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Psychiatry Coding & Reimbursement Alert

ICD-10 Update: Get Specific For Postpartum Depression With F53

Hint: Use the same ICD-10 code for a diagnosis of puerperal psychosis.

When your clinician diagnoses a patient with postpartum depression, you'll be elated to know that there is a specific code for the condition in ICD-10. So, you'll no longer have to report it under a more generalized code as you had to do when you were using ICD-9 codes.

ICD-9: When your psychiatrist arrives at a diagnosis of postpartum depression, you will report the diagnosis with the ICD-9 code, 648.4x (Mental disorders complicating pregnancy, childbirth, or the puerperium). You should note you have no specific code for this condition, and you should report it with this generalized ICD-9 code. You'd also use this code to report catatonic disorders in conditions classified elsewhere and for transient organic mental disorders not associated with alcohol or drugs. If the depression is truly postpartum, then the fifth digit will be "4," which indicates "postpartum condition of complication." Code 648.4 is for conditions classifiable to 290-303, 305.0, 305.2-305.9, 306-316, and 317-319. Per ICD-9, you should use an additional code from one of these families to identify the condition.

ICD-10: When you begin using ICD-10 codes, you'll have reason to rejoice as you have a specific code for postpartum depression in the ICD-10 code set. You should report a diagnosis of postpartum depression using F53 (Puerperal psychosis). Even though the descriptor to F53 mentions the term "puerperal psychosis," which is a more severe form of postpartum illness, you report a diagnosis of postpartum depression using this ICD-10 code itself.

Caveat: You cannot use F53 when your clinician's diagnosis is postpartum dysphoria (O90.6); psychosis in schizophrenia, schizotypal, delusional, and other psychotic disorders (F20-F29); or mood disorders with psychotic features (F30.2, F31.2, F31.5, F31.64, F32.3, F33.3).

Focus on These Basics Briefly

Documentation spotlight: Your psychiatrist will arrive at a diagnosis of postpartum depression based on a complete history and a complete evaluation of the patient. Your psychiatrist will perform 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 interpretation of screening and evaluation questionnaires.

If your clinician suspects postpartum depression, he will obtain any previous history of depression, history of postpartum depression in the family, and history of recent stress or other risk factors for the depression.

Some of the findings that your clinician would most likely record in a patient with postpartum depression will include depression of mood, changes to appetite, fatigue, feeling like crying, insomnia, suicidal tendencies, and negative thoughts about the child that include thoughts about harming the child or killing the child.

Upon examination, your clinician might note tachycardia and some degree of shortness of breath. These signs and symptoms are generally seen when the patient is also suffering from anxiety.

Tests: Some routine investigations that your clinician might order when he suspects a diagnosis of postpartum depression will include CBC, to check for anemia, and thyroid function tests. These tests are performed to rule out any medical causes for the depressive symptoms that the patient is experiencing.

Apart from these routine investigations, your clinician will also want to subject the patient to screening and evaluation questionnaires such as Edinburgh postnatal depression scale (EPDS), Montgomery-Asberg Depression Rating Scale (MADRS), Beck Depression Inventory II (BDI-II), and Postpartum Depression Screening Scale (PDSS) to check for postpartum depression and, if the patient is suffering from depression, the severity of the condition.

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The care planning will include crisis psychotherapy and emergency intervention if the patient is suffering from suicidal tendencies or harmful negative thoughts towards the infant. Further, your clinician might want to treat the patient through behavioral psychotherapy. Depending on the severity of the depression, your psychiatrist might also opt to put the patient on anti-depressant medication along with the psychotherapy.

Example: Your psychiatrist reviews a 32-year-old female patient who has been referred by her obstetrician for suspected postpartum depression. The patient has had a previous history of depression about eight years back for which she was on medication for about three years. She had also undergone behavioral psychotherapy at that time for the condition. She complains that she has been having mood swings about two weeks after her child's delivery, and she says that she has been crying for no reason at all.

She also says that she has been feeling very fatigued and had been having thoughts about the wellbeing of the child. She was under lot of duress, because she did not have any help in looking after the child while her husband was constantly away on work. She had been feeling low for many days now and had finally expressed her predicament to her doctor when she began to have thoughts about physically harming the child.

Your clinician then subjected the patient to the EPDS and the BDI-II questionnaire, whose results were 10 and 14, respectively. Your psychiatrist also requested routine blood and urine tests that ruled out anemia, substance abuse, and problems with thyroid function.

Based on history, signs and symptoms, results of tests, and interpretation of evaluation questionnaires, your psychiatrist arrives at a diagnosis of postpartum depression.

What to report: You will report the initial diagnostic evaluation that the psychiatrist provided with 90792 (Psychiatric diagnostic evaluation with medical services). You report the diagnosis with 648.44 if you are using ICD-9 codes or report F53 when reporting the diagnosis with ICD-10 codes.

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