



American Academy
of Value Based Care

Major Depressive Disorder

Quick Reference Guide

2025

AAVBC Major Depressive Disorder Quick Reference Guide

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:** >48hrs → Immediate intervention; Medical stabilization; evaluate capacity; coordinate with social work/home support

Diagnostic Thresholds^{1, 11}

Test	Diagnostic Value	Elderly Adjustment
DSM-5-TR criteria	≥5 of 9 core symptoms x ≥2 weeks	Atypical: apathy, somatic focus, slowed cognition
PHQ-9	≥10 = moderate; 15–19 = mod-severe; ≥20 = severe	≥5 in frail elderly
PHQ-9 item 9	≥1 = positive for suicidal ideation	Safety check, Immediate risk assessment
GDS-15 (≥65)	5–8 = mild; ≥9 = severe	Preferred with dementia or high somatic load

Clues to Dig Deeper^{11,17}

- **TSH 2.5–4.5mIU/L:** Subclinical hypothyroid in ≈20% of MDD, fatigue, and cognitive slowing mimic depression → Check anti-TPO Ab
- **B12 200–400pg/ml:** Borderline deficiency impairs monoamine synthesis → Check methylmalonic acid/homocysteine
- **Anemia (low Hb/ferritin):** Fatigue, apathy, cognitive dulling overlap with depression → Order CBC, ferritin, TIBC
- **Morning cortisol >20ug/dL:** Consider Cushing's in depression + HTN + central obesity → Obtain 1-mg dexamethasone suppression test
- **Low vitamin D (<20ng/mL):** Seen in >30% of depressed adults; linked with poor response → Replace (800–2000 IU daily) and re-check

Common Oversights^{3,10,11}

- **"Just grieving"** → Grief + MDD can coexist; treat if functional impairment >2 weeks
- **"Normal aging"** → Depression is NOT normal; screen all >65 annually
- **"Dementia only"** → ≈40% patients with dementia have comorbid depression
- **Missing bipolar** → Failed ≥2 antidepressants → Screen with MDQ for bipolar
- **"Stable on meds"** → Document PHQ-9 + function to maintain HCC capture

Key Differentials in Elderly^{1, 11, 12}

Presentation	Differential Diagnosis	Key Tests
Fatigue + cognitive decline	Depression vs hypothyroid vs B12	TSH, B12, CBC ± ferritin, MoCA
Apathy + motor slowing	Depression vs Parkinson's vs NPH	Neuro exam, MRI brain
Irritability + weight loss	Depression vs hyperthyroid vs occult malignancy/chronic inflammatory disease	TSH, CBC, CMP, consider CRP/age-appropriate cancer screen
Memory complaints	Depression ("pseudodementia") vs dementia vs delirium	MoCA, TSH, B12, UA/infection screen; repeat cognitive testing

Comorbidity Screening^{1,3,5,10}

Condition	Screening Tool	Frequency	Notes
Anxiety	GAD-7	Initial + annual	70% comorbidity; "MDD with anxious distress"
Substance or alcohol use	AUDIT-C	Initial + annual	30% comorbidity; USPSTF Grade B
Cognitive impairment	MOCA or MMSE	At AWV and when complaints/functional decline present	Rule out depression vs neurocognitive disorder; Medicare AWV cognitive assessment, Part B
Sleep disorders/OSA	STOP-BANG Questionnaire	If fatigue, insomnia, or resistant HTN, obesity noted	High overlap (≈50% of MDD)

Staging/Severity by Function (DSM-5-TR Framework)¹

Status	PHQ-9 Score	Functional Description	Management Focus
Mild	5-9	Minor impairment in social/occupational function	Active monitoring or psychotherapy
Moderate	10-14	Noticeable difficulty maintaining work or ADLs	Pharmacotherapy ± psychotherapy; reassess at 8-12 wk
Moderately severe	15-19	Marked impairment; limited ability to function daily	Urgent treatment, close monitoring
Severe	20-27	Extreme impairment, possible psychosis or suicidality	Urgent evaluation; consider hospitalization or ECT

3. MEAT DOCUMENTATION ESSENTIALS^{1,3,11}

MONITOR: "PHQ-9 score 16 (moderately severe, ↑ from 12 last month), sleep diary shows 3-4hrs nightly, weight 142lbs (↓12lbs/7.8% in 6 weeks), taking sertraline 150mg daily and duloxetine 30mg daily, with 90% adherence per pharmacy data"

EVALUATE: "Suicide risk assessment: passive death wishes without plan, protective factors include grandchildren and faith; MADRS 28 indicating severe depression with prominent guilt; cognitive testing shows 2SD decline in processing speed"

ASSESS: "Recurrent MDD, severe without psychotic features (F33.2), current episode 4 months following spouse's death, complicated by treatment resistance after failing fluoxetine 60mg x10 wks and venlafaxine 225mg x8 wks"

TREAT: "Increased duloxetine to 60mg targeting depression + chronic pain, referred to geriatric psychiatrist for augmentation options, started weekly CBT with Dr. Smith, enrolled in senior center grief support group"

