BCA’s 15 Minute Coding Pearl Series

Major Depressive Disorder (MDD)

Diagnosis Coding

A PDF copy of these slides & a BCA ICD-10 Common Codes List is available for printing

Recorded February 2017
Actual Recording Time 14 Minutes
Bonnie Hoag, RN, CCS-P and Holly E. Gault, BSN, RHIT eligible
Brown Consulting Associates, Inc.
Twin Falls, Idaho
Bonnie R. Hoag, RN, CCS-P, is the founder and a principal owner of Brown Consulting Associates, Inc., (BCA) which was established in 1989. Bonnie has served as a national physician office consultant and seminar speaker for a variety of firms, including St. Anthony Publishing and Consulting in Alexandria, Virginia and Medical Learning Inc. in Minneapolis, Minnesota. Bonnie presents multiple seminars each year to groups such as Montana Medical Association, Idaho Medical Association, Iowa Medical Society, and National Association of Community Health Centers.

Since 1990 she and other BCA consultants have provided unique training to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) throughout the U.S. Nearly 50 percent of BCA’s clinic client-base is FQHC facilities. She has provided FQHC/RHC seminars for HRSA, National Health Service Corp, National Association of Community Health Centers, and various Regional Primary Care Associations. Bonnie is honored to serve on the board of directors at a large community health center in her community. With her guidance, Brown Consulting Associates, Inc. has developed and presents live, web-based certification training.

As a senior consultant Bonnie’s work on the BCA auditing team involves E/M and procedure coding and documentation audits. This includes onsite and live web-based training with clinicians where their medical records are used during training with a goal to improve the quality of the medical records and coding compliance. She has a special interest in Chronic Care Management projects and new Behavioral Health Consultant (BHC) services. Bonnie and other BCA consultants serve as a coding instructor for BCA's six-month, live web-based CCEP program, which is designed for coders and billers who wish to become certified.

Historically, Bonnie spent twelve years as director and instructor for the coding program at the College of Southern Idaho. She has served on the AHIMA National Physician Practice Council Group. In the “early days” of state-based managed care, Bonnie worked with the State of Idaho Department of Health as a “Physician Representative.”

On occasion Bonnie is called upon to work with health care legal defense attorneys to assist physicians in resolving third-party-payer coding actions. Bonnie has provided physician/clinician training and coder/biller training in nearly one hundred different health centers nationwide.

Sixteen years of clinical experience combined with twenty-six years of coding consulting and training provides an exceptional skill base for application to the challenging and changing medical coding environment.

Bonnie graduated from Los Angeles County-USC Medical Center School of Nursing in 1973. Her nursing experience includes office and hospital nursing in the areas of surgery, ER, ICU, and home health. She served as an Air Force Flight Nurse.

Bonnie worked in physician office nursing and management, dealing directly with reimbursement issues in Las Vegas, Nevada; Salt Lake City, Utah; and Twin Falls, Idaho. She has been teaching and consulting since 1988 and has worked in 41 states. As a physician reimbursement consultant, Bonnie visits physician offices, clinics and ERs to assess the issues that directly and indirectly affect reimbursement and CMS compliance.
Shawn R. Hafer, CCS-P, CPC, is a senior consultant and co-owner of Brown Consulting. She has enjoyed more than 20 years of physician coding and reimbursement experience in a variety of specialties. She holds coding certifications from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) and is a member of both organizations. Her background provides an excellent foundation for the demanding medical coding environment.

Shawn has been with Brown Consulting since 1999, and is uniquely qualified due to her diverse management skills, experience, and coding and billing expertise. Shawn also serves as a senior auditor conducting hundreds of medical record audits each year providing both clinician and coder training in all facets of coding and documentation.

Shawn's creative skills and experience have lead to the development of many coding tools and published training material used by Brown Consulting clients and Brown Consulting students. Shawn developed Brown’s popular New Doctor Training Program. She also developed the Brown Girls Favorite ICD-10-CM Diagnosis Code Booklet. Shawn spends much of her training time at clinic locations ranging from small rural health clinics served only by visiting providers to large inner-city clinics with more than 100 clinicians.

