



Documentation and Coding Series: Major Depressive Disorder

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In our annual Blue Review readership survey, many of you asked for more articles on coding. In response, our Coding Compliance department has identified resources to help providers accurately code and document patient conditions. Additional articles in the series will run throughout the year. Let us know what you think. [Email us!](#)

Depression is the most common behavioral health disorder. It carries a high cost in terms of relationship problems, family suffering and lost work productivity, according to the [American Psychiatry Association](#). Accurately and completely documenting and coding Major Depressive Disorder (MDD) can **help our members access needed resources**. Below is information from the [ICD-10-CM Official Guidelines for Coding and Reporting](#).

Coding for MDD

When coding and documenting for MDD, **it's critical to capture the episode and severity** with the most accurate diagnosis codes.

Documentation should include:

- **Episode** – single or recurrent
- **Severity** – mild, moderate, severe without psychotic features or severe with psychotic features
- **Clinical status of the current episode** – in partial or full remission

The fourth and fifth characters in the ICD-10-CM codes capture the severity and clinical status of the episode.

F32.9 MDD, single episode, unspecified, is equivalent to Depression Not Otherwise Specified (NOS), Depressive Disorder NOS and Major Depression NOS. This code should rarely be used and only when nothing else, such as the severity or episode, is known about the disorder.

Best Practices

- Include patient demographics, such as name, date of birth and date of service in all progress notes.
- Document all information legibly, clearly and concisely.
- Ensure a credentialed provider signs and dates all documents.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventive exam as an opportunity to capture conditions impacting member care.
- Consider including [Social Determinants of Health \(SDoH\) ICD-10 Z codes](#) on the claims to better track and address the social needs of our members.

For more details, see the [ICD-10-CM Official Guidelines for Coding and Reporting](#), Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01-F99).

Continued on next page

Sample ICD-10-CM Codes for Single MDD Episode	
F32.0	Single episode, mild
F32.1	Single episode, moderate
F32.2	Single episode, severe without psychotic features
F32.3	Single episode, severe with psychotic feature
F32.4	Single episode, in partial remission
F32.5	Single episode, in full remission
F32.8x	Other depressive disorders
F32.9	Single episode, unspecified
Sample ICD-10-CM Codes for Recurrent MDD Episodes	
F33.0	Recurrent, mild
F33.1	Recurrent, moderate
F33.2	Recurrent, severe without psychotic features
F33.3	Recurrent, severe with psychotic symptoms
F33.4x	Recurrent, in remission
F33.8	Other recurrent depressive disorders
F33.9	Recurrent, unspecified

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.