Depression

Depression

Major depressive disorder or clinical depression is a common but serious mood disorder. It can cause severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. Symptoms must be present for at least two weeks to be diagnosed[1]. Causes of depression are not known, but a prominent theory is altered brain and chemical functions[2].

Symptoms of Depression

The signs and symptoms of depression can be experienced most of the day, or nearly every day, for at least two weeks. This can include feelings of sadness, anxiousness, hopelessness, irritability, guilt, decreased energy or fatigue, loss of interest, feeling restless, difficulty concentrating or sleeping, appetite changes, and/or thoughts of death or suicidal ideations[1].

Treatment of Depression

Depression can be treated, even in severe cases. The earlier the treatment begins, the more effective it is. Depression can be treated with medication and psychotherapy, or a combination of the two[1]. When treating depression, studies show co-existing illnesses can improve cost and utilization. Research also suggests pets and exercise can be a potent weapon against mild to moderate depression[2].

Depression

Goal

To provide coding and risk adjustment education including documentation on specificity of the disease and enhance the awareness of related HEDIS measures. Encourage open discussions between coder/provider.

Audience

Billers, Coders, Providers, including but not limited to Nurse Practitioners, Physician Assistants, General Practitioners, Family Medicine, Internal Medicine, Therapists, Master Level Providers, Psychologists, and Psychiatrists.

Resources

1. National Institute of Mental Health: Bipolar Disorder (revised February 2018) https://www.nimh.nih.gov/health/topics/depression/index.shtml
2. WebMD Depression: What Is It? (reviewed July 3, 2018) http://www.webmd.com/depression/ss/slideshow-depression-overview
3. 2019 ICD-10-CM Expert for Physicians: The Complete Official Code Set, Optum360. 2018 Optum360 LLC
4. PHQ Screeners: Depression Screening; Kroenke K, Spitzer RL, Psychiatric Annuals 20002; 32:509-521http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
5. HEDIS 2019 Technical Specification for Health Plans
6. US Preventive Services Task Force; https://www.uspreventiveservicestaskforce.org/

Visit our website:
https://www.homestatehealth.com/providers/tools-resources/coding-page.html

Depression Coding Guidance

TIPS:	ICD-10 Mapping & Education
➢ ICD-10-CM	F32.0 – F33.9 (Major depressive disorder)
➢ Attempt for more specificity…	Avoid broad terms and unspecified codes such as “Depression”, F32.9 (ICD 10 CM code) ☐ Be thorough in picking up the details in documentation ☐ This can lead to a better understanding of the depression and assist with accurate coding ☐ Remember to code out other mood affective disorders, such as, Manic (F30.-) and Bipolar (F31.-)
➢ In the documentation use terms that specify…	**Severity** ☐ Mild ☐ Moderate ☐ Severe **Episodes** ☐ Single ☐ Recurrent ☐ In Remission, partial or full
➢ Depression Screening Tool	☐ PHQ-9 is a nine question instrument for patients to complete in a primary care setting to screen for the presence and severity of depression. The results are used to assist the provider in making a depression diagnosis including the severity. ☐ Note all disclaimers on the website ☐ Visit http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
➢ Refilling medication	Verify depression is documented in the note and that it is listed and addressed in the Assessment & Plan, noting status and any medication changes.
➢ HEDIS 2019	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. There are 2 rates reported for this measure: ➢ Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ➢ Continuation Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months) [5].
➢ US Preventive Services Task Force	Recommend screening all patients over the age of 12 for depression at every visit **or** at a standard interval) [6].

PHQ 9 Questionnaire for Depression Screening

home state health

After member has completed the screening, count the number of boxes checked in each of the columns. Take the number and multiply by the value indicated below. Add the subtotals of each to produce the total score. Range is from 0 – 27.
https://www.phqscreeners.com/sites/g/files/g10049256/f/201412/PHQ-9_English.pdf

Not at all	(#) ___ x 0 = ___
Several days	(#) ___ x 1 = ___
More than half of the days	(#) ___ x 2 = ___
Nearly every day	(#) ___ x 3 = ___
Total score	___

