The Patient Health Questionnaire (PHQ-9) incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool, and can objectively determine if the episode is mild, moderate, or severe.

You should see patients with depression at least annually to manage the condition and monitor for potential medication side effects.

It’s important to document a thorough medication reconciliation at every visit.

Under ICD-10, only a major depressive disorder that’s documented and coded as severe (as opposed to mild or moderate) falls into a Hierarchical Condition Category for risk adjustment.

When is it appropriate to diagnose major depressive disorder?

At least five of these symptoms must be present for at least two weeks to diagnose major depressive disorder:

- Depressed mood
- Loss of interest in most or all activities
- Insomnia or hypersomnia
- Change in appetite or weight
- Psychomotor retardation or agitation
- Low energy
- Poor concentration
- Feeling of worthlessness or guilt
- Recurrent thoughts of death or suicide ideation

The episode shouldn’t be attributed to physiological effects of a substance or another medical condition.

What if it isn’t major depressive disorder?

Consider these:

- Dysthymia, when symptoms are intermittent, more mild, and last more than two years in adults and one year in adolescents and children
- Unhappiness (R45.2; R45 section has multiple symptoms and signs involving emotional state)
- Adjustment disorders (F43.2- codes)
- Reaction to severe stress (also one of the F43 codes)

Major depressive disorder can’t be coded with bipolar disorder (F31.-) or manic episode (F30.-).
**Documenting**

**ICD-10 requires detailed documentation**
- When documenting major depressive disorder, make sure to indicate:
  - Episode: Single or recurrent
  - Severity: Mild, moderate, severe (with or without psychotic features)
  - Clinic status of the current: In partial or full remission

<table>
<thead>
<tr>
<th>Severity</th>
<th>F32.0 Mild</th>
<th>F32.1 Moderate</th>
<th>F32.2 Severe without psychotic features</th>
<th>F32.3 Severe with psychotic features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Status</td>
<td>F32.4 In partial remission</td>
<td>F32.5 In full remission</td>
<td></td>
<td></td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>Clinical Status</td>
<td>F33.40 In remission, unsp.</td>
<td>F33.41 In partial remission</td>
<td>F33.42 In full remission</td>
<td></td>
</tr>
</tbody>
</table>

**Avoid “suspected”, “probable”**
- Avoid using terms such as “suspected” or “probable.” In an outpatient setting, if depression is suspected but not confirmed, code the symptoms only.

**Remember 311, depression unspecified**
- Under ICD-10, when the term “depression” is used without supplementary details, the patient would be coded with F32.9, which is major depressive disorder, single episode, unspecified.

**Medication reconciliation counts**
- A comprehensive medication reconciliation, including documentation of each medication’s
  - indication
  - length of treatment
  - benefits
  - side effects
  - plan for continued treatment
  is sufficient documentation of monitoring, evaluating, assessing or treating (MEAT) of the corresponding condition to support coding it on a claim.

For more information about coding mental health or any other chronic and complex conditions, reach out to our Provider Engagement Team at 877-342-5258 Opt. 4 or email us at ProviderEngagementTeam@premera.com. Additional resources are available at [https://www.premera.com/wa/provider/commercial-risk-adjustment/](https://www.premera.com/wa/provider/commercial-risk-adjustment/).