Psychiatry Coding & Reimbursement Alert

ICD-10 Update: Rejoice Over One-to-One Transition For Depressive Episodes of Bipolar Disorder

Hint: Use different code sets when the condition is in partial or full remission.

When your clinician arrives at a diagnosis of bipolar disorder with the most recent episode depressive, you will need to check on the severity of symptoms and presence or absence of psychotic behavior. These factors help you decide the right ICD-10 code choice. In addition, you will need to see if the condition is in remission.

ICD-9: When your clinician diagnoses a bipolar disorder with the current or most recent episode as depressed, you'll have to first start out with the base code, 296.5x (Bipolar I disorder, most recent episode [or current]depressed). This code further expands with a 5th digit based on severity of symptoms, presence or absence of psychotic behavior, and whether or not the condition is in remission.

So, the ICD-9 code, 296.5 expands using a fifth digit into the following seven codes:

- 296.50 (Bipolar I disorder, most recent episode [or current]depressed, unspecified)
- 296.51 (Bipolar I disorder, most recent episode [or current]depressed, mild)
- 296.52 (Bipolar I disorder, most recent episode [or current]depressed, moderate)
- 296.53 (Bipolar I disorder, most recent episode [or current]depressed, severe, without mention of psychotic behavior)
- 296.54 (Bipolar I disorder, most recent episode [or current]depressed, severe, specified as with psychotic behavior)
- 296.55 (Bipolar I disorder, most recent episode [or current]depressed, in partial or unspecified remission)
- 296.56 (Bipolar I disorder, most recent episode [or current]depressed, in full remission)

You will also report from the same set of codes if your clinician's diagnosis is bipolar disorder, now depressed or manic-depressive psychosis, circular type but currently depressed. However, you cannot use 296.5x if your clinician's diagnosis is brief compensatory or rebound mood swings. In such a case, you will have to report this diagnosis with 296.99 (Other specified episodic mood disorder).

ICD-10: When you begin using ICD-10 codes, 296.5x that you report for a diagnosis of bipolar disorder with current episode depressive will crosswalk to F31.- (Bipolar disorder). But again, as in ICD-9, you will have to use further expansion to F31.- to identify the severity and presence or absence of psychotic symptoms and to report the condition in remission.

The three code choices that F31.- will expand into when the current episodes are depressive include:

- F31.3 (Bipolar disorder, current episode depressed, mild or moderate severity)
- F31.4 (Bipolar disorder, current episode depressed, severe, without psychotic features)
- F31.5 (Bipolar disorder, current episode depressed, severe, with psychotic features)

Depending on the severity of symptoms, F31.3 expands into the following three codes:

- F31.30 (Bipolar disorder, current episode depressed, mild or moderate severity, unspecified)
- F31.31 (Bipolar disorder, current episode depressed, mild)
- F31.32 (Bipolar disorder, current episode depressed, moderate)

If the condition is in remission with the most recent episode depressed, you will have to choose another set of codes

based on the severity of the symptoms. You report this with F31.7- (Bipolar disorder, currently in remission). Based on the whether the condition is in partial or full remission, F31.7 expands into the following codes when the most recent episode was in some way depressed:

- F31.75 (Bipolar disorder, in partial remission, most recent episode depressed)
- F31.76 (Bipolar disorder, in full remission, most recent episode depressed)

Reminder: You use F31.- if your clinician's diagnosis is manic-depressive psychosis, manic-depressive illness, or manic-depressive reaction. You cannot use F31.- when your psychiatrist diagnoses bipolar disorder, single manic episode (F30.-); major depressive disorder, single episode (F32.-); or major depressive disorder, recurrent (F33.-). If the patient has cyclothymia, that is separately reportable with F34.0.

Focus on These Basics Briefly

Documentation spotlight: Your psychiatrist will arrive at a diagnosis of bipolar disorder with current episode depressed 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 bipolar disorder with current episode depressed include sadness, depression, reduced psychomotor function, insomnia or hypersomnia, feeling fatigued, reduction in levels of concentration, reduced appetite, and weight loss. Many times, the patients will have increased suicidal tendencies. If such tendencies are present, your clinician might want to undertake immediate emergency intervention in the form of crisis psychotherapy.

Upon examination, your psychiatrist might note that the patient lacks proper personal appearance and poor hygiene habits. Your clinician might also note that the patient appears depressed, moves very slowly, and has the tendency to speak in a low, monotone voice.

The patient will generally be having negative thoughts and might, in many cases, talk about death. The patients might also experience delusions and hallucinations where the patients will feel that they are not of any worth, which adds up to their depression. Your clinician might note that these patients have reduced insight and poor judgment abilities.

Tests: Your clinician might order many lab tests if he suspects a diagnosis of bipolar disorder. 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 disorder include complete blood count to rule out anemia, blood sugar levels, electrolyte concentrations, erythrocyte sedimentation rate (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 check 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 antidepressants and mood stabilizing agents. Some patients have also benefited from other forms of therapy, such as electroconvulsive therapy.