

OHHS Attribution Guidance for the AE Pilot Program

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Definition

Attribution is the process of defining the population on which total costs are calculated for the purposes of identifying savings under a shared savings or risk contract. Effective attribution provides an incentive for providers and Accountable Entities to invest in care management and other appropriate services to keep their attributed population well, in the hope that they will earn savings. Attribution does not affect consumers' **freedom to choose or change their providers** at any point in their care. Consumer freedom of choice is independent of which attribution model Rhode Island Medicaid chooses.

Attribution Methodology Goals

OHHS seeks to establish an attribution method, to be applied across all MCOs and AEs that:

- Allows providers who have **historical responsibility for member costs** to earn savings by reducing those costs in the future;
- Allows **Integrated Health Homes (IHH)** to assume this responsibility for members with an approved IHH diagnosis;
- **Is transparent and understandable to all program participants;**
- **Is consistent with existing models in use in Rhode Island** – e.g., PCMH kids/ICI attribution, current PCP assignment.

Note – no single method accomplishes all of these goals.

Given the timing of this pilot we require that this methodology be implemented for January 1, 2016, for one year, during which the MCOs, together with AE partners and OHHS will assess the effectiveness of the required method and develop a plan for attribution in later years.

What we considered *(supporting materials provided in backup)*

1. EOHHS Attribution Guidance Provided to date *to MCOs in Amendment 10*
2. Learnings from other states and Medicare: Alternative Models
3. Current IHH Attribution Methodology
4. NHPRI Suggested Method
5. Integra/TPC Proposed Model
6. PCMH Kids Details

Attribution Methodology Notes

- A member can only be attributed to one (1) Pilot Entity or shared savings program at a time.

- Attribution must include all Medicaid populations enrolled in managed care. Rhody Health Options (RHO) members shall be excluded from AE attribution unless (i) the RHO member is receiving Medicaid benefits only (not Medicare), or (ii) the RHO member is receiving IHH services from a Type 2 AE contracted with the MCO.

Assignment Hierarchy

1st: IHH Assignment/Type 2 AE

If a member is assigned to an IHH, and that IHH is an approved Type 2 AE, then the member is attributed to the Type 2 AE. IHH assignment is based on BHDDH approved methodology as described below and in Backup #3.

1. **IHH Claims.** Includes CMHC claims only. Certain Procedure Codes excluded. Age \geq 18
2. **Diagnosis:** Include any claim with an approved diagnosis (backup #7).
3. **Specific Agency:** Specific agency based on the most recent paid claim.
4. **RIBHOLD:** Cross referenced vs. RIBHOLD list. Clients with an approved IHH diagnosis reported in RIBHOLD added to the attributed list.
5. **Active OTP Health Home clients** removed (not IHH attributed).

2nd: PCP Assignment

Attribute to the PCP to whom they are assigned upon enrollment

Considerations

- + **Builds on what we have** – consistent with the CTC and PCMH kids methodology.
- + **Easily implemented** – no new data to be collected, process already in place
- + **Captures all members** – all members either select or are assigned a PCP upon enrollment
- + **Prioritizes designated IHH providers who are Type 2 AEs**
- + **Prioritizes Level 3 PCMH** – consistent with MCO contract amendment 9, EOHHS priorities
- **Accuracy unclear** - ~10% of members select a PCP upon enrollment --reliant on assignment
- **Implications for AE attributed lives unclear** -- Assignment rules vary by MCO, and current MCO prioritization rules may result in limited attribution to some new AEs

Backup Documentation

1. EOHHS Attribution Guidance Provided to date
2. Learnings from other states and Medicare
3. IHH Attribution Methodology
4. NHPRI Suggested Method
5. Integra/TPC Proposed Model
6. PCMH Kids Attribution Details

7. Allowed IHH diagnosis codes

Backup 1: EOHHS Attribution Guidance Provided to date to MCOs in Amendment 10

“Attribution means those members who have been specifically defined as receiving primary services through a provider affiliated with an AE Coordinated Care Pilot and whose total costs of care are included within a subcontractual arrangement between Contractor and the Entity.

