Psychiatry Coding & Reimbursement Alert

ICD-10 Update: Click on Specific Code For Trichotillomania in ICD-10

Hint: Don't use this code for isolated tic of hair pulling.

When "trichotillomania" or "hair pulling" is the diagnosis provided by your psychiatrist, you will be pleased to know that you have a specific code that you can report for this condition in ICD-10, an option that you did not have in ICD-9. In ICD-9, you had to report the condition using a more generalized code.

ICD-9: When your psychiatrist confirms a diagnosis of trichotillomania, you report the condition with the ICD-9 code, 312.39 (Disorders of impulse control; trichotillomania). You cannot use this ICD-9 code when your clinician diagnoses the patient with adjustment reaction with disturbance of conduct. You report this with 309.3 (Adjustment disorder with disturbance of conduct).

You also cannot use 312.39 for a diagnosis of stereotypes such as head banging and body rocking occurring in isolation. You report this with 307.3 (Stereotypic movement disorder). Also, when the patient exhibits isolated tics such as thumb sucking, nail biting, or hair plucking, you cannot report 312.39. You report these with 307.9 (Other and unspecified special symptoms or syndromes not elsewhere classified).

Apart from this, the other exclusions under which you cannot report 312.39 include the following:

- drug dependence (304.0-304.9)
- dyssocial behavior without manifest psychiatric disorder (V71.01-V71.02)
- personality disorder with predominantly sociopathic or asocial manifestations (301.7)
- sexual deviations (302.0-302.9).

ICD-10: When you begin using ICD-10 codes post Oct.1, 2015, you will have a specific ICD-10 code to report a diagnosis of trichotillomania. You will report this diagnosis with F63.3 (Trichotillomania). You use the same diagnosis code if your clinician mentions the diagnosis as "hair plucking."

Caveat: As with ICD-9, you cannot use F63.3 when your clinician diagnoses the patient with stereotypes occurring in isolation. You report this with F98.4 (Stereotyped movement disorders). You cannot report F63.3 for a diagnosis of Tourette's syndrome or combined vocal and multiple motor tic disorder [de la Tourette]. You report it with F95.2 (Tourette's disorder) instead of F63.3. If your clinician diagnoses a patient with tics of organic origin, you report this with G25.69 (Other tics of organic origin).

Have a Look at These Basics Briefly

Documentation spotlight: Your clinician will arrive at a diagnosis of trichotillomania 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 some lab tests.

Some of the findings that your clinician would most likely record in a patient with trichotillomania will include hair pulling, hair loss, and repeated attempts towards reduction of the habit of hair pulling. Due to the hair loss, the patient will experience difficulties in social and occupational circles.

Your clinician might note that the patient denies that he has the habit of pulling hair. Some patients might also engage in pulling hair from other people or pets while some also have the habit of pulling hair out of inanimate objects such as dolls and carpets. Your clinician might note that the patient appears anxious, and usually, patients with hair pulling habit

have higher incidence of the habit when they are under stress. Some patients might complain of frequent gastrointestinal symptoms such as pain in the abdomen, nausea and vomiting, GI bleeding, and constipation. This can be attributed to hair cast (Trichobezoar) formation in the GI tract.

Upon examination, your clinician might note that the patient has areas where there is hair loss. The most common area where your psychiatrist will note loss of hair is the scalp although they can be pulled out of other areas such as eyelashes, eyebrows, pubic hair, or from other areas of the body. Your clinician will note that the hair in the adjacent areas (of hair loss) is normal. Your clinician will also note that the patient presents with hair of different length in different areas due to loss and re-growth.

Your clinician will also note that the scalp or the skin (if hair loss is from other areas) does not show any signs of inflammation or infection or other abnormalities that can be indicative of any other dermatological or systemic\ conditions.

If the patient has the habit of ingesting the hair that is being pulled out, then your clinician will note the signs of GI disturbances due to hair cast formation in the digestive tracts. Apart from these signs and symptoms of the GI tract, your psychiatrist might also note the signs of anemia or even obstructive jaundice.

Tests: In most cases, your clinician will rely on the history and the signs and symptoms to arrive at the diagnosis of trichotillomania. However, he might also look at some tests such as trichography to confirm the diagnosis of the condition. But, sometimes, to ascertain that the patient is not suffering from any other condition (such as alopecia areata) that is causing the hair loss, your clinician might resort to performing a punch biopsy and ordering a histological study.

The care planning may include cognitive behavioral psychotherapy along with habit reversal techniques and relaxation techniques.