DEPRESSION

Provider's guide to diagnose and code depression, PHQ-9 screening

The CDC (2010) estimates that 9% of the population is diagnosed with depression; 3.4% of those patients have a diagnosis of major depression. The geriatric population is typically not diagnosed, nor are they screened for the disorder. The diagnosis can have a great impact on other medical co-morbidities, and is associated with: suffering, mortality, and an increase in the utilization of health care resources. Older adults at greatest risk for depression include those that are hospitalized, chronically ill, and/or are institutionalized within the community.

Elderly patients need to be screened on an annual basis for depression. The patient should be asked if over the past two months they have felt:

› Down and out

› A loss of pleasure

› Fatigued or loss of energy

If two affirmative answers are provided in this screening, then the patient needs to be directed to the more in-depth PHQ-9 depression screening tool for further questioning:

› www.mdcalc.com/phq-9-patient-health-questionnaire-9/

› www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf

The PHQ-9 can be performed on a routine basis to follow the progress of treatment. The exam can be repeated every two weeks.

There are many reasons that geriatric patients experience depression, one of which is associated with their sense of losing personal independence, as well as the death of a spouse and/or friends within a social network. Additional risk factors for depression include:

› Genetic or familial history of depression

› Psychological or physical stress

› African American and Hispanic cohorts

› Female gender

› Reduced socio-economic status

› Prior stroke (vascular depression)

Clinical history is an important component when considering depression as a diagnosis. The clinician should be alert for signs and symptoms of: hopelessness, emptiness, anger, fatigue, poor concentration, insomnia, appetite changes, aches and pains, and suicidal thoughts. A loss of interest or pleasure is a diagnostic feature of major depression.

A complete review of the patient's medications should be performed since benzodiazepines, CNS depressants, and pain medications can exacerbate depression. Additionally, careful attention to the social history should be performed to review if alcohol and/or illicit drug use may be an etiological source for depression.

Many of the physical findings are associated with a subjective history. However, there are signs, which illustrate the depression, including: flat affect, weight gain/loss (muscle wasting), psychosis, mood swings, irritability, crying spells, and withdrawal/disinterest.

The PHQ-9 is an important screening tool, which assesses the mental well being of patients. Important definitions to keep in mind include (APA- DSM V [2013]):

› Depression – dysregulation of baseline mood, thought, or behavior

› Dysthymia – chronic depression that lasts for more than two years, also known as neurotic depression

› Psychosis – symptoms suggesting a loss of reality

Patients with a PHQ-9 ≤ 12 are scored as having mild depression. If the PHQ-9 is ≥ 13, the patient is classified as having major depression. Those that are diagnosed with major depression are often provided medications or other therapeutic modalities as form of treatment. Clinicians should always assess for signs of suicide. Depressed patients should be provided the National Suicide Hotline at 1-800-273-TALK (8255).

Scoring the PHQ-9 is as follows:

Score	Interpretation
5 to 9	Mild depression symptoms
10 to 14	If ≤ 12: Mild depression If ≥ 13: Mild– major depression
15 to 19	Moderate – major depression
Greater than 20	Severe – major depression

The clinician must ask the following questions:

› Is the depression a single or recurrent episode?
› For those with a PHQ-9 score of 20 or greater, is there any form of psychosis?
› In the case of unspecified single episode depression; the provider needs to provide specific detail

2015 IDC-10-CM

ICD-10-CM-CODE	ICD-10-CM Description	Definition/tip
F32.0	Major depressive disorder, single episode, mild	
F32.1	Major depressive disorder, single episode, moderate	
F32.2	Major depressive disorder, single episode, severe w/o psychotic features	
F32.3	Major depressive disorder, single episode, severe w/psychotic features	
F32.4	Major depressive disorder, single episode, in partial remission	**Major Depressive disorder, single episode**
F32.5	Major depressive disorder, single episode, in full remission	
F32.8	Other depressive episodes	
F32.9	Major depressive disorder, single episode, unspecified -Depression NOS -Depressive disorder NOS -Major Depression NOS (This is the equivalent of mild depression = ICD9CM code 311)	

2015 IDC-10-CM

ICD-10-CM-CODE	ICD-10-CM Description	Definition/tip
F33.0	Major depressive disorder, recurrent, mild	
F33.1	Major depressive disorder, recurrent, moderate	
F33.2	Major depressive disorder, recurrent, severe w/o psychotic features	
F33.3	Major depressive disorder, recurrent, severe w/ psychotic features	
F33.40	Major depressive disorder, recurrent, in remission, unspecified	
F33.41	Major depressive disorder, recurrent, in partial remission	**Major Depressive disorder, recurrent**
F33.42	Major depressive disorder, recurrent, in full remission	
F33.8	Other recurrent depressive disorders	
F33.9	Major depressive disorder, recurrent, unspecified -Monopolar depression NOS	
F41.8	Other specified anxiety disorders -Anxiety depression (mild or not persistent) -Anxiety hysteria -Mixed anxiety and depressive disorder	
F34.1	Dysthymic disorder -Depression neurosis -Depressive personality disorder -Dysthymia -Neurotic depression -Persistent anxiety depression	

General coding and documentation guidelines include:

› **The clinician must document the degree of depression by using specific words such as: mild, moderate, major, or severe**

› **The clinician needs to define if the depressive episode is a single or recurrent episode**

› **The clinician needs to document if the depressive episode is associated with or without psychotic features**

› Verify patient demographics, including patient name and date of birth

› Documentation of specific findings of depression, including the PHQ-9 score

› List a diagnosis that is specific to the ICD-9 nomenclature

› Document a specific treatment and follow-up plan

› Sign, date, and include the provider's credential on the written or electronic record encounter

› Link the diagnosis of depression when clinically appropriate, for example, depressed patients who experience anxiety

› The clinician needs to define if the depressive episode is in remission - partial remission (the interim period between major and minor depression for a period of less than 2 months following the end of a major depressive episode), or full remission (the period of time where no signs and symptoms of depression were noted during the past 2 months)

› Document depression in combination with anxiety and link the conditions anxiety depression when appropriate

Lastly, there are several treatments which are available to depressed patients. These include medications such as selective serotonin re-uptake inhibitors, as well as cognitive therapies. Be sure to consider all treatment options including a referral to psychiatry. The PHQ-9 is a powerful tool, and should be done annually to assess and evaluate for treatment effectiveness.

References:

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