The basis for attribution shall be:

- *Primary use of a PCP who is an identified participant of the Pilot Entity*
- *A demonstrated relationship with a CMHC and/or receiving of SPMI or SMI services.*

*And based on EOHHS approval of the attribution methodology **may include:***

- *A demonstrated primary clinical relationship with another (non PCP) specialist or provider who is an identified member of the network*
- *A member who is otherwise assigned to the Accountable Entity based on an EOHHS-approved methodology, for example, a member who resides in a census tract of a participating PCP (or CMHC) and has no identified primary source of care.*

A member can only be attributed to one Pilot Entity or Medicaid shared savings program at a time.”

Backup 2: Learnings from other states and Medicare

Medicaid PCMH Kids	Based on PCP selected by member at enrollment, or autoassignment rules
CTC	Varies by carrier
Vermont	<ol style="list-style-type: none"> 1) attributed through claims with qualifying CPT codes in performance year with Medicaid-enrolled primary care providers 2) eligible beneficiaries not assigned through claims, assign them to PCP they selected or were auto-assigned to in PY.
Medicare MSSP	<p>Retrospective alignment in two steps:</p> <ol style="list-style-type: none"> 1.) Assign a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. 2.) For beneficiaries who have not received primary care services from PCPs within the ACO, assign beneficiaries if they receive the plurality of primary care services from other ACO professionals within the ACO. <p>Note: Under the new Track 3 Option, beneficiaries will be assigned prospectively using a 12 month look back</p> <p>Note: If participating in ACO Investment Model (AIM)*: For AIM payments, preliminary prospective beneficiary alignment, as determined by MSSP program regulations</p>
Medicare Pioneer	<ol style="list-style-type: none"> 1) Aligned with the group of primary care providers (same as MSSP, but including NPs and PAs) who billed for the plurality of primary care allowed charges during combined 3 year period. 2) If a beneficiary had less than 10% of E&M allowed charges billed by primary care physicians (in or out of the ACO), alignment will be with the group of eligible specialists who billed for the plurality of allowed charges. 3) Beneficiaries who newly enroll in Medicare may also be aligned with ACOs through an affirmative attestation on behalf of the beneficiary that a specific ACO is his or her primary provider. <p>Notes:</p> <ul style="list-style-type: none"> • Eligible specialists includes: nephrology, oncology, rheumatology, endocrinology, pulmonology, neurology, and cardiology. (Note – not behavioral health) • A primary care specialist may be identified as a participating provider by one and only one Pioneer ACO • Eligible provider includes physician, nurse practitioner, physician assistant or clinical nurse specialist • Participating physician practice identified by TIN. An FQHC, RHC, or CAH2 practice is identified by a combination of a CMS Certification Number (CCN) + practitioner’s individual NPI.
Minnesota IHP	<p>Participants will be attributed to one IHP at a time.</p> <ol style="list-style-type: none"> 1st Participants actively enrolled in care coordination through a certified Health Care Home (HCH) submitting a monthly care coordination claim. 2nd Participants that cannot be attributed based on HCH enrollment may be attributed to the IHP based on the number of E&M visits (i.e., encounters) with provider who specializes in primary care 3rd Participants that cannot be attributed through PC visits may be attributed to the IHP based on their E&M visits with non-primary care (specialty) providers
Iowa Medicaid ACOs	<p>Attribute using two methods.</p> <ol style="list-style-type: none"> 1st: if there is a PCP assignments (from one of our two PCCM program). 2nd: If that is not present attribute based on a plurality of PCP visits. <p>Notes</p> <ul style="list-style-type: none"> ○ Attribution is updated almost monthly, allowing ACOs to always know who is with them. ○ ACOs define their network by providing Tax IDs. A tax ID must be exclusive to one ACO.