Shawn is the architect of our long-standing Brown Consulting Webinar Program offering both clinician and coder webinars and classes. Our fee-based webinars typically involve two-hour training sessions paired with post-training assessments; most are certified with CEUs. Topics include E/M Coding, Level I-III; Diagnosis Coding, (14 separate sessions) including Beginning and Intermediate Diagnosis Coding, as well as ICD-10-CM chapter-based webinars; Preventive Service Webinars; FQHC Specific Webinars; Use of Modifiers I & II; Minor Surgery Coding; Coding from an Op Report; Behavioral Health for Non-prescribers; Behavioral Health/Psychiatry for Prescribers. We also offer various specialty-based webinars and FQHC-specific webinars. Shawn is also responsible for the Brown Consulting Chart Auditing Training Series, which includes six sessions.

Historically, Shawn has worked with healthcare defense attorneys on behalf of physicians involved in third-party payer audits. Shawn authors and presents coding seminars and webinars for our many workshop/seminar partners including the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, West Virginia Primary Care Association and other regional and national groups.

For ten years, Shawn served as a coding instructor at the College of Southern Idaho and for Northwest Regional Primary Care Association, and was a long-term member of the Advisory Committee for Coding Education at the College of Southern Idaho. Shawn attended the College of Southern Idaho in Twin Falls, ID and Pima College in Tucson, AZ.

Meri Harrington, CPC, CEMC, brings with her 12 years of coding and auditing experience with a multispecialty rural health clinic that led the way in the rural residency training program. She was responsible for writing the E&M coding policy for the organization, as well as conducting multiple clinician and peer audits and education sessions. She has also assisted with internal audits to assure Meaningful Use implementation and attestations.

Meri and the BCA team perform documentation quality and coding compliance audits and customized clinician and coder training. She has spent multiple hours working alongside clinicians and peers on projects aimed at improving the user-friendliness of electronic medical record programs.

Meri has a special interest in data analysis and training related to the intricacies of appropriate ICD-10-CM diagnosis codes and chronic care coding with expertise related to HCCs. She has had the
opportunity to work along side third-party payers with a focus on appropriate diagnosis coding as a risk-based measurement instrument.

Meri’s knowledge and study of contemporary “quality” healthcare concerns coupled with her understanding of MACRA, MIPs and other emerging quality-based federal reimbursement plans, has positioned Meri to guide BCA in such a manner that we are able to incorporate emerging physician documentation requirements in current coding and documentation training.

For several years, Meri has served as the director of BCA’s six-month Comprehensive Coding Education Program which is designed to prepare coders and billers for professional national certification.

Meri also enjoys unique auditing and training services with clinics that provide focused services such as Contraceptive Management/Family Planning, and HIV services. Meri spends a great deal of her time working with Family Practice, Pediatrics, Geriatrics and OB-GYN. She is an expert with surgical operative report code extraction.

Historically, Meri’s education includes several years volunteering as an EMT in her local community. Meri attended the Community Colleges of Spokane – Colville IEL. Meri has developed multiple educational programs including the BCA Transition Mission training series, which was extensively utilized by clinics throughout the US as a tool for ICD-10-CM Implementation.

**Ginger Avery, CPC, CPMA,** joined the Brown Consulting team with 20 years of experience in medical coding and billing. She began her career performing home health billing for a rural county hospital. While working for an ASC her administrative skills lead to a significantly improved revenue cycle process. After obtaining her coding certification in 2005, she worked for the medical practice division of a large hospital, and while she specialized in cardiology, she also worked closely with hospitalists and family practice clinicians. She performed internal audits and provider education, and worked closely with projects aimed at improving the use of electronic medical record programs.

Ginger enjoys clinician medical record auditing and clinician and coder training. Ginger is extensively involved in a major third-party HCC project. Because of her coding expertise and her interest in CMS and state regulation she monitors BCA’s Coding Question Program. Ginger has extensive experience with data extraction from multiple EMR/EHR products, making her Brown Consulting’s ‘go to EMR advisor.’ Ginger has taken the lead in our new 15-Minute Coding Pearl Series. She plans to make these brief, topic-focused, on-demand recording available to clients on our codinghelp.com website in October 2016.

