2023 CMS Web Interface

MH-1 (NQF 0710): Depression Remission at Twelve Months

Measure Steward: MNCM

Contents

INTRODUCTION

There are a total of 10 individual measures included in the 2023 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 organizations an opportunity to better understand each of the 10 individual measures included in the 2023 CMS Web Interface data submission method. Each measure 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 2023 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

DESCRIPTION:
The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial Patient Health Questionnaire-9 item version (PHQ-9) or Patient Health Questionnaire-9 Modified for Teens and Adolescents (PHQ-9M) score greater than nine during the index event. Patients may be assessed using PHQ-9 or PHQ-9M on the same date or up to 7 days prior to the encounter (index event).

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients with a diagnosis of bipolar disorder any time prior to the end of the measure assessment period

OR

Patients with a diagnosis of select personality disorders any time prior to the end of the measure assessment period

OR

Patients with a diagnosis of schizophrenia or psychotic disorder any time prior to the end of the measure assessment period

OR

Patients with a diagnosis of pervasive developmental disorder any time prior to the end of the measure assessment period

OR

Patients who were permanent nursing home residents any time during denominator identification period or the measure assessment period

OR

Patients with a diagnosis of personality disorder emotionally labile any time prior to the end of the measure assessment period

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
Denominator Identification Period - The period in which eligible patients can have an index event. The denominator identification period occurs prior to the measurement period and is defined as 14 months to two months prior to the start of the measurement period. The denominator identification period is from 11/1/2021 to 10/31/2022. For patients with an index event, there needs to be enough time following index for the patients to have the

opportunity to reach remission twelve months +/- 60 days after the index event date.

Index Event Date - The date on which the first instance of elevated PHQ-9 or PHQ-9M greater than nine AND diagnosis of depression or dysthymia occurs during the denominator identification period (11/1/2021 to 10/31/2022). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).

Measure Assessment Period - The index event date marks the start of the measurement assessment period for each patient which is 14 months (12 months +/- 60 days) in length to allow for a follow-up PHQ-9 or PHQ-9M between 10 and 14 months following the index event. This assessment period is fixed and does not "start over" with a higher PHQ-9 or PHQ-9M that may occur after the index event date.

Remission - Is defined as a PHQ-9 or PHQ-9M score of less than five.

Twelve Months - Is defined as the point in time from the index event date extending out twelve months and then allowing a grace period of sixty days prior to and sixty days after this date. The most recent PHQ-9 or PHQ-9M score less than five obtained during this four month period is deemed as remission at twelve months, values obtained prior to or after this period are not counted as numerator compliant (remission).

GUIDANCE:

When an index assessment is conducted with PHQ-9M, the follow-up assessment can use either a PHQ-9M or PHQ-9.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission 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 did not have Fee-for-Service (FFS) Medicare as their primary payer 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 submitted 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., 12/31/2023).*

The Measurement Period is defined *as January 1 – December 31, 2023.*

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*
- ***Non-FFS Medicare:*** *Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient has an active diagnosis of major depression or dysthymia during the denominator identification period (11/1/2021 to 10/31/2022)
  - If the patient has a documented diagnosis of major depression or dysthymia in the medical record select "Yes"

  OR

  - If you are unable to confirm the diagnosis of major depression or dysthymia for the patient select "Not Confirmed - Diagnosis"

  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 and Denominator Exclusion codes can be found in the 2023 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

Note: *This outcome measure is indicated for patients with a diagnosis of major depression or dysthymia. These diagnosis codes are identified during the CMS sampling process and can be found in the Denominator Codes tab in the MH Coding Document. Confirmation of the diagnosis of major depression or dysthymia can occur using any of the following methods:*

- *Diagnosis code on the encounter or problem list (regardless of vendor assigned description of the code)*
- *Words "major depression", "major depressive disorder", "dysthymia", "dysthymic disorder", "pervasive depressive disorder" (DSM 5 term for dysthymia) on progress notes or problems lists can be used to confirm the diagnosis. Additionally, in paper records, the description "depression" may be used with the option to confirm by billing code.*

If "Not Confirmed – Diagnosis" or "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected, *the patient will be "skipped" and another patient must be submitted 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.*

Other CMS Approved Reason *is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.*

