Another Medical Condition

Code: 293.89 (F06.1)

Another Medical Condition
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Another Medical Condition
Diagnostic Criteria 293.89 (F06.1)

A. The clinical picture is dominated by three (or more) of the following symptoms:
1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
2. Catalepsy (i.e., passive induction of a posture held against gravity).
3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
4. Mutism (i.e., no, or very little, verbal response [Note: not applicable if there is an established aphasia]).
5. Negativism (i.e., opposition or no response to instructions or external stimuli).
6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
9. Agitation, not influenced by external stimuli.
10. Grimacing.
11. Echolalia (i.e., mimicking another's speech).
12. Echopraxia (i.e., mimicking another's movements).
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder (e.g., a manic episode).
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Unspecified Catatonia 121
Coding note: Include the name of the medical condition in the name of the mental disorder (e.g., 293.89 [F06.1] catatonic disorder due to hepatic encephalopathy). The other medical condition should be coded and listed separately immediately before the catatonic disorder due to the medical condition (e.g., 572.2 [K71.90] hepatic encephalopathy; 293.89 [F06.1] catatonic disorder due to hepatic encephalopathy).
Diagnostic Features

The essential feature of catatonic disorder due to another medical condition is the presence of catatonia that is judged to be attributed to the physiological effects of another medical condition. Catatonia can be diagnosed by the presence of at least three of the 12 clinical features in Criterion A. There must be evidence from the history, physical examination, or laboratory findings that the catatonia is attributable to another medical condition (Criterion B). The diagnosis is not given if the catatonia is better explained by another mental disorder (e.g., manic episode) (Criterion C) or if it occurs exclusively during the course of a delirium (Criterion D).
Associated Features Supporting Diagnosis

A variety of medical conditions may cause catatonia, especially neurological conditions (e.g., neoplasms, head trauma, cerebrovascular disease, encephalitis) and metabolic conditions (e.g., hypercalcemia, hepatic encephalopathy, homocystinuria, diabetic ketoacidosis). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the etiological medical condition.
Differential Diagnosis

A separate diagnosis of catatonic disorder due to another medical condition is not given if the catatonia occurs exclusively during the course of a delirium or neuroleptic malignant syndrome. If the individual is currently taking neuroleptic medication, consideration should be given to medication-induced movement disorders (e.g., abnormal positioning may be due to neuroleptic-induced acute dystonia) or neuroleptic malignant syndrome (e.g., catatonic-like features may be present, along with associated vital sign and/or laboratory abnormalities). Catatonic symptoms may be present in any of the following five psychotic disorders: brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, and substance/medication-induced psychotic disorder. It may also be present in some of the neurodevelopmental disorders, in all of the bipolar and depressive disorders, and in other mental disorders.
Unspecified Catatonia
This category applies to presentations in which symptoms characteristic of catatonia cause clinically significant distress or impairment in social, occupational, or other important areas of functioning but either the nature of the underlying mental disorder or other medical condition is unclear, full criteria for catatonia are not met, or there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
Coding note: Code first 781.99 (R29.818) other symptoms involving nervous and musculoskeletal systems, followed by 293.89 (F06.1) unspecified catatonia.
122 Schizophrenia Spectrum and Other Psychotic Disorders
Other Specified Schizophrenia Spectrum and
Other Psychotic Disorder
298.8 (F28)
This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class. The other specified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific schizophrenia spectrum and other psychotic disorder. This is done by recording "other specified schizophrenia spectrum and other psychotic disorder" followed by the specific reason (e.g., "persistent auditory hallucinations").
Examples of presentations that can be specified using the "other specified" designation include the following:
1. Persistent auditory hallucinations occurring in the absence of any other features.
2. Delusions with significant overlapping mood episodes: This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).
3. Attenuated psychosis syndrome: This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained).
4. Delusional symptoms in partner of individual with delusional disorder: In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for *delusional disorder*.
Unspecified Schizophrenia Spectrum and
Other Psychotic Disorder
298.9 (F29)
This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class. The unspecified schizophrenia spectrum and other psychotic disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific schizophrenia spectrum and other psychotic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
Bipolar and
Related Disorders
Bipolar and related
disorders are separated from the depressive disorders in
DSM-5 and placed between the chapters on schizophrenia spectrum and other psychotic disorders and depressive disorders in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics. The diagnoses included in this chapter are bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.
The bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder or affective psychosis described in the nineteenth century, differing from that classic description only to the extent that neither psychosis nor the lifetime experience of a major depressive episode is a requirement. However, the vast majority of individuals whose symptoms meet the criteria for a fully syndromal manic episode also experience major depressive episodes during the course of their lives.
Bipolar II disorder, requiring the lifetime experience of at least one episode of major depression and at least one hypomanic episode, is no longer thought to be a "milder" condition than bipolar I disorder, largely because of the amount of time individuals with this condition spend in depression and because the instability of mood experienced by individuals with bipolar II disorder is typically accompanied by serious impairment in work and social functioning.
The diagnosis of cyclothymic disorder is given to adults who experience at least 2 years (for children, a full year) of both hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania, or major depression.
A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with manic-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced bipolar and related disorder and bipolar and related disorder due to another medical condition.
The recognition that many individuals, particularly children and, to a lesser extent, adolescents, experience bipolar-like phenomena that do not meet the criteria for bipolar I, bipolar II, or cyclothymic disorder is reflected in the availability of the other specified bipolar and related disorder category. Indeed, specific criteria for a disorder involving short-duration hypomania are provided in Section III in the hope of encouraging further study of this disorder.
Bipolar I Disorder
Diagnostic Criteria

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.
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124 Bipolar and Related Disorders
Manic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.
Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.
Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.
Hypomanic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
Bipolar I Disorder 125
C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).
Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.
Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.
Major Depressive Episode
A. 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.
Note: Do not include symptoms that are clearly attributable to another medical condition.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (*Note:* In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. 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.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another