Historically, Ginger served as a member of the compliance committee and was responsible for writing policies and procedures related to billing, coding and auditing. Ginger obtained her Certified Professional Medical Auditor (CPMA) credential in 2014. Ginger has served the coder-community in many ways with her most recent duty as past President of her local American Academy of Professional Coders (AAPC) chapter.
Holly E. Gault, BSN, AAS joined the Brown Consulting team in 2016. She earned a Bachelor of Science degree in Nursing from Idaho State University in 2009. Holly began her transition from a home health/hospice RN to Health Information Management by returning to ISU where she earned an Associate Degree in Health Information Technology and graduated in May 2016. She is eligible to sit for the national RHIT examination.

Although a new Health Information graduate, Holly is no stranger to teaching. As an honor student during her ISU academic years, she was employed by ISU as a tutor. Her training duties included topics such as anatomy, physiology, pathology, biology, ICD-10-CM diagnosis coding, ICD-10-PCS coding, and CPT coding. She also provided EMR training.

Holly is currently helping to develop BCA’s 15-Minute Coding Pearl educational series, which are brief on-demand videos. You are invited to view these videos at codinghelp.com.

Brown’s Commitment Brown Consulting Associates, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, PCMH programs, value-based reimbursement projects and private insurance carriers. In addition to serving physician offices, Brown Consulting Associates provides specialized training for various third party payers, outpatient hospital-based clinics, and Federally Qualified Health Centers and Rural Health Clinics. Brown Consulting Associates offers physician and staff education designed and customized to enhance quality, operations and federal compliance.

Our association with the American Health Information Management Association, American Academy of Professional Coders, Medical Group Management Association as well as other groups, helps us to stay in touch with current issues and trends. Our programs and services are designed to assist physicians and their staff to meet the new demands and challenges of coding, documentation, compliance and reimbursement. Customized in-office services and web-based programs designed to educate clinicians, coders and staff will continue to be our focus.
MDD as a Diagnosis

ICD-10: Mood [affective] disorder (F30-F39)

Medical science cannot fully explain a clear cause for major depressive disorder (MDD) and there is not an assured cure. For some, MDD may be a relatively short episode of depression, followed by remission. For others, depression is a life-long chronic condition. Techniques for diagnosing depression are quite standard. Treatment is directed at relieving symptoms and improving quality of life. A combinations of therapies may be employed including medication and counseling.

Medical Science & MDD

- Brain Morphology
- Chemical Balance (neurotransmitters)
- Hormones
- Genetics
- Familial Considerations
Preexisting/Contributors/Risk Factors

1. **Chronic illness** can be a risk factor or contributor
2. Certain **medications** can be risk factors
3. **Substance** use, abuse, and dependence can be risk factors
4. Certain traits such as low self-esteem, self-critical, or pessimism are often discovered in the patients history
5. **Traumatic events**, abuse, death of others, relationship problems, or financial problems are often noted
6. Childhood and adolescent problems may surface as risk factors later in life
7. Circumstances involving sexual identity may lead to life-long depression
8. History or **co-existence of other mental health** disorders is seen with some frequency

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**CDC Depression Stats - US**

*Below the poverty level*

<table>
<thead>
<tr>
<th>Group</th>
<th>Below poverty level</th>
<th>At or above poverty level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>15.6%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12.6%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>7.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>6.9%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

*Significantly higher than 11% of all above poverty levels*

*Includes race and ethnicity groups not shown separately.

NOTES: Depression is defined as moderate to severe depressive symptoms. The poverty level is set by the U.S. Department of Health and Human Services and is based on family income and family size. Access data table for Figure 3.