Diagnosis	Score	For Score	Proposed Actions	ICD-10-CM
No or Minimal depression	0 – 4	≤ 4	Suggests the patient may not need depression treatment	Not applicable
Mild depression	5 – 9	5 – 14	Clinical judgement should be used for treatment, based on the duration of symptoms and functional impairment	F32.0 or F33.0
Moderate depression	10 – 14			F32.1 or F33.1
Moderately severe depression	15 – 19	>14	Depression should be treated, using antidepressant, psychotherapy and or a combination of treatment	F32.1 or F33.1 (moderate) F32.3 or F32.3 (severe)
Severe depression	20 – 27			F32.2 or F33.2 (w/o psychotic features) F32.3 or F33.3 (w/ psychotic features)
In Partial Remission	If member has been previously diagnosed with depression (regardless of severity), document that the depression is "in partial remission" in the note. *DSM 5 defines partial remission as patient has some symptoms but not meeting full criteria for the last 12 months.*			F32.4 or F33.41
In Full Remission	If member has been previously diagnosed with depression (regardless of severity), document that the depression is "in full remission" in the note. *DSM 5 defines full remission as patient has no symptoms for the last 12months.*			F32.5 or F33.42

Billing Sample #1

Primary Care Physician Documentation: Medical record SOAP format (condensed)

home state health

DOS: 04/14/2018
Gender: F **DOB:** XX/XX/1966 **Pulse:** 69 **Temp:**98.7˚F **B/P:** 142/86 **Weight: 130**lb **Height: 5**.6 **BMI:** 21
HPI: A 52 y.o. female with a history of hypertension and Fe deficiency anemia. Here today for routine follow-up. Patient also complains of decreased interest in things she used to enjoy; experiencing decreased energy, concentration and poor appetite. She is having some family issues with son and his wife.

PHQ 9 Assessment: (Included positive questions)
Little interest or pleasure in doing things? (score=2)More than half the days
Feeling down, depressed, or hopeless? (score=1) Several days
Feeling tired or having little energy? (score= 1) Several days
Trouble concentrating on things, such as reading the newspaper or watching television? (score=1) Several days

Not at all	(#) ___ x 0 = ___
Several days	(#) _3_ x 1 = _3_
More than half of the days	(#) _1_ x 2 = _2_
Nearly every day	(#) ___ x 3 = ___
	Total score _5__

Problem List/History: HTN: on HCTZ 25 mg, no chest pain and some palpitation with family issues. Fe deficiency anemia: has been off Fe supplement for 1 year; denies blood in stool and urine.
ROS: Denies SOB, N/V, abd pain, dysuria, and constipation. Denies suicidal ideations or wanting to hurt others.
PMH: Menorrhagia; Anemia
PSH: Smokes ½ PPD x 25 years, encouraged her to quit
Assessment and Plan:
HTN – change HCTZ to Amlodipine 5 mg daily
Chronic Fe Def anemia – etiology believed due to menorraghia but did have TAH in 2016. Labs today showed Hgb 8.7, no active bleeding, start Fe TID, order colonoscopy and repeat CBC in 2 weeks.
Depression, mild single episode – decreased interest, energy and concentration, No SI/HI Performed PHQ Screening with score of 5. Start outpatient behavioral health therapy. Schedule follow up in one month. Consider family counseling. Given pamphlet on how to quit smoking.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
I10	Hypertension	• ***Assessment & Plan***: Provider listed hypertension – changed medication from HCTZ to Amlodipine.
D64.9	Anemia, unspecified	• ***Assessment & Plan***: Provider listed Chronic iron deficiency anemia- reviewed labs and ordered Fe TID and repeat labs in 2 weeks.
F32.0	Major Depressive disorder, single episode, mild	• ***HPI, Assessment & Plan***: Depression, mild single episode. Patient completed the PHQ 9 Questionnaire with a score of 5. Provider documented Mild Single Episode . Patient was started on outpatient behavioral health therapy.
F17.210	Nicotine dependence, cigarettes	• ***PSH, Assessment & Plan:*** Provider listed smoker of ½ pack a day for 25 years; encouraged her to quit. The provider gave her a pamphlet on how to quit smoking.
Z87.410	Personal history of cervical dysplasia	• ***Assessment & Plan***: Provider stated patient with a history of TAH total abdominal hysterectomy in regards to the anemia. • ***Rationale***: ICD-10-CM guidelines state to code any factors influencing health status. This was related to the Fe deficiency anemia and follow up was ordered in 2 weeks.
Z79.899	Long term (current) use of drug therapy	• ***Medications*:** HCTZ listed as current medication. • ***Rationale*:** Codes from Z79- category indicate a patient's continuous use of prescribed drug for the long-term treatment of a condition.
Z63.79	Other stressful life events affecting family and household	• ***HPI, Assessment & Plan***: Provider listed family issues with son and his wife as this could be causing the decreased interest in things she used to enjoy, decreased energy and concentration. Assessment & Plan notes to consider family counseling.
Z68.21	Body Mass Index (BMI), 21.0-21.9	• ***HPI*:** Patient BMI documented as 21 • ***Rationale*:** Codes from Z68- category indicates a patient's BMI was documented in the record and this can assist with HEDIS BMI measure.

