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- F01** **Vascular dementia**
 Vascular dementia is a generalized condition describing problems with impaired memory, reasoning, judgment, planning, and other cognitive thought processes from brain damage due to reduced blood flow. Vascular dementia is similar to Alzheimer's disease, but is often stroke-related and usually occurs more suddenly. Changes may also appear in noticeable downward declines from the previous level of functioning. This is a common form of dementia estimated to account for about 40% of dementia cases, particularly in the elderly, and is related to certain risk factors such as hypertension, atherosclerosis, cerebrovascular disease, diabetes, and smoking.
- F01.50** **Vascular dementia without behavioral disturbance** **HCC**
 Vascular dementia occurs when the brain is deprived of vital oxygen and nutrients whenever blood vessels are chronically damaged or stenosed and blood flow to the brain is reduced or blocked, such as in a stroke. Symptoms include memory loss, depression, restlessness, agitation, trouble focusing or paying attention, confusion, unsteady gait, a decline in the ability to reason and organize thoughts, or analyze a situation. Risk factors such as high blood pressure, atherosclerosis, diabetes, smoking, lupus, and atrial fibrillation puts a person at high risk. Treatment mainly consists of controlling the underlying conditions posing the greatest risk. Medication aimed at regulating or boosting levels of brain cell chemical messengers involved in memory, judgment, and information processing may be given to help with the dementia symptoms.
- F01.51** **Vascular dementia with behavioral disturbance** **HCC**
 Patients with vascular dementia may have behavioral disturbances at some point, which includes wandering off, hoarding, aggressiveness, sexual disinhibitions, screaming or incessant vocalizations, perseveration on bathroom activities, attention seeking, and any combative or violent behavior that puts patients and others in danger. Behavioral disturbances cause additional comorbidity and mortality, and increase stress for caregivers. Treatment is pharmacological with environmental interventions, as well as addressing any other causes of behavioral issues, such as pain, other medical illnesses, personal emotional needs, and the current use of any inappropriate medications.
Note: When wandering in vascular dementia is noted as a behavioral disturbance, assign code Z91.83 in addition.
- F02** **Dementia in other diseases classified elsewhere**
 Dementia is a generalized condition reflecting a loss of cognitive and intellectual functions, such as impaired memory, reasoning, judgment, and other cognitive thought processes, without impaired perception or consciousness, due to some form of brain damage. Dementia occurs in many other diseases, such as with Alzheimer's, epilepsy, multiple sclerosis, Parkinson's, niacin and vitamin B deficiencies, systemic lupus erythematosus, acquired hypothyroidism, and poisoning and toxic reactions.
Note: The underlying disease, such as recurrent seizures, dementia in Parkinsonism, traumatic brain injury, and Huntington's disease must be reported first. Although dementia in Parkinson's disease is reported here, dementia with Parkinsonism must be coded first with G31.83 as dementia with Lewy bodies. Dementia occurring with substance abuse disorders is coded elsewhere in chapter 5, and dementia that occurs due to atherosclerosis or hypertensive cerebrovascular disease is reported at vascular dementia.
- F02.80** **Dementia in other diseases classified elsewhere without behavioral disturbance** **HCC**
 Dementia is a generalized condition reflecting a loss of cognitive and intellectual functions, such as impaired memory, reasoning, judgment, and other cognitive thought processes, without impaired perception or consciousness, due to some form of brain damage. Dementia occurs in many other diseases, such as Alzheimer's or epilepsy, typically due to the changes in the brain that the disease process itself effects on that organ. This can stem from hormonal imbalances, nutritive deficiencies, brain tissue degeneration, or infection. Symptoms of dementia include memory loss, depression, restlessness, agitation, trouble focusing or paying attention, confusion, unsteady gait, a decline in the ability to reason and organize thoughts, analyze a situation, or plan out an action. Treatment is aimed at the underlying condition, attempting to halt further permanent brain damage, and alleviating dementia symptoms, possibly with medicaments that regulate brain cell chemistry.
- F02.81** **Dementia in other diseases classified elsewhere with behavioral disturbance** **HCC**
 Most patients with dementia will have behavioral disturbances at some point, which includes wandering off, hoarding, aggressiveness, sexual disinhibitions, screaming or incessant vocalizations, perseveration on bathroom activities, attention seeking, and any combative or violent behavior that puts patients and others in danger. Behavioral disturbances cause additional comorbidity and mortality, and increase stress for caregivers. Treatment is pharmacological with environmental interventions, as well as addressing any other causes of behavioral issues, such as pain, other medical illnesses, personal emotional needs, and the current use of any inappropriate medications.
Note: When wandering in dementia with other diseases is noted as a behavioral disturbance, assign code Z91.83 in addition.

