

SPECIAL REPORT

NEW NCQA STANDARDS: AN OPPORTUNITY TO LEAD

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The National Committee on Quality Assurance (NCQA), which surveys and accredits 60% of all managed care organizations which cover 85% of all insured lives in this country, has released a new set of standards which address the coordination of medical and psychiatric care. It specifically calls on all medical and behavioral managed care plans to have mechanisms in place to maximize coordination of care between systems and to meet specific clinical standards in the care of depression. **These new standards represent an important opportunity for psychiatrists to provide expertise to managed care organizations in order to help them meet these standards.** The NCQA Standards, which follow, outline the obligation for both the managed behavioral health organization carve-out and the general medical plan to coordinate mental health care.

The NCQA Accreditation '99 plan has also increased its mission to include the incorporation of Health and Employer Data and Information Set (HEDIS) measures into the accreditation process. HEDIS measures include clinical outcomes, process outcomes, and patient satisfaction outcomes. In 1999, HEDIS will introduce the first indicator specifically relevant to outpatient mental health practice that will focus on the clinical management of antidepressant treatment. The measure will be used in both medical and mental health settings. The indicator aims to measure the adequacy of clinical management of patients who are diagnosed with major depression and who are receiving treatment with an antidepressant. This indicator establishes its rationale through use of the AHCPR Clinical Guideline on Depression in the Primary Care Setting. 1999 will mark the first year where obtaining accreditation status will require reporting and auditing of HEDIS measures.

Action Steps

Concretely, these new standards present an opportunity to develop relationships with medical colleagues and administrators to help to assist them meet these standards.

- Psychiatrists can become involved with medical groups to discuss: (1) existing mechanisms for referral, (2) development of integration strategies, (3) their participation in the training of primary care physicians, and (4) the development and implementation of clinical algorithms.
- Managed care plans will be significantly at risk for not meeting NCQA accreditation if they cannot meet these standards. Therefore, appropriate financial remuneration should be addressed in any of these discussions.
- Many plans will call upon social workers, case managers and psychologists to meet these needs.
- C-L Psychiatrists are ideally positioned to drive this process.

This is a clear opportunity for us to present ourselves as the experts in this area. All managed care plans being accredited starting in July 1999 will be required to meet these standards or risk their accreditation standing. Begin working within your practice setting. Contact Carol Alter, MD for more information (carol.alter@bms.com).

Quality Management and Improvement
Effective April 1, 1997 through March 31, 1998

SOURCE: NCQA ACCREDITATION '97

QI 6 Continuity and Coordination of Care*

The organization ensures that the behavioral healthcare services provided to its covered population are coordinated and integrated with general medical care. To this end, the organization:

QI 6.1 Exchanges information in an effective, timely, and confidential manner throughout its continuum of care, including medical, inpatient, partial, outpatient, and community settings.

QI 6.2 Has mechanisms to inform primary care physicians about the diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.

QI 6.3 Reviews medical and behavioral healthcare pharmacy benefits and formularies.

QI 6.4 Collaborates with medical practitioners to increase appropriate use (and reduce inappropriate use) of psychopharmacological medications and reduce the incidence of adverse drug reactions.

QI 6.5 Verifies that individuals with behavioral health disorders receive timely access and follow up to medically necessary treatments, support services, and assessments.

QI 6.6 Verifies that individuals with coexisting medical and behavioral health problems receive timely, appropriate treatment and follow up.

QI 6.7 Evaluates the continuity and coordination of care, including patient-approved communications between behavioral healthcare providers and primary care physicians.

Rationale

Behavioral health care services must be carefully coordinated and integrated with general medical care. Whenever possible, organizational providers should collaborate with relevant medical delivery systems and other health care practitioners to ensure that patients receive thoughtful, continuous, and appropriate care. Many psychiatric problems present as medical illnesses, and, conversely, many medical or surgical problems present with psychiatric symptoms. The organization must demonstrate the ability to assess, treat, and follow up with individuals as they use multiple providers, service sites, and levels of care, both within and outside of the organization. For example, individuals who have been hospitalized for major depression should receive timely and appropriate follow up with a psychiatrist for medication evaluation and management and assessment of comorbidity, as appropriate. Appropriate information sharing and careful monitoring of medication usage is especially important when individuals use medical and behavioral healthcare systems simultaneously.

**For the first two years of the Behavioral Health Accreditation Program (until April 1, 1999), the level of accountability for this standard will be limited to its structural components. At minimum, the organization should have the mechanisms in place to accomplish these activities.*

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Quality Management and Improvement
Effective July 1,1999

SOURCE: NCOA ACCREDITATION '99

QI 9 Continuity and Coordination of Care

The managed care organization ensures the continuity and coordination of care that members receive.

