eCW Clinical Documentation Guide

Measure Name	**Depression Remission at Twelve Months**
Relevance	NPO Population Clinical Quality Dashboard [*NQF 0710: Behavioral Measure]* ACO Quality Measure #40 *[GPRO: "At Risk" Measure]* MIPS Clinical Quality Measure *[CMS 159 (EHR): Outcome Measure]*
Measure Definition	***The percentage of patients, 18 years of age and older, with a diagnosis (new or existing) of Major Depression or Dysthymia and an initial PHQ-9 score > 9, who demonstrate remission at 12 months, as defined by a PHQ-9 score < 5***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Index Date	The **Index Date** is defined as the date of the first PHQ-9 score > 9 occurring between 13 months (December 1) and 1 month (November 30) prior to the start of the Measurement Period
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 years of age at the beginning of the Measurement Period II. **AND**, Have been seen for an applicable visit encounter during, or within the 12 months prior to, the Measurement Period A. **AND**, Scored > 9 on a PHQ-9 Depression assessment administered during the above applicable encounter B. **AND**, Had an active diagnosis for Major Depression (including Remission) at the time of the above applicable encounter C. **OR**, Had an active diagnosis of Dysthymia at the time of the above applicable encounter
Numerator	The **Numerator** consists of patients, from the Denominator, who scored < 5 on a follow-up PHQ-9 Depression assessment, administered 12 months (+/- 30 days) after the Index Date *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They received palliative care services during the Measurement Period II. **OR**, They had an active diagnosis for a Personality Disorder during the Measurement Period III. **OR**, They had an active diagnosis for Bipolar Disorder during the Measurement Period IV. **OR**, They received care in a long-term residential facility during the Measurement Period
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been seen for an applicable visit encounter during, or within the 12 months prior to, the Measurement Period** **A. The following E&M codes identify applicable visit encounters:** 1. 90791 - 90792, 90832, 90834 and 90837 2. 99201 - 99205 and 99212 - 99215 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes* → *Billing*) **II. The patient must have had an active diagnosis for Major Depression or Dysthymia documented at the time of the above applicable visit** **A. The following ICD-10 codes indicates Major Depression (including Remission):** 1. F32.0 - F32.5 and F32.9 2. F33.0 - F33.3, F33.40 - F33.42 and F33.9 **B. The following ICD-10 code indicates Dysthymia: F34.1** **C. Document the appropriate diagnosis code in the Problem List of the patient's chart in eCW** *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Measure Documentation *(continued)*	1. Add a diagnosis to the patient's Problem List in one of the following ways: a. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* b. From the ICW (Right-Hand Chart Panel), click the "Overview" tab 1) Click the orange button (with three dots) in the Progress Note band 2) Click "Add" 2. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field **III. The patient must have scored > 9 on a PHQ-9 Depression assessment administered between 1 and 13 months prior to the beginning of the Measurement Period** **A. Access the PHQ-9 Depression Assessment tool as follows:** 1. From within the open Progress Note for the visit, click on the carat adjacent to the "Smart Forms" field (SF; top, left-hand corner of note) 2. Select the PHQ-9 questionnaire from the drop-down list of options 3. A new window, with the questionnaire displayed, will open **B. Document the patient's answers to <u>all</u> of the PHQ-9 questions** 1. When the answers to all questions have been recorded, a numerical score will be generated 2. Click "Save" 3. Click "OK" to close a. The PHQ-9 questions, responses and final score will import into the Progress Note b. The PHQ-9 responses and final score will alos be saved as structured data within the EMR *(continued)*

<table>
<tr><th>Measure Name</th><th>Depression Remission at Twelve Months (continued)</th></tr>
<tr><td>Measure Documentation
(continued)</td><td>
<u>To Satisfy This Measure</u>
(Numerator Documentation)

I. Recall the patient for an applicable visit encounter 12 months (+/- 30 days) after the Index Date (the date of the initial PHQ-9 > 9 Depression assessment administered during the year prior to the Measurement Period)

II. Administer a follow-up PHQ-9 Depression assessment at the above applicable encounter

A. Access the PHQ-9 Depression Assessment tool from the "Smart Forms" section of a Progress Note, as described above
B. Record the patient's answers to all PHQ-9 questions
C. Save and close the PHQ-9 Depression assessment

