



American Academy
of Value Based Care

Major Depressive Disorder

Quick Reference Guide

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AAVBC Major Depressive Disorder Quick Reference Guide

Table of Contents

CLINICAL SNAPSHOT.....	3
RECOGNITION & DIAGNOSIS.....	3
Medicare Screenings.....	3
Subtle Early Signs in Older Adults >65yrs.....	3
Geriatric Risk Factors.....	4
RED FLAGS - URGENT ACTION.....	4
Diagnostic Thresholds.....	4
Clues to Dig Deeper.....	5
Common Oversights.....	5
Key Differentials in Elderly.....	5
Comorbidity Screening.....	5
Staging/Severity by Function (DSM-5-TR Framework).....	6
MEAT DOCUMENTATION ESSENTIALS.....	6
Clinical Documentation Elements.....	6
Reframing Common Documentation Shortcuts.....	7
TREATMENT & REFERRAL QUICK GUIDE.....	7
Therapy Escalation Criteria.....	7
APA-Aligned Recommendations.....	7
Non-Rx Treatment Documentation.....	8
When to Refer.....	8
Follow-up Timing.....	8
Patient Education & Adherence.....	9
Comorbidity Management.....	9
Cost-Smart Options.....	9
Quality Metrics Tie-In.....	9
CODING REMINDERS & CASE EXAMPLES.....	10
Specificity Requirements.....	10
Annual Clinical Review and Confirmation.....	10
Good Documentation is Comprehensive Coding.....	10
EHR Tips.....	10
Brief Case Examples.....	11
REFERENCES.....	11

1. CLINICAL SNAPSHOT

Definition: APA DSM-5-TR / WHO / NIH: Major depressive disorder (MDD) is characterized by persistent depressed mood or loss of interest/pleasure (anhedonia) for ≥ 2 weeks, accompanied by ≥ 5 of 9 DSM-5-TR symptoms causing clinically significant distress or functional impairment. Neurobiological correlates include monoamine dysregulation (serotonin, norepinephrine, dopamine) and HPA-axis hyperactivity.¹

ICD-10 Codes: F32.x single episode (Mild (F32.0), Moderate (F32.1), Severe without psychotic features (F32.2), Severe with psychotic features (F32.3), F33.x recurrent (Mild (F33.0), Moderate (F33.1), Severe without psychotic features (F33.2), Severe with psychotic features (F33.3))²

HCC/RAF V28 Mapping: **HCC 155** (Major Depression, Moderate or Severe without Psychosis) F32.1-3, F33.1-3 with RAF (0.299); **HCC 152** (non-schizophrenia psychosis, major depression with psychotic features) F32.3, F33.3 with RAF (0.484); **HCC 154** (Bipolar Disorders without Psychosis) F31.0 - F31.9 with RAF (0.351) **NO HCC** (Depression, Mild or unspecified) for F33.0, F32.0, F32.9³

Prevalence (U.S): 8.4% adults, 4.5% adults >50, 10.5% women vs 6.2% men, Annual cost estimate \$236.6-\$326.2B (2020 values) (\$13,700 PMPY). A leading cause of disability with high recurrence, >40% will experience a recurrence within 2 years. After two prior episodes, 5-year recurrence risk is approximately 75%⁵⁻⁷

2. RECOGNITION & DIAGNOSIS

Medicare Screenings⁸⁻¹⁰

Test	Coverage	Frequency	CPT/HCPCS Code	Notes
PHQ-9	Annual wellness visit	Annual	G0444	Document score and follow-up plan
Depression screen (General)	Medicare Part B	Annual	G0442	15-minute screen
Behavioral Health Integration (BHI)	Ongoing collaborative care	Monthly	99492-99494	Includes PHQ-9 monitoring, care coordination, medication management
Follow-up after Mental Health Hospitalization	Quality measure	7 & 30 days	HEDIS FUH	Required for quality reporting and RADV validation

Subtle Early Signs in Older Adults >65yrs¹¹

- Cognitive complaints without sadness → "Pseudodementia" precedes mood symptoms in 40%
- Multiple somatic complaints → Headaches, GI distress, chronic pain often mask mood symptoms
- Apathy/withdrawal → Mistaken for normal aging, review PHQ-9 item 1 (anhedonia)
- Sleep changes → Early morning awakening 3-4 am, classic neurovegetative sign

- Unexplained weight loss → >5% in a month, even with normal appetite

Geriatric Risk Factors

Factor	Risk Signal	Evidence Summary	Clinical Implication
Bereavement ¹²	Very high in the first months	Marked elevation in depressive symptoms after spousal loss, peaking early and attenuating over 6–12 mo	Proactive screening after loss (PHQ-9 at 2–4 wk, repeat at 3 mo). Offer grief supports/psychotherapy; monitor sleep, weight, safety
Serious medical illness (e.g., cancer, stroke, CHF, Parkinson's) ¹²	≈2-3× vs healthy peers	Geriatric review summarizes 2–3× higher odds of depression with disabling medical conditions in late life	Screen at each visit in multimorbidity; integrate pain, sleep, disability management; coordinate with specialty care
Chronic pain ¹³	≈20-40% prevalence	Bidirectional relationship	Treat pain and mood together; track function and PHQ-9 at follow-ups
Social isolation /loneliness/living alone ¹⁴	Moderate	Clear risks for depression ;unidirectional path from social isolation → depressive symptoms; bidirectional links for loneliness	Ask about supports/loneliness; "social prescriptions" (senior centers, group exercise); connect to community programs and caregiver supports
Polypharmacy (≥5 meds; especially CNS agents, corticosteroids, sedative-hypnotics) ¹⁵	Moderate	Observational data show associations between polypharmacy and depressive symptoms	Reconcile meds each visit; flag CNS-active and corticosteroids; consider deprescribing protocols and pharmacist collaboration

RED FLAGS - URGENT ACTION^{1,11,16,24}

- **Active suicidal ideation or recent attempt:** Emergency evaluation → Possible inpatient care; Specific plan + means + intent = imminent risk; 911/ED transfer or crisis call (988). Document PHQ-9 item 9 score, protective factors, and safety plan
- **Psychotic features:** Delusions of guilt/poverty, command hallucinations → Urgent psychiatric consultation/hospitalization; high suicide and non-adherence risk
- **Catatonia:** Stupor, mutism, posturing, negativism → Medical emergency; DSM-5-TR defines catatonia as ≥3 characteristic signs; risk of dehydration, PE, autonomic instability
- **Severe self-neglect/ failure to maintain intake:** >48 hrs → Immediate intervention; Medical stabilization; evaluate capacity; coordinate with social work/home support

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