# Mental health disorders

ICD-10-CM

Clinical overview

## Definitions and overview

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the American Psychiatric Association (APA) advises a mental health disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning.

- Mental health disorders are usually associated with significant distress or disability in social, occupational, or other important activities.
- An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental health disorder.
- Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental health disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

**Bipolar disorder** is a mental health disorder that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar disorder experience high and low moods — known as mania and depression — which differ from the typical ups-and-downs most people experience.

**Major depression** is marked by a depressed mood and loss of interest or pleasure in all activities that lasts for at least two weeks and represents a change from previous functioning. (See separate guideline for Major Depression).

**Paranoid personality disorders** are characterized by an unfounded but relentless mistrust and suspicion of others.

**Personality disorders** are a group of disorders characterized by long-term patterns of behavior and experiences that differ significantly from what is expected by the person's culture. These patterns of behavior cause distress or problems functioning. Personality disorders affect at least two of the following ways of:

- thinking about oneself and others
- responding emotionally
- relating to other people
- controlling one's behavior

**Psychosis** is a symptom, not an illness. The word "psychosis" is used to describe conditions of the mind in which there has been some loss of contact with reality. It can be caused by a mental or physical illness, substance abuse, or extreme stress or trauma.

**Schizophrenia** is a serious mental health disorder that involves an abnormal interpretation of reality. It is characterized by delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social or occupational dysfunction.

## Diagnostic criteria, signs and symptoms

**This guideline addresses medical record documentation and diagnosis coding. It is beyond the scope of this document to list specific diagnostic criteria for each mental health disorder listed herein. Healthcare providers must consult the DSM-5 manual – which is the gold standard – for detailed and specific criteria used to diagnose each mental health disorder.**

## Mental health disorders and substance use disorders

Mental health disorders and substance use disorders sometimes co-exist for the following reasons:

- Mental health problems and substance use disorders share some underlying causes.
- Some people with mental health problems may turn to substance use to self-medicate.
- Use of certain substances can cause people with addiction to experience mental health issues

## Causes / Contributing factors

There is no single cause for mental health disorders. Contributing factors can include:

- Genetic predisposition; family history
- Lifetime experiences, stressors and trauma
- Biological factors (e.g., hormonal and brain chemical imbalances)
- Traumatic brain injury (TBI)
- Alcohol and drug use
- Serious medical conditions
- Loneliness and social isolation

## Diagnostic tools

- Medical history and physical exam
- Laboratory blood testing to evaluate for underlying medical conditions
- Psychological/psychiatric evaluation

## Treatment

Treatment depends on the particular mental health disorder and its severity. Treatment typically includes:

- Individual and family counseling
- Patient education and support groups
- Medications

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Best documentation practices for physicians

## Subjective

The subjective section of the office note should document current symptoms or patient complaints related to the mental health disorder.

## Objective

In the objective section, include any current associated physical exam findings (such as flat affect, agitation, flight of ideas, etc.) and results of diagnostic testing.

## Assessment

### Specificity:

Avoid vague diagnosis descriptions, e.g., "other" or "unspecified." Document each condition to the highest level of specificity, including the following as appropriate:

- Severity – mild, moderate, severe
- Remission – partial or full
- Specific type, such as particular type of schizophrenia or personality disorder
- Underlying cause – use linking terms such as "due to"
- All related symptoms/conditions, such as with psychotic features, delusions, hallucinations, delirium, dementia, sleep disturbance, etc.

### Abbreviations:

A good rule of thumb for any medical record is to limit – or avoid altogether – the use of abbreviations. The meaning of an abbreviation or acronym can often be determined based on context, but this is not always true. Examples:

- BPD – bipolar disorder versus borderline personality disorder
- MDD – major depressive disorder versus manic depressive disorder

**Best practice is as follows:**

- The initial notation of an abbreviation or acronym should be spelled out in full with the abbreviation in parentheses: "Major depressive disorder (MDD)". Subsequent mention of the condition can then be made using the abbreviation.
- The diagnosis should be spelled out in full in the final impression or plan.

### Current versus historical:

- When the condition is current, include it in the final Assessment along with the current status (improved, worsening, etc.); and link the final diagnosis to any medications currently being used to treat the condition.
- Do not use past-tense terms such as "status post" or "history of" to describe current mental health disorders. In diagnosis coding, conditions described as "history of" indicate a historical condition that no longer exists as a current problem.
- Do not use "history of" to describe a condition in remission. Instead, document partial or full remission.
- Mental health disorders that are truly resolved classify to code Z86.59, Personal history of other mental and behavioral disorders.

### Followed by a different provider:

When the mental health disorder is being followed and managed by a different provider, it is still appropriate to include the diagnosis in the final assessment when the condition has impact on patient care, treatment and management.

Example: "Severe recurrent major depression per records from her psychiatrist, Dr. Ben Jones"

## Treatment plan

- Document a clear and concise treatment plan.
- List details of medication therapy, clearly linking each medication to the condition it is treating.
- Provide details of planned diagnostic testing.
- Specify to whom or where referrals or consultation requests are made.
- Include the date or time frame for the next appointment.