- F03 Unspecified dementia**
This category includes both senile and presenile dementia, NOS and senile and presenile psychoses, NOS. Primary degenerative dementia and senile dementia expressed as depressive or paranoid type is also reported here as unspecified dementia either with or without behavioral disturbance. This is a loss of cognitive and intellectual functions, such as impaired memory, judgment, reasoning, and other intellectual or cognitive thought processes, without impaired perception or consciousness, generally in patients older than 65, and brought on by atrophy of parts of the brain. In the uncomplicated state it is often mild in manifestation.
Note: Unspecified senility is not considered to be dementia, but a symptom coded R41.81.
- F03.90 Unspecified dementia without behavioral disturbance HCC**
Dementia is a group of symptoms caused by changes in the brain resulting in intellectual and social disabilities that interfere with regular functioning. Different symptoms are experienced with dementia, which includes problems with at least 2 brain functions, such as memory loss and impaired judgment. Symptoms vary with the cause and the etiology is often unknown. Other signs and symptoms include inability to reason; difficulty communicating, planning, coordinating motor functions, or learning new information; as well as personality and mood changes.
- F03.91 Unspecified dementia with behavioral disturbance HCC**
Most patients with dementia will have behavioral disturbances at some point, which includes wandering off, hoarding, aggressiveness, sexual disinhibitions, screaming or incessant vocalizations, perseveration on bathroom activities, attention seeking, and any combative or violent behavior that puts patients and others in danger. Behavioral disturbances cause additional comorbidity and mortality, and increase stress for caregivers. Treatment is pharmacological with environmental interventions, and addressing causes such as pain, other medical illnesses, personal needs, and inappropriate medications.
Note: When wandering off is noted as a behavioral disturbance, assign code Z91.83 in addition.
- F04 Amnestic disorder due to known physiological condition HCC**
Amnestic disorder involves the loss of previously established memories, the inability to create new memories, or to learn new information. Amnestic disorder often results from an underlying physiological condition that causes structural or chemical damage to parts of the brain that produces disturbances in memory.
Note: Amnestic disorder brought about by the use of alcohol or other psychoactive substance is coded elsewhere in chapter 5.
- F05 Delirium due to known physiological condition**
This category level code is used to report delirium resulting from other known physiological conditions that may be temporary, lasting for a brief period of time, or more permanent. Conditions known to produce delirium reported here include psycho-organic brain syndromes, confusional states not due to alcohol, infective psychoses, and dementia with delirium superimposed. Delirium can be defined as an acute state of confusion and agitation in which the patient will seem to be disoriented, and will overreact to emotional and physical stimuli.
Note: Delirium that is not otherwise specified is reported as a symptom with code R41.0.
- F06 Other mental disorders due to known physiological condition**
This category is used to report mental disorders that are the result of other medical conditions. These conditions are classified as due to another known physiological condition and may be temporary, lasting for a brief period of time, or more permanent. Conditions known to cause the mental disorders reported here include endocrine disorders, circulating exogenous hormones, other drugs and substances the body finds toxic, systemic diseases affecting the brain, and epilepsy. Some of the disorders classified here include hallucinations, catatonia, depression, anxiety, and other psychotic disorders.
Note: Delirium due to a known physiological factor is coded to F05 and can be defined as an acute state of confusion and agitation in which the patient will seem to be disoriented, and will overreact to emotional and physical stimuli.
- F06.1 Catatonic disorder due to known physiological condition**
Catatonia is defined as a state of apparent unresponsiveness in someone who is apparently awake to experience external stimuli. The patient usually will not be able to provide a coherent history, is withdrawn, and often mute. One group of symptoms relates to motor behavior disturbances such as slowed motor activity or immobility in which the same rigid body position is held for days, weeks, or even months. Catatonic patients may also display a waxy flexibility in which they hold a body position placed by someone else. Other signs and symptoms relate to behavioral responses to others and include negativistic halting against or going along with blindly; automatic obedience; echolalia in which the patient automatically repeats the vocalizations made by another; echokinesis, the involuntary imitation of another's actions; and the inappropriate repetition of stereotypical movements such as body rocking, tapping, abdomen patting, and moving the jaw, eyes, or mouth. There is also an alternative presentation of catatonia in an excited state with agitated, purposeless movements unrelated to the environment, possible combativeness, and autonomic instability. Underlying physiological causes include infectious, metabolic, and neurological conditions such as encephalitis, diffuse encephalopathy, poisoning by neuroleptics or other toxic substances, neuroleptic malignant syndrome, or nonconvulsive status epilepticus, or another mental disorder. Medications used in treatment include lithium carbonate, amobarbital, benzodiazepines, carbamazepine, tricyclic antidepressants, thyroid hormone, zolpidem, and muscle relaxants. Electroconvulsive therapy may be indicated when the patient is not responding to pharmacotherapy within 5 days, or is displaying signs of malignant catatonia.
Note: The underlying physiologic condition must be reported first. Schizophrenic catatonia is considered another type of catatonia and is reported with F20.2 as is depressive catatonia, reported with codes from categories F31-F33. Unspecified catatonia is reported as stupor with R40.1.

