major depressive disorder, recurrent, unspecified	F33.9
• Dysthymia	F34.1
• Persistent mood disorder, unspecified	F34.9
• Adjustment disorder with depressed mood	F43.21

### What counts as a diagnosis of major depression? (SNOMED CT codes)

• Chronic major depressive disorder, single episode (disorder)
• Severe recurrent major depression with psychotic features, mood-incongruent (disorder)
• Moderate major depression, single episode (disorder)
• Moderate recurrent major depression (disorder)
• Recurrent major depressive episodes, mild (disorder)
• Recurrent major depressive episodes, moderate (disorder)
• Recurrent major depressive episodes, severe, with psychosis (disorder)
• Recurrent major depressive episodes, in full remission (disorder)

#### What counts as a diagnosis of major depression? (SNOMED CT codes)

- Major depression, single episode, in complete remission (disorder)
- Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)
- Major depressive disorder, single episode with postpartum onset (disorder)
- Chronic recurrent major depressive disorder (disorder)
- Recurrent major depressive episodes (disorder)
- Severe recurrent major depression with psychotic features (disorder)
- Major depression in partial remission (disorder)
- Recurrent major depressive disorder with melancholic features (disorder)
- Major depression, melancholic type (disorder)
- Severe recurrent major depression with psychotic features, mood-congruent (disorder)
- Recurrent major depression in partial remission (disorder)
- Severe major depression with psychotic features, mood-congruent (disorder)
- Depressive disorder (disorder)
- Severe recurrent major depression without psychotic features (disorder)
- Major depression, single episode (disorder)
- Major depressive disorder (disorder)
- Recurrent major depressive disorder with atypical features (disorder)
- Recurrent major depressive disorder with catatonic features (disorder)
- Mild recurrent major depression (disorder)
- Major depression in remission (disorder)
- Major depressive disorder, single episode with atypical features (disorder)
- Severe major depression, single episode, with psychotic features (disorder)
- Recurrent major depression in complete remission (disorder)
- Severe major depression with psychotic features, mood-incongruent (disorder)
- Major depression in complete remission (disorder)
- Major depressive disorder, single episode with melancholic features (disorder)
- Recurrent major depression (disorder)
- Recurrent major depression in remission (disorder)
- Major depressive disorder, single episode with catatonic features (disorder)
- Major depression single episode, in partial remission (disorder)
- Recurrent major depressive disorder with postpartum onset (disorder)
- Severe major depression with psychotic features (disorder)
- Severe major depression without psychotic features (disorder)
- Severe major depression, single episode, without psychotic features (disorder)
- Severe major depression, single episode, with psychotic features, mood-congruent (disorder)
- Mild major depression, single episode (disorder)
- Moderate major depression (disorder)
- Mild major depression (disorder)

#### What counts as an encounter? (CPT codes)

- Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services.



### What counts as an encounter? (CPT codes)

- Critical care, evaluation and management of the critically ill or critically injured patient.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making
- Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)
- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a history, an examination, and medical decision making
- Family psychotherapy (conjoint psychotherapy with patient present)\*
- Group psychotherapy (other than of a multiple-family group)\*
- Home visit for individual, family, or marriage counseling.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an examination, and medical decision making
- Hospital discharge day management\*
- Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supporting psychotherapy)\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility,
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient; with medical evaluation and management services\*
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient; with medical evaluation and management services
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient.\*
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient; with medical evaluation and management services.\*
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, new patient.
- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.\*
- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.

### What counts as an encounter? (CPT codes)

- Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an examination, and medical decision making
- Inpatient consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.\*
- Interactive group psychotherapy\*
- Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication\*
- Multiple-family group psychotherapy\*
- Nursing facility discharge day management.
- Observation care discharge day management
- Office consultation for a new or established patient, which requires these 3 key components: A problem focused history a history, an examination, and medical decision making
- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient.
- Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy\*
- Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure).
- \* Psychiatric diagnostic interview examination\*
- Psychoanalysis\*
- Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.\*
- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components a history, an examination, and medical decision making.
- Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services.
- Critical care, evaluation and management of the critically ill or critically injured patient.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making
- Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)