To submit a skip request, follow these steps:

1. *After confirming the beneficiary for the sample, scroll to the measure you would like to skip.*
2. *When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.*
3. *In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to*

resolve the skip request. You also need to provide specific information about the beneficiary's condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

NOTE:

- ***Active Diagnosis of Major Depression or Dysthymia*** *is defined as a diagnosis that is either on the patient's problem list, a diagnosis code description 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 period*
- ***Patient must be age 12 years or older*** *at the time of the index assessment (confirming diagnosis and PHQ-9 or PHQ-9M greater than 9)*
- ***Index Event Date*** *is defined as the date on which the first instance of elevated PHQ-9 or PHQ-9M greater than 9 AND diagnosis of major depression or dysthymia occurs during the denominator identification period (11/1/2021 to 10/31/2022). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).*
- ***Denominator Exclusions -*** *active diagnosis of bipolar disorder, personality disorder (select types; cyclothymic, borderline, histrionic and factitious), schizophrenia, psychotic disorder or pervasive developmental disorder, or personality disorder emotionally labile any time prior to the end of the measure assessment period. Patients who were a permanent nursing home resident any time during the denominator identification period or the measure assessment period.*
- ***Permanent Nursing Home Resident*** *is defined as a patient who is residing in a long-term residential facility any time during the denominator identification period or during the measurement assessment period. It does not include patients who are receiving short-term rehabilitative services following a hospital stay, nor does it include patients residing in assisted living or group homesettings.*
- ***Two rates will be reported*** *– Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the denominator identification period between 11/1/2021 and 10/31/2022
    - If the patient did have a PHQ-9 or PHQ-9M administered during the denominator identification period select "Yes"

    OR

    - If the patient did not have a PHQ-9 or PHQ-9M administered during the denominator identification period select "No"

Denominator codes can be found in the 2023 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

If "No" is selected, *the patient is not considered denominator eligible. The patient will be "skipped" and another patient must be submitted in their place, if available.*

NOTE:

- ***PHQ-9 or PHQ-9M administration*** *does not require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk)*
- ***Index event date*** *is the date in which the first instance of elevated PHQ-9 or PHQ-9M greater than 9 AND diagnosis of depression or dysthymia occurs during the denominator identification period (11/1/2021 to 10/31/2022). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).*
- ***Measure Assessment Period-*** *the index event date marks the start of the measurement assessment period for each patient which is 14 months (12 months +/- 60 days) in length to allow for a follow-up PHQ-9 or PHQ-9M between 10 and 14 months following the index event. This assessment period is fixed and does not start over with a higher PHQ-9 or PHQ-9M that may occur after the index date.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient had a PHQ-9 or PHQ-9M score greater than 9 between 11/1/2021 and 10/31/2022
  - If the patient did have a PHQ-9 or PHQ-9M greater than 9 during the denominator identification period select "Yes"

    IF YES

    - Record the date of the index PHQ-9 or PHQ-9M score greater than 9 in **MM/DD/YYYY** format. This is the patient's index date.

    AND

    - Enter the score of the PHQ-9 or PHQ-9M associated with the Index Date

  OR

  - If the patient did not have a PHQ-9 or PHQ-9M greater than 9 during the denominator identification period select "No"

Denominator codes can be found in the 2023 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

If "No" is selected, *the patient is not considered denominator eligible. The patient will be "skipped" and another patient must be submitted in their place, if available.*

NOTE:

- ***Enter the first instance of PHQ-9 or PHQ-9M greater than 9*** *that is also associated with a diagnosis of major depression or dysthymia during the time period of 11/1/2021 and /10/31/2022. This is the Index Event Date for this patient and marks the start of the 14 month assessment period (12 months +/- 60 days)*
- ***All nine questions*** *must be answered to have a valid summary score. If a patient chooses more than one response for a single question, select the "worse" response (higher number) to calculate the summary score*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period (12 months +/- 60 days from the Index Event Date). Within the +/- 60 day window (120 days total), the most recent PHQ-9 or PHQ-9M is used to determine remission.
    - If the patient did have one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period, select "Yes"

    OR

    - If the patient did not have one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period, select "No"