Making the Diagnosis

1. Physical medical exam
2. Psychiatric diagnostic evaluation
3. Blood chemistry (BMP or CMP) / other studies
4. DSM-5 diagnostic criteria, PHQ-9, Beck depression inventory, and other diagnostic tools
5. Screening for “mimic” or co-existing concerns such as substance abuse
6. Screening for other disorders such as mania, bipolar, schizoaffective, schizophrenia etc.

Who May Assign Dx Codes?

Clinician Credentials, Federal/State Law &
Third-parties May Have A Say

<table>
<thead>
<tr>
<th>Psychiatric &amp; Behavioral Health Credentials</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAMFT CMFT LMHS MSSW</td>
<td>MDs and DOs</td>
</tr>
<tr>
<td>AAPH CP LP MSW</td>
<td>NPs, PMHNPs, PAs</td>
</tr>
<tr>
<td>ABECISW CSW LPA NAHC</td>
<td>Clinical Psychologists</td>
</tr>
<tr>
<td>ABPAmS DIAABM LPC NBCC</td>
<td>CSW/LCSWs</td>
</tr>
<tr>
<td>ABMP DABFN LPE NCC</td>
<td></td>
</tr>
<tr>
<td>ARPH DO LSP NP</td>
<td></td>
</tr>
<tr>
<td>ACP DPM LSW NIHSP</td>
<td></td>
</tr>
<tr>
<td>ACBSW DSW MA PA</td>
<td></td>
</tr>
<tr>
<td>ANA ESO MC PA</td>
<td></td>
</tr>
<tr>
<td>BCCS ESB MD PMA-INP</td>
<td></td>
</tr>
<tr>
<td>BCOSW LCP MED PsyD</td>
<td></td>
</tr>
<tr>
<td>BBN LCSW MFC RHCP</td>
<td></td>
</tr>
<tr>
<td>CADC LGBW MFCC RISW</td>
<td></td>
</tr>
<tr>
<td>CCOP LICSW MFCT RN</td>
<td></td>
</tr>
<tr>
<td>GCMHC LMFC MS RNCS</td>
<td></td>
</tr>
<tr>
<td>GCMG LMFOC MS ScD</td>
<td></td>
</tr>
<tr>
<td>CFNP LMFT MSN SW</td>
<td></td>
</tr>
<tr>
<td>GSW LMHC MSS</td>
<td></td>
</tr>
</tbody>
</table>

Medicaid/Others

Selected masters prepared counselors? Others?
Clinic must verify
Consider also state law

Know what your license and your clinic policy permits.
Depression Symptoms

- Sleeping problems
- Low energy and/or fatigue
- Irritability
- Headaches
- Excess weight or obesity, which can lead to heart disease and diabetes
- Pain and physical illness
- Alcohol or substance misuse, abuse, or dependence
- Anxiety, panic disorder, or social phobia
- Family conflicts, relationship difficulties, and work or school problems
- Social isolation
- Suicidal feelings, suicide attempts, or suicide
- Self-mutilation such as cutting
- Chronic disease, disability

“The Basic Five”

HIPAA Protected ICD Guidelines

1. The 1st listed dx identifies condition requiring the greatest work effort as determined by the clinician and supported in the medical record.
2. Code all conditions that require/affect care.
3. Code reasons for all studies.
4. Code to the highest level of specificity known.
5. Do not use “rule out” for unconfirmed diagnoses; instead report known signs and symptoms.
MDD Coding Fundamental Resources

1. **ICD-10-CM** (Official Guidelines & Codes)
2. **DSM-5** American Psychiatric Association
   - Defines terminology and the conditions
   - Defines diagnostic criteria for conditions
   - Outlines treatment for conditions
3. **PHQ-9**
   - Patient generated diagnostic and follow-up evaluation tool for clinician use
4. **Your communication/collaboration with medical & other providers should be well documented.**

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**Tools for Diagnosing and Monitoring**

**MDD “Severity” Specifiers are mild, moderate & severe**

**Clinicians complete the DSM5**

- If five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning (at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure)
- Depressed mood most of the day, nearly every day (as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful)).
- Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day (as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful)).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Feelings of worthlessness or guilt, or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective or observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or an attempt, or a specific plan for committing suicide

