Illinois Department of Public Aid

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INFORMATIONAL NOTICE

TO: Participating Physicians, Nurse Practitioners, Nurse Midwives, General Hospitals, Federally Qualified Health Centers, Encounter Rate Clinics, Rural Health Clinics, Certified Health Departments, and School Based/Linked Centers

RE: Screening for Perinatal Depression

The state's human services agencies, the Illinois Departments of Public Aid (DPA), Public Health (DPH), Human Services (DHS), Children and Family Services (DCFS), Department of Corrections (DOC) and the Conference of Women Legislators, in coordination with the University of Illinois at Chicago (UIC) Women's Mental Health Program, are working together to address perinatal depression with the ultimate goal of improving maternal and child health outcomes through screening, identification, referral and treatment of this illness.

This notice provides information on DPA's initiation of reimbursement for screening for perinatal depression and information about consultation services available to providers. The attached *Information for Physicians on Prescription Products to Treat Perinatal Depression* (July 2004) can also be found on DPA's Web site at <http://www.dpaillinois.com/mch/medchart.html>.

Background

Medicaid covers over 40 percent of Illinois births each year, and an estimated 66 percent of those births are unintended. Medicaid covers approximately 89 percent of teen births in Illinois. It is estimated that 10-20 percent of women in the United States who give birth experience a major depression within six months of delivery, with the occurrences substantially higher in women with low socioeconomic status.

Perinatal depression may occur at any time during the pregnancy, immediately after delivery, or even up to one year after delivery. The consequences of untreated perinatal depression can be devastating and have long-term adverse effects for the woman, her child and other family members. Yet, perinatal depression remains both under recognized and under treated. Early detection of symptoms and prompt initiation of treatment can greatly reduce adverse consequences. Medications and psychosocial interventions can effectively treat depression both during pregnancy and the postpartum period.

Risk Assessment

DPA provides reimbursement for "risk assessment" for children and pregnant women. Effective with dates of service on or after December 1, 2004, reimbursement will be available for perinatal depression screening as a "risk assessment" to identify women who may be at risk of, or who are experiencing, perinatal depression. A list of risk factors for identifying women who may be at risk of prenatal or

postpartum (perinatal) depression is available on DPA's Web site at http://www.dpaillinois.com/mch/risk.html and is also attached. Often, risk factors may not be evident and depression may not be apparent without specific screening.

DPA has reviewed the Edinburgh Postnatal Depression Scale (EPDS) and finds it to be an appropriate tool for screening pregnant and postpartum women for perinatal depression. Used with the woman's prior knowledge and consent, the EPDS is a reliable scale that is recognized as an appropriate screening instrument for early identification of depression during both the prenatal and postpartum periods. The EPSD contains ten questions and can usually be quickly administered and scored. A copy of the EPDS and its scoring guidelines can be found on DPA's Web site at http://www.dpaillinois.com/mch/edinburgh.html and is attached. Other screening tools that have been validated for use in obstetric populations may also be used to conduct perinatal "risk assessment" for women covered by DPA's Medical Programs. These include the Beck Depression Inventory and the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (see http://www.illinoisaap.org for more information on these tools). Prior to using a perinatal depression screening instrument other than the EPDS, the Beck Depression Inventory or the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire, the provider must obtain written approval from DPA in order to obtain reimbursement for the screening. Requests must be submitted in writing to DPA's Maternal and Child Health Program and include documentation that the screening instrument has been formally validated, is nationally distributed, and is individually administered. Please be aware that reimbursement will only occur for screenings using one of the listed and approved tools.

Providers

Enrolled physicians and other providers performing primary care services may complete a perinatal depression screening during a prenatal or postpartum visit, or during an infant well-child or episodic visit. Family Case Management (FCM) agencies that are certified local health departments will be reimbursed by DPA for depression screening. FCM agencies may complete a screening during a face-to-face case management or WIC encounter.

Encounter Rate Clinics (ERCs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will not receive separate reimbursement for perinatal depression screenings because ERCs, FQHCs and RHCs are paid an encounter rate that encompasses all services provided during an encounter. ERCs, FQHCs and RHCs should, however, include the appropriate "risk assessment" procedure code on the encounter claim. The screening can be performed during a medical or a behavioral health encounter (for those enrolled to provide behavioral health services).

Billing Procedures

Reimbursement is available for both prenatal and postpartum depression screening, as a "risk assessment." The current reimbursement rate for procedure codes H1000 and 99420 is $14.60. Information about DPA's reimbursement rates is available on DPA's Web site at <http://www.dpaillinois.com/feeschedule/>.

