

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Clinical Pathway: Diagnosis and Treatment of Major Depressive Disorders	Utilization Management
Date: 10-03 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10, 9-10, 9-11 Revised by QI Committee: 9-06, 01-10, 9-11	Page: 1 of 5 Policy Number: UM-8.6

Purpose: The purpose of this policy is to provide guidance to Beacon Comprehensive Behavioral Health Management (Beacon CBHM) staff and providers when providing clinical services for the treatment of a major depressive disorder. This policy provides suggestions and recommended practices but does not prescribe treatment. The provider should consider these guidelines in the treatment of a patient but may depart from them when clinically indicated.

Policy:

1.0 Definition of Major Depressive Disorder

- 1.1 Major Depressive Disorder is characterized by one single or two or more recurrent Major Depressive Episodes without a history of Manic, Mixed or Hypomanic Episodes. When coding Major Depression, the *fourth digit* in the diagnostic code indicates if it is a Single or Recurrent Episode. The *fifth digit* indicates the current severity or state of the disturbance. Whenever the criteria for Major Depressive Disorder is met, the severity of the episode is noted as (1) *Mild*, (2) *Moderate*, (3) *Severe without Psychotic Features*, or (4) *Severe with Psychotic Features*. If the criteria for Major Depressive Disorder are not currently present, the *fifth digit* is used to indicate whether the disorder is in (5) *Partial Remission* or (6) *In Full Remission*.
- 1.2 A Major Depressive Episode is characterized by a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms, which may include:
 - 1.2.1 Changes in appetite or weight, sleep, and psychomotor activity
 - 1.2.2 Decreased energy; feelings of worthlessness or guilt
 - 1.2.3 Difficulty thinking, concentrating, or making decisions
 - 1.2.4 Recurrent thought of death or suicidal ideation, plans or attempts.

The episode may be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2.0 Evaluation

Appropriate evaluation for Major Depressive Disorder includes rule-out of possible differential diagnoses. The following assessment should be completed by the end of the patient’s second session and/or prior to assigning a Major Depressive Disorder diagnosis.

- 2.1 A thorough medical exam to rule out symptoms related to a general medical condition.

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Clinical Pathway: Diagnosis and Treatment of Major Depressive Disorders	Utilization Management
Date: 10-03 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10, 9-10, 9-11 Revised by QI Committee: 9-06, 01-10, 9-11	Page: 2 of 5 Policy Number: UM-8.6

- 2.2 Psychosocial evaluation including:
 - 2.2.1 History of recent trauma, separation, life transition, death of family or friend, or childbirth
 - 2.2.2 Cultural, age and gender specific features of presenting complaints
 - 2.2.3 Comprehensive chemical dependency history to include both current and lifetime use of drugs and alcohol as depressive symptoms may be related to substance abuse disorder and individuals with mood disorders tend to self-medicate with drugs and/or alcohol.
 - 2.2.4 History of any suicidal, homicidal, and/or aggressive behaviors and consequences (e.g., hospitalization, arrest, etc)
 - 2.2.5 Family history including outpatient therapy, hospitalization, drug or alcohol treatment
 - 2.2.6 Special attention should be given to medication history including type, dosage, when taken, for how long, compliance, and response
- 2.3 Full Mental Status Exam with particular emphasis on a thought disturbance.
- 2.4 Evaluation of current level of functioning including but not limited to:
 - 2.4.1 Sleep
 - 2.4.2 Appetite
 - 2.4.3 Job/School Performance
 - 2.4.4 Relationships
 - 2.4.5 Concentration/Memory changes
 - 2.4.6 Risk of Suicide or Homicide

3.0 Diagnosis

If the following criteria are met, a diagnosis of Major Depressive Disorder may be given. Ongoing evaluation (e.g., history, laboratory findings, or physical examination) should clarify diagnosis further as to severity and to differentiate between other mood related disorders.

- 3.1 The presence of a Major Depressive Episode as defined above.
- 3.2 The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 3.3 The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- 3.4 The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Clinical Pathway: Diagnosis and Treatment of Major Depressive Disorders	Utilization Management
Date: 10-03 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10, 9-10, 9-11 Revised by QI Committee: 9-06, 01-10, 9-11	Page: 3 of 5 Policy Number: UM-8.6

- 3.5 The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

4.0 Intervention

According to the American Psychiatric Association, successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. Treatment consists of an acute phase, a continuation phase and a maintenance phase.