Numerator codes can be found in the 2023 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***The only tools appropriate*** *for indicating remission is a completed PHQ-9 or PHQ-9M*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient achieved remission with a follow-up PHQ-9 or PHQ-9M performed and a score less than 5 at 12 months (+/- 60 days) of the initial (index event date) PHQ-9 or PHQ-9M score greater than 9
  - If the patient did have a PHQ-9 or PHQ-9M less than 5 select "Yes"

    IF YES

    - Record the date of the PHQ-9 or PHQ-9M score less than 5 in **MM/DD/YYYY** format. This is the patient's Remission Date.
    - If the patient had more than one PHQ-9 or PHQ-9M administered during the +/- 60 day window (120 days total), enter the date of the most recent PHQ-9 or PHQ-9M

    AND

    - Enter the score of the PHQ-9 or PHQ-9M associated with the Remission Date

  OR

  - If the patient did not have a PHQ-9 or PHQ-9M less than 5 select "No"

Numerator codes can be found in the 2023 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***If more than one PHQ-9 or PHQ-9M score was obtained*** *between the 10 and 14 month window, select the most recent PHQ-9 or PHQ-9M date and score within that window*
- ***Scores obtained prior to or after*** *this period are not counted as numerator compliant (remission)*
- ***Patient remission****, a follow-up PHQ-9 or PHQ-9M result less than 5, may be determined during a telehealth encounter*
- ***PHQ-9 or PHQ-9M administration*** *does not require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk)*

DOCUMENTATION REQUIREMENTS

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

Claims data cannot be used to confirm a diagnosis (DM, HTN etc.,) used for sampling purposes as claims are the original source of the diagnosis sampling. Claims data can be used to prepare the CMS Web Interface Excel, but supporting medical record documentation will be required to substantiate what is submitted in the event of an audit.

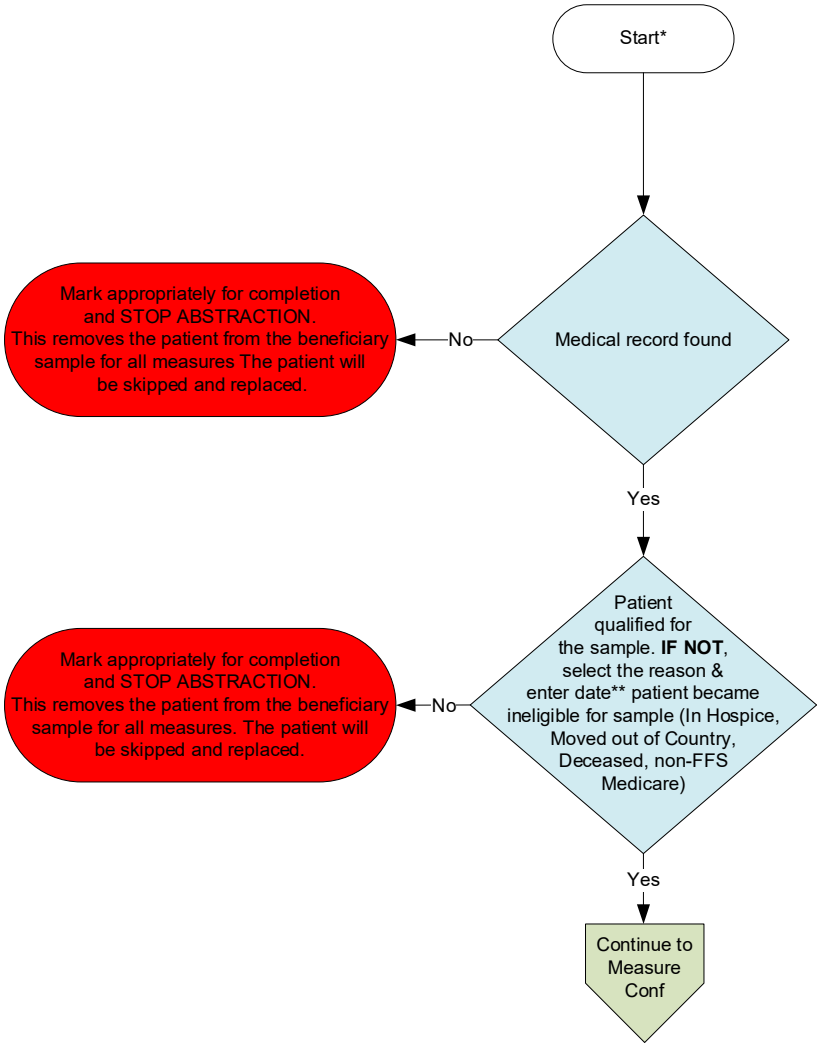
Appendix I: Performance Calculation Flow

