

# MAJOR DEPRESSIVE DISORDER

- When documenting major depression, it is imperative to specify the episode – single or recurrent
- Assess and document the severity or status of symptoms – mild, moderate, severe, in remission
- Document major depression when the condition impacts care, even when asymptomatic or stable

## Clinical Concepts

Major Depressive Disorder (MDD) is an episode of clinically significant distress or impairment that persists for a minimum of 2 weeks, involving  $\geq 5$  symptoms of clinical depression *occurring nearly every day*, at least one of which must be dysphoria or anhedonia. Clinical symptoms of depression include:

- Dysphoria (depressed mood)
- Anhedonia (decreased interest or pleasure in activities)
- Unintended change in appetite or weight
- Insomnia or hypersomnia
- Psychomotor agitation or significant slowing
- Decreased energy or fatigue
- Feelings of worthlessness or excessive guilt
- Poor concentration or new indecisiveness
- Recurrent thoughts about death or suicide

Standardized tools like the PHQ-9 help clinicians determine severity and guide treatment decisions.

PHQ-9 Score	Severity	Result
0-4	Minimal	Not depressed or in remission
5-9	Mild	Consider MDD; evaluate treatment options and follow-up
10-19	Moderate	Warrants active treatment with pharmacotherapy/psychotherapy and follow-up
20-27	Severe	Increased suicide risk or presence of psychosis; refer to behavioral health specialist

*\*PHQ-9 score  $\geq 10$  suggestive of MDD*

An individual can only have one single major depressive episode during their lifetime, which may be in remission with ongoing treatment for many years. Once that episode resolves, any new episodes of depression would be considered recurrent.

Two months with no symptoms or the near absence of symptoms is generally regarded as defining remission from the depressive episode.

## Documentation Matters

**History** – document the date of onset, presence or absence of current depressive symptoms, and any

previous medical interventions or mental health hospitalizations, history of self-harm, and any social or environmental factors that may be influencing mood.

**Exam** – document the presence of objective findings such as flat affect, weight loss/gain, somatic symptoms, and related assessment results, such as PHQ-9 scores.

**Assessment** – document the depression diagnosis to the highest level of specificity known. Include the current status/severity of the condition and link any contributing factors or comorbidities impacting mood.

**Plan** – document the treatment or management and the timeframe for reevaluation or follow-up. Link associated prescription medications, specialist referrals, and lifestyle management recommendations.

## Coding Guidance

When documenting major depression, specify:

- **Episode**
  - Single or recurrent
- **Severity**
  - Mild, moderate, or severe
- **Clinical Status (if applicable)**
  - Partial or full remission

To be reported on a claim, documentation must indicate that major depression was addressed during the encounter or demonstrate that the condition had an impact on patient care or management.

Avoid using non-specific terms and unspecified codes when details of the condition are known.

Document MDD, even if the symptoms are well-controlled with medication or active psychotherapy.

Anxiety and depression are to be coded as separate conditions unless documentation specifically indicates they are linked as a single disorder.

## References

[ICD-10-CM Official Guidelines for Coding & Reporting Up to Date: Depression in Adults](#)

### Major Depressive Disorder Diagnoses

ICD-10-CM	Code Description	HCC Model
F32.0	Major depressive disorder, single episode, mild	-
F32.1	Major depressive disorder, single episode, moderate	CMS
F32.2	Major depressive disorder, single episode, severe without psychotic features	CMS/HHS
F32.3	Major depressive disorder, single episode, severe with psychotic features	CMS/HHS
F32.4	Major depressive disorder, single episode, in partial remission	-
F32.5	Major depressive disorder, single episode, in full remission	-
F32.9	Major depressive disorder, unspecified	-
F33.0	Major depressive disorder, recurrent, mild	-
F33.1	Major depressive disorder, recurrent, moderate	CMS
F33.2	Major depressive disorder, recurrent, severe without psychotic features	CMS/HHS
F33.3	Major depressive disorder, recurrent, severe with psychotic features	CMS/HHS
F33.41	Major depressive disorder, recurrent, in partial remission	-
F33.42	Major depressive disorder, recurrent, in full remission	-

### Additional Diagnoses to Consider

ICD-10-CM	Code Description	HCC Model
F10*- F19*	Substance use disorders <ul style="list-style-type: none"> <li>• Specify substance, severity, and clinical status</li> </ul>	CMS/HHS
F34.1	Dysthymic disorder	-
F41*	Anxiety disorders	-
F42*	Obsessive-compulsive disorders	-
F43*	Reactions to severe stress and adjustment disorders	-
Z59*	Problems related to housing and economic circumstances	-
Z60*	Problems related to social environment	-
Z62*	Problems related to upbringing	-
Z63*	Problems related to primary support group, including family circumstances	-
Z91.4*	Personal history of psychological trauma, not elsewhere classified	-
Z91.51	Personal history of suicidal behavior	-
Z91.52	Personal history of non-suicidal self-harm	-

\*Additional characters needed to complete code