Backup 3: IHH Attribution Methodology

The IHH Attribution methodology utilized Medicaid paid claims from MMIS with the following criteria:

1. IHH Claims

- Any Fund Source*
- Limited to CMHC claims only
- Procedure Codes excluded:
 - H2011 (Crisis)
 - H0005:UD, H0004:UD, H0001:UD (SA Residential)
 - H0005, H2036 (IOP)
 - X0341:HH:TG (ASU/CSU)
- Dates of Service >= 1/1/15
- Age >= 18 as of 9/1/15

2. Clients were attributed if they had any claim with an approved diagnosis

(See diagnosis table – backup #7).

3. Attributed **to a specific agency** based on the most recent paid claim

4. **Those not attributed based on claim diagnoses** were then cross referenced against RIBHOLD reported diagnoses. Clients with an approved IHH diagnosis reported in RIBHOLD were added to the attributed list. The remainder create the “Not attributed” list.

5. **All active OTP Health Home clients removed** from attributed list and added to the not attributed list

* Only fund 26 was used for the purposes of estimating cost projections. This is an important caveat to consider when comparing this attribution methodology vs the total number of projected IHH members in previous discussions and handouts.

Backup 4: NHPRI Suggested Method

EOHHS also requested options to consider for attribution. As we mentioned, the concept of BH attribution is new territory and is complicated by the substantial amount of BH/BHDDH claims which are in FFS/MMIS. We look forward to a future meeting to discuss these ideas for consideration:

Type 1 Attribution

PCMH Kids attribution approach developed and agreed upon between the health plans and EOHHS. This may need a few adjustments, but is generally acceptable.

Type 2 Attribution (below is a step-wise description)

- 1. Identify universe from EOHHS/BHDDH IHH health plan member file** (most recent file shared 10/15)
- 2. Calculate total cost of care from health plan claims**
- 3. Calculate Health Home costs from EOHHS/BHDDH claims. Create an average Health Home cost/PMPM.**
 - ☐ The referenced file was provided to the health plans by Grant. Keep in mind it contains all BHDDH Health Home claims. The file is not health plan or member-specific.
 - ☐ Neighborhood requests a member-identifiable claims files with our members only
 - ☐ This would allow for easier attribution and more accurate rate-setting and AE budgeting and savings calculations.
- 4. Attribution determination:** if the majority of total cost of care is for behavioral health services AND there exists a plurality of outpatient BH visits to the Type 2 AE
- 5. If Step 4 is met then assign to Type 2 AE**

Backup 5: Integra/TPC Proposed Model

Proposed Attribution Methodology

We propose the following criteria to determine those members who should be attributed to the Integra Type II Accountable Entity Pilot. These criteria will identify those members whose care will be best managed and provided within a behavioral health accountable entity.

This set of criteria would be applied to current patients/clients and, with modifications, will serve to determine attribution for new clients/patients – either those newly enrolled in Medicaid or those who seek or are directed to receive care at The Providence Center.

The proposed attribution methodology is a combination of:

Diagnosis + Service @ TPC + Behavioral Health Spending

Diagnosis

We propose to use the federal definition of serious mental illness, promulgated by the Center for Mental Health Services (CMHS) in the Federal Register should apply. It reads as follows:

“...adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R and or their ICD-9-CM equivalent (and subsequent revisions) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities...”*

The definition states that “adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness... DSM-III-R ‘V’ codes, substance use disorders, and development disorders are excluded from this definition...”

Federal Register: Volume 58, Number 96. Pages 29422-29425

(This definition has not been updated in the Federal Register since 1994, an earlier version of the DSM is used as the reference (DSM-III-R). The current version of the DSM will apply for this initiative.)*

Service At The Providence Center

The member received care at The Providence Center during State Fiscal Year 2015.

Behavioral Health Proportion of Total Cost of Care

One of the primary purposes of the Type II AE is to ensure that high cost, high utilizers whose high total cost of care is a result of their behavioral health conditions are served appropriately. To that end it is important to identify members for whom behavioral health is the dominant form of care they seek, need, and receive.

An analysis that looks simply at the majority of spending will fail to identify all such members and will be overly prone to distortion in the case of those receiving high-cost medicines (Hepatitis C) or those who have traumatic events or serious health episodes which skew the data on total cost of care.