***Disclaimer**: Refer to the measure submission document for specific coding and instructions to submit this measure.*

Patient Confirmation Flow

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 "Non-FFS Medicare", will only need to be done **once** per patient.

***Two rates will be reported** – Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.*

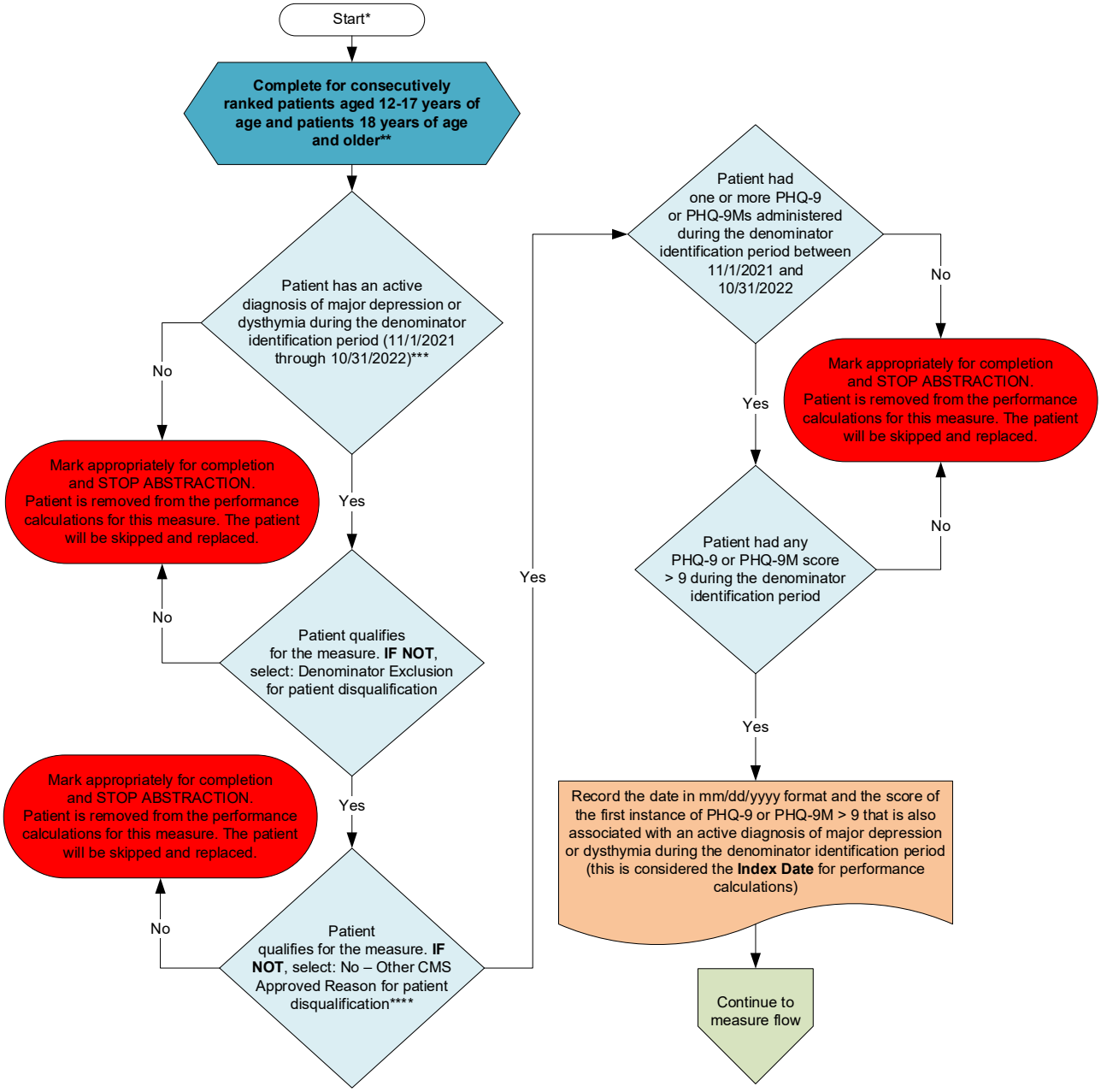


*See the posted measure submission document for specific coding and instructions to submit this measure
**If date is unknown, enter 12/31/2023

