Clinical Documentation Issues

Related to ICD-10-CM Mental and Behavioral Health Diagnoses

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Learning Objectives:

• Recognize pertinent documentation details required to assign specific ICD-10-CM codes for common mental health and substance use disorders.
• Formulate compliant and effective physician queries to assist in obtaining needed substance use and mental disorder documentation.
• Assess the impact that different substance use and mental health disorder codes have on the severity of illness scores and the MS-DRG assignment.
Overview and Impact of Mental and Behavioral Health Disorders

• The number of outpatient visits to emergency departments, hospitals, clinics, and physician offices with mental disorders as a primary diagnosis was 63.3 million in 2012.

• Inpatient hospital stays with psychoses as the principal diagnosis was 1.5 million and had an average length of stay of 7.2 days.

• Depression is the most common type of mental illness, affecting more than 26% of adults in the United States.

• Anywhere between 13%-20% of children experience a mental disorder on a yearly basis.
Documenting Mental Health Disorders

• Clinical documentation’s primary purpose for a mental disorder patient is to help ensure organized, efficient, and quality care. The secondary purpose is to enable the assignment of correct codes used to identify severity of illness (SOI), ensure coverage of services, and determine payment. Documentation is also used to determine the following:
  ▪ Support the medical necessity of the inpatient admission
  ▪ Establish a working diagnosis to assign a working diagnosis related group (DRG)
  ▪ Assign present on admission (POA) indicators
  ▪ Demonstrate that best practice guidelines have been followed
  ▪ Collect information for reporting quality and performance measures
• To meet the above goals CDI Specialist must review all parts of the medical record and query the providers for clarification of any documentation to get to the level of specificity needed for coding, billing, and reporting mental health disorders.
The objective of an inpatient hospitalization for a mental disorder patient is to treat the current acute episode, but equally important is to put measures in place that will prevent subsequent episodes. To start the process the intake clinician must accurately document the following in the ED note and the H and P:

- Mental disorder signs and symptoms to establish acuity of episode such as:
  - Hallucinations
  - Delusions
  - Paranoia
  - Disorganized speech
  - Erratic mood swings
  - Withdrawal
  - Suicidal ideation
  - Confusion
Mental Disorders: Emergency Department and Admission Documentation

- Type and severity of known or suspected mental disorder
- Presence of any symptoms that suggest a physiologic condition
- List of any known or suspected coexisting or comorbid medical conditions that might impact management or treatment of the patient
- Neurologic examination if indicated
- History of mental disorders, episodes, treatment and response, including social service records, reports of interview with family, and others
- History of, or current substance abuse
Mental Disorders: Documentation to Establish Medical Necessity

• Admitting documentation should state why the patient had to be admitted as an inpatient and could not be treated as an outpatient.

• The below clinical indicators show medical necessity for an inpatient stay:
  ✓ Acute psychotic symptoms (hallucinations, delusions)
  ✓ Potential for self-harm or harm of others
  ✓ Severe withdrawal symptoms
  ✓ Suicidal ideation
  ✓ Violent behavior
Mental disorders are caused by brain disorders.

Brain disorders can be related to chemical imbalances, electrical problems, DNA mutations, brain anomalies, environmental factors, trauma, exposure to drugs or other substances, or medical disease.
Neurons

• Basic working unit of the brain and nervous system.
• All sensations, movements, thoughts, memories and feelings are the result of the signals that pass through the three basic parts of the neuron.
Neurotransmitters

- Neurotransmitter molecules are secreted from sacs at the ends of the axon when a signal is generated or passed on from another neuron.

<table>
<thead>
<tr>
<th>Neurotransmitter</th>
<th>Description</th>
<th>Associated Mental Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dopamine</strong></td>
<td>Helps to control movement and aids in the flow of information to the front of the brain, which is linked to thought and emotion. It is also linked to reward systems in the brain.</td>
<td>Studies suggest that insufficient dopamine or problems using it in the thinking and feeling regions of the brain may play a role in disorders like schizophrenia or attention deficit hyperactivity disorder (ADHD).</td>
</tr>
<tr>
<td><strong>Gamma-Aminobutyric Acid (GABA)</strong></td>
<td>Regulates muscle tone and reduces neuron excitability throughout the nervous system.</td>
<td>High levels have a sedating, depressant effect.</td>
</tr>
<tr>
<td><strong>Glutamate</strong></td>
<td>Enhances the electrical flow among brain cells that is required for normal brain development and function.</td>
<td>Problems in making or using glutamate have been linked to many mental disorders, including autism, obsessive-compulsive disorder (OCD), schizophrenia, and depression.</td>
</tr>
<tr>
<td><strong>Norepinephrine</strong></td>
<td>Contributes to attentiveness, emotions, sleeping, dreaming, and learning. Also causes blood vessels to contract and heart rate to increase.</td>
<td>Plays a role in mood disorders, such as manic depression.</td>
</tr>
<tr>
<td><strong>Serotonin</strong></td>
<td>Contributes to regulating body temperature, sleep, mood, appetite, and pain.</td>
<td>Low levels can contribute to depression, suicide, impulsive behavior, aggressiveness.</td>
</tr>
</tbody>
</table>
Common presenting symptoms that fall under the AMS umbrella include the following:

- Agitation
- Altered behavior (any type of change, such as aggressiveness, inattentiveness, combativeness, or inappropriate behavior for setting)
- Coma
- Confusion
- Disorientation
- Lethargy
- Memory loss
- Obtundation
- Poor control of emotions
- Poor judgment or thought defects
- Somnolence
- Stupor
- (Persistent) vegetative state

### Altered Mental Status – Umbrella Term

<table>
<thead>
<tr>
<th>ICD-10-CM code</th>
<th>Description</th>
<th>Additional information about code</th>
</tr>
</thead>
<tbody>
<tr>
<td>R40.0</td>
<td>Somnolence</td>
<td></td>
</tr>
<tr>
<td>R40.1</td>
<td>Stupor</td>
<td></td>
</tr>
<tr>
<td>R40.20</td>
<td>Unspecified coma</td>
<td>MCC</td>
</tr>
<tr>
<td>R41.0</td>
<td>Disorientation, unspecified</td>
<td>Includes unspecified confusion and delirium</td>
</tr>
</tbody>
</table>
| R41.82         | Altered mental status, unspecified | Includes:  
  - Change in mental status NOS  
  Excludes:  
  - Altered level of consciousness  
  - Altered mental status due to known condition—code to condition  
  - Delirium, unspecified |
| R53.83         | Other fatigue                      | Includes:  
  - Fatigue NOS  
  - Lack of energy  
  - Lethargy  
  - Tiredness |
| R40.3          | Persistent vegetative state        | MCC                               |
Altered Mental Status: Causes

- Acute or late effect of stroke
- Alzheimer’s disease
- Cerebral ischemia
- Delirium
- Dementia
- Drug-drug interaction
- Dysthymia
- Glucose imbalance
- Hydrocephalus
- Infection
- Intracranial trauma

- Migraine
- Neurodegenerative disorders
- Neoplasms of the CNS
- Organ failure, such as liver
- Psychiatric diseases
- Medication reactions
- Seizure disorder
- Sepsis
- Transient ischemic attack
- Vegetative state
AMS Query