We believe the following criteria will provide the necessary filters to account for these facts and result in reliable identification of those who would be best served in a Level II Accountable Entity:

- *Members for whom a behavioral health provider was the largest single source of non-institutional, non-inpatient, spending – excluding pharmacy*

And/Or

- *Members with a total behavioral health spend exceeding \$2,000 during SFY15.*

Proposed Attribution Member for “New” Members

For incumbent members whose service from The Providence Center started after July 1, 2015 and for those new members who join or seek service at TPC going forward, we propose using the Diagnosis criteria above in conjunction with their functional assessment score on the DLA.

The DLA score threshold would be a score of 5.0 or less which indicates moderate to extreme functional impairment.

The Providence Center would submit a roster of qualifying patients on a monthly basis to include in the attributed population.

Note: This draft is provided for discussion purposes. Integra is open to modifying this proposal based on continued discussions with the MCOs.

Backup 6: PCMH Kids Attribution Details Updated May 27, 2015

	UHC	TUFTS	BCBSRI	NHPRI
Look back	27 months	27 months	24 months	27 months
Patient Attribution Method	<p>Commercial - Last PCP seen in look back period. If multiple providers seen on the day of most recent visit, most visits during look back. If no visits in look back, use pharmacy claims</p> <p>Medicaid – PCP selected by member at enrollment</p>	Last physician seen in look back period for E&M visit	<p>1. Self-selection (i.e., member who has self-selected a PCP). If no self-selected, then;</p> <p>2. PCP with the most recent well visit is attributed as the PCP, if there is no well visit, then;</p> <p>3. PCP with the greatest number of sick visits is attributed as the PCP. In the event of two or more PCP's have the same number of sick visits, the PCP with the most recent sick visit will be attributed as the PCP.</p>	PCP selected by member at enrollment
Codes used for attribution	<p>EM: 99201-99205, 99211-99215</p> <p><u>Consults</u>: 99241-99245</p> <p><u>Confirmatory Consultations</u>: 99271-99275</p> <p>Home Visit E&M: 99341-99345, 99347-99350</p> <p><u>OV Preventative</u>: 99381-99387, 99391-99397</p> <p><u>Preventative Counseling</u>: 99401-99404, 99406-99409, 99411-99412</p> <p><u>Newborn care not in hospital</u>: 99432</p>	<p>CPT® codes 99201-99215 and 99381-99397, 99381-99387, 99391-99397;</p> <p>If not well visit, then greatest # of sick visits codes 99201-99205, 99211-99215</p>	<p><u>Well visit</u> 99381-99387, 99391-99397</p> <p><u>Preventative Med</u>: 99381-99387, 99391-99397</p> <p><u>Sick visits</u> 99201-99205, 99211-99215</p>	
When PCP leaves a practice	Attribute patient up to 6 months or until primary care claim w/ other doc (mid- quarter grace period)	Attribute patient until E&M claim with other participating physician or patient would fall out at next attribution calculation if most recent visit is with physician who left a practice and is no longer participating in the CSI	Attribute patient up to 6 months or until primary care claim w/ other doc	Patient stays with practice until a visit with another practice.
Age	Members <18	All ages are included (must be seen by PCMH-Kids participating phys)	All ages are included (must be seen by PCMH-Kids participating practice)	Members <18
Other	PCP specialty must be family practice, internal medicine or pediatrics.	Patients must have been enrolled in plan as of the end of the attribution look back period.	Patients no longer enrolled in plan on date of attribution calculation are eliminated. PCP specialty must be internal medicine or family practice.	