**Patient completes PHQ-9, Clinician scores**

<table>
<thead>
<tr>
<th>PHQ-9 Patient Health Questionnaire (PHQ-9)</th>
<th>M.D. &amp; M.D. Patient Criteria</th>
<th>M.D. &amp; M.D. Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0 1 2 3</td>
<td>1. Little interest or pleasure in doing things</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0 1 2 3</td>
<td>2. Feeling down, depressed or hopeless</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0 1 2 3</td>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0 1 2 3</td>
<td>4. Feeling tired or having little energy</td>
</tr>
<tr>
<td>5. Poor appetite or oversleeping</td>
<td>0 1 2 3</td>
<td>5. Poor appetite or oversleeping</td>
</tr>
<tr>
<td>6. Feeling bad about yourself, or that you’re a failure or have let yourself or your family down</td>
<td>0 1 2 3</td>
<td>6. Feeling bad about yourself, or that you’re a failure or have let yourself or your family down</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching TV</td>
<td>0 1 2 3</td>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching TV</td>
</tr>
<tr>
<td>8. Feeling lonely or isolated, or feeling like an outcast or being cut off from others</td>
<td>0 1 2 3</td>
<td>8. Feeling lonely or isolated, or feeling like an outcast or being cut off from others</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or that you would be better off if something bad happened to you</td>
<td>0 1 2 3</td>
<td>9. Thoughts that you would be better off dead, or that you would be better off if something bad happened to you</td>
</tr>
</tbody>
</table>

**Scores:**
- 0 points = normal
- 1-4 points = mild depression
- 5-9 points = moderate depression
- 10-14 points = moderately severe depression
- 15-20 points = severe depression

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Major Depressive Disorder (MDD)

**BCA ICD-10 Common Codes List Snapshot (pg 21)**

### Episode:
- [] single
- [] recurrent

### Severity:
- [] mild
- [] moderate
- [] severe
- [] full remission
- [] partial remission

<table>
<thead>
<tr>
<th>Major Depressive Disorders (MDD)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD, single episode code choices</td>
<td></td>
</tr>
<tr>
<td>&quot;Single episode&quot; is the first-ever episode. DSM-5, pg 162: Do code for MDD based on single or recurrent and severity.</td>
<td></td>
</tr>
<tr>
<td>MDD, single episode; (The patient's 1st Dx of MDD - may last months)</td>
<td>F32.0</td>
</tr>
<tr>
<td>MDD, single episode; mild severity</td>
<td>F32.1</td>
</tr>
<tr>
<td>MDD, single episode; moderate severity</td>
<td>F32.2</td>
</tr>
<tr>
<td>MDD, single episode; severe, WITHOUT psychotic symptoms</td>
<td>F32.3</td>
</tr>
<tr>
<td>MDD, single episode; severe, WITH psychotic symptoms</td>
<td>F32.4</td>
</tr>
<tr>
<td>MDD, single episode; in PARTIAL remission</td>
<td>F32.5</td>
</tr>
<tr>
<td>MDD, single episode; in FULL remission</td>
<td>F32.6</td>
</tr>
<tr>
<td>MDD, single episode; severity cannot be specified</td>
<td>F32.9</td>
</tr>
</tbody>
</table>

**NEW**

**Assigned the majority of the time**

Always avoid “unspecified” codes

Notice “No HCC value”
The “Episode” Specifiers

**Single or Recurrent**

**Single:** A “single episode” identifies circumstances where MDD is first diagnosed. Some people will continue to struggle with MDD for their entire life, or may go in to remission. This of “single” as a once-in-a-lifetime diagnosis. 

*See Details in DSM-5, written by APA; page 188*

**Recurrent:** A “recurrent episode” indicates that the patient had at least a two month break in symptoms then had a recurrence. Remission may occur, but any future recurrence will again be a “recurrent episode.”