Billing Sample #2

Psychiatry Specialist Documentation: Medical record SOAP format (condensed)

home state health

DOS: 12/26/2018
Gender: F **DOB:** XX/XX/1999 **Pulse:** 80 **Temp:** 98.8°F **Weight:** 150 lb **Height:** 5.3.5 **BMI: 26.2**

HPI: A 19 y.o. female came in for follow up for her depression and anxiety. Her energy, motivation and appetite have been well; no hopelessness/helplessness nor worthlessness. She denies suicidal ideations. She continues to work on losing weight and exercising at college gym. She continues to complain of migraines as she thinks they are stress related. Her neurologist ordered topamox however her mom has concern about her taking this. She has been seeing the college therapist every other week. She reports that her moods have improved but anxiety has been worse. She states she is extremely anxious about cleanliness. She is not having panic attacks, just very anxious about cleanliness. She denies any substance alcohol or nicotine use.

PHQ 9 Assessment: (Included positive questions)

Trouble falling or staying asleep, or sleeping too much? (score=2)More than half the days

Trouble concentrating on things, such as reading the newspaper or watching television? (score=1) Several days

Not at all	(#) ___ x 0 = ___
Several days	(#) _1_ x 1 = _1_
More than half of the days	(#) _1_ x 2 = _2_
Nearly every day	(#) ___ x 3 = ___
	Total score _3__

Assessment/Plan:

She has had improvement of her depressive symptoms over the year and has been doing well in context of recent college transition. She continues to struggle with anxiety symptoms with impact on sleep and some concerns for obsessive compulsive disorder which will be further assessed with college therapist. She is currently on Cymbalta which will be maximized for anxiety management. She seems to be benefiting from topamox for migraine symptoms and should continue as ordered. She will be establishing care with a psychiatrist in her college town.

Increase Duloxetine to 120 mg po daily for anxiety. Depression is recurrent in partial remission. Continue to monitor and see college therapist.Lower Trazadone to 50 mg PRN for sleep.
Establish psychotherapy care in college town.No acute medical conditions or substance use today.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
F33.41	Major depressive disorder, recurrent in partial remission	• ***HPI, Assessment & Plan:*** Provider documents patient came in for follow up for depression. Provider noted the depression is recurrent and in partial remission. PHQ 9 score of 3. • ***Rationale*:** In order to code the major depressive; disorder, recurrent in partial remission, the provider must document as such, otherwise use F32.9, if only depression listed.
F41.9	Anxiety disorder, unspecified	• ***HPI:*** Provider documents follow up for anxiety. • ***Assessment & Plan:*** Provider documents increasing Cymbalta (Duloxetine)for anxiety.
G43.909	Migraine, unspecified not intractable, without status migrainosus	• ***HPI :*** Provider documents her neurologist ordered topamax for treatment of migraines. • ***Assessment & Plan***: Provider addresses migraines and states should continue medication as ordered.
F42.9	Obsessive-compulsive disorder, unspecified	• ***Assessment & Plan:*** Provider documents concerns for obsessive compulsive disorder and notes that it will be addressed further through therapy.
Z72.820	Sleep deprivation	• ***Assessment & Plan:*** provider documented patient struggles with anxiety symptoms and impacting sleep. The provider decreased trazadone medication to assist with sleep.
Z79.899	Other long term (current) drug therapy	• ***Assessment & Plan***: Patient had been taking Cymbalta. • ***Rationale***: Codes from Z79- category indicate a patient's continuous use of prescribed drug for the long-term treatment of a condition or for prophylactic use.
Z68.26	Body mass index (BMI) 26.0-26.9	• ***HPI*:** Patient BMI documented as 26.2 • ***Rationale***: Codes from Z68- category indicates a patient's BMI was documented in the record and this can assist with HEDIS BMI measure.