- QI 9.1 The managed care organization monitors the continuity and coordination of care that members receive across practices and provider sites, including at a minimum primary care practice sites with 50 or more members.
- QI 9.2 The managed care organization ensures continuity and coordination of general medical care with behavioral health care. To this end, the organization collaborates with its behavioral health specialists to:
 - QI 9.2.1 Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners and behavioral health practitioners and providers.
 - QI 9.2.2 Promote the appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care.
 - QI 9.2.3 Evaluate the use of psychopharmacological medication, to increase appropriate use (and decrease inappropriate use) and reduce the incidence of adverse drug reactions.
 - QI 9.2.4 Coordinate timely access for appropriate treatment and follow-up for individuals with coexisting medical and behavioral disorders.
- QI 9.3 The managed care organization collects and analyzes data to evaluate continuity and coordination of care.
 - QI 9.3.1 The managed care organization analyzes data to identify any opportunities for improvement.
 - QI 9.3.2 The managed care organization collaborates with its behavioral health specialists to identify an opportunity to improve coordination of behavioral health with general medical care.
- QI 9.4 The managed care organization implements interventions to improve continuity and coordination of care.
 - QI 9.4.1 The managed care organization implements interventions when it identifies an opportunity for improvement.
 - QI 9.4.2 The managed care organization collaborates with its behavioral health specialists to take action to improve coordination of behavioral health with general medical care.

Rationale

This 1999 standard incorporates previous requirements for continuity and coordination of general medical care. This entails monitoring the activity, analyzing the data to identify any opportunities for improvement, and taking action toward improvement, if indicated.

In addition, this 1999 standard outlines explicit points for coordination of behavioral health care with medical care, to ensure that members receive seamless, continuous and appropriate care. This strengthens industry-wide accountability by creating an MCO standard that corresponds to the 1997 and 1998 standard (QI 6) in NCQA's accreditation program for managed behavioral healthcare organizations (MBHOs).

Behavioral disorders can have a medical basis or implications for the individual's physical health. Conversely, a patient with medical/surgical condition may have a behavioral complication or comorbidity. The clinical literature includes numerous studies that document the quality problems occurring nationwide resulting from the fragmentation of behavioral health and medical care. Common findings include:

- under-detection and under-diagnosis of mental health and substance abuse (MH/SA) disorders in the primary care setting;
- a high incidence of MH/SA complications with certain inpatient diagnoses (e.g., acute cardiac conditions); and
- the overuse and inappropriate use of psycho-pharmaceuticals.

These findings point to the importance of managed care entities demonstrating performance levels and improvements in the continuity and coordination of behavioral health care with general medical care provided by PCPs. This includes appropriate information sharing and careful monitoring of medication usage, which are critical when individuals use medical and behavioral health care systems simultaneously.

NCQA utilized a behavioral health stakeholder task force to assist in developing the MBHO accreditation standards over the last few years. This group particularly emphasized coordination of behavioral health with general medical care, and a closely related issue, prevention and early detection and intervention for MH/SA disorders. The importance of these issues was echoed in the more than 200 responses received during the public comment period on the draft MBHO standards. Addition of this requirement of the MCO accreditation standards creates equal accountability for coordination of behavioral health with general medical care, and facilitates industry progress toward population-based managed behavioral health care.

Note: QI activities or studies that include MCO/MBHO collaboration on clinical issues (preventive or non-preventive) could potentially satisfy this standard's requirements. Moreover, if this QI activity also meets the requirements of QI 10, QI 11, or QI 12, NCQA would count it under those standards as well.

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Summary of Changes to HEDIS 1999

SOURCE: HEDIS 1999, Volume 2

ANTIDEPRESSANT MEDICATION MANAGEMENT

Description

The following three components of this measure assess different facets of the successful pharmacological management of depression:

1. **Optimal Practitioner Contacts for Medication Management.** The percentage of Medicaid, commercial, and Medicare members age 18 years and older as of the 120th day of the reporting year who were diagnosed with a new episode of depression, treated with antidepressant medication, and who had at least three follow up contacts with a primary care practitioner of mental health practitioner during the 84-day (12-week) Acute Treatment Phase. At least one of the three follow up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant, or other practitioner with prescribing privileges). This process measure assesses the adequacy of clinical management of new treatment episodes for adult members with a major depressive disorder.
2. **Effective Acute Phase Treatment.** The percentage of Medicaid, commercial, and Medicare members age 18 years and older as of the 120th day of the reporting year, who were diagnosed with a new episode of depression, treated with antidepressant medication, and who remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase. This intermediate outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