Clinical Documentation Elements

Reflecting diagnostic clarity, severity, and longitudinal clinical course

- **Link clinical relationships:** Use clear attribution and document the attribution explicitly → "Insomnia secondary to major depressive disorder" NOT "depression and insomnia"
- **Specify episode, history & onset:** "MDD first episode 2019, current episode 3/2024"
- **Show severity and symptom burden:** Document DSM-5-TR severity and objective measure when available (PHQ-9 score) → "Severe MDD, PHQ-9 = 22"
- **Specify type:** Use correct ICD-10 → F33.2 (recurrent, severe) or F33.1 (moderate); avoid F32.9 unspecified
- **Document annually:** Must be reviewed annually (by 12/31) during a face-to-face or telehealth encounter to remain active

Reframing Common Documentation Shortcuts

Replace	Use Phrase
"Stable"	"PHQ-9 = 8 x 3 mo, no suicidal ideation"
"Doing well"	"PHQ-9 improved 50% (18 → 9), resumed part-time work"
"Depression"	"Recurrent MDD, moderate (F33.1), partially controlled on meds"
"Compliant"	"Medication adherence 95% per pharmacy refill data; attends CBT sessions weekly."

4. TREATMENT & REFERRAL QUICK GUIDE^{1,9,11,16,18}

Therapy Escalation Criteria

Trigger	Action	Elderly Considerations
No response 4-6 weeks	Optimize dose or switch class (SSRI ↔ SNRI or to bupropion/mirtazapine)	<i>Start low, go slow</i> ; monitor falls, hyponatremia, SIADH; avoid strong anticholinergics (e.g., paroxetine), avoid TCAs
Partial response by ≈8 weeks	Augment (e.g., bupropion, mirtazapine, or atypical antipsychotic such as aripiprazole/brexipiprazole)	Prefer agents with low anticholinergic burden; close orthostasis and EPS monitoring
Failed ≥2 adequate trials (Stage II TRD)	Augment with lithium (aim low therapeutic range) or T3 (liothyronine); consider rTMS/ECTc	Monitor closely; Lower lithium target (≈0.4–0.6 mEq/L), check eGFR/TSH; T3 with thyroid monitoring
Severe, psychotic, catatonic, or high-suicide risk	Urgent psychiatry; ECT consideration	ECT is often well-tolerated and effective in late-life depression

APA-Aligned Recommendations

Clinical Scenario	First Choice (usual dose range mg/day)	Alternative	Avoid in Elderly
Initial mild-moderate	Sertraline 25–100 or Escitalopram 5–20	Venlafaxine XR 37.5–225 or Duloxetine 30–60	Paroxetine (anticholinergic), TCAs (falls, anticholinergic)
With prominent anxiety	Escitalopram 5–20 or Duloxetine 30–60 Venlafaxine XR 37.5–225	Sertraline 25–100mg/day	Benzodiazepines (falls, delirium, dependence)
With pain (neuropathic, OA, LBP)	Duloxetine 30-60mg	Venlafaxine XR	TCAs (fall risk)
With insomnia /weight loss	Mirtazapine 7.5–30mg HS	Trazodone 25–50 mg HS (for sleep)	High-dose trazodone (orthostasis, falls)
Treatment-resistant (after ≥2 trials)	Augment: Aripiprazole 2–10mg/day or Brexipiprazole 0.5–3mg/day	Lithium 300–900mg/day (aim 0.4–0.8; lower in elderly) or T3 25–50mcg/day	MAOIs

Non-Rx Treatment Documentation

"Referred for 12-session CBT course (Medicare covers 80%); prescribed behavioral activation with daily pleasant events scheduling; taught sleep hygiene including 10pm sleep restriction; enrolled in senior center social activities 2x/week; vitamin D 2000IU daily for level 18ng/mL"

When to Refer

Specialty	URGENT (<24 hours)	ROUTINE (2-4 weeks)
Psychiatry	Suicidal ideation with plan/means/intent, psychosis, catatonia, severe self-neglect, consider Baker Act	Failed ≥2 adequate trials, suspected bipolar or psychotic features
Geriatric Psych	Severe + dementia/delirium or unsafe home situation	Complex polypharmacy, frailty, recurrent falls or hyponatremia on antidepressants
Neuropsych	Rapid cognitive decline	Depression vs dementia; baseline testing
Sleep Medicine	Severe insomnia >1 week with safety risk (driving, near falls)	Suspected OSA (STOP-Bang positive), parasomnias

Follow-up Timing

- **New diagnosis:** 2 weeks for risk check, adherence, side effects
- **Medication start or dose change:** 2–4 weeks for early response/tolerability; **4–6 weeks** to determine response/next step
- **Stable/maintenance:** Every 3 months with PHQ-9 trend + functional status.
- **Severe/high-risk:** Weekly until stable; consider collaborative care or ECT if not improving.
- **Post-hospitalization for mental illness:** Visit within 7 days, again within 30 days (HEDIS FUH quality measure)