Billing Sample #3

Psychiatry Clearance Note: Medical record SOAP format (condensed)

home state health

DOS: 11/29/2018
Gender: F **DOB:** XX/XX/1983 **Pulse**: 69 **Temp:** 98.8˚F
Weight: 304lb **Height:** 5.6 **BMI:** 49.07

HPI: The patient is a 35-year-old woman seeking weight loss surgery. She has struggled trying to lose weight; she states she has always been an overeater. Her fiancé passed away October 2017 due to unexpected complications in the hospital. She was diagnosed with depression. Since then, she has been able to cope and feeling much better. She is calm and denies suicidal ideations. She denies tobacco use at this time but does have a history of smoking.

Assessment & Plan: The patient is being evaluated for a candidate for weight loss surgery. She is morbid obese. She experienced significant depression after the unexpected death of her loved one. She completed the PHQ 9 screening today with a score of 0. This depression was thought to be part of the grieving process and now she is able to cope with day to day activities. She is no longer taking medication to treat the depression. I asked her to make a follow up appointment with me one month post surgery. She is encouraged to ask for support from family, friends, and healthcare providers if she starts to experience additional stress during the post surgery period. It is recommended she attend the support group for minimum one year post surgery to make lifestyle changes.

Diagnosis: Morbid obesity due to excess calories; Depression in full remission but would like to see one month after surgery.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
F32.5	Major depressive disorder, single episode, in full remission	• *HPI, Assessment & Plan:* Depression is noted in the HPI due to an unexpected death of a loved one. Provider screened the patient using the PHQ 9 and the results were 0. Provider documented that the patient is in full remission.
E66.01	Morbid (severe) obesity due to excess calories	• ***HPI:*** She states she has always been an overeater. • ***Assessment & Plan***: Provide documented morbid obese. Under the Diagnosis section the provider noted the morbid obesity is due to excess calories. • ***Rationale*:** ICD 10 CM states to use additional code to identify body mass index (BMI) if known.
Z68.42	Body mass index (BMI), 45.0-49.9, adult	• ***HPI:*** The BMI of 49.07 is documented at the beginning of the record. • ***Rationale***: Codes from Z68- category indicates a patient's BMI was documented in the record and this can assist with HEDIS BMI measure.
Z87.891	Personal history of nicotine dependence	• ***HPI:*** The patient is a 35-year-old woman with history of smoking, currently she denies tobacco use. • ***Rationale***: ICD 10 CM coding guidelines state to assign status code Z87.891 when a patient has a history of tobacco use.

MORE CODING TIPS:

home state health

One way to document & code ***chronic conditions*** is by utilizing the acronym MEAT:

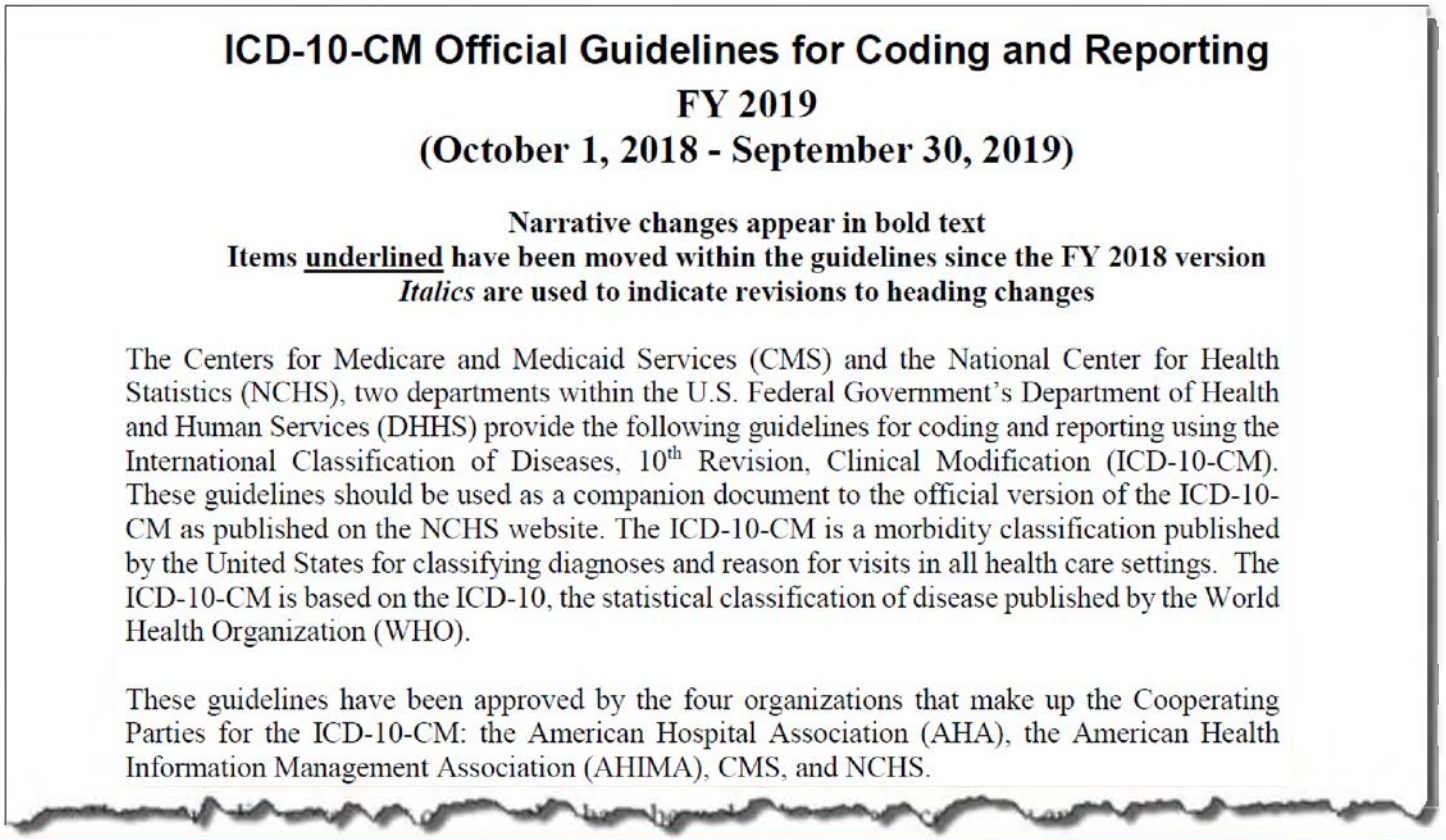
Monitor	• symptoms • disease progression/regression • ordering of tests • referencing labs/other tests
Evaluate	• test results • medication effectiveness • response to treatment • physical exam findings
Assess/ Address	• discussion, review records • counseling • acknowledging • documenting status/level of condition
Treat	• prescribing/continuation of medications • surgical/other therapeutic interventions • referral to specialist for treatment/consultation • plan for management of condition

General Notes:

- ❑Chronic Conditions can be coded during any type of visit even if they are stable.
- ❑Verify the condition, any medications, DME, injections, infusions.
- ❑Documentation must support that it was addressed

What are the ICD-10-CM Guidelines?

The ***ICD-10-CM Official Guidelines for Coding and Reporting*** are rules that supplement the conventions and instructions within the ICD-10-CM classification. Adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).



ICD-10-CM Official Guidelines for Coding and Reporting

FY 2019

(October 1, 2018 - September 30, 2019)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2018 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

Physician's Role

Risk adjustment is an important process that allows the State and Federal government to appropriately allocate revenue to health plans for the high risk members enrolled.

- ❑ Physician data (coding information submitted on physician claims) is critical for accurate risk adjustment.
- ❑ Physician claims data is the largest source of medical data for the risk adjustment models which help to determine how resources are allotted for care of the population.
- ❑ Specificity of diagnosis coding is substantiated by the medical record. Accurate coding helps to best reflect the cost of caring for members/patients:
  - ✓ It demonstrates the level of complexity for the patient encounters.
  - ✓ It is vital to a healthy revenue cycle, and more important, to a healthy patient.
- ❑ Each progress note must:
  - ✓ Support what is coded and billed (ICD-10-CM, CPT, and HCPCS).
  - ✓ "Stand alone" making sure a single service date has proficient data to support the medical decision making.
  - ✓ Be complete and contain legible signature & credentials.
  - ✓ Show medical necessity.

"Document for others as you would want them to document for you."