Psychiatry Coding & Reimbursement Alert

ICD-10 Update: Rejoice on Simplified Reporting of Manic Episode Diagnosis With F30

Hint: You no longer have to look at documentation to see if the episodes are recurrent.

When your clinician arrives at a diagnosis of manic episodes in a patient, you will only need to focus on severity of symptoms and presence of psychotic behavior and check if the condition is in remission. While these factors affect your code choice in ICD-10, you will no longer need to worry about single episodes or recurrent episodes of mania, as this does not influence code selection.

ICD-9: When your clinician diagnoses a manic episode, you'll have to start by basing your reporting of the diagnosis on whether the patient is experiencing these symptoms as a single or recurrent episode. Depending on this, you will report your clinician's diagnosis either with 296.0x (Bipolar I disorder, single manic episode) or 296.1x (Manic disorder, recurrent episode). Both these codes further expand with a 5th digit based on severity of symptoms, presence of psychotic behavior, and whether or not the condition is in remission.

For example, the ICD-9 code, 296.0 expands using a fifth digit into the following seven codes:

- 296.00 (Bipolar I disorder, single manic episode, unspecified)
- 296.01 (Bipolar I disorder, single manic episode, mild)
- 296.02 (Bipolar I disorder, single manic episode, moderate)
- 296.03 (Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior)
- 296.04 (Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior)
- 296.05 (Bipolar I disorder, single manic episode, in partial or unspecified remission)
- 296.06 (Bipolar I disorder, single manic episode, in full remission)

Similarly, 296.1 also expands into seven different codes using the fifth digit expansion. You use 296.1x when the episodes of mania are recurrent.

Both 296.0x and 296.1x exclude circular type mania if there was a previous attack of depression. In that case, you would look to 296.4x (Bipolar I disorder, most recent episode [or current] manic), which uses the same set of fifth digits as 296.0x and 296.1x.

ICD-10: When you begin using ICD-10 codes, you can enjoy simplified coding for a diagnosis of manic episode. When your clinician's diagnosis is manic episode, you will not have to worry about identifying whether the patient is experiencing mania for the first time or if the condition is recurrent as you have to do in ICD-9.

With ICD-10, you will have to report only one set of codes for manic episodes, irrespective of whether the condition is a single episode or recurrent. You report a manic episode in ICD-10 with F30 (Manic episode).But, again as in ICD-9, you will have to use further expansion to F30 to identify the severity and presence or absence of psychotic symptoms and to report the condition in remission.

The six code choices that F30 initially expands into include:

- F30.1 (Manic episode without psychotic symptoms)
- F30.2 (Manic episode, severe with psychotic symptoms)
- F30.3 (Manic episode in partial remission)
- F30.4 (Manic episode in full remission)
- F30.8 (Other manic episodes)

- F30.9 (Manic episode, unspecified)

Depending on the severity of symptoms, F30.1 expands into the following four codes:

- F30.10 (Manic episode without psychotic symptoms, unspecified)
- F30.11 (Manic episode without psychotic symptoms, mild)
- F30.12 (Manic episode without psychotic symptoms, moderate)
- F30.13 (Manic episode, severe, without psychotic symptoms)

Reminder: You can also use F30.- when your clinician's diagnosis is single episode bipolar disorder or mixed affective episode. However, you cannot use this ICD-10 code when your psychiatrist diagnoses bipolar disorder (F31.-); major depressive disorder, single episode (F32.-); or major depressive disorder, recurrent (F33.-).

Brush up on These Basics Briefly

Documentation spotlight: Your psychiatrist will arrive at a diagnosis of a manic episode 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.

Some of the findings that your clinician would most likely record in a patient with mania include grandiosity, excessive speech, reduced necessity of sleep, feeling distracted, racing thoughts, deep and intense focus on any activity, and taking part in dangerous activities that fetch immense pleasure and pain.

Upon examination, your psychiatrist might note that the patient lacks proper personal appearance and that the patient's clothes appear disorganized (not color coordinated), although these patients generally prefer wearing vibrant and vivid clothing. Your clinician might also note that the patient appears joyous and hyperactive and has the tendency to speak very fast.

The patient will generally be having grandiose thoughts and might be, in many cases, delusional. They also suffer from suicidal and homicidal tendencies, and your clinician will try to assess a patient for these tendencies, as it might need emergency intervention.

Tests: Your clinician might order many lab tests if he suspects a diagnosis of mania. Many of these tests are aimed at confirming whether or not some other associated condition exists that might be producing similar symptoms. In addition, some of these tests will help assess the patient's general health condition as this might be vital to plan therapy.

Some of the tests that your clinician might order in a patient with suspicion of a diagnosis of bipolar I disorder include complete blood count, electrolyte concentrations, ESR, kidney function tests, and tests for hormonal counts to assess the functioning of the thyroid. Your psychiatrist will also ask for a urinalysis to assess for substance abuse.

Apart from these tests, your clinician might also ask for other diagnostic tests such as an MRI scan, ECG, and EEG, again to rule out other conditions and to assess the patient for future pharmacological and therapeutic interventions.

The immediate care planning will include assessment of the patient for suicidal or homicidal tendencies that might require rapid attention and crisis psychotherapy. At later dates, your clinician might include psychotherapy and group therapy. He might also opt for concurrent medication with antipsychotics or benzodiazepines. Some patients have also benefited from other forms of therapy, such as electroconvulsive therapy.