AAVBC

American Academy
of Value Based Care

# Major Depressive Disorder

## Quick Reference Guide

2025

# AAVBC Major Depressive Disorder Quick Reference Guide

## Table of Contents

# 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, F32.9[3]

**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 Screenings[8-10]

| 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 >65yrs[11]

- 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

## 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 2.5-4.5 mIU/L:** Subclinical hypothyroid in ≈20% of MDD, fatigue, and cognitive slowing mimic depression → Check anti-TPO Ab
- **B12 200-400 pg/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 >20 ug/dL:** Consider Cushing's in depression + HTN + central obesity → Obtain 1-mg dexamethasone suppression test
- **Low vitamin D (<20 ng/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) | *Start low, go slow*; 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/brexpiprazole) | 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 25–100 mg/day | Benzodiazepines (falls, delirium, dependence) |
| **With pain (neuropathic, OA, LBP)** | Duloxetine 30-60 mg | Venlafaxine XR | TCAs (fall risk) |
| **With insomnia /weight loss** | Mirtazapine 7.5–30 mg HS | Trazodone 25-50 mg HS (for sleep) | High-dose trazodone (orthostasis, falls) |
| **Treatment-resistant (after ≥2 trials)** | Augment: Aripiprazole 2–10 mg/day or Brexpiprazole 0.5–3 mg/day | Lithium 300–900 mg/day (aim 0.4–0.8; lower in elderly) or T3 25–50 mcg/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 10 pm sleep restriction; enrolled in senior center social activities 2x/week; vitamin D 2000IU daily for level 18 ng/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 ≥ 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 (≈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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