F06.4**Anxiety disorder due to known physiological condition**

Anxiety disorder is marked by persistent, uncontrollable worry and fear about aspects of a person's life, usually lasting at least 6 months, that becomes too much for the person to control, negatively affecting their day to day life. Although there are many types of anxiety disorders with differing symptoms, such as generalized, obsessive-compulsive, post-traumatic, and panic disorders, similar psychological symptoms can also occur in anxiety disorder specifically due to a known underlying medical condition. The main set of symptoms clusters around uncontrollable, excessive, and irrational fear or dread that leaves the person filled with obsessive worry, fearfulness, and uncertainty. Medication may be used to control the symptoms of anxiety while treatment is aimed at the underlying medical condition, which may include pain disorders, metabolic disturbances, nutritional deficiencies, encephalopathy, or other nervous system disorders.

Note: Anxiety disorder due to alcohol or substance abuse is not considered an underlying physiological condition and is reported elsewhere in chapter 5.

F07.0**Personality change due to known physiological condition**

A change in personality due to an injury or disease of the brain, resulting from damage to the frontal lobe. The effects of this injury vary, but typically result in the patient showing apathy, a lack of planning, emotional bluntness, and the absence of abstract thought.

F07.81**Postconcussional syndrome**

Postconcussional syndrome is a condition in which the patient suffers symptoms such as headache, amnesia, and lack of concentration due to a severe blow to the skull.

F10**Alcohol related disorders**

Alcohol related disorders usually occur along with heavy, prolonged bouts of drinking and normally occur mainly in patients with alcoholism. Alcohol produces a depressant effect, and over time it can seriously impair brain function, besides the effects on other body systems. Alcohol related disorders are classified based on whether the patient is abusing or dependent upon alcohol, intoxicated or in withdrawal, and whether the patient suffers from other related disorders, such as anxiety, sleep, or mood disorders, or psychotic disorders with delusions or hallucinations, or amnesia.

Note: Delirium can be defined as an acute state of confusion and agitation. The patient will seem to be disoriented, and will overreact to emotional and physical stimuli. Delusional patients exhibit false beliefs inconsistent with their own knowledge and experiences. Hallucinations, however, involve false sensory stimulation.

F10.2**Alcohol dependence**

Alcohol dependence is a substance use disorder characterized by an individual's compulsive need to use alcohol.

F10.920**Alcohol use, unspecified with intoxication, uncomplicated HCC**

Idiosyncratic alcohol intoxication presents as a disorder unique to the individual that occurs after ingesting a small amount of alcohol, and is not caused by excessive drinking.

F12.23**Cannabis dependence with withdrawal HCC**

Cannabis (marijuana) derives from the leaves and seeds of the Cannabis sativa or Cannabis indica plant. Cannabis and its associated chemicals, cannabidiol (CBD) and the psychoactive constituent tetrahydrocannabinol (THC), alter the brain's neurotransmitters and biochemistry. THC targets brain cells called cannabinoid receptors to trigger the well-known "high" and is the main chemical in marijuana sought for recreational use. THC alters the senses and mood, impairs body movement, thinking, and memory and produces hallucinations when consumed in high doses. THC in cannabis is also used medically to prevent nausea and vomiting in chemotherapy, for chronic pain, and to increase appetite. Cannabidiol (CBD) has antipsychotic effects and is used for treating MS, epilepsy, dystonia, bipolar disorder, and anxiety. There has been no evidence as yet of dependence or withdrawal triggered by CBD use; however, between 10- 30% of heavy THC marijuana users show signs of dependence. These may include craving the drug, inability to stop taking it, using more cannabis than intended, increasing the amount of time spent seeking, using, or recovering from the drug, and increasing tolerance to it (meaning higher doses are needed to obtain the same effect). Use of cannabis before age 18 and daily use of it increase the likelihood of dependence. Symptoms of cannabis withdrawal appear within 24 hours of cessation of the drug and include irritability, anger, aggression, anxiety or nervousness, difficulty sleeping, decreased appetite or weight loss, depressed mood, abdominal pain, shakiness, sweating, fever, chills, and headache. These symptoms generally peak within two to three days and diminish within one to two weeks without treatment.