- Dear Dr. Doe,
  - The documentation in the medical record indicates AMS. Although the patient has dementia the documentation shows the patient is not at baseline with increased restlessness, confusion, and decreased appetite. Would you please clarify in your progress notes if the AMS could be further clarified as:
  1. AMS only
  2. Encephalopathy
  3. Delirium
  4. Unable to determine
  5. Other, please specify

Thank you,
Susan, CDI Specialist
AHIMA-Guidelines for Achieving a Compliant Query Process

“Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option. As such, providing a new diagnosis as an option in a multiple choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information. Multiple choice query formats should also include additional options such as “clinically undetermined” and “other” that would allow the provider to add free text. Additional options such as “not clinically significant” and “integral to” may be included on the query form if appropriate.”
Delirium is defined as "a disturbance of consciousness with reduced ability to focus, sustain, or shift attention." Physical and mental disorders that deprive the brain of oxygen, or create deficiencies or excesses in the amount of neurotransmitters available, result in delirium, because they alter brain activity to the point where it does not function properly. It is thought that the unpredictable nature of the increases and decreases in neurotransmitters is what causes some delirious patients to have hyperactive symptoms, while others have hypoactive or mixed symptoms. This concept also helps to explain why it is so difficult to effectively prevent and treat delirium.
Delirium due to known physiological condition

Delirium is caused by some precipitating factor, most often a medical one. Therefore, the care provider should document an underlying cause, if one is known or suspected. In ICD-10-CM, there is a code just for delirium due to known physiological condition (F05). It includes delirium that is postprocedural, or superimposed on dementia, or identified as sundowning.

- Code underlying condition first
- Code F05 as a secondary.
- F05 is a CC that is rarely excluded.
- Delirium is not an integral symptom of any disease. Therefore, it should always be listed as a secondary diagnosis, as instructed.

F05 Delirium due to known physiological condition
- Acute or subacute brain syndrome
- Acute or subacute confusional state (nonalcoholic)
- Acute or subacute infective psychosis
- Acute or subacute organic reaction
- Acute or subacute psycho-organic syndrome
- Delirium of mixed etiology
- Delirium superimposed on dementia
- Sundowning

Code first the underlying physiological condition
Excludes 1: delirium NOS (R41.0)
Excludes 2: delirium tremens alcohol-induced or unspecified (F10.231, F10.921)
## Reimbursement and SOI for F05

<table>
<thead>
<tr>
<th>MS-DRG 195</th>
<th>MS-DRG 194</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Simple Pneumonia w/o CC/MCC</strong></td>
<td><strong>Simple Pneumonia with CC</strong></td>
</tr>
<tr>
<td>Principal Diagnosis: J189-Pneumonia</td>
<td>Principal Diagnosis: J189-Pneumonia</td>
</tr>
<tr>
<td>Secondary Diagnosis: R41.0-Disorientation, unspecified (Delirium, unspecified)</td>
<td>Secondary Diagnosis: F05-Delirium due to known physiological condition</td>
</tr>
<tr>
<td>RW: 0.7111</td>
<td>RW: 0.9695</td>
</tr>
<tr>
<td>Reimbursement: $5117.89</td>
<td>Reimbursement: $6977.62</td>
</tr>
<tr>
<td>SOI: 1</td>
<td>SOI: 2</td>
</tr>
<tr>
<td>ROM: 1</td>
<td>ROM: 1</td>
</tr>
</tbody>
</table>
If the care provider believes the delirium is an adverse effect of a medication, he or she must document the following information about delirium to ensure it is coded and reported properly:

- Time and circumstances of onset of the delirium
- Detailed description of the symptoms, and their severity and duration
- Medications believed to be causing the adverse effect, if appropriate
- Time patient took or was given medication, its dosage and route of administration, and who did the administering (self, spouse, nurse, and so forth)
- Any treatment provided to counteract adverse effect or treat symptoms
- Response to treatment and resolution of symptoms

**Attending Progress Note 8/20/14:**
“Last night the patient was given a 25 mg dose (1 capsule) of chlordiazepoxide by the nursing staff as prescribed by the house staff for insomnia. She has no prior history of taking this drug. The nurses noted that she became confused, disoriented, and very agitated within an hour of taking the medication, and was becoming difficult to keep in bed and attempted to pull out her IVs on two occasions. The patient’s agitation subsided after a dose of Haloperidol was given. The patient’s acute delirium has resolved.”
Delirium due to Substance Abuse or Dependency

- Delirium associated with alcohol or substance abuse or dependence is captured as part of the alcohol or substance abuse codes.
- The relationship must be documented and the delirium clearly linked to the alcohol or substance abuse or dependency.
- The substance abuse codes with delirium are CCs.

### Example ICD-10-CM Codes

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<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>MCC/CC Status</th>
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<tbody>
<tr>
<td>F10.121</td>
<td>Alcohol abuse with intoxication delirium</td>
<td>CC</td>
</tr>
<tr>
<td>F10.231</td>
<td>Alcohol dependence with withdrawal delirium</td>
<td>CC</td>
</tr>
<tr>
<td>F13.121</td>
<td>Sedative, hypnotic, or anxiolytic abuse with intoxication delirium</td>
<td>CC</td>
</tr>
<tr>
<td>F18.221</td>
<td>Inhalant dependence with intoxication delirium</td>
<td>CC</td>
</tr>
</tbody>
</table>
Substance Abuse with Delirium Documentation Details Needed for Coding

- **Name of substance** (alcohol, opioids, cannabis, sedative, hypnotics or anxiolytics, cocaine, stimulants, hallucinogens, nicotine, inhalants, other psychoactive substances)
- **Use level** (Use, Abuse or Dependency)
  - **Acuity**
    - Uncomplicated
    - With intoxication (uncomplicated or with accompanying condition)
    - With withdrawal
    - In remission (early and sustained)
- **Related symptoms** (such as, amnesia, anxiety, delirium, delusions, hallucinations)
- **Related conditions/disorders** (such as dementia mood disorders, perceptual disorders, psychotic disorders, sexual dysfunction, sleep disorders)

Diagnoses of delirium or other related symptom or condition must be linked to the substance involved using connecting terms such as "due to," "caused by," "secondary to," or "resulting from"

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Encephalopathy

- *Encephalopathy* is a broad term encompassing all types of brain dysfunction induced by an underlying medical condition.
- Encephalopathy goes hand-in-hand with delirium. Delirium represents the mental manifestations of brain dysfunction, and encephalopathy identifies the underlying pathophysiologic process.

- The characteristics of encephalopathy include the following:
  - Sudden, acute, or subacute onset.
  - Fluctuating levels in arousal, with a wide range of brain dysfunction affecting memory, speech, orientation, thought process, concentration, judgment, personality, or behavior.
  - Due to an underlying systemic cause, such as fever, infection, dehydration, electrolyte imbalance, acidosis, organ failure, sepsis, hypoxia, drugs, poisons, toxins, trauma, and cancer.
Encephalopathy Classifications

• DMS-5 classifies acute toxic and metabolic encephalopathy as delirium. The term encephalopathy does not even appear in its definitions.

• ICD-10-CM, on the other hand, does not distinguish between acute and chronic encephalopathy, and it classifies encephalopathy separately from delirium.

• To capture the full spectrum of the disease in ICD-10-CM, both delirium and the specific type of encephalopathy must be documented, along with the underlying cause, as demonstrated in these example diagnostic statements:
  - Delirium due to metabolic encephalopathy caused by urinary tract infection and dehydration
  - Hypertensive encephalopathy with delirium
Encephalopathy Codes and Documentation Requirements

Encephalopathy is classified to a variety of codes in various chapters in ICD-10-CM depending on the type and cause of the encephalopathy.