1. The PHQ-9 responses and final score will automatically import into the Progress Note for the visit
2. The PHQ-9 responses and final score are stored as structured data in the patient's chart in the EMR

D. A follow-up PHQ-9 score < 5 indicates Depression remission and satisfies this measure
E. Note:If more than 1 PHQ-9 Depression assessment is administered during the 11-13 month follow-up window, select the most recent PHQ-9 date and score within that window to determine if Depression remission has been achieved
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<tr><td>Exclusion and/or Exception Documentation</td><td>
<u>To Exclude a Patient From This Measure</u>
(Exclusion/Exception Documentation)

I. If applicable, document the receipt of Palliative Care services during the Measurement Period

A. Document a Palliative Care intervention as structured data

1. eCW recommends the following structured data path:

Progress Notes → Preventive Medicine → Counseling → Provider to Provider Communication → Palliative Care

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Measure Name	**Depression Remission at Twelve Months** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. The required structured data fields are outlined (boxed) in the path, above **a. Some configuration and mapping may first be required** 1) If necessary, add the "Provider to Provider Communication" item to the "Counseling" folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "Preventive Medicine" link b) Click on the "Counseling" folder c) If "Provider to Provider Communication" is not listed in the options displayed: (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Provider to Provider Communication" in the Name field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options d) Enter the following information on both sides (Community and Local): (a) Section = Preventive Medicine (b) Category =Counseling (c) Item = Provider to Provider Communication *(continued)*

Measure Name	**Depression Remission at Twelve Months** *(continued)*
Exclusion and/or Exception Documentation (continued)	(3) From the Community side, select the desired reporting field (E.g., "Palliative Care") (4) Click "Add" (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped **b. Document the Palliative Care encounter within the structured data field** **B. <u>OR</u>, Document the ICD-10 diagnosis code for a Palliative Care encounter as an Assessment in a Progress Note or Virtual Visit** **1. The following ICD-10 code identifies a Palliative Care encounter: Z51.5** 2. Record the Palliative Care diagnosis code from one of the following locations: a. *Progress Notes → Assessments* b. *Progress Notes → Assessments → Problem List*
	II. If applicable, record a diagnosis for Personality Disorder in the Problem List of the patient's chart in eCW **A. The following ICD-10 codes indicate Personality Disorder** 1. F21 2. F34.0 3. F60.0 - F60.7, F60.81, F60.89 and F60.9 4. F68.10 - F68.13 *(continued)*

Measure Name	**Depression Remission at Twelve Months** *(continued)*
	B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
Exclusion and/or Exception Documentation (continued)	**III. If applicable, record a diagnosis for Bipolar Disorder in the Problem List of the patient's chart in eCW** **A. The following ICD-10 codes indicate Bipolar Disorder** 1. F30.10 - F30.13, F30.2 - F30.4 and F30.8 - F30.9 2. F31.0, F31.10 - F31.13, F31.2, F31.30 - F31.32, F31.4 - F31.5, F31.60 - F31.64, F31.70 - F31.78, F31.81, F31.89 and F31.9 B. Add the appropriate diagnosis code to the Problem List, as detailed above C. Also, indicate the onset date of the disorder, if known, in the associated "Onset Date" field in the Problem List
	IV. If applicable, record an E&M code for care services received at a long-term residential facility in the patient's chart in eCW **A. The following E&M codes identify long-term residential facility care encounters: 99324 -99328 and 99334 - 99337** **B. Record the appropriate E&M code in the Billing section of a Progress Note or Virtual Visit** (*Progress Notes → Billing*) *(continued)*

Measure Name	**Depression Remission at Twelve Months** *(continued)*
Trouble-Shooting	**Having Problems? Check Out These Trouble-Shooting Tips** **I. Verify that ALL questions for the PHQ-9 Depression Screening Tool have been answered**
	II. Verify that the PHQ-9 Depression Screening results were documented in the Progress Notes for applicable E&M encounters
	III. Verify that the PHQ-9 Depression Screens were administered during the appropriate timeframes
	IV. Verify that any structured data fields used have been properly mapped to corresponding Community elements
	V. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Confirm diagnoses assessed by specialists, ER and hospital physicians B. Add applicable diagnoses to the patient's Problem List in your EMR C. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0710: "**Depression Remission at Twelve Months**" II. eClinicalWorks "**MIPS - CMS 159 - Depression Remission at Twelve Months**" III. **2016 GPRO Supporting Documentation**