Backup 7: Allowed IHH diagnosis codes

ID	DSM-IV Code	DSM Code2	Axis	ICD-9 Dx Categories	DSM-IV-TR Category
1	295.10	29510	I	HEBEPHRENIA-UNSPEC	Schizophrenia, Disorganized Type
2	295.11	29511	I	HEBEPHRENIA-SUBCHRONIC	
3	295.12	29512	I	HEBEPHRENIA-CHRONIC	
4	295.13	29513	I	HEBEPHREN-SUBCHR/EXACERB	
5	295.14	29514	I	HEBEPHRENIA-CHR/EXACERB	
6	295.15	29515	I	HEBEPHRENIA-REMISSION	
7	295.2	2952	I	CATATONIC SCHIZOPHRENIA*	
8	295.20	29520	I	CATATONIA-UNSPEC	Schizophrenia, Catatonic Type
9	295.21	29521	I	CATATONIA-SUBCHRONIC	
10	295.22	29522	I	CATATONIA-CHRONIC	
11	295.23	29523	I	CATATONIA-SUBCHR/EXACERB	
12	295.24	29524	I	CATATONIA-CHR/EXACERB	
13	295.25	29525	I	CATATONIA-REMISSION	
14	295.3	2953	I	PARANOID SCHIZOPHRENIA*	
15	295.30	29530	I	PARANOID SCHIZO-UNSPEC	Schizophrenia, Paranoid Type
16	295.31	29531	I	PARANOID SCHIZO-SUBCHR	
17	295.32	29532	I	PARANOID SCHIZO-CHRONIC	
18	295.33	29533	I	PARAN SCHIZO-SUBCHR/EXAC	
19	295.34	29534	I	PARAN SCHIZO-CHR/EXACERB	
20	295.35	29535	I	PARANOID SCHIZO-REMISS	
28	295.5	2955	I	LATENT SCHIZOPHRENIA*	
29	295.50	29550	I	LATENT SCHIZOPHREN-UNSP	
30	295.51	29551	I	LAT SCHIZOPHREN-SUBCHR	
31	295.52	29552	I	LATENT SCHIZOPHREN-CHR	
32	295.53	29553	I	LAT SCHIZO-SUBCHR/EXACER	
33	295.54	29554	I	LATENT SCHIZO-CHR/EXACER	
34	295.55	29555	I	LAT SCHIZOPHREN-REMISS	
35	295.6	2956	I	RESIDUAL SCHIZOPHRENIA*	
36	295.60	29560	I	RESID SCHIZOPHREN-UNSP	Schizophrenia, Residual Type
37	295.61	29561	I	RESID SCHIZOPHREN-SUBCHR	
38	295.62	29562	I	RESIDUAL SCHIZOPHREN-CHR	
39	295.63	29563	I	RESID SCHIZO-SUBCHR/EXAC	
40	295.64	29564	I	RESID SCHIZO-CHR/EXACERB	
41	295.65	29565	I	RESID SCHIZOPHREN-REMISS	
42	295.7	2957	I	SCHIZOAFFECTIVE TYPE*	
43	295.70	29570	I	SCHIZOAFFECTIVE-UNSPEC	Schizoaffective Disorder
44	295.71	29571	I	SCHIZOAFFECTIVE-SUBCHR	
45	295.72	29572	I	SCHIZOAFFECTIVE-CHRONIC	

46	295.73	29573	I	SCHIZOAFF-SUBCHR/EXACER	
47	295.74	29574	I	SCHIZOAFFECT-CHR/EXACER	
48	295.75	29575	I	SCHIZOAFFECTIVE-REMISS	
49	295.8	2958	I	SCHIZOPHRENIA NEC*	
50	295.80	29580	I	SCHIZOPHRENIA NEC-UNSPEC	
51	295.81	29581	I	SCHIZOPHRENIA NEC-SUBCHR	
52	295.82	29582	I	SCHIZOPHRENIA NEC-CHR	
53	295.83	29583	I	SCHIZO NEC-SUBCHR/EXACER	
54	295.84	29584	I	SCHIZO NEC-CHR/EXACERB	
55	295.85	29585	I	SCHIZOPHRENIA NEC-REMISS	
56	295.9	2959	I	SCHIZOPHRENIA NOS*	
57	295.90	29590	I	SCHIZOPHRENIA NOS-UNSPEC	Schizophrenia, Undifferentiated Type
58	295.91	29591	I	SCHIZOPHRENIA NOS-SUBCHR	
59	295.92	29592	I	SCHIZOPHRENIA NOS-CHR	
60	295.93	29593	I	SCHIZO NOS-SUBCHR/EXACER	
61	295.94	29594	I	SCHIZO NOS-CHR/EXACERB	
62	295.95	29595	I	SCHIZOPHRENIA NOS-REMISS	
63	295.96	29596	I	SCHIZOPHRENIA NOS-REMISS	
64	296	296	I	AFFECTIVE PSYCHOSES*	
65	296.0	2960	I	MANIC DIS, SINGL EPISODE*	
66	296.00	29600	I	MANIC DISORDER-UNSPEC	Bipolar I Disorder, Single Manic Episode, Unspecified
67	296.01	29601	I	MANIC DISORDER-MILD	Bipolar I Disorder, Single Manic Episode, Mild
68	296.02	29602	I	MANIC DISORDER-MOD	Bipolar I Disorder, Single Manic Episode, Moderate
69	296.03	29603	I	MANIC DISORDER-SEVERE	Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features
70	296.04	29604	I	MANIC DIS-SEVERE W PSYCH	Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features
71	296.05	29605	I	MANIC DIS-PARTIAL REMISS	Bipolar I Disorder, Single Manic Episode, In Partial Remission
72	296.06	29606	I	MANIC DIS-FULL REMISSION	Bipolar I Disorder, Single Manic Episode, In Full Remission
73	296.1	2961	I	MANIC, RECURRENT EPISODE*	
74	296.10	29610	I	RECUR MANIC DIS-UNSPEC	
75	296.11	29611	I	RECUR MANIC DIS-MILD	
76	296.12	29612	I	RECUR MANIC DIS-MOD	
77	296.13	29613	I	RECUR MANIC DIS-SEVERE	
78	296.14	29614	I	RECUR MANIC-SEV W PSYCHO	
79	296.15	29615	I	RECUR MANIC-PART REMISS	
80	296.16	29616	I	RECUR MANIC-FULL REMISS	
81	296.2	2962	I	DEPR PSYCH, SINGL EPISOD*	
82	296.20	29620	I	DEPRESS PSYCHOSIS-UNSPEC	Major Depressive Disorder, Single Episode, Unspecified

83	296.21	29621	I	DEPRESS PSYCHOSIS-MILD	Major Depressive Disorder, Single Episode, Mild
84	296.22	29622	I	DEPRESSIVE PSYCHOSIS-MOD	Major Depressive Disorder, Single Episode, Moderate
85	296.23	29623	I	DEPRESS PSYCHOSIS-SEVERE	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
86	296.24	29624	I	DEPR PSYCHOS-SEV W PSYCH	Major Depressive Disorder, Single Episode, Severe With Psychotic Features
87	296.25	29625	I	DEPR PSYCHOS-PART REMISS	Major Depressive Disorder, Single Episode, In Partial Remission
88	296.26	29626	I	DEPR PSYCHOS-FULL REMISS	Major Depressive Disorder, Single Episode, In Full Remission
89	296.3	2963	I	DEPR PSYCH, RECUR EPISOD*	
90	296.30	29630	I	RECURR DEPR PSYCHOS-UNSP	Major Depressive Disorder, Recurrent, Unspecified
91	296.31	29631	I	RECURR DEPR PSYCHOS-MILD	Major Depressive Disorder, Recurrent, Mild
92	296.32	29632	I	RECURR DEPR PSYCHOS-MOD	Major Depressive Disorder, Recurrent, Moderate
93	296.33	29633	I	RECUR DEPR PSYCH-SEVERE	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
94	296.34	29634	I	REC DEPR PSYCH-PSYCHOTIC	Major Depressive Disorder, Recurrent, Severe With Psychotic Features
95	296.35	29635	I	RECUR DEPR PSYC-PART REM	Major Depressive Disorder, Recurrent, In Partial Remission
96	296.36	29636	I	RECUR DEPR PSYC-FULL REM	Major Depressive Disorder, Recurrent, In Full Remission
97	296.4	2964	I	BIPOLAR AFFECTIVE, MANIC*	
98	296.40	29640	I	BIPOL AFF, MANIC-UNSPEC	Bipolar I Disorder, Most Recent Episode Hypomanic, Manic, Unspecified
99	296.41	29641	I	BIPOLAR AFF, MANIC-MILD	Bipolar I Disorder, Most Recent Episode Manic, Mild
100	296.42	29642	I	BIPOLAR AFFEC, MANIC-MOD	Bipolar I Disorder, Most Recent Episode Manic, Moderate
101	296.43	29643	I	BIPOL AFF, MANIC-SEVERE	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
102	296.44	29644	I	BIPOL MANIC-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
103	296.45	29645	I	BIPOL AFF MANIC-PART REM	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
104	296.46	29646	I	BIPOL AFF MANIC-FULL REM	Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
105	296.5	2965	I	BIPOLAR AFFECT, DEPRESS*	
106	296.50	29650	I	BIPOLAR AFF, DEPR-UNSPEC	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
107	296.51	29651	I	BIPOLAR AFFEC, DEPR-MILD	Bipolar I Disorder, Most Recent Episode Depressed, Mild
108	296.52	29652	I	BIPOLAR AFFEC, DEPR-MOD	Bipolar I Disorder, Most Recent Episode Depressed, Moderate

109	296.53	29653	I	BIPOL AFF, DEPR-SEVERE	Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
110	296.54	29654	I	BIPOL DEPR-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
111	296.55	29655	I	BIPOL AFF DEPR-PART REM	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
112	296.56	29656	I	BIPOL AFF DEPR-FULL REM	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
113	296.6	2966	I	BIPOLAR AFFECTIVE, MIXED*	
114	296.60	29660	I	BIPOL AFF, MIXED-UNSPEC	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
115	296.61	29661	I	BIPOLAR AFF, MIXED-MILD	Bipolar I Disorder, Most Recent Episode Mixed, Mild
116	296.62	29662	I	BIPOLAR AFFEC, MIXED-MOD	Bipolar I Disorder, Most Recent Episode Mixed, Moderate
117	296.63	29663	I	BIPOL AFF, MIXED-SEVERE	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
118	296.64	29664	I	BIPOL MIXED-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
119	296.65	29665	I	BIPOL AFF, MIX-PART REM	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
120	296.66	29666	I	BIPOL AFF, MIX-FULL REM	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
121	296.7	2967	I	BIPOLAR AFFECTIVE NOS	Bipolar I Disorder, Most Recent Episode Unspecified
122	296.70	29670	I	BIPOLAR AFFECTIVE NOS	
123	296.8	2968	I	MANIC-DEPRESSIVE NEC/NOS*	
124	296.80	29680	I	MANIC-DEPRESSIVE NOS	Bipolar Disorder NOS
125	296.81	29681	I	ATYPICAL MANIC DISORDER	
126	296.82	29682	I	ATYPICAL DEPRESSIVE DIS	
127	296.89	29689	I	MANIC-DEPRESSIVE NEC	Bipolar II Disorder
128	301.2	3012	II	SCHIZOID PERSONALITY*	
129	301.20	30120	II	SCHIZOID PERSONALITY NOS	Schizoid Personality Disorder
131	301.22	30122	II	SCHIZOTYPAL PERSONALITY	Schizotypal Personality Disorder
138	301.83	30183	II	BORDERLINE PERSONALITY	Borderline Personality Disorder
139	300.3	3003	I	OBSESSIVE-COMPULSIVE DIS	Obsessive-Compulsive Disorder
140	300.30	30030	I	OBSESSIVE-COMPULSIVE DIS	
144	297.1	2971	I	PARANOIA	Delusional Disorder
145	297.10	29710	I	PARANOIA	
146	298.9	2989	I	PSYCHOSIS NOS	Psychotic Disorder NOS
147	298.90	29890	I	PSYCHOSIS NOS	
150	296.9	2969	I	MOOD DISORDER NOS*	
151	296.90	29690	I	MOOD DISORDER NOS	Mood Disorder NOS