AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

# Bipolar Disorder

## Quick Reference Guide

2026

# Table of Contents

# 1 CLINICAL SNAPSHOT

**Definition:** Bipolar disorder is a chronic, episodic mood disorder **defined by recurrent episodes of mania or hypomania,** often alternating with major depressive episodes, and durable inter-episode functional impact. Bipolar I is defined by at least one lifetime manic episode lasting **≥7 days** (or requiring hospitalization) with marked functional impairment or psychotic features; Bipolar II requires at least one hypomanic and one major depressive episode without a full manic episode; cyclothymic disorder involves chronic subthreshold mood oscillation for **≥2 years**. Bipolar disorder is neurobiological and sits among the top causes of disability in working-age adults worldwide.[1]

### ICD-10 Codes:

**F31.0** (hypomanic), **F31.1x** (manic without psychotic features), **F31.2** (manic with psychotic features), **F31.3x–F31.5** (depressed, with severity and psychotic specifiers), **F31.6x** (mixed features), **F31.7x** (in partial or full remission), **F31.81** (Bipolar II), **F31.89** (other specified), and **F31.9** (bipolar disorder, unspecified) — **all map to HCC 154 under CMS-HCC V28**. **Avoid F31.9** (unspecified), replace with the specific episode type (manic, depressed, mixed) and remission status once the clinical picture is defined. Document the specific episode type, severity, and psychotic features in the assessment and plan.

**Prevalence and Burden:** Lifetime prevalence is **~1%** for Bipolar I and **2–4%** for the bipolar spectrum; 12-month prevalence **~1–2%**. Average diagnostic delay is **12–15 years** from first mood symptoms to correct diagnosis, largely because depressive episodes outnumber manic episodes 3:1 and patients typically present during depression. Suicide risk is profound — lifetime suicide **~6–7%**, **20–30×** general-population rate, and bipolar disorder accounts for roughly **20%** of deaths in older adults with the disorder.[2,3]

## HCC/RAF V28 Mapping

| ICD-10 CODE(S) | HCC CATEGORY (V28) | RAF WEIGHT (CNA)* | DOCUMENTATION REQUIREMENT |
|---|---|---|---|
| **F31.1x (Bipolar I, current episode manic, without psychotic features) F31.2 (with psychotic features)** | HCC 154 | 0.351 | Document **episode type (manic)**, severity (mild/moderate/severe), and presence/absence of **psychotic features** explicitly in the A&P. Include functional impact (work, home, self-care), hospitalization if any, and treatment plan |
| **F31.3x–F31.5 (Bipolar I, current episode depressed; severity + psychotic specifiers)** | HCC 154 | 0.351 | Specify **severity** (mild/moderate/severe) and **psychotic features**. MDD-pattern documentation in a patient with a history of mania is a common miscoding error — **bipolar depression** is clinically and pharmacologically distinct. Link the manic history explicitly |

| ICD-10 CODE(S) | HCC CATEGORY (V28) | RAF WEIGHT (CNA)* | DOCUMENTATION REQUIREMENT |
|---|---|---|---|
| **F31.6x (Bipolar I, current episode mixed)** | HCC 154 | 0.351 | **Mixed features** (manic + depressive symptoms concurrently) carry elevated suicide risk and often respond differently than pure mania or depression. **Document the symptom overlap explicitly** rather than defaulting to one pole. DSM-5-TR 'with mixed features' specifier must be documented in the note, not inferred |
| **F31.7x (Bipolar I, in remission — partial or full)** | HCC 154 | 0.351 | **Remission** is coded when **criteria** for an **active episode** are **not met** but the patient remains **on maintenance** therapy or requires monitoring. Document partial (residual symptoms) **vs** full remission, current maintenance regimen (lithium, quetiapine, valproate, lamotrigine, etc.), and continued surveillance. '**History of**' language does **NOT** apply — bipolar disorder is chronic |
| **F31.81 (Bipolar II)** | HCC 154 | 0.351 | **Bipolar II** requires at least one hypomanic episode and one major depressive episode without a full manic episode.[1] Frequently miscoded as MDD when hypomania is missed; ask about periods of decreased sleep with increased energy, productivity, or irritability. Functional impairment can rival Bipolar I |
| **F31.9 (Bipolar disorder, unspecified)** | HCC 154 | 0.351 | **Avoid unspecified coding as default.** Acceptable only when specificity is not yet determinable. Replace with **F31.1x/F31.2/F31.3x–.5/F31.6x/ F31.7x** once episode type and severity are defined — unspecified coding obscures clinical |

