Psychiatry Coding & Reimbursement Alert

ICD-10 Update: F34.1 Allows Smooth Sailing For Dysthymia

Hint: Check exclusions list to avoid wrong diagnosis.

When your clinician diagnoses dysthymia, you'll need to report this diagnosis using ICD-10 codes in the same way in which you will report this condition using ICD-9 system.

ICD-9: You'll use 300.4 (Dysthymic disorder) to report a diagnosis of dysthymia. You will use the same diagnosis code if your clinician mentions the diagnosis as anxiety depression, depression with anxiety, depressive reaction, neurotic depressive state, or reactive depression. However, you cannot report 300.4 if the diagnosis is adjustment reaction with depressive symptoms (309.0-309.1), depression NOS (311), maniac depressive psychosis, depressed type (296.2-296.3) or reactive depressive psychosis (298.0).

"Note that for codes 296.2 and 296.3, you will need a fifth digit further describing the nature of the episode," observes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. In either case, the fifth digit options are as follows:

- 0 □ unspecified
- 1 □ mild
- 2 □ moderate
- 3 □ severe, without mention of psychotic behavior
- 4 □ sever, specified as with psychotic behavior
- 5 □ in partial or unspecified remission
- 6 □ in full remission

ICD-10: When you begin using ICD-10 codes, a dysthymic disorder diagnosis will crosswalk from 300.4 to F34.1 (Dysthymic disorder). You will also report F34.1 if your clinician makes a diagnosis of depressive neurosis, depressive personality disorder, neurotic depression, persistent anxiety depression or dysthymia.

However, you cannot report F34.1 if your clinician makes a diagnosis of mild anxiety depression or anxiety depression that is not persistent. These are reported using F41.8.

Focus on These Basics Briefly

Documentation spotlight: Your psychiatrist will arrive at a diagnosis of dysthymic disorder based on a complete history and an evaluation of the person's signs and symptoms; the encounter will include a complete mental status examination, a complete psychiatric and medical history of the patient and family, and a review of systems, along with ordering and interpreting diagnostic tests.

Some of the symptoms that your clinician might note in the documentation will include depression, anxiety, restlessness, excessive anger, irritability, poor self-esteem, low energy levels, lack of interest in activities of leisure, negativity about the future, fatigue, disturbed sleep and appetite changes.

Upon examination, your clinician might note lack of attention to grooming, changes to posture, speech disturbances, reduction in eye contact, changes to expressions, and weight loss.

If your clinician suspects dysthymic disorder, he will try to rule out depression and substance abuse that can show similar results. Your clinician will use the observations made during a physical exam, and use results of lab tests such as a complete blood count, thyroid tests and urinalysis to help rule out other conditions that might be causing these symptoms and also help rule out substance abuse.

Your psychiatrist may also ask the patient to fill out assessment questionnaires, such as the patient health questionnaire-9 (PHQ-9). Your clinician might also use depression rating scales such as Hamilton Rating Scale of Depression (HAM-D), Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR16) or the Beck Depression Inventory (BDI) to rule out major depression and to confirm the diagnosis of dysthymia.

Based on the replies to these questionnaires, depression rating, history, observations made during physical exam and test results, your clinician will be able to arrive at a diagnosis of dysthymic disorder.

When your clinician makes a diagnosis of dysthymia, he will also perform a safety evaluation as a part of the mental status examination to help rule out suicidal or homicidal tendencies that need to be handled with immediate effect.

The care planning will include medical management with selective serotonin reuptake inhibitors (SSRIs). Your psychiatrist will also use psychodynamic psychotherapy and interpersonal therapy to help overcome the feelings of negativity and to improve social skills and communication and also undertake cognitive behavioral therapy to help overcome the feelings of depression.

Example: Our psychiatrist was called to assess a 21-year-old female patient who was admitted to the emergency department of our hospital after she attempted to slash her wrists with a kitchen knife.

After stabilizing her, the ED physician observed signs of depression and decided to call in our psychiatrist to assess her. Her father, who accompanied her, provided a family history of dysthymia on her mother's side and told our psychiatrist that her mother had committed suicide about three years back.

Her father told our psychiatrist that his daughter had developed some feelings of negativity from the time of her mother's death and she started becoming more withdrawn since then. Of late, he said that she had become more irritable and angry and would often get into binge eating that would continue into the night.

Upon examination, our psychiatrist noted a disheveled appearance, slow responses to questions, and lack of eye contact. There seemed to be no signs of weight loss.

Since the patient had a family history of dysthymia, our psychiatrist ordered a CBC, thyroid scan, and a check for vitamin B-12 levels. He also ordered urinalysis to rule out any substance abuse.

Your psychiatrist also employed the 17-item Hamilton Rating Scale of Depression (score noted was 10) to rule out major depression and to confirm a diagnosis of dysthymia.

Our psychiatrist counseled the patient to help alleviate her suicidal thoughts and prescribed sertraline for the patient to help reduce the symptoms of depression. He also planned psychodynamic psychotherapy and behavioral psychotherapy at a later date.

Our psychiatrist spent a total of 120 minutes in providing services to the patient, which included recording history, physical and mental status examination, review of lab test results and administration of the HAM-D to the patient.

What to report: Since your psychiatrist was involved in crisis management of the suicidal tendency, you will report the services provided by your psychiatrist using the new psychotherapy for crisis codes 90839 for the first hour of services provided and +90840 x2 for services provided beyond the first hour. "Code +90840 is for 'each additional 30 minutes,' which is why you will report it twice in addition to 90839 for the 120-minute service," notes Moore.

You will report the diagnosis with F34.1 if you are using the ICD-10 codes and 300.4 if you're using ICD-9 codes.