When billing for prenatal depression screening, use procedure code H1000.

If the woman is postpartum and covered by DPA's Medical Programs, the perinatal depression screening should be billed using procedure code 99420 with modifier HD (pregnant/parenting women's program) under the **woman's** Recipient Identification Number (RIN). Maintain the results and copy of the screening instrument in the mother's file.

If the postpartum depression screening occurs during a well-child visit or episodic visit for an infant (under age one) covered by DPA's Medical Programs, the screening may be billed as a "risk assessment" using procedure code 99420 with modifier HD (pregnant/parenting women's program) under the **infant's** RIN. Record this screening as a "risk assessment" in the infant's record. Maintain the results and copy of the screening instrument in a separate file, not in the infant's file. For record keeping suggestions, visit <http://www.illinoisaap.org>.

Consultation and Referral Services

A statewide Perinatal Mental Health Consultation Service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service provides consultation with psychiatrists, and information about medications that may be used in the management of perinatal depression both during and after pregnancy.

The Perinatal Mental Health Consultation Service toll-free telephone number is 1-800-573-6121.

Perinatal Depression Resources

Provider and patient-focused information and resources are available on DPA's Web site at <http://www.dpaillinois.com/>. The site provides links to other state agencies, helplines and sources for more information. The Web site also includes a brochure that may be downloaded and copied for distribution to patients. Patients may also be referred to the **DHS Helpline at 1-800-843-6154 or TTY 1-800-447-6404** for additional resource information.

Provider associations partnering in this effort are the Illinois Chapter, American College of Obstetrics and Gynecology (ACOG); the Illinois Chapter, American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP). For more information, please visit the ICAAP Web site at <http://www.illinoisaap.org> or the IAFP Web site at <http://www.iafp.com>.

To reduce copying and mailing cost, the department may not always include hardcopies of attachments referenced in notices and bulletins. Web site links will be identified so providers may view and print the material from the Internet. Providers wishing to receive e-mail notification, when new provider information has been posted by the department, may register at the following IDPA Web sites:
http://www.dpaillinois.com/provrel/ or http://www.ildpa.com/provrel/

For questions regarding the Maternal and Child Health Program please contact DPA's Bureau of Maternal and Child Health Promotion at 217-524-7478. For billing related questions, please contact DPA's Bureau of Comprehensive Health Services at 1-877-782-5565.

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs

RISK FACTORS ASSOCIATED WITH PERINATAL DEPRESSION*

There are identifiable risk factors commonly associated with perinatal depression. These risk factors, or combinations of risk factors, serve as predictors of who may be at risk of depression. **Even in the absence of these risk factors, administration of a screening instrument, such as the Edinburgh Postnatal Depression Scale (EPDS), is encouraged.**

Significant Predictors for Perinatal Depression	**Other Predictors for Perinatal Depression**
Prenatal depression	Difficult family relationships
Child care stress	Work stress / new job
Life stress	Severe financial difficulties
Poor social support	Recent stressful events
Prenatal anxiety	Victim of violence or abuse
Poor marital relationship	Low confidence as a parent
History of previous depression	Family history of postpartum depression
Difficult infant temperament	Teen or adolescent
Maternity blues	Complicated or difficult pregnancy
Single marital status	Thyroid problems or family history of thyroid problems
Previous postpartum depression	Poor diet or severe morning sickness
Severe premenstrual syndrome (PMS)	Oral-contraceptive use or Depo-Provera shot soon after delivery
Family history of depression	Early or recent loss of a parent
Taking excessive sick leave during pregnancy	Other psychiatric disorders
Frequent visits to doctor during pregnancy	Excessive lability of mood during pregnancy
Bereavement	Transient baby blue syndrome symptoms during first ten postpartum days
Prior stillborn	

*References:

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Information for Physicians on Prescription Products to Treat Perinatal Depression - July 2004
Treatment decisions should be based on patient characteristics and clinical judgment.

