



Major depression/Major depressive disorder



Clinical overview

Definition

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the American Psychiatric Association (APA) advises that major depression is a mental disorder, marked by a depressed mood and loss of interest or pleasure in all activities, that lasts for at least two weeks and represents a change from previous functioning.

Causes

The exact cause is not known. Factors thought to play a role include:

- Biological differences/physical changes in the brain, function and effect of brain chemicals (called neurotransmitters), and hormone balance
- Genetics/inherited traits
- Situational life events
- Trauma

Signs and symptoms

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day
- Significant weight loss when not dieting, or weight gain, or decrease or increase in appetite
- Insomnia or hypersomnia nearly every day
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide

Complications

- Alcohol or substance abuse
- Anxiety
- Work or school problems, family conflicts, relationship difficulties, social isolation
- Heart disease
- Suicide

Diagnostic tools

- Standardized depression screening tools, such as the patient health questionnaire (PHQ)-9 a nine-item patient health questionnaire used to screen for and diagnose depression and to monitor response to treatment
- Psychological evaluation

Treatment

- Psychotherapy/mental health counseling
- Medications (linked to diagnosis)
- Electroconvulsive therapy (ECT)



Best documentation practices for healthcare providers

Subjective

In the subjective section of the office note, document the presence or absence of any current symptoms related to major depressive disorder (e.g., depressed mood, insomnia, feeling of worthlessness, etc.).

Objective

The objective section should include physical exam findings (e.g., flat affect, weight loss or gain, etc.) and related assessment results, such as PHQ-9 scores.

Assessment

Specificity: Describe each final diagnosis clearly, concisely and to the highest level of specificity. Use all applicable descriptors and include the following:

- Episode – single or recurrent
- Severity – mild, moderate, severe
- Presence or absence of psychosis/psychotic features
- Remission status – partial or full

Treatment plan

- Document a clear and concise treatment plan for Major depressive disorder, linking related medications to the diagnosis.
- Indicate in the office note to whom or where any referral or consultation requests are made.
- Document when the patient will be seen again, even if only on an as-needed basis.



Coding tips

Major depression coexisting with bipolar disorder

- Major depression coexisting with bipolar disorder classifies to the applicable combination code under category F31 for bipolar disorder. Bipolar disorder includes both depression and mania; i.e., depression is a component of bipolar disorder. It is more important to capture the bipolar disorder. Therefore, a code for depression is not reported separately. (American Hospital Association [AHA], 2020)
- Category F31.- Bipolar disorder, has an **Excludes1** note advising categories F32.-; major depressive disorder, single episode and F33.- major depressive disorder, recurrent are NOT CODED HERE! An **Excludes1** note shows that you should never use the excluded code at the same time as the code above the **Excludes1** note. An **Excludes1** note is used when the 2 conditions can't occur together, depression and mania are both components of bipolar disorder so the depression would not be coded separately.

Additional reminders

- While MDD is a commonly accepted medical abbreviation for major depressive disorder, this abbreviation also can be used to represent manic depressive disorder, which classifies to a different diagnosis code.
- "Chronic depression" and "depression" without further description both code to F32.A, Depression, unspecified.



Coding examples

Example 1

Assessment and plan	<p>HPI: Depression disorder</p> <p>Past medical history: Bipolar depression</p> <p>Psychiatric/Behavioral review of systems: Positive for sleep disturbance; patient is nervous/anxious; depression</p> <p>Psychiatric exam: She is attentive; Affect is flat and angry.</p> <p>Assessment diagnosis #3: Moderate episode of recurrent major depressive disorder with documented treatment.</p>
ICD-10-CM code	<ul style="list-style-type: none"> F33.1 Major depressive disorder, recurrent, moderate
Comment	Bipolar depression is documented as historical in the PMH. Only the moderate recurrent depression is documented and supported in this example.

Example 2

Assessment and plan	Depression continue Duloxetine
ICD-10-CM code	<ul style="list-style-type: none"> F32.A Depression, unspecified
Comment	<p>Approximately 30% of patients report symptoms of depression to their primary care providers; however, fewer than 10% of these patients have major depression. When untreated, an episode of depression may last from 6 months to two years or more, and episodes tend to recur several times over a lifetime.</p> <p>Previously in ICD-10-CM, the default for depression not otherwise specified (NOS) was code F32.9, major depressive disorder, single episode, unspecified. However, this code did not separately capture the actual occurrence of depression not further specified, and statistically inflated the incidence of major depressive disorder. (American Hospital Association [AHA], 2021)</p> <p>It is important to use all applicable descriptors including:</p> <ul style="list-style-type: none"> Episode- single or recurrent Severity- mild, moderate, severe Presence or absence of psychosis/psychotic features Remission status – partial or full <p>*A diagnosis of depression only is too vague to classify as major depression.</p>

Example 3

Medical record documentation	<p>HPI: Moderate recurrent major depression</p> <p>Problems List: Recurrent major depression</p> <p>Assessment diagnosis: Recurrent major depression – continue medication</p>
ICD-10-CM code	<ul style="list-style-type: none"> F33.1 Major depressive disorder, recurrent, moderate
Comment	<p>Major depression is recurrent however the severity is further defined in the HPI.</p> <p>Reminder: Be sure to document to the highest level of specificity to capture the level of the patient's depression accurately at the time of the encounter.</p>

Example 4	
Assessment and plan	Diagnosis #1: Depression Diagnosis #5: Major depressive disorder, recurrent in partial remission Diagnosis #12: Major depressive disorder, recurrent in full remission Diagnosis #15: Major depressive disorder, single episode, severe without psychotic features
ICD-10-CM codes	<ul style="list-style-type: none"> Query the physician for clarification
Comment	When multiple variations of major depressive disorder are documented in the same encounter, no ICD-10 code can be assigned without a provider query to confirm the current level. This example illustrates why it is important to update your problem lists, PMH, Assessment etc. to prevent contradiction in the documentation.

References

- American Hospital Association (AHA). (2020). Bipolar disorder and recurrent major depressive disorder. *ICD-10-CM/PCS Coding Clinic, First Quarter 2020*, 23.
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