WAlden University, LLC

**Student Name**

**College of Nursing-PMHNP, Walden University**

**NRNP 6675: PMHNP Care Across the Lifespan II**

**Faculty Name**

**Assignment Due Date**



Pathways Mental Health

Psychiatric Patient Evaluation

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| **Instructions** | |  | **Use the following case template to complete Week 2 Assignment 1. Assign *DSM-5-TR* diagnosesand ICD-10 codes to the services documented in the case scenario. You will add your narrative answers to the assignment questions to the bottom of this template and submit them together as one document.** |
| Identifying Information | |  | Identification was verified by stating their name and date of birth.  Time spent for evaluation: 1103am-1151am |
| Chief Complaint | |  | “My primary doctor thinks I need more help than she can give me now.” |
| HPI | |  | 42 young female was evaluated for psychiatric evaluation and referred by her primary care provider for worsening depression and panic symptoms. She is currently prescribed escitalopram 5mg po daily for depression, alprazolam 1mg po daily for anxiety.   Today, the client reported symptoms of worsening in past month for depression with anergia, anhedonia, motivation, reports anxiety, frequent worry, reports feeling restlessness, palpitations “feels like everything is closing in on me, can’t focus, hard time breathing,” no reported obsessive/compulsive behaviors. Client reported feelings like want to sleep and never wake up.. There is no evidence of psychosis or delusional thinking. Client denied past episodes of hypomania, hyperactivity, erratic/excessive spending, involvement in dangerous activities, self-inflated ego, grandiosity, or promiscuity. Client reports increased irritability and easily frustrated. Has low frustration tolerance, sleeping 10-12 hrs/24hrs, appetite decreased. She has somatic concerns with GI upset and headaches. Client denied any current binging/purging behaviors, denied withholding food from self or engaging in anorexic behaviors. No self-mutilation behaviors. |
| Diagnostic Screening Results | |  | Screen of symptoms in the past week:  Severity Measure for Panic Disorder = Total Score 38 |
| Past Psychiatric and Substance Use Treatment | |  | * Entered mental health system when she was age 29 after a family suicide. * Previous Psychiatric Hospitalizations: * Previous Detox/Residential treatments: * Previous psychotropic medication trials: sertraline (became suicidal), trazodone (worsened nightmares), bupropion (became suicidal) * Previous mental health diagnosis per client/medical record: |
| Substance Use History | |  | Have you used/abused any of the following (include frequency/amt/last use):   |  |  |  | | --- | --- | --- | | Substance | Y/N | Frequency/Last Use | | Tobacco products | N |  | | ETOH | Y | last drink 2 weeks ago, reports drinks 2 times weekly one drink | | Cannabis | N |  | | Cocaine | N |  | | Prescription stimulants | N |  | | Methamphetamine | N |  | | Inhalants | N |  | | Sedative/sleeping pills | N |  | | Hallucinogens | N |  | | Street Opioids | N |  | | Prescription opioids | N |  | | Other: specify (spice, K2, bath salts, etc.) | Y | reports one-time ecstasy use as a teenager |   Any history of substance related:   * Blackouts: - * Tremors:   - * DUI: - * D/T's: - * Seizures: -   Longest sobriety |
| Psychosocial History | |  | Client was raised by single mother. She is married; has 2 children.  Employed at local day care as administrative assistant.  Education: High School Diploma  Denied current legal issues. |
| Suicide / Homicide Risk Assessment | |  | Suicide Inquiry: Denies active suicidal ideations, intentions, or plans. |
| Mental Status Examination | |  | She is a 42 yo Hispanic female who looks her stated age. She is cooperative with examiner. She is disheveled, dressed appropriately. There is psychomotor restlessness. Her. Her mood is anxious and mildly irritable. She denies any auditory or visual hallucinations. There is no evidence of any delusional thinking. She denies any current suicidal or homicidal ideation. |
| Clinical Impression | |  | The client is a 42 yo Hispanic female who presents with a history of treatment for depression and panic symptoms.  Moods are anxious and irritable. She has reported symptoms related to her depression and panic. no evident mania/hypomania, no psychosis, denied current cravings for drugs/alcohol, exhibits no withdrawal symptoms, has somatic concerns of GI upset and headaches.  At the time of disposition, the client adamantly denies SI/HI ideations, plans, or intent and has the ability to determine right from wrong and can anticipate the potential consequences of behaviors and actions. |
| Diagnostic Impression | |  | [Student to provide DSM-5-TR diagnoses with ICD-10 coding] Double click inside this text box to add/edit text. Delete placeholder text when you add your answers. |
| Treatment Plan | |  | 1. Medication:  * Increase escitalopram 10mg po daily * Continue with alprazolam Instructed to call and report any adverse reactions.  1. Order labs 2. Patient has emergency numbers: Emergency Services 911, the national Crisis Line 800-273-TALK, the MHC Crisis Clinic. Patient was instructed to go to nearest ER or call 911 if they become actively suicidal and/or homicidal. 3. Time allowed for questions and answers provided. Provided supportive listening. 4. RTC in 30 days 5. Follow up with PCP for GI upset and headaches |
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# Narrative Answers

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|  | [In 1-2 pages, address the following:What reimbursement billing code would you use for this session? Provide your justification for using this billing code.Explain what pertinent information is required in documentation to support your chosen DSM-5-TR diagnoses, ICD-10 coding, and billing code.Explain what pertinent documentation is missing from the case scenario and what other information would be helpful to narrow your coding and billing options. (There are at least 12 missing pertinent components of documentation).Discuss legal and ethical dilemmas related to overbilling, upcoding, and fraudulent practices. Propose 2 strategies for promoting legal and ethical coding and billing practices within your future clinical roles.Finally, explain how to improve documentation to support coding and billing for maximum reimbursement. Add your answers here. Delete instructions and placeholder text when you add your answers. |

References

## Add APA-formatted citations for any sources you referenced

Delete instructions and placeholder text when you add your citations.