F12.93**Cannabis use, unspecified with withdrawal HCC**

Cannabis (marijuana) derives from the leaves and seeds of the Cannabis sativa or Cannabis indica plant. Cannabis and its associated chemicals, cannabidiol (CBD) and the psychoactive constituent tetrahydrocannabinol (THC), alter the brain's neurotransmitters and biochemistry. THC targets brain cells called cannabinoid receptors to trigger the well-known "high" and is the main chemical in marijuana sought for recreational use. THC alters the senses and mood, impairs body movement, thinking, and memory and produces hallucinations when consumed in high doses. THC in cannabis is also used medically to prevent nausea and vomiting in chemotherapy, for chronic pain, and to increase appetite. Cannabidiol (CBD) has antipsychotic effects and is used for treating MS, epilepsy, dystonia, bipolar disorder, and anxiety. There has been no evidence as yet of withdrawal triggered by CBD use; however, even prescribed use of THC in medical marijuana as well as recreational use may trigger symptoms of withdrawal upon cessation. Withdrawal symptoms typically appear within 24 hours of cessation of the drug and include irritability, anger, aggression, anxiety or nervousness, difficulty sleeping, decreased appetite or weight loss, depressed mood, abdominal pain, shakiness, sweating, fever, chills, headache. These symptoms generally peak within two to three days and diminish within one to two weeks without treatment.

F19.930	<p>Other psychoactive substance use, unspecified with withdrawal, uncomplicated HCC</p> <p>Drug withdrawal occurs when drug use is curtailed, resulting in physical or psychological symptoms that can vary widely depending on the drug(s) the patient was taking. Symptoms can last anywhere from hours to weeks, and commonly feature headache, anxiety, depression, chills, sweats, and tremors.</p>	F24	<p>Shared psychotic disorder HCC</p> <p>A shared psychotic disorder occurs when a delusional person convinces another person that their delusions are real. The person convinced to accept the delusions as real typically shares a close relationship with the delusional person.</p>
F20	<p>Schizophrenia</p> <p>Schizophrenia is a term for a group of chronic, severe mental disorders which affect behavior and thought patterns. The cause of these disorders is unknown, but is believed to be genetic. The onset of the disease usually happens in late adolescence or early adulthood, and affects males more often than females. While there are several variations of schizophrenia, symptoms such as hallucinations, delusions, and disorganized behavior are common among all of them.</p>	F30	<p>Manic episode</p> <p>Mood disorders reports dramatic, recurrent, or severe forms of mood disturbances that are accompanied by extreme changes in energy and behavior, either very low depressive type or the high manic type. Psychoses may also be present in bipolar and major depressive disorder with hallucinations of things that are not there or delusions of false ideas or beliefs. These disorders may occur in singular episodes, may be cyclic or recurring in nature, and may also appear mixed at the same time.</p> <p>Note: The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria require that when coding bipolar disorders, the episode(s) cannot be better accounted for by any kind of schizophrenic-related type of disorder, delusional disorder, or psychotic disorder.</p> <p>This category codes bipolar disorder, single manic episode. Bipolar disorder is one of the most common mental disorders, also referred to as manic depressive disorder. A single manic episode is the presence of only one manic period when it is not a recurrence, and with no past major depressive episodes. Approximately 90% of those with a single manic episode will go on to have recurrent episodes. The manic mood is characterized by unusually high levels of energy; a lack of need for very much sleep; racing thoughts or fast speech; a euphoric mood; difficulty concentrating; unrealistic beliefs in one's own abilities; excessive spending; and intrusive or aggressive behavior. Up to 70% of all manic episodes occur immediately preceding or following a major depressive episode, so caution should be used when reporting this category.</p>