Antidepressant	Advantages During Pregnancy	Disadvantages During Pregnancy	Recommended Dose* (mg/day)	Percent of Dose to Breastfeeding Baby**	Reported Side Effects to Breastfeeding Infants	Teratogenicity
Bupropion (**Wellbutrin**[R]; **Zyban**[R])	• No sexual side effects • No excess weight gain • Helps with smoking cessation	• No systematic studies in human pregnancy • Lowers seizure threshold • Can cause insomnia	• 200 – 300 mg	• Not known	• None reported to date	Unknown
Citalopram (**Celexa**[R])	• Few interactions with other medications	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 20 – 40 mg	• 0.7% - 9.0%	• Uneasy sleep	Morphologic – none Behavioral - unknown
Desipramine (**Norpramin**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	• 100 – 200 mg	• 1.0%	• None	None
Fluoxetine (**Prozac**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up • **Expert Consensus Guidelines top choice during pregnancy (if not planning to breastfeed)**	• Long half-life can lead to neonatal toxicity (tachypnea, respiratory distress, tremors, agitation, motor automatisms) • Increased bleeding tendency (rare)	• 20 – 60 mg	• 1.2% - 12.0%	• Vomiting, watery stools, excessive crying, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain	None
Mirtazapine (**Remeron**[R])	• No sexual side effects • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting	• No systematic studies in human pregnancy • Can cause excessive weight gain • Tends to be sedating	• 15 – 45 mg	• Not known	• Not known	Unknown
Nortryptiline (**Pamelor**[R])	• More studies in human pregnancy, including neurodevelopmental follow-up	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthosatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	• 50 – 150 mg	• Not known	• None	None
Paroxetine (**Paxil**[R])	• **Expert Consensus Guidelines second choice during pregnancy (if planning to breastfeed)**	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 20 – 60 mg	• 0.1% - 4.3%	• None	Morphologic – none Behavioral - unknown
Sertraline (**Zoloft**[R])	• **Expert Consensus Guidelines top choice during pregnancy (if planning to breastfeed)**	• No behavioral studies in human pregnancy • Increased bleeding tendency (rare)	• 50 – 200 mg	• 0.4% - 1.0%	• None	Morphologic – none Behavioral - unknown
Venlafaxine (**Effexor**[R])	• Balanced antidepressant; may be effective when selective agents are not	• No behavioral studies in human pregnancy	• 75 – 225 mg	• 5.2% - 7.4%	• None	Morphologic – none Behavioral – unknown

* Physicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Dosages are from the *Physician's Desk Reference*, 56th ed. Table based on Wisner et al *Postpartum Depression* Article in *N Eng J Med*, Vol. 347, No. 3, July 18, 2002, pg. 196.

** This is a weight-adjusted estimate.

General notes:

- About 70% of women with recurrent major depression relapse during pregnancy if they discontinue antidepressant medication.
- Untreated major depression during pregnancy is associated with increased risk of preterm birth, lower birth weight, and neonatal irritability.
- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation signs in the fetus or neonate. These signs can include irritability, excessive crying, difficulty sleeping, difficulty feeding, increased tone, hyperreflexia, shivering, tachypnea, and convulsions. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.
- Pharmacokinetic changes during pregnancy can affect antidepressant dosing. For SSRI (citalopram, fluoxetine, paroxetine, sertraline) and tricyclic (desipramine, nortryptiline) antidepressants, most women need increased doses toward the second half of pregnancy to maintain a therapeutic effect.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
□ Yes, all the time
☒ Yes, most of the time
□ No, not very often
□ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have copied quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

The American College of Obstetricians and Gynecologists

Illinois Section of District VI
Illinois Obstetrical & Gynecological Society

Dear Colleague:

As you know, perinatal depression is a significant problem facing childbearing age women. Depression continues to be under-recognized and under-treated. The Illinois Section of the American College of Obstetrics and Gynecology (ACOG), the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP) are working with the Illinois Department of Public Aid and the Illinois Department of Human Services to assist physicians in the identification and management of this important health problem. The following materials are enclosed with this letter:

- A Provider Notice from the Illinois Department of Public Aid regarding screening for perinatal depression. The Medicaid program is initiating coverage for screening with the Edinburgh Postpartum Depression scale. The reimbursement rate is $14.60. Physicians providing care to either the mother or child may bill. The Provider Notice also includes:
  - A copy of the Edinburgh Postpartum Depression scale and scoring guide.
  - An announcement regarding a new consultation service for primary care physicians. Under this new service, you may consult with a psychiatrist from the Women's Clinic at the UIC Department of Psychiatry regarding the management of patients with perinatal depression by calling a toll-free telephone number, **1-800-573-6121.**
  - Directions for calling the Illinois Department of Human Services Customer Care Line (**1-800-843-6154).** You may call this number to find a mental health professional in your area to whom you may refer women suffering from perinatal depression.
- A copy of the Illinois Department of Human Services medication guide for the pharmacotherapy of perinatal depression, developed in conjunction with the Department of Psychiatry of the University of Illinois at Chicago School of Medicine.

We encourage you to routinely screen women in your practice who are pregnant or who have a newborn infant to identify perinatal depression and take appropriate action to treat this prevalent but treatable illness.

Sincerely,

Howard T Strassner, Jr., M.D.
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