**ABBREVIATIONS:** A&P = assessment and plan; CMS = Centers for Medicare & Medicaid Services; CNA = community non-dual aged; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; HCC = hierarchical condition category; MDD = major depressive disorder; MEAT = monitor/evaluate/assess/treat; RAF = risk adjustment factor; V28 = CMS-HCC model version 28. * Annual risk value illustrative at base rate ~$10,402/year; actual plan payment varies by county and contract year. RAF 0.351 represents community non-dual aged (CNA) coefficient under the 2024 CMS-HCC V28 model applied at 100% for PY2026; normalization factor 1.067

*RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting*

### Risk-Adjusted Care Resources per Patient/Year

Risk-adjusted care resource allocation — MA base rate ($10,402.34) × RAF coefficient; HCC 154

**BIPOLAR I AND 2**

**$3,651**

HCC 154 · RAF 0.351

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

### AAVBC PERSPECTIVE

**A CONDITION DEFINED BY WHAT GETS MISSED — NOT WHAT GETS SEEN**

*Bipolar disorder is chronically misidentified. The most common clinical error is not failing to recognize mania, it is diagnosing the depressive phase as unipolar depression and initiating treatment that can destabilize the patient. Antidepressant monotherapy in an unrecognized bipolar patient can precipitate manic episodes, mixed states, and rapid cycling. This misdiagnosis is not rare: research suggests that a substantial proportion of patients diagnosed with unipolar depression have an underlying bipolar disorder, and that an incorrect diagnosis of unipolar depression leads to inadequate treatment for years. The screening process is the "safety valve" of the clinical workflow, using tools such as the MDQ, HCL-32, and a comprehensive patient history.*

# 2 RECOGNITION AND DIAGNOSIS

## Medicare Screenings

As the clinical stakes of a missed diagnosis are so high, moving from subjective clinical suspicion to the use of **standardized, validated screening instruments** is a necessary step in ensuring diagnostic accuracy and patient safety.[2–4]

| TOOL/ PROTOCOL | DESCRIPTION AND PURPOSE | CLINICAL APPLICATION | CPT CODE | KEY CLINICAL AND VBC ANCHORS |
|---|---|---|---|---|
| **MDQ** | **Bipolar I Screen:** A brief survey focused on overt manic symptoms | Use only for high-risk patients (atypical, early-onset, or psychotic depression) | 96127/ G0444 | **High specificity (97%)**; low sensitivity. Do not use for universal screening. Positive results require a structured interview |

| TOOL/ PROTOCOL | DESCRIPTION AND PURPOSE | CLINICAL APPLICATION | CPT CODE | KEY CLINICAL AND VBC ANCHORS |
|---|---|---|---|---|
| **HCL-32** | **Bipolar II Screen:** A 32-item list designed to identify subtle hypomania | High-risk triggers; superior for detecting Bipolar II/Hypomania | 96127 | **Sensitivity ~80%**. More effective at capturing subtle mood elevations than the MDQ |
| **PHQ-9** | **Depression Monitor:** Validated tool for measuring depressive symptom burden | Annual screening (AWV) or active episode monitoring | G0444 /96127 | **Score >10 = Moderate Depression**. Item 9+ requires immediate C-SSRS assessment. 20% of PHQ-9+ cases are bipolar |
| **YMRS** | **Mania Severity Scale:** A clinician-rated scale assessing 11 manic symptoms | Track confirmed manic episodes; not for screening | 96127 | **Remission <12; Severe >26.** Track treatment response. Pair with MADRS for mixed-feature episodes |
| **Lithium Surveillance** | **Safety Monitoring:** Lab battery to prevent renal, thyroid, and cardiac toxicity | **Pre-Lithium:** Cr/eGFR, TSH, $Ca^{2+}$, ECG.Maintenance: eGFR/TSH q6–12 m; Level q3–6 m | 82565/ 84443/ 82310/ 93000 | **Elderly Ranges (ISBD):** • Age 60–79: 0.4–0.8 mEq/L • Age >80: 0.4–0.7 mEq/L |
| **Metabolic Screening** | **SGA Monitoring:** Surveillance for side effects of 2nd-gen antipsychotics | Baseline, 12wks, Annually: BMI, Fasting Glucose/A1c, Lipids, BP | 83036 (HbA1c)/ 80061 (Lipids) | HEDIS MY 2026: Closes SSD (Diabetes Screening) and SMC (CV Monitoring) gaps for patients on Antipsychotics |