Most encephalopathy codes are MCCs or CCs, but a few are not, so it is very important for the care provider to document the following details about the encephalopathy to ensure it is coded and reported accurately:

- Type of encephalopathy (metabolic, toxic, hepatic, alcoholic, anoxic/hypoxic, hypertensive)
- Delirium, if appropriate
- Description of symptoms and manifestations of the encephalopathy to support the diagnosis and demonstrate severity and complexity of the patient's condition
- Underlying cause of encephalopathy
- Additional information as required by instructions in the code book, such as:
  - Vaccination information
  - Alcohol or substance use, abuse, or dependence
  - Medications
  - Organ failure
  - Causative organisms
  - Type and location of cancer

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>G04.32</td>
<td>Postimmunization acute necrotizing hemorrhagic encephalopathy</td>
<td>Documentation must identify the vaccine</td>
<td>MCC</td>
</tr>
<tr>
<td>G13.1</td>
<td>Other systemic atrophy primarily affecting central nervous system in neoplastic disease</td>
<td>Documentation must identify (and list-first) the underlying neoplasm</td>
<td>non-CC</td>
</tr>
<tr>
<td>G31.82</td>
<td>Leigh’s disease (subacute necrotizing encephalopathy)</td>
<td>Documentation must identify any associated dementia with or without behavior disturbance</td>
<td>CC</td>
</tr>
<tr>
<td>P91.61</td>
<td>Mild hypoxic ischemic encephalopathy [HIE]</td>
<td>Condition must have originated in the neonatal period</td>
<td>CC</td>
</tr>
</tbody>
</table>
Dementia

*Dementia* is the term traditionally used to describe a variety of symptoms associated with the gradual decline of cognitive function that are severe enough to interfere with the activities of daily living.

According to the DSM-5 definition, to be considered with dementia, the patient must have significant impairment (loss of independence) in one or more of the following cognitive domains:

- Memory
- Language
- Execution of purposeful movement
- Recognition of familiar things
- Executive function (self-control)
- Visual and spatial perception

In the DSM-5, the term dementia is subsumed by the term "major neurocognitive disorder." However, it allows the continued use of the term "dementia" where it is customary to do so, as in geriatrics.
Dementia Codes

Coding dementia in ICD-10-CM usually requires two codes, sometimes three if the patient wanders.

For cases with behavioral disturbance, there is also an instruction to use an additional code to identify if the patient wandered (Z91.83) away from his or her caretaker outside the safe or allowed zone.

The ICD-10-CM codes for dementia cases should appear in the following order:
1. Code for the underlying cause
2. Code for the type of dementia (with or without behavior disturbance)
   - Agitated, combative, or aggressive behavior
3. Code for wandering, if applicable

All the dementia codes that include "with behavioral disturbance" are classified as CCs.

### Example ICD-10-CM Codes

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>F01.50</td>
<td>Vascular dementia without behavioral disturbance</td>
<td>Includes vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Code first the underlying physiological condition or sequelae of cerebrovascular disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use additional code, if applicable, to identify wandering in vascular dementia (Z91.83)</td>
</tr>
<tr>
<td>F01.51</td>
<td>Vascular dementia with behavioral disturbance</td>
<td>Use additional code, if applicable, to identify wandering in vascular dementia (Z91.83)</td>
</tr>
<tr>
<td>F02.80</td>
<td>Dementia in other diseases classified elsewhere without behavioral disturbance</td>
<td>Code first the underlying physiological condition</td>
</tr>
</tbody>
</table>
Mental Disorders: Overview

- Common Mental Disorders:
  - Anxiety
  - Bipolar disorder, type I & II
  - Depression
  - Eating disorders
  - Intellectual disabilities
  - PTSD
  - Mood disorders
  - Schizophrenia
Common Causes

- Genetics
- Brain anomalies
- Family history and life experience
- Biological factors
- Brain injury
- Exposure to infectious organisms or toxic substances
- Substance abuse
- Medical conditions such as cancer or epilepsy
Common Risk Factors

- Family history
- Being exposed to toxins or infections in utero
- Excessive stress
- Living with chronic health problems
- Brain damage
- Exposure to traumatic situations
- Substance abuse
- Child abuse or neglect as a child
- Lack of friends, or meaningful relationships
- Sociocultural environment
Psychoses

- Psychosis is a symptom of many mental disorders including:
  - Schizophrenia
  - Bipolar disorder
  - Major depression
  - Schizoaffective disorder
- Psychoses are characterized by dramatic changes in personality, as well as impaired functioning.
- Antipsychotics are used to manage psychosis, particularly in schizophrenia and bipolar disorder, and are being increasingly used in the management of nonpsychotic disorders.
- If a patient is being given an antipsychotic medication and there isn’t a corresponding diagnosis be sure to query for it.
Psychosis Query

Dr. Doe,

Haloperidol was ordered for the patient on Day 2 of admission. Could you please clarify the diagnosis and/or diagnoses for which this medication was ordered? Thank you.

Susan, CDI Specialist
Psychotic Episodes

• A person experiencing a psychotic episode might hallucinate, become paranoid, or experience a change in personality. Episodes can last anywhere from a few hours to a month or more.

• Psychotic episodes can occur with an existing condition such as schizophrenia, or occur independently. The following are some examples of conditions other than mental disorders that can cause a psychotic episode:

  ✓ Brain tumor
  ✓ Head injury
  ✓ Meningitis
  ✓ Sarcoidosis
  ✓ Trauma

  Cerebrovascular disease
  Hypoglycemia
  Multiple sclerosis
  Systemic lupus erythematosus
  Traumatic event (combat, child abuse)
Psychotic Episodes: ICD-10-CM and Documentation Requirements

- ICD-10-CM has mental disorder codes that identify manifestations of the episode as well as its underlying mental disorder. Care providers must document the underlying mental disorder causing the psychotic episode if it was determined.

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F30.2</td>
<td>Manic episode, severe with psychotic symptoms</td>
</tr>
<tr>
<td>F32.3</td>
<td>Major depressive disorder, single episode, severe with psychotic feature</td>
</tr>
</tbody>
</table>
Psychotic Episodes: ICD-10-CM Codes and Documentation Requirements

- ICD-10-CM also has codes for situations in which the psychotic episode is due to a mental disorder that has a known underlying physiologic cause. In these situations, the care provider must document the mental disorder, the underlying physiologic condition, as well as the psychotic manifestation.

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional information to Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.2</td>
<td>Psychotic disorder with delusions due to known physiological condition</td>
<td>Code first the underlying condition, such as epilepsy</td>
</tr>
<tr>
<td>F06.32</td>
<td>Mood disorder due to known physiological condition with major depressive-like episode</td>
<td>Code first the underlying condition, such as multiple sclerosis</td>
</tr>
<tr>
<td>F07.0</td>
<td>Personality change due to known physiological condition</td>
<td>Code first the underlying condition, such as meningitis</td>
</tr>
</tbody>
</table>
Query-Cause of the Psychotic Episode?

• Dear Dr. Doe,

Patient was admitted for treatment of viral encephalitis, and during the course of his stay experienced documented personality changes and hallucinations. Could you please clarify in your notes, if determined, the cause of the personality changes and hallucinations?