**Note:** Recurrent is likely most common, even if the patient is “new” their depressive episode may be “recurrent”

*See Details in DSM-5, written by American Psychiatric Association; page 188*

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The “Severity” Specifiers

**Mild, Moderate & Severe**

**Mild:** At this time, few if any symptoms (beyond the DSM requirement of 5-9) are present. Intensity of symptoms is distressing but manageable. Symptoms result in minor impairment in social or occupational functioning. 

*See Details in DSM-5, page 188*

**Moderate:** Number and intensity of symptoms and/or functional impairments are between those identified as “mild” and “severe.” 

*See Details in DSM-5, page 188*
**The “Severity” Specifiers**

*Mild, Moderate & Severe*

**Severe:** At this time the number of current symptoms is substantially in excess of the 5-9 required for diagnosis. The intensive of symptoms is seriously distressing and unmanageable, symptoms markedly interfere with social and/or occupational functioning.  

**Note:** When the severity level is “severe” provide further detail indicating whether or not symptoms of psychosis are present.

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**Remission**

**Full Remission of MDD?**

DSM-5 states “Remission as such that individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree), while others experience many years with few or no symptoms between discrete episodes.”

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**Partial Remission of MDD?**

1) “symptoms of the immediately previous major depressive episode are present, but full criteria are no longer met, **OR**

2) there is a period lasting less than 2 months without any significant symptoms of a major depressive episode following the end of such an episode.”
**Patient Generated PHQ-9**

**Clinician may consider when marking Dx**

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**Assessment & Plan**

2nd FU visit today, for patient with MDD, recurrent episode. After my evaluation & consideration of PHQ-9 score of 7...

1. **Dx:** MDD, recurrent, mild  
2. Marijuana abuse  
3. Homelessness  

Case manager/SW and I discussed homeless, client will visit with SW now. Also scheduled client to see our Psych NP for medical/medication considerations. Start group Mon. RTN: 30 days or sooner if problem. Client agrees & appreciative.

P. Hernandez, LCSW

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**In Summary**

Diagnosis specificity improves quality of the medical record and allows capture of appropriate HCC values.

Allow DSM-5 & PHQ to guide coding specificity and related documentation for Major Depression Disorder.

Report all conditions that affect/require care.

Document communication with behavioral clinicians.

Assure diagnoses are correct/current in the medical record.

Thank You!
Resources

ICD-10-CM Code Book [for 2017], (various published) October 1, 2016
DSM-5, American Psychiatric Association, published in 2013
The National Institute of Mental Health (February 1, 2010). Symptoms and Treatment of Depression. Retrieved
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PA: Lippincot Williams & Wilkins.
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Lam, R., Otter, H., To, A. (November, 2002). Treatment of Depression in Primary Care Part 1; Principles of Acute
http://www.bcmj.org/article/treatment-depression-primary-care%E2%80%94part-1-principles-acute-treatment
Harvard Health Publications (June 2009). What Causes Depression? Retrieved February 2017 from:
http://www.health.harvard.edu/mind-and-mood/what-causes-depression

Do You Have Questions?

You may send us your coding questions
codingquestions@codinghelp.com
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### BCA ICD-10-CM Common Codes List