3. **Effective Continuation Phase Treatment.** The percentage of Medicaid, commercial, and Medicare members age 18 years and older as of the 120th day of the reporting year, who were diagnosed with a new episode of depression, treated with antidepressant medication, and who remained on an antidepressant drug for at least 180 days (6 months). This intermediate outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen by determining whether adult members completed a period of Continuation Phase Treatment adequate for defining a *recovery* according to AHCPR *Depression in Primary Care* (Source: *Depression in Primary Care, Volume 2. Treatment of Major Depression. Clinical Practice Guideline, Number 5.* Rockville, MD. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 93-0551. April 1993).

Primary Care and Behavioral Health Care Practitioners Defined

For purposes of this measure, appropriate primary care practitioners and behavioral health care practitioners are responsible for medical management. Primary care practitioners may include general or family practice physicians, geriatricians, internal medical physicians, pediatricians, obstetricians and gynecologists, physician assistants, or any other practitioner whom the health plan considers a primary care practitioner.

Behavioral health care practitioners are practitioners whom members are able to see for mental health services. Behavioral health practitioners meet any of the following six criteria:

- A doctor of medicine (MD) or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry or, if not certified, has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by state of practice.
- An individual who is licensed as a psychologist in his/her state of practice.
- An individual who is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work or is listed on the National Association of Social Worker's Clinical Register or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse, if required by state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or certified to do so by the state of practice or, if licensure or certification is not required by the state of practice, is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and is licensed or certified to do so by the state of practice or, of licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board of Certified Counselors (NBCC).

A Glossary of Terms:

Intake Period. The 12-month time "window" starting on the 121st day of the year prior to the reporting year and ending on the 120th day of the reporting year and used to capture potential new episodes of treatment. This measure assesses continuous treatment for up to a 231-day period following the start of medication (Index Prescription Date). To assure adequate opportunities for capturing prescription treatment data, the Intake Period for identifying new episodes must, by definition, end 245 days prior to the end of the HEDIS reporting period (i.e., 245 days equals 180 treatment days + 51 potential gap days + 14 days on or after the initial diagnostic visit for obtaining prescriptions). For the 1998 reporting year, the intake period is May 1, 1997 through April 30, 1998.

Index Episode Start Date. The earliest encounter during the Intake Period with a qualifying diagnosis of major depression.

Index Prescription Date. The earliest prescription for antidepressants filled within a 44-day period defined as 30 days prior to, and 14 days on or after, the Index Episode Start Date.

Negative Diagnosis History. A period of 120 days (4 months) on or before the Index Episode Start Date, during which time the member had no claims/encounters containing either a principal or secondary diagnosis of depression (refer to Table 2).

Negative Medication History. A period of 90 days (3 months) prior to the Index Prescription Date, during which time the member had no pharmacy claims for either new or refill prescriptions for a listed antidepressant drug (refer to the NDC listing at the end of this measure specification).

New Episode. To qualify as a *New Episode*, two criteria must be met: (1) a 120-day (4-month) “negative diagnosis history” on or before the Index Episode Start Date, and (2) a 90-day (3-month) “negative medication history” on or before the Index Prescription Date.

Administrative Date Specification

1. Optimal Practitioner Contacts for Medication Management

Calculation: This specification uses membership, claims/encounter and pharmacy data to identify members 18 years and older as of the 120th day of the reporting year who had a pharmacy benefit, who were diagnosed with a new episode of major depressive disorder, and who were initiated on a trial or antidepressant medication. For these health plan members, *Optimal Practitioner Contacts for Medication Management* is defined as the percentage who received at least 3 follow up outpatient visits (primary or behavioral specialty care, one of which is with a prescribing practitioner) during the 84-day (12 week) Acute Treatment Phase.

Denominator

Population(s): Medicaid, commercial, and Medicare (report each population separately)

Age(s): 18 years and older as of the 120th day of the reporting year.

Continuous Enrollment: The 12-month period encompassing the new episode of medication therapy (i.e., 120 days on or before the Index Episode Start Date). Enrollees may have one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one month gap in coverage (i.e., a member whose coverage lapses for two months (60 days) is not considered continuously enrolled).