Thank you.

Susan, CDI Specialist
Query-Cause of a Psychotic Episode

• Dear Dr. Doe:
  Your patient was admitted with viral encephalitis and during the course of his stay experience documented personality changes and hallucinations. Would you please document in your progress notes the cause of the personality changes and hallucinations such as:
  1. Viral encephalitis
  2. Other medical condition (please specify)
  3. Other mental disorder (please specify)
  4. Unable to determine
  5. None of the above
Thank you.

Susan, CDI Specialist
Schizophrenia
A Psychotic Disorder
Criteria for a diagnosis of schizophrenia must include two or more of specified symptoms for a period of one month or more and at least one of the symptoms has to be hallucinations, delusions, or disorganized speech.

Symptoms may include:
- Hallucinations
- Delusions
- Disorganized speech
- Catatonic behavior
- Movement disorders
- Flat affect
- Speaking little
- Lack of ability to sustain activities

For a diagnosis of schizophrenia the patient must also exhibit social or occupational dysfunction, such as lack of self care, poor performance or attendance at work or school, or interpersonal problems for a significant portion of time since onset, or at least 6 months.
Risk factors include:
- Stress from a major life event
- Having a sibling or parent with schizophrenia
- Pregnancy, prenatal, perinatal complications, such as older father, birth trauma, and fetal hypoxia

Medications include:
- Aripiprazole (Abilify)
- Clozapine (Clozaril)
- Haloperidol (Haldol)
- Perphenazine
- Risperidone (Risperdal)

Treatment and therapy:
- Electroconvulsive therapy
- Psychotherapy
- Family therapy
- Social skills therapy
- Life assistance-education, job training, housing, support groups
# Schizophrenia: ICD-10-CM Codes and Documentation Requirements

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>F20.0, Paranoid schizophrenia, is characterized by delusions, auditory hallucinations, and the person’s conviction that others are plotting against him/her or family members. Patients with paranoid schizophrenia maintain an unshaken belief that they are being persecuted and may exhibit anger and anxiety as a result. Because they cannot be convinced that their delusion is not true, they can appear argumentative and suspicious toward others.</td>
</tr>
<tr>
<td>Disorganized</td>
<td>F20.1, Disorganized schizophrenia, is characterized by speech and behavior that are disorganized or difficult to understand, along with irrational or inappropriate emotions or a lack of emotion. For example, a patient with disorganized schizophrenia may laugh at a funeral or cry when seeing someone mow his or her lawn. The patient’s disorganized behavior may disrupt normal activities and make it difficult to function in society.</td>
</tr>
<tr>
<td>Catatonic</td>
<td>F20.2, Catatonic schizophrenia, is characterized by sudden and irrational disturbances of movement. These patients may remain completely immobile for periods of time and then move in a repetitive manner for periods of time. They may not say anything for hours, or they may senselessly repeat anything said to them.</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>F20.3, Undifferentiated schizophrenia, is a broad term applied to patients who display some of the symptoms seen in the other types of schizophrenia but not enough of any one of the symptoms to define it as a particular type of schizophrenia.</td>
</tr>
<tr>
<td>Residual</td>
<td>F20.5, Residual schizophrenia, is defined as a past history of at least one episode of schizophrenia but currently having no positive symptoms (delusions, hallucinations, or disorganized speech or behavior). Residual schizophrenia may represent a transition between a full-blown episode and complete remission, or it may continue for years without any further psychotic episodes.</td>
</tr>
<tr>
<td>Schizotypal disorder</td>
<td>F20.81, Schizotypal disorder is a short-term form of schizophrenia, in which a patient suffers from delusions or hallucinations for at least 1 month and up to 6 months. The patient is treated with the same antipsychotic medications prescribed for schizophrenia. If the patient still has the symptoms after 6 months, he or she usually then is diagnosed with schizophrenia.</td>
</tr>
</tbody>
</table>
If the schizophrenia has lasted at least a year, DSM-5 instructs that the following details be documented about the schizophrenia:

- Specify episode
  - First
  - Multiple
  - Continuous
- Specify current acuity
  - Acute
  - Partial remission
  - Full remission
- Specify if with catatonia
- Rate severity of the primary symptoms of psychosis* on a scale of 0 (symptoms not present) to 4 (symptoms present and severe)

*Delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania symptoms

ICD-10-CM Classification

ICD-10-CM has separate codes for each subtype of schizophrenia which are consistent with how they were classified in DSM-IV:

- Paranoid
- Disorganized
- Catatonic
- Undifferentiated
- Residual
- Schizophreniform Disorder

However, the subtypes of schizophrenia are no longer included in DSM-5.

It is unclear if care providers will continue to document the subtype of schizophrenia.

- If they do, the schizophrenia can be assigned a specific ICD-10-CM code.
- If they do not, the schizophrenia will be assigned to the unspecified ICD-10-CM code (F20.9).
Mood Disorders
Mood Disorders: Overview

- Mood disorders typically last 1 to 2 weeks duration and the person feels unusually happy or sad. Some people only experience manic episodes while others experience depressive episodes, and some people experience both.
- Mood disorders can be due to a physiological condition that directly affects the brain, or they could be cause by a systemic disease. Many mood disorders are due to alcohol and substance abuse.

<table>
<thead>
<tr>
<th>ICD-10-CM code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.32</td>
<td>Mood disorder due to known physiological condition with major depressive-like episode</td>
<td>Mental disorders due to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Endocrine disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exogenous hormone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exogenous toxic substance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Primary cerebral disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Somatic illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Systemic disease affecting the brain</td>
</tr>
<tr>
<td>F06.33</td>
<td>Mood disorder due to known physiological condition with manic features</td>
<td>Code first the underlying physiologic condition</td>
</tr>
<tr>
<td>F10.24</td>
<td>Alcohol dependence with alcohol-induced mood disorder</td>
<td></td>
</tr>
<tr>
<td>F11.24</td>
<td>Opioid dependence with opioid-induced mood disorder</td>
<td></td>
</tr>
</tbody>
</table>
The care provider must include the following details in his or her documentation of a manic or depressive episode in order to have it coded correctly:

- Duration of the episode
- Description of the episode
- Severity of the episode
- Presence or absence of psychotic symptoms
- Remission status

When coding the account the coding specialist can use documented hallucinations or delusion to support the coding of “manic (or depressive) episode code with psychotic symptoms,” but the care provider must specify the level of severity.
Query: Level of Severity for a Manic Episode

• Dear Dr. Doe,

The patient has a documented secondary diagnosis of a manic episode without psychotic features. Would you please specify in your progress notes if the episode was mild, moderate, or severe, or in partial or full remission. Thank you.

Susan, CDI Specialist
Mood Disorders: Manic Episodes

- Manic episodes must last at least a week to be considered an “episode.” During these episodes the person can be both very happy and very irritable. They tend to talk fast, are restless, sleep very little and partake in high risk behaviors.
- Manic episodes are often emergencies that require immediate hospitalization and medication to avoid the possibility of a dangerous escalation.
- The care provider must clearly document his or her concern for the patient’s safety, or that of others to support the need for admission.
- Some patient’s level of mania is not as intense or as long and this is described as hypomania which must last at least 4 days.
Mood Disorders: Manic Episodes ICD-10-CM Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F30.12</td>
<td>Manic episode without psychotic symptoms, moderate</td>
<td>Include instances in which a patient with bipolar disorder has a single manic episode</td>
</tr>
<tr>
<td>F30.2</td>
<td>Manic episode, severe with psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>F30.4</td>
<td>Manic episode in full remission</td>
<td></td>
</tr>
<tr>
<td>F30.8</td>
<td>Other manic episodes</td>
<td>Hypomania</td>
</tr>
</tbody>
</table>
Mood Disorders: Brief and Unspecified Depressive Episodes

- A single nonrecurrent depressive episode of any length or severity is classified in ICD-10-CM as “unspecified depression.”

