CDI Issues Related to ICD-10-CM Mental and Behavioral Health Codes
March 17, 2016

Questions and Answers

1. **What is the difference between disorientation and delirium?**

   Delirium is defined as "a disturbance of consciousness with reduced ability to focus, sustain, or shift attention." Disorientation (confusion) is a symptom of delirium. For example, a senile dementia patient may be disoriented but not suffering from delirium.

2. **Is it correct to say that dementia is chronic progressive and delirium is acute?**

   Delirium is caused by some precipitating factor, most often a medical one. Therefore, the care provider should document an underlying cause. Delirium is not an integral symptom of any disease. Delirium is sudden severe confusion.

3. **What are you using for a dx of Major Neurocognitive disorder without underlying cause?**

   There does not appear to be a specific code for major neurocognitive disorder without underlying cause. An update article regarding DSM-5 written by the APA and the ICD-10-GEMS listing seem to offer code G31.9, Degenerative disease of nervous system, unspecified.

4. **If a patient has vascular dementia, what needs to be documented to code the underlying cerebral atherosclerosis?**

   The MD must document the diagnosis. There are many causes of vascular dementia (e.g. stroke, hypertension, diabetes) so cannot be assumed to be caused by cerebral atherosclerosis.

5. **For the vascular dementia question, there is a notation in the code book to code first the physiological condition. What is needed to code cerebral atherosclerosis?**

   Assuming your question is that cerebral atherosclerosis is the known underlying physiological condition: For the index main term Atherosclerosis, it says to see Arteriosclerosis. Arteriosclerosis, cerebral provides the code I67.2, Cerebral atherosclerosis, followed by the code for the vascular dementia.

6. **For hallucination while going thru withdrawal, is hallucination part of the withdrawal & not coded separately?**

   The question is not specific to what is causing the withdrawal. Unspecified hallucinations fall into category R44, Other symptoms and signs involving general sensations and perceptions. At the beginning of the category there is an Excludes1 Note for alcoholic, drug, mood, and schizophrenic hallucinations. The Excludes1 Note means that the more specific code for the hallucination with one of these other problems should be used rather than a nonspecific code from the R44 category. Unless there is a further exclusion note with the withdrawal code, it could be appropriate to code also the hallucinations as they are not inherent to every withdrawal patient. They also need to meet the criteria for coding an additional diagnosis and should require or affect patient care treatment or management in some way.

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7. What code would you use for drug induced delirium due to steroids?

The coder needs to determine if this is a poisoning or adverse effect and the type of steroid, then follow the guidelines for coding a poisoning or adverse effect.

8. If a patient has a single depressive episode and the psychiatrist documents why this episode doesn’t meet MDD, the diagnosis per DSM-5 is "Other specified depressive disorder" and it should be F32.8, not F32.9

Sorry, there isn’t enough information to answer this question. Be guided by the physician's documentation and when it does not correlate to symptoms or treatment, query the physician for clarification.

9. Why is there an “excludes 1” code if you try to code suicidal ideation with the depression codes?

Specific code numbers were not given here. We see no such Excludes1 Note for these two conditions except perhaps at the category level for the symptom code of suicidal ideation. At the end of 2015, the National Center for Health Statistics (NCHS), the Federal agency responsible for use of the ICD-10-CM in the United States, issued interim advice as it pertains to excludes 1 notes and unrelated conditions. The following information can be found on the NCHS website: http://www.cdc.gov/nchs/data/icd/Interim_Coding_advice_on_Excludes_1_note.pdf

There are circumstances that have been identified where some conditions included in Excludes1 notes should be allowed to both be coded, and thus might be more appropriate for an Excludes1 note. However, due to the partial code freeze, no changes to Excludes notes or revisions to the official coding guidelines can be made until October 1, 2016. The new guidance concerning Excludes1 notes is intended to allow conditions to be reported together when appropriate even though they may currently be subject to an Excludes1 note.

10. How would you code anxiety/depression when it is documented that way?

It appears that using the index, whether you use Anxiety or Depression as the main term, the code suggested is F41.8, Other specified anxiety disorders.

Verification in the tabular list uses the descriptions:
- Anxiety depression (mild or not persistent)
- Anxiety hysteria
- Mixed anxiety and depressive disorder
- These seem to be in line with what you are trying to code.

11. Can you please advise what the correct coding would be for a patient with Bipolar disorder as well as depression?

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.