F20.0	<p>Paranoid schizophrenia HCC</p> <p>Paranoid schizophrenia is marked by displays of megalomania, delusions of persecution and/or grandeur, hallucinations, and aggressive behavior.</p>		
F20.1	<p>Disorganized schizophrenia HCC</p> <p>Disorganized schizophrenia is characterized by inappropriate, disinhibited behavior. The patient may display strange emotional responses, and may appear agitated. Hallucinations and delusions may occur, but are not the prominent features of the disorder.</p>		
F20.2	<p>Catatonic schizophrenia HCC</p> <p>Catatonic schizophrenia is marked by a state of rigid stupor in which the body's limbs can be posed, or the patient displays purposeless motion and refusal to follow commands or suggestions.</p>		
F20.5	<p>Residual schizophrenia HCC</p> <p>Residual schizophrenia is observed in patients recovering from schizophrenia during which mild symptoms return.</p>	F31.0	<p>Bipolar disorder, current episode hypomanic HCC</p> <p>Current hypomanic episode is a mild to moderate level of mania associated by patients with good feelings that increase functioning and productivity. It can turn into severe mania or depression and the mood symptoms, although perceived as good, can actually cause distress or impairment in social and occupational functioning. A hypomanic episode that turns into a more severe manic episode later is still considered hypomanic in the current episode.</p>
F20.81	<p>Schizophreniform disorder HCC</p> <p>Schizophreniform disorder is used as a preliminary diagnosis for schizophrenia. If the schizophreniform disorder cannot be cured in six months, then the diagnosis is changed to schizophrenia.</p>		
F20.89	<p>Other schizophrenia HCC</p> <p>Simple type schizophrenia is often undiagnosed, and is the least severe type of the disease. Symptoms include a gradual withdrawal from contact with others, as well as mild hallucinations and delusions.</p>	F31.1	<p>Bipolar disorder, current episode manic without psychotic features</p> <p>Bipolar disorder is one of the most common mental disorders, also referred to as manic depressive disorder. The occurrence of a cyclical manic episode is coded here in which there has previously been at least one major depressive episode. The current manic mood is characterized by unusually high levels of energy; a lack of need for very much sleep; racing thoughts or fast speech; a euphoric mood; difficulty concentrating; unrealistic beliefs in one's own abilities; excessive spending; and intrusive or aggressive behavior.</p> <p>Note: If "recurrent manic episode" is stated, but not otherwise specified, report code F31.89.</p> <p>Note: When the current manic episode is severe and occurs with psychotic symptoms report F31.2.</p>
F21	<p>Schizotypal disorder HCC</p> <p>Schizotypal disorder is a condition in which the patient is uncomfortable forming close relationships with others and suffers abnormal anxiety in social situations.</p>		
F23	<p>Brief psychotic disorder HCC</p> <p>Brief psychotic disorder includes paranoid reaction and psychogenic paranoid psychosis. An acute paranoid reaction causes the patient to have severe delusions of persecution, believing that someone or something is conspiring to do them harm. Psychogenic paranoid psychosis is a type of disorder in which the patient's paranoid state is in response to an external stimulus, and has a longer duration than an acute paranoid reaction.</p>		