### What counts as an encounter? (CPT codes)

- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a history, an examination, and medical decision making
- Family psychotherapy (conjoint psychotherapy with patient present)\*
- Group psychotherapy (other than of a multiple-family group)\*
- Home visit for individual, family, or marriage counseling.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an examination, and medical decision making
- Hospital discharge day management\*
- Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supporting psychotherapy)\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility,
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient; with medical evaluation and management services\*
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face-to-face with the patient; with medical evaluation and management services
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient.\*
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, face-to-face with the patient; with medical evaluation and management services.\*
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, new patient.
- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.\*
- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an examination, and medical decision making
- Inpatient consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.\*
- Interactive group psychotherapy\*

#### What counts as an encounter? (CPT codes)

- Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication\*
- Multiple-family group psychotherapy\*
- Nursing facility discharge day management.
- Observation care discharge day management
- Office consultation for a new or established patient, which requires these 3 key components: A problem focused history a history, an examination, and medical decision making
- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient.
- Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy\*
- Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure).
- \* Psychiatric diagnostic interview examination\*
- Psychoanalysis\*
- Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.\*
- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components a history, an examination, and medical decision making.

\*These visits may be at a school, Indian Health Service freestanding facility, Tribal 638 freestanding facility, office, home, assisted living facility, group home, mobile unit, urgent care facility, outpatient hospital, custodial care facility, independent clinic, federally qualified health center, psychiatric facility, community mental health center, non-residential substance abuse treatment facility, public health clinic, or rural health clinic.

## EXCEPTION OR EXCLUSION CRITERIA

#### What counts a diagnosis of depression? (ICD-9 codes)

- |   |        |
|---|--------|
| • Major depressive disorder, single episode, in full remission  | 296.26 |
| • Major depressive disorder, recurrent episode in full remission  | 296.36 |
| • Bipolar I disorder, most recent or current episode manic  | 296.4  |
| • Bipolar I disorder, most recent or current episode manic, unspecified                                   | 296.40 |
| • Bipolar I disorder, most recent or current episode manic, mild  | 296.41 |
| • Bipolar I disorder, most recent or current episode manic, moderate                                      | 296.42 |
| • Bipolar I disorder, most recent or current episode manic, severe, without mention of psychotic behavior | 296.43 |
| • Bipolar I disorder, most recent or current episode manic, severe, specified as with psychotic behavior  | 296.44 |
| • Bipolar I disorder, most recent or current episode manic, in partial or unspecified remission           | 296.45 |

#### What counts a diagnosis of depression? (ICD-9 codes)

• Bipolar I disorder, most recent or current episode manic, in full remission	296.46
• Bipolar I disorder, most recent or current episode depressed	296.5
• Bipolar I disorder, most recent or current episode depressed, unspecified	296.50
• Bipolar I disorder, most recent or current episode depressed, mild	296.51
• Bipolar I disorder, most recent or current episode depressed, moderate	296.52
• Bipolar I disorder, most recent or current episode depressed, severe, without mention of psychotic behavior	296.53
• Bipolar I disorder, most recent or current episode depressed, severe, specified as with psychotic behavior	296.54
• Bipolar I disorder, most recent or current episode depressed, in partial or unspecified remission	296.55
• Bipolar I disorder, most recent or current episode depressed, in full remission	296.56
• Bipolar I disorder, most recent or current episode mixed	296.6
• Bipolar I disorder, most recent or current episode mixed, unspecified	296.60
• Bipolar I disorder, most recent or current episode mixed, mild	296.61
• Bipolar I disorder, most recent or current episode mixed, moderate	296.62
• Bipolar I disorder, most recent or current episode mixed, severe, without mention of psychotic behavior	296.63
• Bipolar I disorder, most recent or current episode mixed, severe, specified as with psychotic behavior	296.64
• Bipolar I disorder, most recent or current episode mixed, in partial or unspecified remission	296.65
• Bipolar I disorder, most recent or current episode mixed, in full remission	296.66
• Bipolar I disorder, most recent or current episode unspecified	296.7
• Other and unspecified bipolar disorders	296.8
• Bipolar disorder unspecified	296.80
• Atypical manic disorder	296.81
• Atypical depressive disorder	296.82
• Other episodic mood disorder	296.89
• Other and unspecified episodic mood disorder	296.9
• Other specified episodic mood disorder	296.90
• Adjustment disorder with depressed mood	296.99
• Adjustment disorder with mixed anxiety and depressed mood	309.0

#### What counts as a diagnosis of depression? (ICD-10 codes)

- Bipolar affective disorder
- Severe depressive episode with psychotic symptoms
- Recurrent depressive disorder, current episode severe, with psychotic symptoms
- Unspecified mood disorder
- Adjustment disorder

#### What counts as a diagnosis of depression? (SNOMED CT codes)

- Chronic bipolar II disorder, most recent episode major depressive (disorder)
- Severe recurrent major depression with psychotic features, mood-incongruent (disorder)
- Moderate major depression, single episode (disorder)
- Bipolar II disorder, most recent episode major depressive (disorder)
- Moderate recurrent major depression (disorder)

#### What counts as a diagnosis of depression? (SNOMED CT codes)

- Drug-induced depressive state (disorder)
- Single major depressive episode, mild (disorder)
- Single major depressive episode, moderate (disorder)
- Single major depressive episode, severe, with psychosis (disorder)
- Single major depressive episode, in full remission (disorder)
- Recurrent major depressive episodes, mild (disorder)
- Recurrent major depressive episodes, moderate (disorder)
- Recurrent major depressive episodes, severe, with psychosis (disorder)
- Recurrent major depressive episodes, in full remission (disorder)
- Bipolar affective disorder, current episode depression (disorder)
- Bipolar affective disorder, currently depressed, mild (disorder)
- Bipolar affective disorder, currently depressed, moderate (disorder)
- Bipolar affective disorder, currently depressed, severe, with psychosis (disorder)
- Bipolar affective disorder, currently depressed, in full remission (disorder)
- Atypical depressive disorder (disorder)
- Reactive depressive psychosis (disorder)
- Postviral depression (disorder)
- Chronic depression (disorder)
- Late onset dysthymia (disorder)
- Severe major depression, single episode, with psychotic features, mood-incongruent (disorder)
- Depressed bipolar I disorder in full remission (disorder)
- Bipolar II disorder, most recent episode major depressive with catatonic features (disorder)
- Post-schizophrenic depression (disorder)
- Endogenous depression first episode (disorder)
- Masked depression (disorder)
- Depressive conduct disorder (disorder)
- Mild postnatal depression (disorder)
- Severe postnatal depression (disorder)
- Seasonal affective disorder (disorder)
- Early onset dysthymia (disorder)
- Major depressive disorder, single episode with postpartum onset (disorder)
- Chronic recurrent major depressive disorder (disorder)
- Severe depressed bipolar I disorder with psychotic features, mood-incongruent (disorder)
- Single major depressive episode (disorder)
- Recurrent major depressive episodes (disorder)
- Endogenous depression - recurrent (disorder)
- Maternity blues (disorder)
- Severe recurrent major depression with psychotic features (disorder)
- Bipolar I disorder, most recent episode depressed with atypical features (disorder)
- Endogenous depression (disorder)
- Bipolar II disorder, most recent episode major depressive with postpartum onset (disorder)
- Mild depression (disorder)



#### What counts as a diagnosis of depression? (SNOMED CT codes)

- Moderate depression (disorder)
- Severe depression (disorder)
- Secondary dysthymia early onset (disorder)
- Recurrent major depressive disorder with melancholic features (disorder)
- Major depression, melancholic type (disorder)
- Involutional depression (disorder)
- Severe recurrent major depression with psychotic features, mood-congruent (disorder)
- Recurrent major depression in partial remission (disorder)
- Severe major depression with psychotic features, mood-congruent (disorder)
- Bipolar II disorder, most recent episode major depressive with melancholic features (disorder)
- Depressive disorder (disorder)
- Cotard's syndrome (disorder)
- Secondary dysthymia late onset (disorder)
- Severe recurrent major depression without psychotic features (disorder)
- Major depression, single episode (disorder)
- Major depressive disorder (disorder)
- Primary dysthymia early onset (disorder)
- Recurrent major depressive disorder with catatonic features (disorder)
- Mild recurrent major depression (disorder)
- Recurrent brief depressive disorder (disorder)
- Premenstrual dysphoric disorder in remission (disorder)
- Major depression in remission (disorder)
- Major depressive disorder, single episode with atypical features (disorder)
- Severe major depression, single episode, with psychotic features (disorder)
- Bipolar II disorder, most recent episode major depressive with atypical features (disorder)
- Chronic depressive personality disorder (disorder)
- Recurrent major depression in complete remission (disorder)
- Minor depressive disorder (disorder)
- Depressed bipolar I disorder (disorder)
- Depressed bipolar I disorder in partial remission (disorder)
- Chronic bipolar I disorder, most recent episode depressed (disorder)
- Depressed bipolar I disorder in remission (disorder)
- Severe depressed bipolar I disorder with psychotic features, mood-congruent (disorder)
- Postpartum depression (disorder)
- Premenstrual dysphoric disorder (disorder)
- Severe depressed bipolar I disorder with psychotic features (disorder)
- Severe major depression with psychotic features, mood-incongruent (disorder)
- Severe depressed bipolar I disorder without psychotic features (disorder)
- Recurrent major depression (disorder)
- Moderate depressed bipolar I disorder (disorder)
- Primary dysthymia late onset (disorder)
- Recurrent major depression in remission (disorder)