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In the index under the main term Disorder, sub term bipolar, there are many possible selections for this condition with depression. Once the specific type or status of the bipolar condition is known, a code for with depression can be chosen. The first selection for example is current or in remission. Next the coder must have terminology such as manic or mixed.

If there was truly no other information known and the provider cannot further specify, the coder should refer to the index and select Disorder, bipolar, current episode, depressed (F31.9). The tabular list description is F31.9, Bipolar disorder, unspecified. The term depression by itself codes to F32.9 which has an Excludes1 Note for bipolar disorder.

12. In ICD-10, there does not seem to be a code for regular "depression;" rather, it codes to "major depression." Is it known why there is no code for "depression, unspecified"? And should all documented instances of "depression" code to major depression?

In the absence of any official coding guidance, follow the instructions for coding. To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

13. When documentation says tobacco use, do you assume it is tobacco dependence or do we query physician?

When documentation states ‘tobacco use’ you cannot assume it is dependence. You must query the physician.

14. We are having issues with payers denying certain primary diagnosis such as autism, overanxious disorder of childhood and adolescence, and V61.29 other parent child relationship problems. Do you have any advice on how we can get these claims paid or get these diagnosis covered? Do we need to educate the providers to use other diagnoses? How do we know what the insurance will or will not pay for ahead of time?

I would look to providing a diagnosis more related to the actual reason why the child is being admitted. Is the child self-harming, or abusive to others? What is the exact reason for the child-parent relationship problem? Does the child threaten his family? It may be easier to get claims paid with a diagnosis with more specificity to the actual behavior.

15. When you query a physician for a more specific diagnosis as the cause of the altered mental status I did not think you could suggest another diagnosis as this would be leading the physician.

Altered mental status is an umbrella term which captures many alternative diagnoses. As long as the clinical indicators suggest a more specific term such as delirium or encephalopathy and the AMS is being treated (increased monitoring, antibiotics, fluids) it would not be considered leading. What would be leading would be to offer a diagnosis which in no way would be appropriate such as encephalopathy when it’s clear the patient is having delirium.

16. Will you address documentation for "Adjustment Disorders" following illness/trauma that requires rehab?

If the documentation clearly associates the adjustment disorder with the medical condition then a code from the F06 category might be the most appropriate. The MD should specify the nature of the adjustment.

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disorder (depression (F06.3-), anxiety (F06.4-), other or unspecified (F06.8). The coding instructions for category state to code first the underlying physiologic condition.

17. When coding Schizophrenia what do you recommend how we code it when the specifics for DSM-5 are so different from ICD-10?

If assigning ICD-10-CM codes you cannot use the specific type codes if the documentation does not support them. If the MDs are using DSM-5 terminology you will end up in the less specific ICD-10-CM Codes. This is an issue that will need to be addressed by the MD staff. What level of ICD-10-CM specificity do they want to support? What documentation do you need as facility for management, reimbursement and reporting purposes? An internal documentation policy based on the group’s decision will need to be developed and put in place to drive CDI efforts and coding and to use as support in case of audit.

18. What would your recommendation be when a Psychiatrist documents “traits”? Such as Borderline personality Traits versus Borderline Personality Disorder?

Documentation of traits doesn’t capture an actual diagnosis. Documenting “traits” is like documenting symptoms. You would need to query the provider and ask if the patient actually had the disorder as well.

19. If someone comes in with depression and it isn’t documented as single or recurrent but they have a history of depression, should we code recurrent?

No. If ‘recurrent’ isn’t documented you need to query the physician.

20. For any type of remission does the physician have to document "in remission" or will any document of the patient quitting suffice?

The physician must document “in remission” in order to code the account appropriately.

21. When patient has bipolar disorder and depression, should CDI be querying for a link and does the provider need to document ‘currently’ depressed in order to code the bipolar disorder to further specificity?

Yes, it would be appropriate to query for a link between the bipolar disorder and the depressive episode.

22. When dealing with alcohol or drug use does the abuse or dependence have to be clearly documented by the attending physician before it can be coded as abuse or dependence?

Yes. The documentation of abuse or dependence needs to be clearly documented. It can be documented by any treating provider as long as there isn’t a conflict with the attending.

23. Alcohol use disorder is documented how is that coded or is a physician query needed.

Yes. The documentation of abuse or dependence needs to be clearly documented. It can be documented by any treating provider as long as there isn’t a conflict with the attending.