F31.3	<p>Bipolar disorder, current episode depressed, mild or moderate severity</p> <p>Bipolar disorder is one of the most common mental disorders, also referred to as manic depressive disorder. The occurrence of a cyclical depressed episode is coded here in which there has previously been at least one major manic episode. A current depressive episode is characterized by feelings of hopelessness, worthlessness, guilt, or helplessness; decreased energy and fatigue; difficulty remembering or making decisions; a lasting sad, empty, or anxious mood; pervasive pessimism; sleeping too much or not being able to sleep; weight loss or gain; and suicidal thoughts or attempts.</p> <p>Note: When a current depressed episode is severe, occurring with psychotic symptoms, report F31.5.</p> <p>Note: A recurrent episode of major (reactive) (psychogenic) (endogenous) (seasonal affective) depression is coded to category F33.</p>	F32.81	<p>Premenstrual dysphoric disorder</p> <p>Premenstrual dysphoric disorder (PMDD) is a severe form of premenstrual syndrome (PMS). PMDD is characterized by depression, anxiety, tension and irritability that typically begins after release of the ovum. There may be a genetic predisposition due to a variant in the estrogen receptor alpha gene and/or Catechol-O-methyl transferase (COMT) gene. Low levels of the brain neurotransmitter serotonin may also be present in women who experience PMDD.</p>
F31.6	<p>Bipolar disorder, current episode mixed</p> <p>Use this subcategory to report a current episode of bipolar disorder stated to be a mixed episode. In a mixed episode, symptoms of both mania and depression are present together, but neither one dominates. For instance, a person may feel sad on one hand, but also very energetic at the same time. Patients often present as agitated with trouble sleeping or lack of need for much sleep. They may have suicidal thoughts or even display psychosis.</p>	F34.0	<p>Cyclothymic disorder</p> <p>Cyclothymic disorder is characterized by mild mood swings between elevated mood and mild depression. Be careful not to confuse this condition with bipolar disorder, a similar condition in which the mood swings are much more severe.</p>
F31.81	<p>Bipolar II disorder HCC</p> <p>This code reports bipolar II disorder, which is defined as a history of one or more major depressive episodes, accompanied by at least one hypomanic episode, and without history of a manic or mixed episode. The major difference between bipolar I and bipolar II relies on bipolar II having hypomania, but no manic episodes. Bipolar II cannot have psychotic features such as hallucinations and delusions that may occur in bipolar I. Symptoms do cause distress or impair functioning, but not markedly enough to require hospitalization.</p>	F34.1	<p>Dysthymic disorder</p> <p>Dysthymic disorder is also described as persistent depressive disorder, chronic depressive personality disorder, or neurotic depression. Dysthymia is a serious, chronic, depressive state that persists for at least 2 years and is accompanied by symptoms such as fatigue, insomnia, anxiety, low self-esteem, and disruption of appetite. Dysthymia is a mood disorder that is less severe than a psychosis, lasting longer than major depressive disorder. Sufferers may have symptoms for a long time before being diagnosed and many believe that depression is simply part of their character.</p>
F31.9	<p>Bipolar disorder, unspecified HCC</p> <p>This code is used to report the circular type of bipolar disorder, or manic depressive psychosis, in which the current state or most recent episode is not specified as either manic, depressive, or mixed. This code also reports atypical bipolar affective disorder not otherwise specified.</p>	F40.01	<p>Agoraphobia with panic disorder</p> <p>Agoraphobia is a fear of open spaces or crowds, traveling, or leaving a safe place. The patient will suffer panic attacks when forced into these situations.</p>
F32	<p>Major depressive disorder, single episode</p> <p>A single major depressive episode is the presence of only one depressive period with no past manic episodes and no recurrence of a previous depressive episode—defined as a shift in polarity from mania, or an interval of less than two months without depressive symptoms. The depressive episode is characterized by feelings of hopelessness, worthlessness, guilt, or helplessness; decreased energy and fatigue; difficulty remembering or making decisions; a lasting sad, empty, or anxious mood; pervasive pessimism; sleeping too much or not being able to sleep; weight loss or gain; and suicidal thoughts or attempts.</p> <p>Note: Single episodes of major depressive disorder are only coded when there has been no previous major manic episode. If the depressive episode follows a previous manic episode, it should be coded as bipolar disorder with most recent (or current) episode depressed.</p>	F40.1	<p>Social phobias</p> <p>Patients suffering from social anxiety disorder, or phobia, have an intense fear of appearing in public, especially in situations where they are the center of attention.</p>
		F40.10	<p>Social phobia, unspecified</p> <p>Patients suffering from this condition have an intense fear of appearing in public, especially in situations where they are the center of attention.</p>
		F40.2	<p>Specific (isolated) phobias</p> <p>Phobias are an intense fear or loathing of an object or situation.</p>
		F41.0	<p>Panic disorder [episodic paroxysmal anxiety]</p> <p>Panic disorder without agoraphobia, or a fear of crowds, is thought to be a malfunction of the patient's flight or fight response. The patient suffers unexplained bouts of intense fear or anxiety, accompanied by symptoms such as elevated heart rate, sweating, trembling, dizziness, and/or shortness of breath. Fear of dying is also a hallmark of panic disorder.</p>
		F41.1	<p>Generalized anxiety disorder</p> <p>This condition is marked by persistent, uncontrollable worry about aspects of a person's life. This disorder is diagnosed when the anxiety symptoms last longer than six months, with anxiety present on the majority of days in that time.</p>