**ABBREVIATIONS:** AWV = Annual Wellness Visit; BMI = body mass index; BP = blood pressure; $Ca^{2+}$ = calcium; Cr = creatinine; C-SSRS = Columbia-Suicide Severity Rating Scale; ECG = electrocardiogram; eGFR = estimated glomerular filtration rate; HCL-32 = Hypomania Checklist-32; HEDIS = Healthcare Effectiveness Data and Information Set; ISBD = International Society for Bipolar Disorders; MADRS = Montgomery-Åsberg Depression Rating Scale; MDQ = Mood Disorder Questionnaire; MY = measurement year; PHQ-9 = Patient Health Questionnaire-9; SGA = second-generation antipsychotic; SMC = Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia; SSD = Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; TSH = thyroid-stimulating hormone; VBC = Value-Based Care; YMRS = Young Mania Rating Scale

## Subtle Early Signs

Identifying the subtle early signs of bipolar disorder (often referred to as prodromal symptoms) is a clinical challenge because they are frequently dismissed as high productivity, personality quirks, or "standard" depression. Because bipolar disorder is a disorder of circadian and energy regulation, the earliest signs usually manifest in these systems rather than overt mood shifts.[5–8]

| SIGN/SYMPTOM | CLINICAL SIGNIFICANCE |
|---|---|
| **Decreased need for sleep (e.g., 2–4 hours with high energy next day)** | Pathognomonic marker. Unlike insomnia (fatigue), this involves high energy/activity. **Action: Perform a structured bipolar interview before initiating any antidepressant** |
| **Antidepressant-Induced Mood Switch (irritability/agitation after SSRI/SNRI)** | Treatment-emergent mania. Highly suggestive of a bipolar diathesis. **Action: Stop antidepressant immediately**; transition to a mood stabilizer. Do not re-challenge with monotherapy |
| **High-Risk Depressive Features (<25 years old, hypersomnia, or psychosis)** | Bipolar "Mask." High pre-test probability for Bipolar Depression. **Action: Screen with MDQ or HCL-32**; investigate family history and past "high energy" episodes |
| **New-onset mania in an older adult (≥60)** | Rule out secondary causes. Suspicion for CNS lesions (stroke, tumor), dementia, thyrotoxicosis, or steroid use. **Action: Order neuroimaging, TSH, and CMP; perform a comprehensive medication review** |
| **Post-partum psychosis or severe post-partum** | Psychiatric Emergency. High correlation with a Bipolar I diagnosis. **Action: Require immediate inpatient evaluation and mood stabilizer initiation; coordinate breastfeeding-safe regimens** |
| **Cyclical pattern of periods of high productivity/low sleep/ elevated mood/depressive crashes** | Classic Bipolar II/Cyclothymia. Frequently mislabeled as personality or stress, leading to a 12–15 year diagnostic delay. **Action: Use mood diaries and collateral history; refer for a structured diagnostic interview** |

**ABBREVIATIONS:** CNS = central nervous system; HCL-32 = Hypomania Checklist-32; MDD = major depressive disorder; MDQ = Mood Disorder Questionnaire; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant; TSH = thyroid-stimulating hormone

## Geriatric Risk Factors

Effective management of the geriatric patient requires a shift in focus, as late-onset symptoms often necessitate a rigorous investigation into secondary organic causes rather than a primary psychiatric etiology alone.[11]

| FACTOR | RISK SIGNAL | NOTES |
|---|---|---|
| **Older adult with bipolar disorder (OABD, ≥60)** | **50–70% experience cognitive dysfunction.** Trajectories split across typical aging (**32–38%**), selective impairment (**28–45%**), and progressive-to-dementia (**18–40%**). Cardiovascular mortality and suicide risk are highly amplified | Annual cognitive screen (MoCA); baseline neuropsychological testing if new cognitive complaints; differentiate episode-related from progressive impairment |