Measure Confirmation Flow for MH-1

Measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" should be evaluated for each measure where the patient appears.

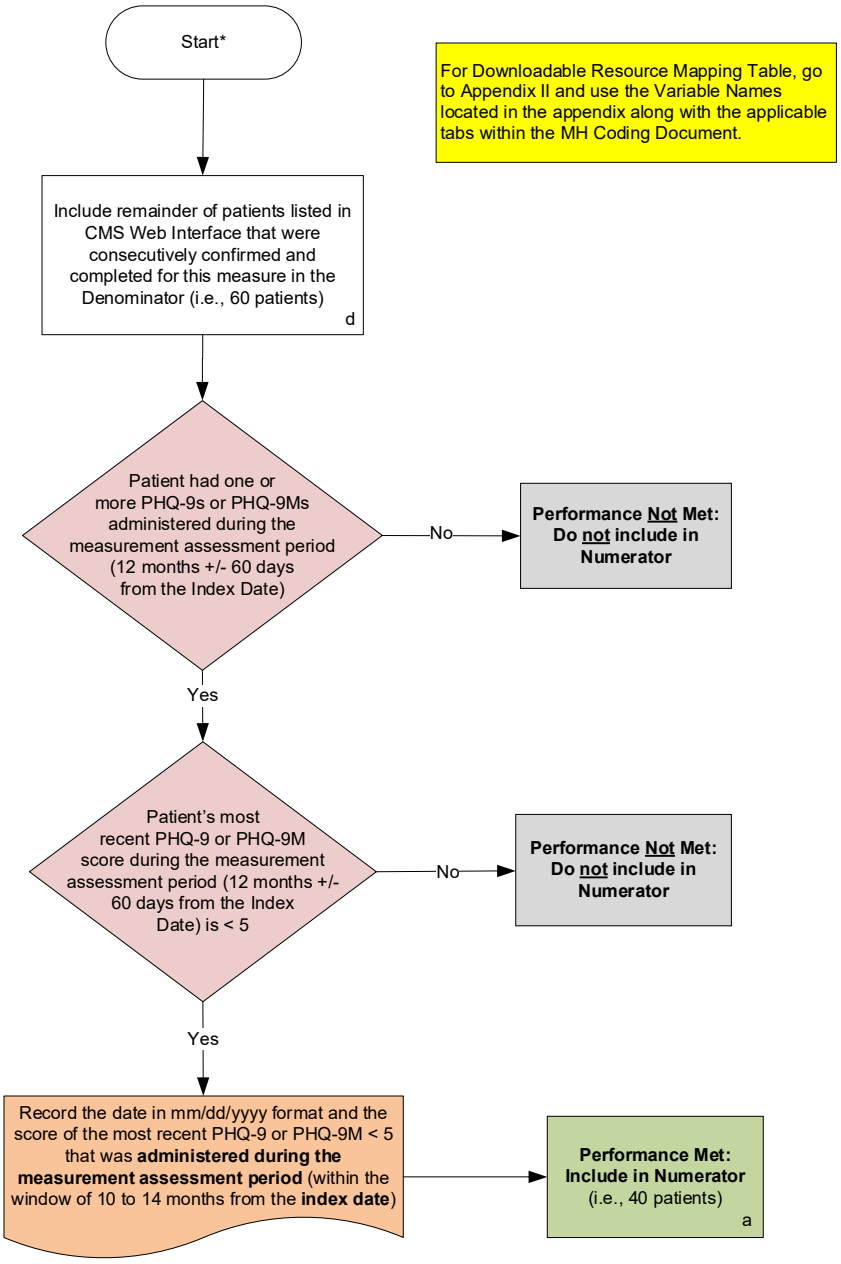
Two rates will be reported – *Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.*



*See the posted measure submission document for specific coding and instructions 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 MH-1 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 the CMS Web Interface updated the resolution of the skip request to be "Approved".