<table>
<thead>
<tr>
<th>ICD-10-CM code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unspecified depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unspecified depressive disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unspecified major depression</td>
</tr>
<tr>
<td>F33.8</td>
<td>Other recurrent depressive disorders</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recurrent brief depressive episode</td>
</tr>
</tbody>
</table>
Patients with a major depressive disorder (MDD) experience disabling symptoms of sadness, anger, and loss of interest in life. A patient may be diagnosed as having a major depressive episode if he or she has five of the symptoms below present for most of the day, every day during the same two week period.

One symptom must be either of the following:
- Depressed mood (or irritable)
- Lack of interest or pleasure in all, or nearly all activities

The remainder of the symptoms can be:
- Significant weight loss or gain
- Insomnia or hypersomnia
- Fatigue
- Feelings of worthlessness
- Diminished ability to think
- Recurrent thoughts of death
- Recurrent suicidal ideation
Mood Disorders: Major Depressive Disorder Treatment

Treatment for MDD consists of antidepressant medications and psychotherapy. The types of medications most commonly used act by blocking the recycling, or reuptake of serotonin by the sending neuron.
Antidepressants for Major Depressive Disorder Include:

**Selective Serotonin Reuptake Inhibitors:**
- ✓ Celexa
- ✓ Lexapro, Cipralex
- ✓ Paxil, Seroxat
- ✓ Prozac
- ✓ Luvox
- ✓ Zoloft, Lustral

**Serotonin-norepinephrine Reuptake Inhibitors:**
- ✓ Pristiq
- ✓ Cymbalta
- ✓ Ixel, Savella
- ✓ Effexor
- ✓ Fetzima

**Tricyclic Antidepressants:**
- ✓ Elavil, Endep
- ✓ Anafranil
- ✓ Adapin, Sinequan
- ✓ Tofranil
- ✓ Surmontil
- ✓ Norpramin
- ✓ Pamelor, Aventyl, Noritren

**Monoamine Oxidase Inhibitors:**
- ✓ Marplan
- ✓ Nardil
- ✓ Eldepryl
- ✓ Parnate
- ✓ Aurorix, Manerix
- ✓ Pirazidol
For coding and reporting purposes the care provider should include the following in the documentation details of a major depressive episode:

- Duration of the episode
- Description of the episode
- Documentation of the severity of the episode
- Presence or absence of psychotic symptoms
- Episode status-single or recurrent
- Remission status-partial or full
Mood Disorders: Major Depression Disorder ICD-10-CM Codes

The ICD-10-CM codes separate single episode from recurrent episode and they identify the presence of psychotic features.

Severity is also specified:

- **Mild**: Presence of only 5-6 depressive symptoms and mild disability
- **Moderate**: Presence of more than 6 symptoms and compromised capacity
- **Severe**: Presence of most of the criteria symptoms and observable disability

If the patient has hallucinations or delusion, he is classified as having severe MDD with psychotic features.
# Major Depressive Disorder ICD-10-CM Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.3</td>
<td>Major depressive disorder, single episode, severe with psychotic features</td>
<td>Includes mood-congruent and mood-incongruent psychotic features</td>
</tr>
<tr>
<td>F32.5</td>
<td>Major depressive disorder, single episode, in full remission</td>
<td>Atypical depression; post-schizophrenic depression</td>
</tr>
<tr>
<td>F32.8</td>
<td>Other depressive episodes</td>
<td></td>
</tr>
<tr>
<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
<td>(Major) depression, NOS</td>
</tr>
<tr>
<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
<td>Includes recurrent depressive reaction, endogenous depression, psychogenic depression, seasonal depressive disorder</td>
</tr>
<tr>
<td>F33.2</td>
<td>Major depressive disorder, recurrent, severe without psychotic features</td>
<td></td>
</tr>
<tr>
<td>F33.41</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
<td></td>
</tr>
</tbody>
</table>
Mood Disorders: Types of Bipolar Disorder

• Bipolar I Disorder

The features of bipolar I disorder include manic or mixed episodes that last at least 7 days, or manic symptoms that are so severe that the person needs immediate hospital care. Usually depressive episodes occur as well, typically lasting two weeks.

• Bipolar II Disorder

Bipolar II disorder includes a pattern of depressive episodes and hypomanic episodes but no full-blown manic or mixed episodes.

• Rapid Cycling Bipolar Disorder

Rapid-cycling bipolar disorder has a pattern of four or more distinct manic or depressive episodes in 1 year. It can occur at any point in the patient’s life and can come and go over many years.
Mood Disorders: Bipolar Disorder Associated Conditions and Treatment

• People with bipolar disorders are at higher risk for heart disease, migraines, diabetes, obesity, among other illnesses. These illnesses may cause symptoms of mania or depression.

• If a bipolar disorder patient has any associated medical conditions or medication reactions, it should be documented to show the severity of the patient’s illness.
Mood Disorders: Bipolar Disorder Treatments

• Treatment is aimed at helping control the mood swings and related symptoms. Bipolar disorder is a chronic condition and required that medications be taken for a lifetime.

• Mood stabilizing medications such as Lithium have always been the first choice to control bipolar disorder. Many other patients do extremely well on anticonvulsant drugs such as Neurontin, Topamax and Trileptal. Both Depakote and Lamictal are also utilized in the treatment of mood disorders, including bipolar disorder.

• If you see one of the above medications being ordered and there isn’t a diagnosis be sure to query the care provider.
Mood Disorders: Bipolar Disorder ICD-10-CM Documentation Requirements

• For accurate coding and reporting purposes the care provider documentation must include the following details about the patient’s current or most recent bipolar disorder episode:
  ✓ Type of bipolar disorder
  ✓ Episode type
  ✓ Duration of the episode
  ✓ Severity of the episode
  ✓ Psychotic features
  ✓ Remission status

If any details are missing query the provider.
Query: Bipolar Disorder Documentation

Dear Dr. Doe,

The patient’s provisional diagnosis is stated as being “Bipolar disorder, major depressive episode.” Documentation indicates the patient continues to hallucinate. Would you please specify the severity of the patient’s major depressive episode as being mild, moderate, or severe, and with or without psychotic features? Thank you.

Susan, CDI Specialist
Mood Disorders: Bipolar Disorder ICD-10-CM Codes

- ICD-10-CM classifies bipolar I disorder as simply “bipolar disorder.” The codes identify if the episode is hypomanic, manic, depressed, or mixed. The bipolar codes then specify the level of severity and with psychotic features or not.