Patient Education & Adherence

"Demonstrated medication organizer use, verbalized understanding that improvement takes 4-6 weeks, identified early warning signs (sleep changes, isolation), provided crisis hotline card (988), discussed common side effects and management, addressed cost concerns with GoodRx coupon, PHQ-9 trend + function to be rechecked in 2-4 wk"

Comorbidity Management

Condition	Avoid	Use Instead
Cardiac disease/QT risk	TCAs, high-dose citalopram	Sertraline, escitalopram
Hyponatremia	SSRIs/SNRIs (higher risk)	Bupropion, mirtazapine
Falls/fractures	TCAs, paroxetine, benzodiazepines	Sertraline, bupropion
Cognitive impairment	Anticholinergics	Sertraline, escitalopram, duloxetine
Parkinson's disease (PD)	Routine antipsychotics	Sertraline, citalopram/escitalopram, venlafaxine/duloxetine

Cost-Smart Options

Brand	Generic/Alternative	Estimated monthly savings
Lexapro	Escitalopram	\$150 → \$10/month
Cymbalta	Duloxetine	\$250 → \$15/month
Wellbutrin XL	Bupropion XL	\$300 → \$20/month
Any brand SSRI	Generic sertraline/fluoxetine	\$4/month at several retail pharmacies
Trintellix	Generic SSRI + augmentation	\$400 → \$30/month

Quality Metrics Tie-In

Measure	Target	Documentation
PHQ-9 follow-up	Within 30 days of positive screen	HEDIS DSF; measure requires repeat PHQ-9 or documented follow-up plan within 30 days.
Antidepressant adherence	84 days (acute phase) and 180 days (continuation phase) of continuous therapy after initial fill	HEDIS AMM; document start date, adherence %, and refill data.
Post-discharge follow-up (mental health hospitalization)	7 days and again at 30 days after discharge	HEDIS FUH; requires face-to-face or telehealth encounter documenting evaluation/treatment plan.
Remission at 6 months	PHQ-9 <5 sustained ≥6 months	MIPS quality; follow-up PHQ-9 required within 6 months of baseline to demonstrate remission

5. CODING REMINDERS & CASE EXAMPLES^{1-3,8,18}

Specificity Requirements

- **Episode:** Use correct code family Single (F32.x) vs Recurrent (F33.x)
- **Severity Specifier:** Must specify mild (.0), moderate (.1), severe without psychotic (.2), severe with psychotic (.3)
- **Remission Specifier:** Document only after sustained improvement \geq 2 mo; Full (.40), partial (.41), or unspecified (.42)
- **Features Specifier:** Include when present → anxious distress, mixed features, melancholic, atypical, peripartum, seasonal

Annual Clinical Review and Confirmation

Confirm depression severity, activity, and ongoing management.

- **Annual review:** MDD must be reassessed once per calendar year via face-to-face or synchronous audio-video encounter, with MEAT documented by 12/31
- **Visit modality:** In-person or video telehealth encounters qualify when MDD is addressed and monitoring, assessment, and treatment are documented
- **Clinical context:** Under HCC V28, only moderate or severe MDD carries risk weight (\approx 0.299); mild MDD does not. Psychotic features increase risk categorization (eg, severe MDD with psychotic features)

Good Documentation is Comprehensive Coding

Insufficient	Comprehensive/ Corrective Documentation
"Depression stable"	→ Recurrent MDD, moderate, controlled on sertraline 100mg; PHQ-9 = 8 (improved from 14); continues CBT weekly
"Depression NOS/Unspecified"	→ MDD, single episode, moderate severity (F32.1) — specify episode + severity. Avoid F32.9
Missing severity	→ Add PHQ-9 score, DSM-5-TR severity specifier, and functional impact (e.g., "interfering with ADLs")
No MEAT	→ Include current medications, monitoring plan, and response to treatment in every note. Example: "Sertraline 100mg; monitoring PHQ-9 monthly; mood improving"

EHR Tips

- **Template:** Create a .mddMEAT macro for complete documentation (Monitor + Evaluate + Assess + Treat).
- **Problem list flag:** Tag depression codes as "**HCC_REQUIRED_ANNUAL**" to prompt annual MEAT completion.
- **Best Practice Alert:** Fire alert when **PHQ-9 is >6 mo old** or missing severity specifier

- **Order set:** Build “DEPRESSION_ANNUAL” order set → includes PHQ-9, TSH, B12, vitamin D, and HEDIS DSF/AMM follow-up reminders

Brief Case Examples

SUCCESS: "78yo with recurrent MDD, severe: Documented 'F33.2, PHQ-9=22, failed 2 SSRIs, started augmentation' → Proper HCC 155 capture, RAF 0.299 maintained"

PITFALL: "72yo noted 'depression improved' without PHQ-9 or severity → risk \$3,110 clawback incomplete documentation; Fix: 'Recurrent MDD, mild, F33.0, PHQ-9=7, controlled on escitalopram 10mg'"

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