#### PSYCHIATRIC DX CODE SHEET

<table>
<thead>
<tr>
<th>ADHD; - Features are predominately... (choose)</th>
<th>Code</th>
<th>Major Depressive Disorders (MDD)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD; inattentive type</td>
<td>F90.0</td>
<td>MDD, single episode code choices</td>
<td></td>
</tr>
<tr>
<td>ADHD; hyperactive type</td>
<td>F90.1</td>
<td>&quot;Single episode&quot; is the first-ever episode. DSM-5, pg 162: Dx code for MDD based on single vs recurrent and severity.</td>
<td></td>
</tr>
<tr>
<td>ADHD; combined (inattentive and hyperactive types)</td>
<td>F90.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD; other type, which is not considered as above three types</td>
<td>F90.8</td>
<td>MDD, single episode; (The patient's 1st Dx of MDD - may last months/years)</td>
<td></td>
</tr>
<tr>
<td>Anxiety and Related Dxs F40 F41 F43 and F97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety; generalized</td>
<td>F41.1</td>
<td>MDD, single episode; moderate severity</td>
<td></td>
</tr>
<tr>
<td>Anxiety, mixed (with prominent features of other disorder)</td>
<td>F41.3</td>
<td>MDD, single episode; severe, WITHOUT psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>Panic disorder; w/o agoraphobia (panic attack)</td>
<td>F41.0</td>
<td>MDD, single episode; severe, WITH psychotic symptoms</td>
<td></td>
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<tr>
<td>with agoraphobia</td>
<td>F40.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation anxiety (of childhood)</td>
<td>F93.0</td>
<td>MDD, single episode; in FULL remission</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorder unspecified (doc. in record, but no code)</td>
<td>F41.8</td>
<td>MDD, single episode; severity cannot be specified avoid No F32.9</td>
<td></td>
</tr>
<tr>
<td>Social phobia (anxiety) disorder, generalized</td>
<td>F40.1</td>
<td>MDD, recurrent episode code choices (more common than single episode)</td>
<td></td>
</tr>
<tr>
<td>Acute stress reaction</td>
<td>F43.0</td>
<td>An &quot;episode&quot; likely to last many mos/years. DSM-5, pg 162: &quot;recurrent&quot; = interval of ≥ 2 consecutive months between separate episodes in which criteria for MDD are not met.</td>
<td></td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>F43.1</td>
<td>MDD, recurrent episode; mild subsequent re-dx after remission</td>
<td></td>
</tr>
<tr>
<td>PTSD; acute</td>
<td>F43.2</td>
<td>MDD, recurrent episode; &amp; moderate severity</td>
<td></td>
</tr>
<tr>
<td>PTSD; chronic</td>
<td>F43.3</td>
<td>MDD, recurrent episode; severe</td>
<td></td>
</tr>
<tr>
<td>Anxiety; unspecified</td>
<td>F41.9</td>
<td>MDD, recurrent; &amp; severe, WITHOUT psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>Adjustment Disorders F43.2</td>
<td></td>
<td>MDD, recurrent; &amp; severe, WITH psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>with anxiety</td>
<td>F43.21</td>
<td>MDD, recurrent episode in PARTIAL remission</td>
<td></td>
</tr>
<tr>
<td>with mixed mood (anxiety &amp; depression)</td>
<td>F43.22</td>
<td>MDD, recurrent episode in FULL remission</td>
<td></td>
</tr>
<tr>
<td>with disturbance of conduct</td>
<td>F43.23</td>
<td>MDD, Other recurrent depressive disorder (specified in record)</td>
<td></td>
</tr>
<tr>
<td>with mixed disturbance (emotion/conduct)</td>
<td>F43.24</td>
<td>MDD, recurrent episode, severity cannot be specified avoid No F32.9</td>
<td></td>
</tr>
<tr>
<td>with other symptoms not noted in available codes</td>
<td>F43.25</td>
<td>Other Depressive Episodes (Added 2016)</td>
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</tr>
<tr>
<td>Adjustment disorder unspecified</td>
<td>F43.20</td>
<td>Other specified depressive episode (specified in record) F32.89</td>
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<tr>
<td>Bipolar Disorders F31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar, current episode is manic &amp; mild</td>
<td>F31.11</td>
<td>MDD, recurrent episode; mild subsequent re-dx after remission</td>
<td></td>
</tr>
<tr>
<td>Bipolar; current episode is; manic &amp; moderate</td>
<td>F31.12</td>
<td>MDD, recurrent episode; &amp; moderate severity</td>
<td></td>
</tr>
<tr>
<td>manic &amp; severe but WITHOUT psychotic features</td>
<td>F31.13</td>