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional Information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F31</td>
<td>Bipolar disorder</td>
<td>Includes: manic-depressive illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>manic-depressive psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>manic-depressive reaction</td>
</tr>
<tr>
<td>F31.0</td>
<td>Bipolar disorder, current episode hypomanic</td>
<td></td>
</tr>
<tr>
<td>F31.11</td>
<td>Bipolar disorder, current episode manic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>manic without psychotic features, mild</td>
<td></td>
</tr>
<tr>
<td>F31.64</td>
<td>Bipolar disorder, current episode mixed</td>
<td>With mood-congruent features</td>
</tr>
<tr>
<td></td>
<td>severe, with psychotic features</td>
<td>With mood incongruent features</td>
</tr>
<tr>
<td>F31.75</td>
<td>Bipolar disorder, in partial remission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>most recent episode depressed</td>
<td></td>
</tr>
<tr>
<td>F31.81</td>
<td>Bipolar II disorder</td>
<td></td>
</tr>
<tr>
<td>F31.89</td>
<td>Other bipolar disorder</td>
<td>Includes recurrent manic episodes</td>
</tr>
</tbody>
</table>
Anxiety Disorders
Anxiety Disorders

• Besides depression one of the most common mental disorders in the US
• Can be crippling
• Characterized by intense fear and impending doom
• Can cause an acute exacerbation of another condition
• Anxiety can be caused by a physiological condition
• Anxiety disorders can also be caused by substance or alcohol abuse.
# Anxiety Disorder Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.4</td>
<td>Anxiety disorder due to known physiological condition</td>
<td>Document the underlying physiological condition, such as endocrine disorder, primary cerebral disease, brain injury, systemic illness, hormonal or metabolic imbalance.</td>
</tr>
<tr>
<td>F10.280</td>
<td>Alcohol dependence with alcohol-induced anxiety disorder</td>
<td>Document the blood alcohol level of the patient, if applicable</td>
</tr>
<tr>
<td>F41.0</td>
<td>Panic disorder [episodic paroxysmal anxiety] without agoraphobia</td>
<td>Includes: panic attack, panic state</td>
</tr>
<tr>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
<td>Includes: anxiety neurosis, anxiety reaction, anxiety state, overanxious disorder</td>
</tr>
<tr>
<td>F41.8</td>
<td>Other specified anxiety disorders</td>
<td>Include: anxiety depression (mild or not persistent), anxiety hysteria, mixed anxiety and depressive disorder</td>
</tr>
<tr>
<td>F41.9</td>
<td>Anxiety disorder, unspecified</td>
<td>Includes: anxiety, not otherwise specified</td>
</tr>
</tbody>
</table>
Obsessive Compulsive Disorders

- Obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD) are very different disorders. OCD causes recurrent, unwanted thoughts and repetitive behaviors.
- OCD patients are aware of the disorder and it causes a great deal of stress. The OCD interferes with every aspect of their life.
- DMS-5 differentiates the insight levels as:
  - With good insight
  - With poor insight
  - With absent insight or delusional beliefs
- OCD is often found in patients with schizophrenia or major depression. (Inherent and not coded)
- When OCD does occur independently of other disorders is assigned to ICD-10-CM code F42
Obsessive Compulsive Personality Disorder

- OCPD patients are perfectionists
- Fixated on following procedures
- Comfortable with a system of self-imposed rules for completing tasks
- Must have order and usually exhibit a strong, rigid sense of right and wrong
- Strong beliefs about the way things should be done
- OCPD patient do not think there is anything unusual about their behavior
- OCPD is classified as a personality disorder and is coded as F60.5
- If the documentation describes a patient with OCPD and OCD is being documented, query the provider
Posttraumatic Stress Disorder

• PTSD develops after direct exposure to a terrifying ordeal
• Patients with PTSD usually suffer from depression and other mental disorders
• Many also have had a traumatic brain injury
• PTSD characterized in ICD-10-CM as:
  ✓ Acute, chronic, or unspecified
• PTSD symptoms that should be documented include:
  ✓ Re-experiencing the event
  ✓ Avoidance/numbing, avoiding people
  ✓ Increased arousal/irritation
  ✓ Negative cognitions and mood
# PTSD Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
<th>Additional information about codes</th>
</tr>
</thead>
</table>
| F43.0           | Acute stress reaction | **Criteria:** symptoms <1 month  
Code includes:  
• acute crisis reaction  
• acute reaction to stress  
• combat and operational stress reaction  
• combat fatigue  
• crisis state  
• psychic shock |
| F43.10          | Posttraumatic stress disorder, unspecified |                     |
| F43.11          | Posttraumatic stress disorder, acute | **Criteria:** symptoms 1-3 months |
| F43.12          | Posttraumatic stress disorder, chronic | **Criteria:** symptoms >3 months |
Stress And Adjustment Disorders

• Adjustment disorder is characterized by an unusually severe or prolonged reaction brought on by a stressful life event or change.

• Following criteria must be met to be diagnosed with an adjustment disorder:
  ✓ Symptoms come after a stressor
  ✓ Symptoms more severe than expected
  ✓ No other mental disorders are involved
  ✓ Symptoms are not normal part of grieving over a loved one
Stress and Adjustment Disorders ICD-10-CM Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F43.21</td>
<td>Adjustment disorder with depressed mood</td>
</tr>
<tr>
<td>F43.25</td>
<td>Adjustment disorder with mixed disturbance of emotions and conduct</td>
</tr>
</tbody>
</table>
Eating Disorders-Anorexia Nervosa

- Anorexia nervosa is an extreme behavior related to a patient’s distorted perception of their body image.
- Irrational fear of gaining weight or becoming obese.
- More likely in females, usually young adults or adolescents.
- ICD-10-CM has separate codes for restricting type (F50.01), binge eating type with purging (F50.02), and unspecified anorexia nervosa (F50.00), all of which are CC’s when used as secondary diagnoses.
Eating Disorders-Bulimia Nervosa

• Characterized by the patient eating large amounts of food and feeling a lack of control over the eating.
• The binge eating is followed by ridding the body of the food through excessive exercising, fasting, vomiting, or using laxatives.
• There is only one code for bulimia nervosa (F50.2), which is a CC when coded as a secondary diagnosis.
• Eating disorders can be critical conditions and can require inpatient hospitalization but the care providers must link all conditions such as malnutrition, dehydration, anemia, electrolyte imbalance to the eating disorder.
Intellectual Disabilities

• An IQ of 70 is the threshold for intellectual disability (mental retardation).
• Will never be a principal diagnosis because it isn’t medically treatable.
• In more severe forms it can complicate hospitalizations because of limited ability to understand condition, follow directions, be compliant with care.
• Severe and profound intellectual disabilities are CCs. If not documented be sure to query the care provider for the type of intellectual disability. Mild and moderate disabilities are not CCs.
Mental Disorders: Principal Diagnosis

• The principal diagnosis is defined as “the condition after study, to be chiefly responsible for occasioning the admission to the hospital.”
• A mental disorder diagnosis must satisfy this definition in order to be listed as the principal diagnosis.
• The documentation must demonstrate the following about the mental disorder in order for it to be designated as the principal diagnosis:
  ✓ Present on admission
  ✓ An established condition
  ✓ Chiefly responsible for the admission
Mental Disorders: Secondary Diagnosis

• The mental condition meets the requirements for other diagnosis definition if the documentation meets one of the following criteria:
  1. Clinical evaluation
  2. Therapeutic treatment
  3. Diagnostic procedure
  4. Extending the length of stay
  5. Increased nursing care and or/monitoring
Examples

- Patient was admitted today for phlebitis, suspected deep vein thrombosis in lower right leg. Patient also has residual right-sided paralysis, dysphasia, and major depressive disorder of moderate severity due to a previous CVA.

- Former soldier with severe PTSD admitted for treatment of an infected amputation stump. He claims that being in the hospital causes anxiety and flashbacks to the original injury. An SSRI was administered to help with the anxiety and flashbacks.

- Prostate cancer patient with neoplasm related anemia; schizophrenia in full remission, on medication.
Mental Disorders: CC Status

- Asperger’s syndrome
- Autistic disorder
- Bipolar disorder, except partial or full remission
- Brief psychotic disorder
- Bulimia nervosa
- Delirium due to known physiologic condition
- Dementia with behavioral disturbance
- Hallucinations (all except visual)
- Intellectual disabilities, severe and profound
- Major depress disorder, except for partial or full remission, and single episode
- Recurrent depressive episode
- Recurrent brief depressive episode
- Psychotic disorder with hallucinations or delusions due to known physiological condition
- Suicidal ideations
## Mental Disorders: MS-DRGs

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>876</td>
<td>O.R. Procedure with Principal Diagnoses of Mental Illness</td>
</tr>
<tr>
<td>880</td>
<td>Acute Adjustment Reaction and Psychosocial Dysfunction</td>
</tr>
<tr>
<td>881</td>
<td>Depressive Neuroses</td>
</tr>
<tr>
<td>882</td>
<td>Neuroses Except Depressive</td>
</tr>
<tr>
<td>883</td>
<td>Disorders of Personality and Impulse Control</td>
</tr>
<tr>
<td>884</td>
<td>Organic Disturbances and Mental Disability</td>
</tr>
<tr>
<td>885</td>
<td>Psychoses</td>
</tr>
<tr>
<td>886</td>
<td>Behavioral and Developmental Disorders</td>
</tr>
<tr>
<td>887</td>
<td>Other Mental Disorder Diagnoses</td>
</tr>
</tbody>
</table>
Substance Abuse:

• In 2011 there were over 845,000 drug related ED visits in young adults between ages 18-25. During the same period there were over 403,000 admissions to substance abuse treatment facilities.

• Today 146 people die every day from an overdose of a prescribed opiate medication.

• Drug use is highest among males, in their late teens and twenties and is increasing among people in their 50’s.

• In 2012 an estimated 23 million people needed treatment for a drug or alcohol related problem but only 2.5 million people received treatment at a specialty facility.
Anatomy and Physiology Review: Effects of Alcohol and Drug Use on the Brain

- Drugs affect brain function by interfering with the way neurons send and receive neurotransmitters. This produces a greatly amplified message, ultimately disrupting normal communication.

- Alcohol on the other hand suppresses the release of glutamate and stimulates the release of gamma-aminobutyric acid, which results in an overall depressant effect on the brain and body function.

- Alcohol and drugs target the brain's reward system (Limbic system) and cause it to be flooded with dopamine. Dopamine is a neurotransmitter that helps regulate emotion, motivation, and feelings of pleasure. Over stimulating the limbic system produces euphoric effects which strongly reinforce its use. Eventually the brain adjusts to the surges in dopamine by producing less dopamine, which decreases the euphoria, leading to tolerance which then leads to addiction.
Most Common Reasons Adults Seek Treatment

1. Alcohol
2. Marijuana
3. Pain relievers
4. Cocaine
5. Heroin
6. Stimulants
7. Tranquilizers
8. Hallucinogens
Documenting Substance Abuse Disorders

- Clinical documentations primary purpose for a substance use patient is to help ensure organized, efficient, and quality care. The secondary purpose is to enable the assignment of the correct codes used to identify the patient’s SOI and determine payment.

- Documentation is also used for the following:
  - Support the medical necessity of the inpatient admission
  - Establish a working diagnosis to assign a working diagnosis related group (DRG)
  - Assign present on admission (POA) indicators
  - Demonstrate that best practice guidelines have been followed
  - Collect information for reporting quality and performance measures

- To meet the above goals CDI Specialist must review all parts of the medical record and query the providers for clarification of any documentation to get to the level of specificity needed for coding, billing, and reporting substance abuse disorders.
Mental and Behavioral Disorders due to Substance Abuse

• Definitions:
  ✓ Drug use: uses a substance without abusing it or being dependent on it
  ✓ Drug abuse: a person misuses or overuses a substance
  ✓ Drug dependence: a person needs a drug to function normally
  ✓ Intoxication: the acute state of physical and cognitive impairment caused by drinking alcohol or being exposed to a psychoactive drug
  ✓ Withdrawal: the wide range of symptoms that occur after stopping or dramatically reducing alcohol or drugs and heavy and prolonged use
  ✓ Remission
    o Early remission is defined as no criteria for dependence or abuse have been met for at least 1 month but less than 2 months
    o Sustained remission is no criteria for dependence or abuse have been met for 12 months
Documenting Substance Abuse Disorders

• For each category of substance, the codes are grouped as abuse, dependence, or use, such as the diagnosis of “alcohol dependence” and may be with intoxication, withdrawal, or alcohol-induced psychotic or mental disorder.

• Can then be further specified as with delusions, hallucinations, or uncomplicated
Substance Abuse: Alcohol

- Alcohol in remission is reported with code (F10.21). The use of this code is based on physician documentation and is reserved for those dependent on alcohol who are no longer drinking. Remission is often documented based on the length of time the patient has abstained from alcohol.

- Alcohol withdrawal refers to symptoms that may occur when a person who is alcohol dependent suddenly stops drinking alcohol. Symptoms usually peak by 24-72 hours, but may persist for weeks.
ICD-10-CM Codes for Alcohol Abuse Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>CC</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1010</td>
<td>Alcohol abuse, uncomplicated</td>
<td>No</td>
</tr>
<tr>
<td>F1020</td>
<td>Alcohol dependence, uncomplicated</td>
<td>No</td>
</tr>
<tr>
<td>F10231</td>
<td>Alcohol dependence with withdrawal delirium (includes delirium tremens)</td>
<td>Yes</td>
</tr>
<tr>
<td>F10188</td>
<td>Alcohol abuse with other alcohol-induced disorder</td>
<td>Yes</td>
</tr>
<tr>
<td>F1094</td>
<td>Alcohol use, unspecified with alcohol-induced mood disorder</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Substance Abuse: Drugs

• Cause of drug abuse and dependence is not known. Factors such as peer pressure, emotional distress, environmental stress, and a person’s genetics may play a role.
• Substances in code categories, F11-F18, contain specific codes for use, abuse, dependence, and related disorders.
• Acuity/Severity of ICD-10-CM codes related to drug use are the same as those included with alcohol use and include the terms uncomplicated, with intoxication, with withdrawal, and in remission.
• Drug withdrawal and drug use in remission is reported with a code in the category for the specific type of drug.
• Dependence on nearly all illicit drugs except Cannabis are CC’s
Tobacco Disorders

• Nicotine dependence with withdrawal is a cc (F17213)
  ✓ Review the documentation for indicators for withdrawal which include increased agitation, anxiety, impatience, headaches, depression
  ✓ Review record to see if a nicotine patch has been ordered
    ✓ Offers a great opportunity to query for nicotine withdrawal

• No codes for nicotine use or disorders, only dependence
The webinar focused on clinical documentation issues related to ICD-10-CM mental and substance abuse disorders codes. Topics discussed included dementia, delirium, encephalopathy, psychoses, mood disorders, schizophrenia, posttraumatic stress disorder and other stress and anxiety disorders as well as a brief overview of drug, alcohol, and tobacco use, abuse and dependence codes.
References

Thank you for attending our webinar!