Measure Flow for MH-1

Two rates will be reported *– Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.*



SAMPLE CALCULATION:

Performance Rate=
Performance Met (a=40 patients) = 40 patients = **66.67%**
Denominator (d=60 patients) = 60 patients

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE

*See the posted measure submission document for specific coding and instructions to submit this measure

Patient Confirmation Flow

NOTE: Two rates will be reported – Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.

For 2023, 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 "Non-FFS Medicare", 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 12/31/2023) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. 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 MH-1.

Measure Confirmation Flow for MH-1

NOTE: Two rates will be reported – Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.

For 2023, 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 MH-1. Complete for consecutively ranked patients aged 12 to 17 years of age and patients 18 years of age and older. 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 MH-1 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient has an active diagnosis of major depression or dysthymia during the denominator identification period (11/1/2021 through 10/31/2022).

    a. If no, the patient does not have an active diagnosis of major depression or dysthymia during the denominator identification period, 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 have an active diagnosis of major depression or dysthymia during the denominator identification period, continue processing.

3. 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.

4. 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 the CMS Web Interface updated the resolution of the skip request to be "Approved". Stop processing.

    b. If yes, the patient does qualify for the measure, continue processing.

5. Check to determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the denominator identification period between 11/1/2021 and 10/31/2022.

    a. If no, the patient did not have one or more PHQ-9s or PHQ-9Ms administered during the denominator identification period, 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 did have one or more PHQ-9s or PHQ-9Ms administered during the denominator identification period, continue processing.

6. Check to determine if the patient had any PHQ-9 or PHQ-9M score greater than 9 during the denominator identification period.

   a. If no, the patient does not have a PHQ-9 or PHQ-9M score greater than 9 during the denominator identification period, 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 have a PHQ-9 or PHQ-9M score greater than 9 during the denominator identification period, record the date in mm/dd/yyyy format and the score of the first instance of PHQ-9 or PHQ-9M greater than 9 that is also associated with an active diagnosis of major depression or dysthymia during the denominator identification period (this is considered the **index date** for performance calculations). Continue to the MH-1 measure flow.

Measure Flow for MH-1

NOTE: Two rates will be reported – Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.

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 MH Coding Document.

1. Start processing 2023 MH-1 Flow for the patients that qualified for the sample in the Patient Confirmation Flow and the Measure Confirmation Flow for MH-1. **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. 60 patients).

2. Check to determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the measurement assessment period (12 months plus or minus 60 days from the index event date).

    a. If no, patient did not have one or more PHQ-9s or PHQ-9Ms administered during the measurement assessment period, performance is not met and the patient will not be included in the numerator. Stop processing.

    b. If yes, the patient did have one or more PHQ-9s or PHQ-9Ms administered during the measurement assessment period, continue processing.

3. Check to determine if the patient's most recent PHQ-9 or PHQ-9M score during the measurement assessment period (12 months plus or minus 60 days from the index event date) is less than 5.

    a. If no, patient's most recent PHQ-9 or PHQ-9M score during the measurement assessment period (12 months plus or minus 60 days from the index event date) is not less than 5, performance is not met and the patient should not be included in the numerator. Stop processing.

    b. If yes, patient's most recent PHQ-9 or PHQ-9M score during the measurement assessment period (12 months plus or minus 60 days from the index event date) is less than 5, enter the date in mm/dd/yyyy format and the score of the most recent PHQ-9 or PHQ-9M less than 5 that was administered during the measurement assessment period (within the window of 10 to 14 months from the **index date**). 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' category (numerator, i.e. 40 patients). Stop processing.

Sample Calculation:

Performance Rate equals Performance Met (a equals 40 patients) divided by Denominator (d equals 60 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE.

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 2023 CMS Web Interface MH Coding Document.