<td>MDD, recurrent; &amp; severe, WITHOUT psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>manic &amp; severe and WITH psychotic features F31.2</td>
<td></td>
<td>MDD, recurrent; &amp; severe, WITH psychotic symptoms</td>
<td></td>
</tr>
<tr>
<td>Bipolar, current episode is depressed &amp;</td>
<td>F31.31</td>
<td>MDD, recurrent episode in FULL remission</td>
<td></td>
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<tr>
<td>current episode is; depressed &amp; depressed but WITHOUT psychotic features</td>
<td>F31.32</td>
<td>MDD, Other recurrent depressive disorder (specified in record)</td>
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<tr>
<td>Bipolar; current episode is mixed (manic &amp; dep.)</td>
<td>F31.61</td>
<td>Mood disorder, unspec. (Active psychotic NOS) avoid No F39</td>
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<tr>
<td>Bipolar; current episode is; mixed &amp; moderate</td>
<td>F31.62</td>
<td>Depression Personality Disorders F60</td>
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<tr>
<td>Bipolar; current episode is; mixed &amp; severe, but WITHOUT psychotic features</td>
<td>F31.63</td>
<td>Antisocial F60.2</td>
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<tr>
<td>Bipolar; current episode is; mixed &amp; severe, and WITH psychotic features</td>
<td>F31.64</td>
<td>Avoidant F60.6</td>
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<tr>
<td>Bipolar, current episode hypomanic</td>
<td>F31.10</td>
<td>Borderline F60.3</td>
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<tr>
<td>Bipolar Disorders IN REMISSION (Partial or Full Remission)</td>
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<td></td>
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<tr>
<td>Bipolar disorder PARTIAL</td>
<td></td>
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<tr>
<td>Bipolar disorder FULL remission</td>
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<tr>
<td>hypomanic</td>
<td>F31.71</td>
<td>Dependent F60.7</td>
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<tr>
<td>manic</td>
<td>F31.73</td>
<td>Histrionic F60.4</td>
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<tr>
<td>depressed</td>
<td>F31.74</td>
<td>Narcissistic F60.81</td>
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<tr>
<td>mixed</td>
<td>F31.75</td>
<td>Obsessive-compulsive F60.5</td>
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<tr>
<td>Bipolar disorder, unspecified</td>
<td>F31.77</td>
<td>Paranoid F60.0</td>
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<tr>
<td>Bipolar II disorder</td>
<td>F31.81</td>
<td>Schizoid F60.1</td>
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<tr>
<td>Schizophrenia/Schizoaffective</td>
<td>F20.0</td>
<td>Schizophrenia/Schizoaffective disorder, bipolar type F25.0</td>
<td></td>
</tr>
<tr>
<td>Manic episode w/o psychotic symptoms mild</td>
<td>F30.11</td>
<td>Disorganized F20.1</td>
<td></td>
</tr>
<tr>
<td>Manic episode w/o psychotic symptoms moderate</td>
<td>F30.12</td>
<td>Catatonic F20.2</td>
<td></td>
</tr>
<tr>
<td>Manic episode w/o psychotic symptoms severe</td>
<td>F30.13</td>
<td>Undifferentiated F20.3</td>
<td></td>
</tr>
<tr>
<td>Manic episode with psychotic symptoms severe</td>
<td>F30.2</td>
<td>Residual F20.5</td>
<td></td>
</tr>
<tr>
<td>Manic episode in PARTIAL remission</td>
<td>F30.3</td>
<td>Schizophreniaform disorder F20.81</td>
<td></td>
</tr>
<tr>
<td>Manic episode in FULL remission</td>
<td>F30.5</td>
<td>other specified (documented type, but is not bipolar or depressive) F25.8</td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder, unspecified</td>
<td>F25.9</td>
<td>Schizoaffective disorder, unspecified avoid No F25.9</td>
<td></td>
</tr>
</tbody>
</table>
Coding Pearl Evaluation - Brown Consulting

Please scan & email to laura@codinghelp.com or fax to 208-736-1946

Your web based training session:

1. Did you watch the entire training? ❑ Yes ❑ No

2. Rate your coding competence prior to training.

3. Rate the training.

4. Did you find this training process valuable? ❑ Yes ❑ No

5. Will your coding change as a result of training? ❑ Yes ❑ No

Please note any recommendation for improvement of this training program:

Please note any comments or recommendations you may have for administration:

Please note any follow-up you are requesting from the trainer: