Independence

Clinical documentation improvements and general coding tips: Major depressive disorder

Coding major depressive disorder accurately requires the documentation to note the following:

1. If it is a single episode or recurrent episode; AND
2. If it is mild, moderate, severe without psychotic features, severe with psychotic features; OR
3. If it is in partial remission or full remission

Important documentation notes

- If the documentation **does not meet the specificity as noted** in the above list, then the diagnosis can only support major depression, unspecified (F32.9).
- Always document to the highest degree of specificity: type and episode.
- Avoid documenting in PMH if member is actively taking prescribed medication and/or receiving counseling/therapy.
- If member has dx of depression and dx of anxiety and if there is a causal relationship between the two conditions, then documentation must establish the relationship by stating depression "with," "due to," or "related to" anxiety to capture the code that encompasses both diagnoses (F34.1 or F41.8).

Documentation considerations

- The United States Preventative Task Force (USPTF) recommends that all patients aged 18 and older be screened for depression.
- The PHQ-9 or minimally the PHQ-2 is a recommended screening tool.
- The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders.
  - The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
- If the depression is a chronic recurring diagnosis, providers should know that the diagnosis is always at least mild if there is ongoing pharmacotherapy or psychotherapy.

Resources

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268

www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Independence Blue Cross coding and documentation education materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative guidance of the ICD-10-CM Official Guidelines for Coding and Reporting *as approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). Clinical and coding decisions are to be made based on the following:*

1. The independent judgment of the treating physician or qualified health care practitioner.
2. The best interests of the patient.
3. The clinical documentation as contained in the medical record.