Requirement:

- Health plan pharmacy and mental health benefits
- Diagnosed with a new episode of major depressive disorder during the Intake Period (i.e., during the 12 months ending the 120th day of the reporting year). Refer to the ICD-9-CM codes in Table 1
- Treated with antidepressant medication

Table 1. The following ICD-9-CM codes are used to identify members with an episode of major depression:

296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
298.0	Depressive type psychosis
300.4	Dysthymic disorder
309.1	Prolonged depressive reaction
311	Depressive disorder, not elsewhere classified

Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate depression diagnosis (e.g., 296.4 - 296.9, 309.0, and 309.28) are not included in this list because these codes are less specific in identifying eligible members.

Table 2. Use the following ICD-9-CM diagnoses codes to identify and exclude members having prior depressive Episodes:

296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
296.4	Bipolar affective disorder, manic
296.5	Bipolar affective disorder, depressed
296.6	Bipolar affective disorder, mixed
296.7	Bipolar affective disorder, unspecified
296.8	Manic-depressive psychosis, other and unspecified
296.9	Other and unspecified affective psychosis
298.0	Depressive-type psychosis
300.4	Dysthymic disorder
309.0	Brief depressive reaction
309.1	Prolonged depressive reaction
309.28	Adjustment reaction with mixed emotional features
311	Depressive disorder, not elsewhere classified

Plans should follow the 6 steps below to identify the denominator (eligible) population. This denominator is used to calculate all three rates for this measure.

1. Identify all members with a diagnosis of depression who, during the 12-month Intake Period, had either:

At least one principal diagnosis of major depression (Table 1) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations)

OR

At least two secondary diagnoses of major depression (Table 1) in any outpatient setting (e.g., outpatient or emergency room visits)

OR

At least one secondary diagnosis of major depression (Table 1) associated with any inpatient discharge.

2. Determine the Index Episode Start Date and test for Negative Diagnosis History

- For each member identified in Step 1, determine the Index Episode Start Date by identifying the date of the member's earliest encounter during the Intake Period (i.e., outpatient or emergency room visit date; inpatient discharge date, partial hospitalization visit date) with a qualifying depression diagnosis (Table 1).

- Identify those member who are diagnosed with a new episode of depression. Members considered to have a new episode of depression are those who have a "negative diagnosis history." The range of ICD-9-CM diagnosis codes in Table 2 is more comprehensive to exclude members diagnosed with any type of depression. Members identified as having a negative diagnosis history (i.e., any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date) should be dropped from the denominator.

3. Identify members receiving antidepressant medication therapy. Among members identified in step 2, identify those who filled a prescription for an antidepressant medication with 30 days before or 14 days on or after the Index Episode Start Date. Refer to the list of NDC codes for antidepressant medication at the end of this measure's specification.

4. Calculate Continuous Enrollment. Members must be continuously enrolled in the health plan for 120 days prior the Index Episode Start Date and 245 days (180 medication days plus 51 potential gap days plus 14 days for filling the prescription) after the Index Episode Start Date. Members who have had no more than one gap in enrollment of up to 45 days during the continuous enrollment period should be included. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one month gap in coverage (i.e., a member whose coverage lapses for two months (60 days) is not continuously enrolled).

AND

Members must have a pharmacy and mental health benefit during the continuous enrollment period.

5. Identify the Index Prescription Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for members having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for member delay in filling the initial prescription.
6. From the resulting members from step 5, confirm the new episode by testing for a Negative Medication History. Exclude members who have evidence of antidepressant prescriptions filled during the Negative Medication History Period. They do not represent new treatment episodes.

Numerator 1

Requirement: Three (or more) outpatient follow up visits with a primary care or mental health practitioner (at least one of which is a prescribing practitioner) within 84 days (i.e., within the 12-week acute treatment phase) after a new diagnosis of major depression.

Numerator 1 Instructions

1. Identify all members in the denominator population who had three (3) or more follow up office visits with *either* a primary care practitioner or a mental health practitioner (refer to the definitions of primary care and mental

health practitioners) within 84-days (12 weeks) after their Index Episode Start Date. Do not count the Index Episode Start Date visit.

2. Exclude from the measure (denominator) members who have an acute inpatient or partial hospitalization (day/night care) treatment during the 84-day follow up period.
3. Do not count emergency room visits toward the numerator.
4. Office visits coded with one of the CPT Evaluation and Management codes listed in Table 3 count toward the numerator, *provided* that the practitioner rendering the follow up care practices as either a primary care or mental health practitioner.
5. Plans must verify that at least one of the three follow up visits was rendered by a prescribing practitioner. Members who have not received a follow up visit within the 12-week Acute Phase Follow-up period with a prescribing practitioner should not be counted in the numerator for rate 1.