F42	Obsessive-compulsive disorder Obsessive-compulsive disorders occur when a person suffers from recurrent obsessions of thought or action that are time-consuming or disruptive to daily life. These obsessions can be ideas, thoughts, images, or impulses which produce anxiety or distress.		
F43.0	Acute stress reaction This condition occurs when an extremely high stress level causes a patient to experience intense anxiety and panic.	F44.4	Conversion disorder with motor symptom or deficit A conversion disorder occurs when symptoms impairing physical function occur due to a psychological problem instead of a physical problem and is thought to be a response to stress. In conversion disorder with motor symptoms or deficits, the patient may suffer from abnormal seizure or tic-like movements, muscle weakness or paralysis including swallowing difficulties, and voice loss or other speech deficit symptoms.
F43.1	Post-traumatic stress disorder (PTSD) This condition, once thought to occur mostly in combat veterans, occurs commonly in all levels of society as a response to traumatic events such as rape, physical assault, and natural disasters. A patient afflicted with PTSD will often suffer sudden, powerful memories (flashbacks) of the event that triggered the condition, causing anxiety and panic. They may also withdraw from family and friends, and avoid situations which resemble aspects of the original traumatic event. The patient's emotions may swing wildly, and they may turn to drugs or alcohol as a way of coping.	F44.81	Dissociative identity disorder HCC Dissociative identity disorder is commonly known as multiple personality disorder. This condition arises due to severe emotional and mental stress or trauma in childhood. The patient creates one or more distinct personalities separate from their own as a protective device, each with its own memory, behaviors, thoughts, and motivations. Any of the different personalities may be dominant, lived by the person, with suppression of the true identity.
F43.2	Adjustment disorders Adjustment reactions and disorders occur when the patient has difficulty adjusting to a new environment or situation. They could be a reaction to grief, moving away from home to a different culture, being hospitalized, or other such situations.	F44.89	Other dissociative and conversion disorders This code includes reactive or psychogenic confusion, also called psychogenic twilight state. A patient with this disorder will seem severely disoriented and results from a severe emotional reaction.
F43.25	Adjustment disorder with mixed disturbance of emotions and conduct An adjustment disorder with mixed disturbances of different emotions, as well as a disturbance in conduct that causes the patient to act out in ways that are not socially acceptable.	F44.9	Dissociative and conversion disorder, unspecified An unspecified dissociative disorder or reaction is a temporary state of hysteria in which the patient will lapse into an alternate personality in response to a stressor.
F43.29	Adjustment disorder with other symptoms Adjustment disorder with withdrawal occurs when the patient abnormally isolates themselves to avoid dealing with a new situation. The condition commonly occurs in young children, who become sullen and withdrawn.	F45	Somatoform disorders Somatoform disorders are psychological problems which manifest themselves with physical symptoms.
F44	Dissociative and conversion disorders Dissociative disorders are a type of alternate, or multiple personality disorders that occur when an individual is incapable of remembering or maintaining his or her own true identity. An alternate, or two or more different distinct personalities, each with its own thoughts, emotions, and behaviors is created. These disorders are very rare. A conversion disorder occurs when impaired physical function occurs due to a psychological problem instead of a physical problem. The patient may suffer seizures, paralysis, loss of the voice, or temporary blindness or deafness, also known as hysterical blindness or hysterical deafness. It is thought that this condition is a response to stress.	F45.0	Somatization disorder This condition is marked by physical symptoms that are a manifestation of psychological conflicts. The patient will present with symptoms of illness affecting multiple organ systems, for which the physician will find no physical source.
F44.0	Dissociative amnesia HCC Dissociative amnesia is the result of psychological trauma which causes the patient to temporarily forget personal information and renders him or her unable to perform complex tasks, such as driving or cooking.	F45.1	Undifferentiated somatoform disorder An undifferentiated somatoform disorder is a condition in which the patient has symptoms of a specific physical disease, but does not actually suffer from that disease.
F44.1	Dissociative fugue HCC Dissociative fugue is a disorder occurring in response to a severe, recent stressor, in which the patient invents a new personality and becomes unable to remember his or her previous identity, lasting from days to months.	F45.2	Hypochondriacal disorders Hypochondriasis is also called health fear or health phobia. This is a somatoform disorder marked by an overwhelming fear that one has a serious disease, or by excessive preoccupation with serious illness, even though medical practitioners cannot find any evidence of the disease(s) being present.
		F48.1	Depersonalization-derealization syndrome HCC Depersonalization disorder is a condition in which the patient recurrently looks at themselves from an outsider's point of view, to the point of feeling that they are not in control of themselves. Symptoms of this disorder are similar to those of panic disorder and other anxiety problems.