***MH-1: Depression Remission at Twelve Months**

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator/Denominator Codes	Depression or Dysthymia Diagnosis	MAJOR_DEPRESSION_CODE	I10 SNM
		DYSTHYMIA_CODE	I10 SNM
	Index PHQ-9 or PHQ-9M	PHQ9_TOOL_CODE OR PHQ9M_TOOL_CODE	LN OR LN
	PHQ-9 or PHQ-9M Greater Than 9	PHQ9_TOOL_CODE OR PHQ9M_TOOL_CODE	LN OR LN WITH score greater than 9
Denominator Exclusion/Denominator Exclusion Codes	Exclusion	BIPOLAR_DIS_CODE	I9 I10 SNM
		CARE_SERVICES_LT_RES_CODE	C4 [POS Exc (Place of Service Code = 12, home) = Y] SNM
		PERS_DIS_EMO_LABILE_CODE	I9 I10 SNM
		PERVASIVE_DEV_DIS_CODE	I9 I10 SNM
		SCHIZO_PSYCH_DIS_CODE	I9 I10 SNM
Numerator/Numerator Codes	Assessment PHQ-9 or PHQ-9M	PHQ9_TOOL_CODE OR PHQ9M_TOOL_CODE	LN OR LN
	PHQ-9 or PHQ-9M Less Than 5	PHQ9_TOOL_CODE OR PHQ9M_TOOL_CODE	LN OR LN WITH score less than 5

**For EHR mapping, the coding within MH-1 is considered to be all-inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

Adults:
Depression is a common and treatable mental disorder. 8.1% of American adults age 20 and over had depression in a given 2 week period. Women (10.4%) were almost twice as likely as were men (5.5%) to have had depression. The prevalence of depression among adults decreased as family income levels increased. About 80% of adults with depression reported at least some difficulty with work, home, or social activities because of their depression symptoms. (Centers for Disease Control and Prevention, 2018).

Depression is a risk factor for development of chronic illnesses such as diabetes and coronary heart disease and adversely affects the course, complications and management of chronic medical illness. Both maladaptive health risk behaviors and psychobiological factors associated with depression may explain depression's negative effect on outcomes of chronic illness (Katon, W.J., 2011).

Adolescents and Adults:
The Centers for Disease Control and Prevention states that during 2009-2012 an estimated 7.6% of the U.S. population aged 12 and over had depression, including 3% of Americans with severe depressive symptoms. Almost 43% of persons with severe depressive symptoms reported serious difficulties in work, home and social activities, yet only 35% reported having contact with a mental health professional in the past year.

Depression is associated with higher mortality rates in all age groups. People who are depressed are 30 times more likely to take their own lives than people who are not depressed and five times more likely to abuse drugs. Depression is the leading cause of medical disability for people aged 14 - 44. Depressed people lose 5.6 hours of productive work every week when they are depressed, fifty percent of which is due to absenteeism and short-term disability.

Adolescents:
In 2014, an estimated 2.8 million adolescents age 12 to 17 in the United States had at least one major depressive episode (MDE) in the past year. This represented 11.4% of the U.S. population. The same survey found that only 41.2 percent of those who had a MDE received treatment in the past year. The 2013 Youth Risk Behavior Survey of students grades 9 to 12 indicated that during the past 12 months 39.1% of female (F) and 20.8% of male (M) students indicated feeling sad or hopeless almost every day for at least 2 weeks, planned suicide attempt 16.9% (F) and 10.3% (M), with attempted suicide 10.6% (F) and 5.4% (M). Adolescent-onset depression is associated with chronic depression in adulthood. Many mental health conditions (anxiety, bipolar, depression, eating disorders, and substance abuse) are evident by age 14. The 12-month prevalence of MDEs increased from 8.7% in 2005 to 11.3% in 2014 in adolescents and from 8.8% to 9.6% in young adults (both $P < .001$). The increase was larger and statistically significant only in the age range of 12 to 20 years. The trends remained significant after adjustment for substance use disorders and sociodemographic factors. Mental health care contacts overall did not change over time; however, the use of specialty mental health providers increased in adolescents and young adults, and the use of prescription medications and inpatient hospitalizations increased in adolescents. In 2015, 9.7% of adolescents in Minnesota (MN) who were screened for depression or other mental health conditions, screened positively.

CLINICAL RECOMMENDATION STATEMENTS:

Adults:
Recommendations and algorithm notations supporting depression outcomes and duration of treatment according to Institute for Clinical Systems Improvement Health Care Guideline (Trangle et al., 2016):

Recommendation: Clinicians should establish and maintain follow-up with patients. Appropriate, reliable follow-up is

highly correlated with improved response and remission scores. It is also correlated with the improved safety and efficacy of medications and helps prevent relapse (Trangle et al., 2016).

Proactive follow-up contacts (in person, telephone) based on the collaborative care model have been shown to significantly lower depression severity (Unutzer, 2002). In the available clinical effectiveness trials conducted in real clinical practice settings, even the addition of a care manager leads to modest remission rates (Trivedi, 2006; Unutzer, 2002). Interventions are critical to educating the patient regarding the importance of preventing relapse, safety and efficacy of medications, and management of potential side effects. Establish and maintain initial follow-up contact intervals (office, phone, other) (Hunkeler, 2000; Simon, 2000).

PHQ-9 as monitor and management tool. The PHQ-9 is an effective management tool, as well, and should be used routinely for subsequent visits to monitor treatment outcomes and severity. It can also help the clinician decide if/how to modify the treatment plan (Duffy, 2008; Lowe, 2004). Using a measurement-based approach to depression care, PHQ-9 results and side effect evaluation should be combined with treatment algorithms to drive patients toward remission. A five-point drop in PHQ-9 score is considered the minimal clinically significant difference (Trivedi, 2009).

The goals of treatment should be to achieve remission, reduce relapse and recurrence, and return to previous level of occupational and psychosocial function.

If using a PHQ-9 tool, remission translates to PHQ-9 score of less than 5 (Kroenke, 2001). Results from the STAR*D study showed that remission rates lowered with more treatment steps, but the overall cumulative rate was 67% (Rush, 2006).

Response and remission take time. In the STAR*D study, longer times than expected were needed to reach response or remission. In fact, one-third of those who ultimately responded did so after six weeks. Of those who achieved remission by Quick Inventory of Depressive Symptomatology (QIDS), 50% did so only at or after six weeks of treatment (Trivedi, 2006). If the primary care clinician is seeing some improvement, continue working with that patient to augment or increase dosage to reach remission. This can take up to three months.

This measure assesses achievement of remission, which is a desired outcome of effective depression treatment and monitoring.

Adult Depression in Primary Care - Guideline Aims (Trangle et al., 2016):
- Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder.
- Increase the percentage of patients with major depression or persistent depressive disorder who have follow-up to assess for outcomes from treatment.
- Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed).

Adolescents:
Recommendations supporting depression outcomes and duration of treatment according to American Academy of Child and Adolescent Psychiatry guideline (Birmaher et al., 2007):
- Treatment of depressive disorders should always include an acute and continuation phase; some children may also require maintenance treatment. The main goal of the acute phase is to achieve response and ultimately full symptomatic remission (definitions below).
- Each phase of treatment should include psychoeducation, supportive management, and family and school involvement.
- Education, support, and case management appear to be sufficient treatment for the management of depressed children and adolescents with an uncomplicated or brief depression or with mild psychosocial impairment.

- For children and adolescents who do not respond to supportive psychotherapy or who have more complicated depressions, a trial with specific types of psychotherapy and/or antidepressants is indicated.

Recommendations supporting depression outcomes and duration of treatment according to Guidelines for Adolescent Depression in Primary Care (Zuckerbrot et al., 2018 (Part I), Zuckerbrot et al., 2018 (Part II)):
- Mild depression: consider a period of active support and monitoring before starting other evidence based treatment
- Moderate or severe major clinical depression or complicating factors:
  -- consultation with mental health specialist with agreed upon roles
  -- evidence based treatment (cognitive behavioral therapy (CBT) or interpersonal psychotherapy (IPT) and/or antidepressant selective serotonin reuptake inhibitor (SSRI))
- Monitor for adverse effects during antidepressant therapy
  -- clinical worsening, suicidality, unusual changes in behavior
- Systematic and regular tracking of goals and outcomes
  -- improvement in functioning status and resolution of depressive symptoms

Regardless of the length of treatment, all patients should be monitored on a monthly basis for 6 to 12 months after the full resolution of symptoms

Appendix IV: Use Notices, Copyrights, and Disclaimers