Table 3. CPT Evaluation and Management Codes for office visits related to Acute Phase Follow Up

99201-99205	90801
99211-99215	90841-90845
99241-99245	90847
99381-99387	90849
99391-99397	90853
99401-99404	90862

2. Effective Acute Phase Treatment

Calculation: The denominator for this measure is the same denominator calculated for Measure 1. The denominator for this measure consists of members 18 years or older with health plan pharmacy and mental health benefits, having a new episode of a major depressive disorder, who were treated with an antidepressant medication, and who were members of the health plan for a 12-month period of time encompassing the new episode of medication therapy (i.e., 120 days prior to the start of a new episode plus 180 treatment days plus up to 51 gap days following the start of a new episode plus 14 days to fill a prescription). New episodes are defined as in Measure 1 above.

Denominator: The denominator for all three rates is the same.

Numerator 2

Requirement: An 84-day (12 week acute treatment phase) treatment of antidepressant medication.

Numerator 2 Instructions

1. Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 84 days.
2. Continuous treatment is defined to allow gaps in medication treatment up to a total of 30 days during the 84-day period (i.e., Acute Treatment Phase). Allowable medication changes or gaps include:
 - “Washout” period gap to change medication
 - “Treatment” gaps to refill the same medicationRegardless of the number of gaps, the total number of gap days may be no more than 30 days. Plans may count any combination of gaps (e.g., two washout gaps, each 15 days or two washout gaps of 10 days each and one treatment gap of 10 days). The total number of gap days may not exceed 30 days.
3. To determine continuity of treatment during the 84-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days and a maximum 30 gap days). Plans should begin to count treatment days from the Index Prescription Date and continue to count until a total of 84 treatment days have been established. Members whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are counted as a zero (0) in the numerator.
4. To identify appropriate prescriptions, access NCQA/s web site at www.ncqa.org or call the HEDIS Technical Support line at 202/955-1737 for a NDC list of antidepressant medications.

3. Effective Continuation Phase Treatment

Calculation: The denominator for this measure is the same as for Measures 1 and 2. Include members 18 years or older with health plan pharmacy and mental health benefits, having a new episode of a major depressive disorder, who were treated with an antidepressant medication and who were members of the health plan for a 12-month period of time encompassing the new episode

of medication therapy (i.e., 120 days prior to the start of the new episode plus 180 treatment days plus 51 gap days following the Index Episode Start Date plus 14 days for filling prescription).

Denominator: The denominator for all three rates is the same.

Numerator 3

Requirement: A 180-day treatment of antidepressant medication.

Numerator 3 Instructions

1. Identify all members in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days.
2. Continuous treatment is defined to allow gaps in medication treatment up to a total of 51 days during the 180-day period. Allowable medication changes or gaps include:
 - “Washout” period gap to change medication
 - “Treatment” gaps to refill the same medication
 Regardless of the number of gaps, the total number of gap days may be no more than 51 days. Plans may count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days). The total number of gap days may not exceed 51 days.
3. To determine continuity of treatment during the 180-day period, sum the number of gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days and a maximum 51 gap days). Plans should begin to count treatment days from the Index Prescription Date and continue to count until a total of 180 treatment days have been established. Members whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are counted as a zero (0) in the numerator.
4. To identify appropriate prescriptions, access NCQA’s web site at www.ncqa.org or call the HEDIS Technical Support line at 202/955-1737 for a NDC list of antidepressant medications.

Note

• A claim for depression therapy that has been denied because the member does not have a mental health or pharmacy benefit (e.g., the employer contract the mental health and/or pharmacy benefit services to another vendor or the member’s mental health and/or pharmacy benefit has been used up) should be excluded from this measure. However, if the member has a mental health and/or pharmacy benefit with the plan (or if the plan contracts with the mental health and/or pharmacy benefit with a separate vendor) and the claim for depression treatment or antidepressant medication is denied (e.g., the member failed to get proper authorization), the treatment should be included in the denominator of this measure. Similarly, if the member has a mental health benefit and the claim for any of the follow up visits are denied, the member’s treatment for depression should be included in the denominator of this measure. Members must, however, meet all other eligibility requirements for inclusion in the measure.

Data Elements for Reporting

Plans that anticipate being audited or publicly reporting HEDIS data should be prepared to provide the following data elements

Data Elements*	Administrative	Hybrid	Survey
Antidepressant Medication Management			
Population (Medicaid, commercial, Medicare)	x		
Eligible member population (i.e. members who meet all denominator criteria): Denominator	x		
Number of numerator events	x		
Rate	x		
Lower 95% confidence interval	x		
Upper 95% confidence interval	x		
* Required data element: x			