## Electronic health record (EHR) issues

### "Other" and unspecified codes with descriptions:

Some electronic health records (EHRs) insert ICD-10-CM codes with corresponding descriptions into the assessment section of the office note rather than a provider-stated final diagnosis. For example:

"F32.89 Other specified depressive episodes"

"F39 Unspecified mood [affective] disorder"

These are vague and incomplete diagnoses.

- Codes titled "other" or "other specified" are for use when the medical record provides a specific diagnosis description for which a specific code does not exist.
- The "Other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation that specifies the particular "other" condition.

- Unspecified diagnosis descriptions should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.

**Mismatch between final diagnostic statement and EHR-inserted diagnosis code with description:**
Another scenario that causes confusion is when the assessment section documents a provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match – or may even be contradictory.

**Assessment: Schizophrenia**
F2Ø.1 Disorganized schizophrenia

Here the final diagnosis **in bold** in the Assessment is simply **Schizophrenia**, which codes to F2Ø.9, Schizophrenia, unspecified.

The EHR-inserted diagnosis code with description that follows, however, is F2Ø.1 Disorganized schizophrenia.

This can lead to confusion regarding which diagnostic statement is correct and which diagnosis code should be reported. Documentation elsewhere in the record does not always provide clarity.

To avoid confusion and ensure accurate diagnosis code assignment, the provider-stated final diagnosis must either

a) match the code with description; OR
b) it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

**Note:** ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider's final diagnostic statement. It is the provider's responsibility to provide legible, clear, concise and complete documentation of each final diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

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Tips and resources for coders

## Coding basics

To ensure accurate and specific diagnosis code assignment, review the entire medical record to verify the mental health disorder is current. Next, note the exact description of the mental health disorder documented in the medical record. Then, in accordance with ICD-10-CM official coding conventions and guidelines:

- Search the alphabetic index for that specific description.
- Verify the code in the tabular list, carefully following all instructional notes as appropriate.

## Coding mental health disorders

In the ICD-10-CM coding manual, mental health disorders classify to Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (categories FØ1-F99).

For some diagnoses, the code is complete with only three characters. Other diagnoses classify to three-character categories that require additional characters to provide greater specificity and to complete the code. In industry-standard coding guidelines, these are typically noted with a decimal point and a dash, as in Schizophrenia F2Ø.-

## Mental health disorders due to known physiological conditions (FØ1-FØ9)

| | |
|---|---|
| FØ1.- | Vascular dementia |
| FØ2.- | Dementia in other diseases classified elsewhere |
| FØ3.- | Unspecified dementia |
| FØ4 | Amnestic disorder due to known physiological condition |
| FØ5 | Delirium due to known physiological condition |
| FØ6.- | Other mental health disorders due to known physiological condition |
| FØ7.- | Personality and behavioral disorders due to known physiological condition |
| FØ9 | Unspecified mental health disorder due to known physiological condition |

### Alzheimer's disease and dementia:

- Dementia is an inherent part of Alzheimer's disease; therefore, from a documentation standpoint, the provider does not need to document it separately.
- From a coding standpoint, however, ICD-10-CM requires two codes: 1) a code from category G3Ø- Alzheimer's disease and 2) a code from subcategory FØ2.8-, Dementia in other diseases classified elsewhere with or without behavioral disturbance.

## Psychoactive substance use disorders (Categories F1Ø-F19)

| | |
|---|---|
| F1Ø.- | Alcohol related disorders |
| F11.- | Opioid related disorders |
| F12.- | Cannabis related disorders |
| F13.- | Sedative, hypnotic or anxiolytic related disorders |
| F14.- | Cocaine related disorders |
| F15.- | Other stimulant related disorders |
| F16.- | Hallucinogen related disorders |
| F17.- | Nicotine dependence |
| F18.- | Inhalant related disorders |
| F19.- | Other psychoactive substance related disorders |

(See separate guideline for Substance use disorders).

## Schizophrenia and related disorders (F2Ø-F29)

| | |
|---|---|
| F2Ø.- | Schizophrenia |
| F21 | Schizotypal disorder |
| F22 | Delusional disorders |
| F23 | Brief psychotic disorder |
| F24 | Shared psychotic disorder |
| F25.- | Schizoaffective disorders |
| F28 | Other psychotic disorder not due to a substance or known physiological condition |
| F29 | Unspecified psychosis not due to a substance or known physiological condition |

## Mood [affective] disorders (F3Ø-F39)

| | |
|---|---|
| F3Ø.- | Manic episode |
| F31.- | Bipolar disorder |
| F32.- | Depressive episode |
| F33.- | Major depressive disorder, recurrent |
| F34.- | Persistent mood [affective] disorders |
| F39 | Unspecified mood [affective] disorder |

(See separate guideline for Major depressive disorder).