4.1 Acute Phase

4.1.1 Choice of an initial treatment modality:

Psychiatric management must be included during the acute phase of treatment. This should include:

- 4.1.1.1 Performing a diagnostic evaluation
- 4.1.1.2 Evaluating safety of the patient and others
- 4.1.1.3 Evaluating the level of functional impairments
- 4.1.1.4 Determining a treatment setting
- 4.1.1.5 Establishing and maintaining a therapeutic alliance
- 4.1.1.6 Monitoring the patient's psychiatric status and safety
- 4.1.1.7 Providing education to patients and families
- 4.1.1.8 Working with issues of relapse prevention.

In addition, the psychiatrist may choose between several initial treatment modalities, including pharmacotherapy, psychotherapy, and the combination of medications plus psychotherapy. Selection of an initial treatment modality should be influenced by both clinical and other factors.

4.1.2 Choice of specific pharmacologic treatment:

The initial selection of an antidepressant medication will largely be based on the anticipated side effects, the safety or tolerability of these side effects, patient preference, quantity and quality of clinical trial data, and its cost. On the basis of these considerations, the following medications are likely to be optimal for most patients: Selective serotonin reuptake inhibitors (SSRIs), desipramine, nortriptyline, bupropion, and venlafaxine. In general, monoamine oxidase inhibitors (MAOIs) should be restricted to patients who do not respond to other treatment.

Failure to respond:

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Clinical Pathway: Diagnosis and Treatment of Major Depressive Disorders	Utilization Management
Date: 10-03 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10, 9-10, 9-11 Revised by QI Committee: 9-06, 01-10, 9-11	Page: 4 of 5 Policy Number: UM-8.6

If at least moderate improvement is not observed following 6-8 weeks of pharmacotherapy, the psychiatrist should complete a re-appraisal of the treatment regimen.

4.1.3 Choice of psychotherapy:

Cognitive Behavioral Therapy and Interpersonal Therapy are the psychotherapeutic approaches that have the best-documented efficacy in the literature for the specific treatment of major depressive disorder. When psychotherapy is part of the treatment plan, it must be integrated with the psychiatric management. The frequency of outpatient visits during the acute phase varies from once a week in routine cases to as often as several times a week for rapid stabilization. If more than one clinician is involved in providing the care, it is essential that all treating clinicians have sufficient ongoing contact with the patient and with each other to ensure that relevant information is available to guide treatment decisions.

Failure to respond:

If after *4-8 weeks* of treatment at least a moderate improvement is not observed, the therapist should conduct a thorough review and reappraisal of the diagnosis, complicating conditions and issues, and treatment plan.

4.2 Continuation Phase

During the 16-20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse. In general, the dose used in the acute phase is also used in the continuation phase. There is also growing evidence supporting the use of specific effective psychotherapy during the continuation phase. The frequency of visits must be determined by the patient’s clinical condition as well as the specific treatments being provided.

4.3 Maintenance Phase

4.3.1 In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase. The same full antidepressant doses are employed as were used in prior phases of treatment: use of lower doses of antidepressant medication in the maintenance phase has not been well studied. For cognitive Behavioral Therapy and Interpersonal Therapy, maintenance phase treatments usually involve a decreased frequency of visits (e.g., once-a-month).

4.3.2 The frequency of visits in the maintenance phase must be determined by the patient’s clinical condition. The frequency could range from as low as once every two to three months for stable patients who require only

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Clinical Pathway: Diagnosis and Treatment of Major Depressive Disorders	Utilization Management
Date: 10-03 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10, 9-10, 9-11 Revised by QI Committee: 9-06, 01-10, 9-11	Page: 5 of 5 Policy Number: UM-8.6

psychiatric management and medication monitoring to once-a-month psychotherapy.

- 4.3.3 The decision to discontinue treatment should be based on the same factors considered in the decision to initiate maintenance treatment: probability of recurrence, the frequency and severity of past episodes, the persistence of dysthymic symptoms after recovery, the presence of comorbid disorders, and patient preferences.

5.0 Case Management

Ongoing case management is expected for patients diagnosed with Major Depressive Disorder. This involves:

- 5.1 Understanding the limitation of patient's benefit plan and providing treatment accordingly
- 5.2 Coordinating care with Primary Care Physician, Psychiatrist, and Therapist
- 5.3 Developing community resources such as local chapter of the National Alliance on Mental Illness (NAMI) and other support groups for families
- 5.4 Obtaining consent to involve family members or other support individuals in treatment planning and patient care
- 5.5 Requesting Intensive Case Management services (e.g. social worker, home health nurse) if patient demonstrate noncompliance with treatment

6.0 References

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, APA, Washington DC (2000)

American Psychiatric Association, Treating Major Depressive Disorder, A Quick Reference Guide, APA, Washington DC (2000)