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Documentation of ‘cocaine use disorder’ is insufficient for coding in ICD-10-CM. It implies more than use. It must be affecting the patient adversely in some way for the MD to document “disorder”. It would be appropriate and necessary to query the physician for dependence or abuse to better describe the “disorder.”

25. I’ve been seeing MD’s documenting alcohol use disorder rather than abuse or dependence with withdrawal, stating this is following DSM-5. Are others seeing that? We need abuse and dependence documented or we can’t code it.

The DSM-5 leans towards use and not abuse or dependence. This is the only reason why physicians may be reluctant to document abuse or dependence. Continue to query the physician for abuse or dependence and explain why the documentation is necessary. Whenever there is a discrepancy between DSM-5 and ICD-10-CM it will need to be addressed by the MD staff. What type a level of documentation specificity is needed for ICD-10-CM vs DSM-5? What are they willing/able to provide? What documentation do you need as facility for management, reimbursement and reporting purposes? An internal documentation policy based on the group’s decision will need to be developed and put in place to drive CDI efforts and coding and to use as support in case of audit.

26. When is alcohol use to be coded? Only when there is a behavioral disorder?

Outpatient coding guidelines state "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.” Inpatient coding guidelines state "For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

• Clinical evaluation; or
• Therapeutic treatment; or
• Diagnostic procedures; or
• Extended length of hospital stay; or
• Increased nursing care and/or monitoring."+C10

27. Any guidance on how to code a diagnosis specified as alcohol or drug use disorder in ICD-10?

Yes. The documentation of abuse or dependence needs to be clearly documented. It can be documented by any treating provider as long as there isn’t a conflict with the attending.

Not sure we understand the question and if it is specific to the term “use”, but the guidelines state "When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

• If both use and abuse are documented, assign only the code for abuse
• If both abuse and dependence are documented, assign only the code for dependence
• If use, abuse and dependence are all documented, assign only the code for dependence
• If both use and dependence are documented, assign only the code for dependence."

28. When would you use the "toxic effect of alcohol?"

This is based on the physician’s documentation of that condition. It usually refers to a poisoning. Query the physician if you are uncertain of the terms they use to describe a condition.

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29. If a patient has alcoholic cirrhosis, and the patient has alcohol abuse, is it okay to code?

As with all other diagnoses, the codes for substance use should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis. At this point in time, the coding notes in the tabular list for alcoholic cirrhosis state to Use additional code to identify: alcohol abuse and dependence (F10.-) which does include just use and abuse, unspecified. However, in this case it would seem the term "abuse" does not correlate to alcoholic cirrhosis which is caused by heavy drinking over a prolonged period of time (usually dependence).

30. Could you explain the difference between uncomplicated vs unspecified when referring to alcohol withdrawal?

To our knowledge this term has not been defined for ICD-10-CM. The term may be related to codes in the DSMV. We have found mention of it when talking of Coding ICD-10-CM vs. DSMV codes but nothing official. Be guided by the physician's documentation and the ICD-10-CM index. It is different than unspecified so do not use it instead of unspecified.

31. Hepatic encephalopathy considered the same as Liver failure with coma?

Referring to the index main term Encephalopathy, sub term hepatic (no other information), see Failure, hepatic. Go to Failure, hepatic and the suggested code is K72.90, Hepatic failure, unspecified without coma.

Failure, liver states to see Failure, hepatic. Failure, hepatic with coma is suggested to be K72.91, Hepatic failure, unspecified with coma.

Based on the terminology provided, they are not the same code.

32. A patient with hepatic encephalopathy codes to hepatic failure which includes the encephalopathy with the code, do we code it with coma or without. ICD 9 coding clinic stated to use with coma.

Hepatic encephalopathy does not code to with coma in ICD-10-CM at the present time.

33. On hepatic encephalopathy question please see coding clinic 2nd Q 2007 on page 6-7 and 1st Q 2002 on page 3.

According to the AHA Coding Clinic 4th Quarter 2015:

In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, Coding clinic may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues - not clinical criteria.

As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

Previously published ICD-9-CM advice that is still relevant and applicable to ICD-10 will continue to be re-published in Coding Clinic for ICD-10- CM/PCS. As with the application of any of the coding advice published in Coding Clinic, the information needs to be reviewed carefully for similarities and differences on a case by case basis.
case basis. Care must be exercised as the codes may have changed. Such change could be related to new codes, new combination codes, code revisions, a change in nonessential modifiers, or any other instructional note. This is particularly true as ICD-10-CM has many new combination codes that were not available in ICD-9-CM.