F48.2**Pseudobulbar affect**

Pseudobulbar affect (PBA) is a condition that occurs secondary to underlying neurological conditions, disease, or injury. The structural damage to the brain causes involuntary, frequent, disruptive outbursts of crying or laughing that is incongruent or magnified out of proportion with the patient's emotional state and situation. It is often mistaken for psychiatric disorders such as bipolar disorder, schizophrenia, and depression. PBA has been reported in patients with amyotrophic lateral sclerosis, multiple sclerosis, those who have had traumatic brain injury, and patients one year after suffering stroke.

Note: The underlying neurologic disease or sequelae cause must be reported first, if known, as pseudobulbar affect is a secondary neurologic condition.

F48.8**Other specified nonpsychotic mental disorders**

Other specified nonpsychotic mental disorders includes other specified types of neurosis, such as occupational, or psychasthenic neurasthenia, and psychogenic syncope. The patient suffers physical weakness, fatigue, or collapse due to mental exertion and inadequate rest.

F50.0**Anorexia nervosa**

Anorexia nervosa is an eating disorder caused by an extreme, irrational fear of becoming overweight that leads to radical restriction of food intake. Patients may exercise excessively or binge eat and induce self vomiting. Sufferers also have a distorted self image of their body and diet to the point of starvation and malnutrition, causing serious ill health and even death.

F50.2**Bulimia nervosa**

Bulimia nervosa is a serious eating disorder than mainly affects young women, characterized by binge eating, secretive episodes of consuming a large amount of food in a short time, followed by an attempt to purge the calories eaten, often by self-induced vomiting or with the use of strong laxatives or diuretics, or excessive exercise. A patient with this disease will typically eat compulsively and see themselves as being overweight, even if their weight is normal. The cycles of insatiable appetite and purging are often set apart by long periods of food restriction. Binge eating and purging can cause stomach rupture, acidic erosion of tooth enamel, an inflamed esophagus, irregular menstrual periods, and even irregular heart rhythms due to the lack of necessary vitamins and minerals, such as potassium.

F50.82**Avoidant/restrictive food intake disorder**

Avoidant/restrictive food intake disorder (ARFID) is an eating disorder marked by anxiety over consuming certain foods. The patient is not merely a picky eater, but often fears that eating will trigger choking, vomiting, or an allergic reaction and restricts food intake as a result. In children, this can cause failure to thrive and abnormally halted growth. In adults, ARFID can cause marked weight loss. Nutritional deficiency is a serious consequence in both adults and children, with common effects including weakness and fatigue, hair loss, brittle nails, and reduction in bone density. Low appetite or lack of interest in food is not related to body image concerns or fear of weight gain, in contrast to anorexia nervosa or bulimia. Rather, the patient fears getting sick if certain foods are consumed, but there is no bodily cause. Other key signs of ARFID include a reluctance or inability to eat in front

of others, such as at a restaurant or school cafeteria, and an increasingly shortened list of foods the patient prefers. ARFID patients also tend to be at risk for other psychiatric disorders such as anxiety and depression.

Causes of ARFID may be genetic, though there are possible psychological factors involved, such as obsessive-compulsive tendencies or mood disorders and sociocultural factors, such as perceived pressure to eat clean, unprocessed foods. ARFID is diagnosed and treated on a continuum due to wide variation in signs, symptoms, and underlying causes. Generally, both the apparent concern over the foods causing the disturbance and psychosocial difficulties, such as eating in public, are addressed in addition to correcting nutritional deficiencies and any other clinical concerns related to the disorder. Treatment may include meal coaching, nutritional supplements, and building skills based on positive reinforcement measures.

F50.89**Other specified eating disorder**

This code includes pica in adults. Pica is the urge to eat nonfood substances, such as dirt, paper, paint, and rocks. It also includes the psychogenic loss of appetite characterized by an aversion to food or eating with no pathologic or physiologic explanation. This may occur after an illness when the brain, as a conditioned response, sends signals to the body to avoid a food that was eaten just previous to the illness as a protection against becoming ill again. This code also includes avoidant restrictive food intake disorder (ARFID), which is a complex eating disorder characterized by decreased interest in food/eating, avoidance of certain foods due to sensory characteristics, and/or an increased concern with the consequences or disadvantages of eating. The disorder occurs in the absence of psychological or physiological disease and ultimately results in a failure to meet nutritional needs. ARFID is often associated with a fear of eating and may be triggered by an episode of choking, vomiting, or unpleasant memories associated with certain places (work, school, home, restaurant).

F50.9**Eating disorder, unspecified**

Atypical types of anorexia and bulimia nervosa are included here. One type of atypical anorexic disorder, sometimes called orthorexia nervosa, is characterized by an obsession with avoiding "unhealthy" foods that eventually leads to restrictive eating and can cause malnutrition. The disorder does not usually involve body dysmorphia but does cause anxiety and distress that negatively interferes with everyday life.

Binge Eating Disorder (BED) is a complex eating disorder characterized by recurrent episodes of overeating not followed by purging, exercise, or fasting. Individuals who engage in this behavior are usually overweight or obese and experience guilt, shame, and distress which perpetuates the cycle.

F51.03**Paradoxical insomnia**

A disorder marked by violent, vigorous behavior perceived in a dream, such as running, jumping, punching, or kicking. During normal REM sleep, the muscles are deactivated so that this type of activity cannot take place. Patients suffering from this condition risk injuring themselves or their bedmates.