Please complete the survey, your feedback helps us to design training to meet your needs.

You will receive an email within 3-5 days providing a link to the CE Certificate, the webinar recording and the presentation slides.
You are invited to stay for a short overview on Elsevier’s education solutions for Clinical Documentation Improvement

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- Mental Disorders
- Altered Mental Status: Delirium, Dementia, and Encephalopathy
- CDI Competency Tool

Doc Briefs
- Pediatric Behavior Disorders
- Mood Disorders
- Posttraumatic Stress Disorder
- Pediatric Alcohol and Substance Related Disorders
- Adjustment Disorders
- Alcohol and Substance Related Disorders

Coding
- An Overview
- Schizophrenia and other Psychotic Disorders
- Mood and other Non-Psychotic Disorders
- Alcohol Abuse and Dependence
- Drug Abuse and Dependence
- Dementia and Other Mental Disorders
- Mental Health and Substance Abuse Treatments
Take a Peak at a Doc Brief

Importance of Specific Documentation

Unclear or incomplete documentation of mood disorders can lead to inappropriate treatment and inaccurate reporting of the patient's condition. Documentation is especially problematic for mental health services. Medical record reviews by the Office of Inspector General (OIG) have found that a significant percentage of mental health services are undocumented or inadequately documented and lack critical information about the patient's condition and details of the care provided.

To help describe the patient's severity of illness and support treatments, resource use, or an inpatient level of care, the physician should document the following:

- Onset and duration of symptoms
- Single episode versus recurrent
- Type of episode (hypomanic, manic, depressed, or mixed)
- Current severity (mild, moderate, severe, with or without psychotic features)
- Whether the patient is in partial or full remission
- Etiology
- Acuity
- Clinical indicators
- Related conditions or complications
- Ongoing assessment, treatments, and the patient's response to treatment

Mood disorders are categorized based on the type, severity, and duration of the symptomatic features. To accurately document a mood disorder, document the predominant symptoms, including the following:

- Bipolar disorder, single manic episode
- Mixed affective episode
- Severity
  - Mild, moderate, severe, without psychotic symptoms
  - With psychotic symptoms, severe
  - In full remission/in partial remission

Click each mood disorder tab to view the subtypes.
Take a Peak at a CDI Lesson

Schizophrenia: ICD-10-CM Codes and Documentation Requirements

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>F20.5: Paranoid schizophrenia, characterized by delusions, auditory hallucinations, and the patient’s conviction that others are plotting against her or family members. Patients with paranoid schizophrenia maintain an unshakable belief that they are being persecuted and may exhibit anger and anxiety. As a result, they cannot be convinced that their delusions are not true, they can appear argumentative and suspicious toward others.</td>
</tr>
<tr>
<td>Disorganized</td>
<td>F20.1: Disorganized schizophrenia, characterized by disorganized speech and behavior that is disorganized or difficult to understand, along with unusual or inappropriate emotions or a lack of emotion. For example, a patient with disorganized schizophrenia may laugh or cry even when others or objects seem unrelated or bizarre. The patient's disorganized behavior may be one minor example of the patient's abnormal behavior.</td>
</tr>
<tr>
<td>Catatonic</td>
<td>F20.2: Catatonic schizophrenia, is characterized by sudden and irrational behaviors, such as behavior that is not appropriate for social or cultural context. The patient may remain completely immobile for periods of time. The patient's behavior is repetitive and may continue even when no longer appropriate.</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>F20.3: Undifferentiated schizophrenia is described as a broad term applied to patients who display symptoms of the other categories of schizophrenia but not enough of any one of the symptoms to define it as a specific type of schizophrenia.</td>
</tr>
<tr>
<td>Residual</td>
<td>F20.6: Residual schizophrenia, is defined as a partial history of at least one episode of schizophrenia but currently having no positive psychotic symptoms (delusions, hallucinations, or disorganized speech).</td>
</tr>
</tbody>
</table>

Knowledge Check: Mental Disorder Documentation Components

Psychiatric Assessment
Discharge Plan
ED and Admission Note
Progress Notes

| A 27-year-old woman is brought to the ED because of paranoid behavior and threats to kill her 10-day-old baby. She has been attending the maternity clinic on a regular basis. She will not stay in bed and is pushing staff members away. She is in a paranoid and looks confused. |
| "Patient seen this morning at bedside. He reports less restlessness, no conversations with his deceased grandmother during the night, better sleep, but still refusing food." |
| "Meet with the community mental health nurse and case manager to discuss medication management options. Patient is to take: • Quetiapine 150 mg every evening for psychoses • Clozapine 150 mg every day for psychoses Follow-up appointment made for tomorrow." |
| "Patient is dressed in pajamas and bathrobe, sits quietly without fidgeting. His speech is normal and flows logically with no made-up words..." |

Mental Disorders: Psychiatric Evaluation and Certification

CDI specialists reviewing the patient's record in the ED or in the hospital can help ensure that care providers are documenting information accurately. Here are some examples of PSIs such as Medicare, to ensure that the stay is as detailed as possible.

For example, each Medicare mental disorder patient must receive a psychiatric evaluation within 60 hours of admission. It must include the following:
- A medical history
- Assessment of current mental status
- Statement of patient's legal status
- Chart of current episode of illness and circumstances leading to admission
- Description of etiology and behavior
- Estimate of intellectual functioning, memory, and orientation
- Inventory of the patient's assets in descriptive, not interpretative, fashion

Also, at the time of admission, or as soon thereafter as is reasonable and practicable, the care provider must provide a provisional admission diagnosis, along with diagnosis of any corrected psychiatric diseases and other mental disorder. The provider must state that the services furnished can reasonably be expected to be covered by the patient's insurance or are for diagnostic study.

Inc facilities or psychiatric units of acute care or critical access hospitals must be reaccredited at 12 days as well as providing adequate care to be the hospital's utilization review committee for that patient.

Psychoses

Psychoses are mental disorders that impair thought, perception, and judgment. Psychoses may cause a person to lose contact with reality. Patients with psychotic disorders may withdraw from reality, become delusional, or experience hallucinations. Psychosis is a symptom of many mental disorders, such as schizophrenia, bipolar disorder, major depression, or mood/affective disorder. Psychoses are typically characterized by dramatic changes in personality, as well as impaired functioning. Proper diagnosis involves psychiatric evaluation, physical examination, and laboratory testing. These measures also help to confirm or rule out potential physical illness as the cause of psychosis or the presenting symptoms.

Antipsychotics, also known as neuroleptics, are a class of psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought). In particular, in schizophrenia and bipolar disorder, and are increasingly being used in the management of nonpsychotic disorders.

The most common antipsychotics include the following:
- Aripiprazole
- Asenapine
- Isoniazid
- Olanzapine
- Paliperidone
- Quetiapine
- Risperidone
- Ziprasidone

Noncompliance with antipsychotic medication is common in patients with schizophrenia, due to side effects that may make some patients not want to take their medication. Additionally, after the medications become effective, some patients believe they are cured and no longer need the medication.

If a patient is being given an antipsychotic medication and there is no corresponding mental disorder documented, query for it, as shown in the example.
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