34. If encephalopathy is due to an underlying cause and it resolves with treatment of the underlying cause, do you code the encephalopathy as a secondary diagnosis or do not code at all?

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

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

35. How would you code toxic metabolic encephalopathy due to drugs or medications?

According to the index refer to the main term Encephalopathy, sub terms, toxic, metabolic (G92). When reviewing the tabular list, the note states: Code first (T51-T65) to identify toxic agent. When referring to that code, read and be guided by notes at the beginning of the category for use of additional codes.

36. How would you assign codes for the diagnosis of toxic encephalopathy 2/2 to UTI?

In this case, for coding purposes, based on the terminology provided, this seems like a metabolic encephalopathy, rather than a toxic encephalopathy. In ICD-10-CM toxic encephalopathy is due to drugs, chemicals, foods, and other substances rather than something like an infection.

If there is no combination code for the two conditions, they are coded separately and sequenced according to coding guidelines.

37. Toxic encephalopathy code directs us to code first the Toxic Substance. How to code when it is just an adverse effect of a properly prescribed and administered drug?

Toxic metabolic encephalopathy can also include medication side effects or drug ingestions affecting the chemical transmitters in the brain. Be guided by the provider’s documentation.
38. If a patient has documented delirium and encephalopathy at the same time, both due to the same cause, do we code both?

They can both be coded if they each required their own diagnostic work up or interventions. Also according to DSM-5, in order to capture the full spectrum of the disease both delirium and the specific type of encephalopathy must be documented, along with the underlying cause. In the DSM-5 there is a note that states: "Coding note: Include the name of the other medical condition in the name of the delirium (e.g., 293.0 [F05] delirium due to hepatic encephalopathy). The other medical condition should also be coded and listed separately immediately before the delirium due to another medical condition (e.g., 572.2 [K72.90] hepatic encephalopathy; 293.0 [F05] delirium due to hepatic encephalopathy)."

39. Which code would be the Pdx? What code would you use as the T51-T65 code in this scenario? Would the T code be the Pdx?

I would query the physician for clarification of the diagnosis and explain that "toxic" encephalopathy requires documentation of a toxic substance for it to be coded appropriately.

40. insurances are denying encephalopathy - any query tips or clinical indicators

Encephalopathy is often challenged by auditors as both a principal and secondary diagnosis. Essentially, the definition of encephalopathy is vague and, if the documentation does not support it, it is often denied. Encephalopathy is always the result of another disease or systemic illness. Be guided by the definitions of principal and other diagnosis.

The Official Guidelines for Coding and Reporting offers guidance concerning etiology/manifestation codes, specifically "code also" and "code first" instructions. Although encephalopathy always has an underlying cause, it is not considered part of an etiology/manifestation convention. There is currently no ICD-10-CM "code first" instruction pertaining to the diagnosis of encephalopathy. Be guided by the principal diagnosis: the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Look for documentation of neurological assessments as a provision of care and monitoring. These patients require more nursing care to keep the patient safe, and assign someone to watch over these patients. Look for information about the discharge of the patient. Is it when the underlying condition is completely cured or is it when the patient's mental functioning clears?

41. Isn't Encephalopathy a global cerebral dysfunction; fluctuating level of arousal is the hallmark of delirium?

The definitions we used in the webinar for delirium came from the American Psychiatric Association: Diagnostic and statistical manual of mental disorders, ed 5: DSM-5. And the definition for encephalopathy came from the NIH. National Institute of Neurological Disorders and Stroke and usage in the DSM-5.

42. What is DSM -5?

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. The APA description of the DSM-5: "Used by clinicians and researchers to diagnose and classify mental disorders, the criteria are concise and explicit, intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care."
43. The issue isn't only whether it is a CC - it changes the DRG from 881 to 885.

Because of the mention of MS-DRG 881, Depressive neuroses and MS-DRG 885, Psychoses, I am venturing that the comment is referring to the fact that Major Depressive Disorders, single episode with unspecified severity is assigned to MS-DRG 881 when used as a PDX. Whereas, if the MDD episode (single or recurrent) is specified as being mild, moderate, severe w/o w/o psychotic features, or in partial or full remission, it is classified as a psychoses and assigned to MS-DRG 885.

44. I am an OP Psych coder. What do you mean by CC Status?

CC status stands for Complication or comorbidity status. Codes for conditions classified as Major CCs or CCs have been found to have a significant impact on the costs and resources used during hospitalizations when they occur as secondary diagnoses. These diagnoses can impact the MS-DRG assigned by causing the case to be assigned to a higher weighted (paying) MS-DRG. The Inpatient psychiatric facilities prospective payment system (IFP-PPS also has CCs.

The IPF PPS reimburses inpatient psychiatric facilities at a base per diem (daily) rate. Additional adjustments to this payment are made based on a number of other factors, including the case's MS-DRG assignment and certain CCs.

For the IPF-PPS grouper the CCs are grouped into categories. The ICD-10-CM codes for each of the IPF PPS comorbidity categories were published in the Federal Register/Vol. 79, No. 151/Wednesday, August 6, 2014/Rules and Regulations 45953-55 TABLE 7—FY 2015 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES.


45. What is "LMS"?

"LMS" is the acronym for "Learning Management System". Clients who have our CDI content and use our LMS to manage and view our lessons will find the lessons referred to in the webinar in the course menus on the LMS. If you need more information or assistance please contact us at the phone number on the last slide on the presentation.

46. Any complication coding and documentation for CDI?

The EduCode CDI and Doc Brief curricula do not have specific lessons on complications. We incorporate information about documenting medical and surgical complications into our lessons as they pertain to the topics in the particular lesson. The EduCode coding curriculum is organized into body system courses that correspond to the chapters in the ICD-10-CM code book. Complications will be covered in the course that encompasses the code range that includes the complication code.

47. You stated there were no codes for nicotine use/abuse; wouldn't Z72.0 be appropriate for nicotine use or abuse?

There is no code specific to nicotine use or abuse in the index. Code Z72.0 is specific to tobacco use and excludes tobacco and nicotine dependence and history of tobacco use.

If the documentation says the person is a "smoker", the index instructs the coder to see Dependence, drug, nicotine.
48. With nicotine withdrawal and treatment is provided, I have MDs that document "nicotine patch for prevention of nicotine withdrawal." Is it possible to code using that verbiage from your standpoint because some coders state that the patient is not in withdrawal?

Patients who are trying to quit smoking are often unpredictable in their compliance with a cessation regimen. Prevention of withdrawal is not the same as in withdrawal. A coder can only code based on the documentation of the provider of the patient's nicotine use.

49. The physician documented suicidal ideation with accidental Benadryl overdose; can these diagnoses be coded together? The patient also has depression.

Good question. Unfortunately, this is probably best asked of the physician. It seems like it is possible that the two situations could go together but unlikely.

50. What is the appropriate coding for bronchoscopy and mucous plugging? Is root operation extirpation correct? Our pulmonology doctors were advised and feel drainage is correct not extirpation.

This question is beyond the scope of this webinar but it seems based on the brief explanation that removing a mucous plug would meet the definition of Extirpation:

Definition: Taking or cutting out solid matter from a body part

Explanation: The solid matter may be an abnormal byproduct of a biological function or a foreign body; it may be imbedded in a body part or in the lumen of a tubular body part. The solid matter may or may not have been previously broken into pieces

Examples: Thrombectomy, choledocholithotomy

Drainage refers to fluids.

51. Patient with Epilepsy had Brain lobectomy now experiencing episodic psychosis. Can you please revisit the coding of this scenario?

Sorry, there were several slides addressing this issue. We are not sure which one you are referring to. In general, the care provider must document the mental disorder, the underlying physiologic condition, as well as the psychotic manifestation.

52. We are a psychiatric facility. When coding psychiatric diagnoses due to an underlying medical condition, we often get denied by insurance when putting the medical diagnosis first, as we are a psychiatric facility and insurance wants a psychiatric dx as the primary. We are then asked by billing to move the psychiatric dx to primary. Is it okay to do this?

There isn't much information here to be sure of an answer but we are guessing this is a situation where the coding rules instruct you to sequence the medical diagnosis first? When using ICD-10-CM, the UHDDS definitions include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.).
53. Can you use suicidal ideation as a secondary code with depression and or other MH dx?

At the beginning of the Signs and Symptoms chapter, there is an exclusion note: Excludes1: symptoms and signs constituting part of a pattern of mental disorder (F01-F99) for those conditions you mentioned but it is not inherent with depression. There is no clear cut guidance as there was recently a change to how the Excludes1 Notes are used and, if documented by the provider, the coding guidelines do state: Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present. Also, pay attention to the criteria for a secondary diagnosis.

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