## Examples of various other mental health disorder codes

| | |
|---|---|
| F4Ø.Ø1 | Agoraphobia with panic disorder |
| F44.Ø | Dissociative amnesia |
| F44.81 | Dissociative identity disorder |
| F48.1 | Depersonalization-derealization syndrome |
| F53.1 | Puerperal psychosis |
| F6Ø.Ø | Paranoid personality disorder |
| F6Ø.1 | Schizoid personality disorder |
| F6Ø.2 | Antisocial personality disorder |
| F6Ø.3 | Borderline personality disorder |
| F6Ø.4 | Histrionic personality disorder |
| F6Ø.5 | Obsessive-compulsive personality disorder |

Coding examples

| Example 1 | |
|---|---|
| Medical record documentation | 44-year-old male presents for evaluation of schizophrenia diagnosis. States for past 2 weeks he has been staying up all night playing chess on the computer; then 2 days ago he became obsessed with the idea that his co-workers are conspiring to kill him. He is now having trouble concentrating on anything else.<br><br>Psychiatric exam: Oriented x 3. Speech: normal rate and tone. Thought content: auditory hallucinations and paranoid ideation, but no suicidal or homicidal ideation. Attention and concentration seem impaired – having trouble repeating phrases. |
| Final diagnosis | Paranoid schizophrenia with acute exacerbation perhaps brought on by lack of sleep. Will increase antipsychotic medication and have him return to see me in 2 days. |
| ICD-10-CM code | F2Ø.Ø Paranoid schizophrenia |
| Comments | ICD-10-CM does not include codes for exacerbation of schizophrenia. |

| Example 2 | |
|---|---|
| Medical record documentation – Primary Care Physician (PCP) | 50-year-old female presents for follow-up for diabetes mellitus type 2. Admits she has not been following her diabetes diet and sometimes forgets to take her metformin. Reports her daughter has moved in with her three young children, which has disrupted her life. States the children are "wild," causing her stress. She has ongoing depression for which she is followed by her psychiatrist. Hemoglobin A1c from last week was 7.8. |
| Final diagnosis | • Type 2 diabetes mellitus uncontrolled by hyperglycemia. Reinforced need to adhere to diabetic diet and metformin dosage 500 mg twice daily. Discussed impact of stress on diabetes control. Encouraged regular exercise.<br>• Moderate recurrent major depression – stable on medications being managed by her psychiatrist, Dr. John Smith. |
| ICD-10-CM code | E11.65 Type 2 diabetes mellitus with hyperglycemia<br>F33.1 Major depressive disorder, recurrent, moderate |
| Comments | Even though the PCP is not treating the patient's major depression, the medical record shows this condition impacted care, treatment and management of her diabetes. It is appropriate for the PCP to report code F33.1. |

| Example 3 | |
|---|---|
| Medical record documentation | Patient reports feeling down and having trouble sleeping. Trazadone 50 mg at bedtime has helped a little with her insomnia. Denies anxiety. |
| Final diagnosis | 1. G47.ØØ Insomnia, unspecified<br>2. F39 Unspecified mood [affective] disorder |
| ICD-10-CM code | G47.ØØ Insomnia, unspecified<br>F39 Unspecified mood [affective] disorder |
| Comments | Best documentation practices were not followed. It is the provider's responsibility to describe each final diagnosis to the highest level of specificity. Unfortunately, this provider has simply listed nonspecific code numbers with descriptions in place of a written final diagnosis, resulting in unspecified code assignment. |

| Example 4 | |
|---|---|
| Medical record documentation | 77-year-old male brought to emergency department by his wife. She reports he has dementia due to his Parkinson's disease and has been increasingly combative over the past 6 months. States he has been much worse for the past week and she can no longer handle him at home. Blood pressure 186/102; heart rate 100; respirations 20; temperature 101.3. Will be admitted for complete work-up. |
| Final diagnosis | Parkinson's dementia with increasingly combative and aggressive behavior |
| ICD-10-CM code | G2Ø Parkinson's disease<br>FØ2.81 Dementia in other diseases classified elsewhere with behavioral disturbance |
| Comments | For a diagnosis of Parkinson's dementia, the alphabetic index of the ICD-10-CM manual directs the coder to codes G2Ø, Parkinson's disease and FØ2.8Ø, Dementia in other diseases classified elsewhere without behavioral disturbance disease, unspecified. However, verification of the code FØ2.8Ø in the tabular list shows the correct code to capture the associated combative and aggressive behavior is FØ2.81, Dementia in other diseases classified elsewhere with behavioral disturbance. |

| Example 5 | |
|---|---|
| Medical record documentation | 85-year-old female brought to the primary care physician's office by her daughter. Has lived alone for past 5 years. Daughter reports patient used to cope with being alone by interacting with six baby dolls that were always seated in a row on her living room sofa, considering them her grandbabies. She also enjoyed baking and shared her treats with her neighbors. Daughter reports that over the past year, patient has stopped all of these interactions, becoming even more socially withdrawn with difficulty in interpersonal and family relationships. |
| Final diagnosis | Simple schizophrenia |
| ICD-10-CM code | F2Ø.89 Other schizophrenia |
| Comments | ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.9.a titled "Other and unspecified codes" advises as follows: Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with Not Elsewhere Classified (NEC) in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code. |

**References:** American Hospital Association (AHA) Coding Clinic; American Psychiatric Association; Cleveland Clinic; Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5); ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; MedlinePlus; MentalHealth.gov; National Alliance on Mental Illness; National Institute of Mental Health; WebMD