Codify
BY AAPC

Psychiatry Coding & Reimbursement Alert

ICD-10 Update: Switch To F24 For Reporting Shared Psychotic Disorder in ICD-10

Hint: Use the same ICD-10 code for a diagnosis of Folie Ã deux.

If your clinician's diagnosis is shared psychotic disorder or Folie Ã deux, you will have to just use a simple crossover code to report this diagnosis in ICD-10. In addition, the list of inclusions and exclusions are strikingly similar, so you will not have to alter your reporting much from the way you reported the condition using ICD-9.

ICD-9: When reporting a diagnosis of shared psychotic disorder using ICD-9, you report it with 297.3 (Shared psychotic disorder). You report 297.3 if your clinician's diagnosis is also stated as induced psychosis or paranoid disorder or as Folie Ã deux.

Caveat: You cannot use 297.3 if your clinician diagnoses the patient with acute paranoid reaction. You report this with 298.3 (Acute paranoid reaction). Also, a diagnosis of paranoid schizophrenia cannot be reported with 297.3. Instead, you report this condition with the ICD-9 code, 295.3x (Paranoid type schizophrenia); note that this diagnosis requires a fifth digit for completeness. Finally, if your clinician's diagnosis is alcoholic jealousy or paranoid state, you will report the ICD-9 code, 291.5 (Alcohol-induced psychotic disorder with delusions) rather than reporting it with 297.3.

ICD-10: When you switch to using ICD-10 codes instead of ICD-9 after Oct.1, 2015, you will have to use F24 (Shared psychotic disorder). As with ICD-9, you will use F24 when your psychiatrist's diagnosis is Folie Ã deux, induced psychotic disorder, or induced paranoid disorder.

Reminder: You are not allowed to report F24 when your psychiatrist diagnoses the patient with delusional disorders. You report this diagnosis with F22 (Delusional disorders) instead of F24. Also, a diagnosis of brief psychotic disorder should not be identified with F24. You have a separate ICD-10 code for it, which is F23 (Brief psychotic disorder). Again, if your clinician's diagnosis is either paranoid reaction or psychogenic paranoid psychosis, it is best you report these diagnoses with F23 rather than F24.

Focus on These Basics Briefly

Your psychiatrist will arrive at a diagnosis of shared psychotic disorder 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.

Some of the findings that your clinician would most likely record in a patient with shared psychotic disorder will include another individual close to the patient sharing the same type of psychotic thoughts or delusions. The close person who shares the psychotic thoughts might be a sibling, parent, or spouse or any other person with whom the patient is closely associated. Often, it is the primary patient with the delusional disorder who convinces the second person, because of their close relationship and shared experiences, to accept the delusions.

Apart from paranoia, the patient might also suffer from delusions, hallucinations, and reduced abilities in concentration and attention. Your clinician also might note lack of insight, reduced reasoning abilities, and disorganized thought process.

Some patients might harbor suicidal thoughts and might need crisis management to help them overcome these suicidal tendencies. Some might even experience homicidal and other harmful behavioral patterns.

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Tests: There are no specific diagnostic tests that your psychiatrist will order or perform to arrive at a diagnosis of schizoid personality disorder. Instead, he might want to undertake some tests to rule out other problems that might present with the similar kind of findings. Your psychiatrist might ask for a toxicology screening to rule out substance abuse.

The care planning may include medical management and cognitive behavioral psychotherapy that includes individual and family therapy. The other individual with whom the patient experiences the shared psychotic thoughts will also need similar management.

Example: Your psychiatrist reviews a 22-year-old female patient who experiences thoughts that someone will harm her. She has an identical twin that has similar notions as a result of her relationship with her sister. The patient began to develop these feelings of paranoia when she had a traumatic, abusive relationship in the past. After this relationship, she began to harbor negative thoughts, and she began to restrict her sister also from developing any relations with the opposite sex. Her sister, in turn, began to support her sibling and to believe that someone was trying to harm them both.

Upon examination, your clinician noted that the patient appeared agitated and panicky. She hardly maintained any direct eye contact and glanced furtively from time to time. Her mental status examination was noted with lack of attention and concentration along with lack of judgment and reasoning abilities. The patient did not show any signs of suicidal tendencies, although your clinician notes an aggressive behavioral pattern. Your clinician also notes that the patient has difficulty in trying to recount her painful past and tries to avoid any questions in this regard.

Based on the history and findings during examination, your clinician arrives at a diagnosis of shared psychotic disorder.

What to report: You report the psychodiagnostic evaluation of the patient with 90792 (Psychiatric diagnostic evaluation with medical services). You report the diagnosis with F24 if you are using ICD-10 codes or report 297.3 when reporting with the ICD-9 coding system.

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