#### What counts as a diagnosis of depression? (SNOMED CT codes)

- Recurrent major depressive disorder with postpartum onset (disorder)
- Severe major depression with psychotic features (disorder)
- Mild depressed bipolar I disorder (disorder)
- Severe major depression without psychotic features (disorder)
- Bipolar I disorder, most recent episode depressed with melancholic features (disorder)
- Severe major depression, single episode, without psychotic features (disorder)
- Severe major depression, single episode, with psychotic features, mood-congruent (disorder)
- Dysthymia (disorder)
- Stuporous depression (disorder)
- Postoperative depression (disorder)
- Primary dysthymia (disorder)
- Moderate major depression (disorder)
- Agitated depression (disorder)
- Schizoaffective disorder, depressive type (disorder)
- Menopausal depression (disorder)
- Secondary dysthymia (disorder)
- Reactive depression (situational) (disorder)
- Mild major depression (disorder)
- Generalized neuromuscular exhaustion syndrome (disorder)

## NUMERATOR INCLUSION CRITERIA

#### What counts as an anti-depressant medication (RxNorm codes)

- Amitriptyline hydrochloride
- Amitriptyline hydrochloride / chlordiazepoxide
- Amitriptyline hydrochloride / perphenazine
- Amoxapine
- Bupropion
- Bupropion hydrobromide
- Bupropion hydrochloride
- Citalopram
- Clomipramine hydrochloride
- Clothiapine
- Desipramine
- Desvenlafaxine
- Doxepin
- Doxepin hydrochloride
- Duloxetine
- Escitalopram
- Fluoxetine
- Fluoxetine / olanzapine
- Fluoxetine hydrochloride



#### What counts as an anti-depressant medication (RxNorm codes)

- Fluphenazine hydrochloride / nortriptyline
- Fluvoxamine maleate
- Imipramine hydrochloride
- Imipramine pamoate
- Isocarboxazid
- Maprotiline
- Mirtazapine
- Nefazodone
- Nortriptyline
- Paroxetine
- Phenelzine
- Protriptyline hydrochloride
- Selegiline hydrochloride
- Sertraline
- Tranylcypromine
- Trazodone hydrochloride
- Trimipramine
- Venlafaxine
- Isocarboxazid
- Maprotiline
- Mirtazapine
- Nefazodone
- Nortriptyline
- Paroxetine
- Phenelzine
- Protriptyline hydrochloride
- Selegiline hydrochloride
- Sertraline
- Tranylcypromine
- Trazodone hydrochloride
- Trimipramine
- Venlafaxine

## TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0105	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator <sup>1</sup>							x	x		x	x
Denominator <sup>2</sup>	x					x	x	x		x	x
Exceptions or exclusions							x	x			x

- (Codes with an asterisk (\*) are required from certified EHRs)
- <sup>1</sup> To identify the numerator in this CQM, the following standard codes are required: one "medication" code from RxNorm and one "diagnosis" code from ICD-9, ICD-10, or SNOMED.
- <sup>2</sup> To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, one or more "encounter" codes from CPT, one "diagnosis" code from ICD-9, ICD-10, or SNOMED, and one "medication" from RxNorm.
- <sup>3</sup> To identify the exceptions or exclusions in the CQM, the following standard codes are required: a "diagnosis" code from ICD-9, ICD-10, or SNOMED

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)

Abbreviation	Long Name	Definition/Description
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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