| FACTOR | RISK SIGNAL | NOTES |
|---|---|---|
| **Lithium in patients ≥60** | **Significantly narrower therapeutic window** due to age-related changes in volume of distribution and renal clearance. Target ranges per ISBD 2019 Delphi: **0.4–0.8 mEq/L** (ages 60–79); **0.4–0.7** (age ≥80) | **Start low (e.g., 150–300 mg/day),** titrate slowly; level at 5–7 days; reassess every 3–6 months at steady state; eGFR + TSH every 6 months; review NSAIDs, ACEi/ARBs, thiazide diuretics at every visit |
| **Polypharmacy with lithium-interacting agents (NSAIDs, ACEi/ARB, thiazides, loop diuretics)** | Co-prescription of **NSAIDs, ACE inhibitors, ARBs, or thiazide/loop diuretics** drastically contracts blood volume, forcing proximal renal tubule reabsorption that spikes lithium levels to toxic thresholds. Frequently missed during transitions of care | **Medication reconciliation at every visit**; check lithium level within **1–2 weeks** of any interacting medication initiation, dose change, or discontinuation |
| **Second-generation antipsychotic (SGA) exposure** | Accelerated metabolic syndrome, new-onset diabetes, severe dyslipidemia, rapid weight gain, and **QTc interval prolongation**. Markedly increases orthostatic hypotension, driving fall and fracture risks | Prefer metabolically favorable agents (aripiprazole, lurasidone, cariprazine) when possible in OABD;* baseline + periodic ECG when QTc-prolonging; bone density if long-term |
| **Frailty + functional decline** | Frailty predicts mortality and treatment response independent of chronological age; bipolar disorder accelerates functional decline in OABD | Clinical Frailty Scale at baseline and annually; gait speed or grip strength; tailor pharmacologic intensity to frailty, not age. IFSO-type frailty-guided principles extend to psychotropic prescribing |

**ABBREVIATIONS:** ACEi = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; AWV = annual wellness visit; CV = cardiovascular; ECG = electrocardiogram; eGFR = estimated glomerular filtration rate; IFSO = International Federation for the Surgery of Obesity; ISBD = International Society for Bipolar Disorders; MoCA = Montreal Cognitive Assessment; NSAID = nonsteroidal anti-inflammatory drug; OABD = older adult with bipolar disorder; QTc = corrected QT interval; SGA = second-generation antipsychotic; TSH = thyroid-stimulating hormone. *NOTE: metabolically favorable agents (aripiprazole, lurasidone, cariprazine) are recommended over older generation agents at low doses, safety profile should be evaluated with higher doses

## Diagnostic Thresholds

While early warning signs provide the necessary clinical suspicion, a definitive diagnosis requires a rigorous evaluation against established diagnostic thresholds for symptom duration, intensity, and functional impact.[9,10]

| TEST/MARKER | DIAGNOSIS CRITERION | NOTES |
|---|---|---|
| **Manic episode (DSM-5-TR)** | **Criterion A — Mood and energy change:** A distinct, persistent period of abnormally elevated, expansive, or irritable mood **and** increased goal-directed activity or energy lasting **≥7 days**, or any duration if hospitalization is required.<br>**Criterion B — Associated symptoms: ≥3 symptoms**, or **≥4 if the mood is only irritable**, such as decreased need for sleep, grandiosity, pressured speech, racing thoughts, or high-risk behavior.<br>**Criterion C — Severity:** The episode causes **marked functional impairment**, includes **psychotic features**, or requires hospitalization to prevent harm to self or others. | **Suspect Secondary Mania:** If there is no prior psychiatric history, rule out medical/organic causes (e.g., right-sided stroke, corticosteroids, hyperthyroidism, B12 deficiency)<br>**Look for Atypical Dysphoria:** Older adults often present with severe irritability and confusion rather than classic euphoria<br>**Action:** Initiate urgent psychiatric referral, obtain emergency brain imaging (CT/MRI) and basic labs, and prepare for urgent, low-dose mood stabilizer titration<br>**First-Ever Episode:** Code **F30.1x** (manic episode, single, without psychosis) or **F30.2** (with psychosis)<br>**Recurrent Bipolar:** Code **F31.1x** (without psychosis — append 5th character for severity: .11 mild, .12 moderate, .13 severe) or F31.2 (severe with active psychosis) |
| **Hypomanic episode (DSM-5-TR)** | Same symptom cluster as mania but **≥4 days**, no marked impairment, no psychosis, no hospitalization. At least one lifetime hypomanic episode + one MDE = **Bipolar II (F31.81)** | Hypomania is often under-recognized in primary care and reported as 'feeling great' or high productivity; a structured diagnostic interview confirms |
| **Major depressive episode in a patient with lifetime manic/ hypomanic history** | Depressive episode — **≥2 weeks** of depressed mood or anhedonia + ≥4 additional symptoms — is **bipolar depression, not unipolar MDD**, even if current presentation is purely depressed | **F31.3x–F31.5**, not **F32.x**. Antidepressant monotherapy is **not first-line**; use lithium, quetiapine, lurasidone, or cariprazine (CANMAT 2023 first-line for acute bipolar depression) |
| **Mixed features** | **≥3 symptoms** of the **opposite** pole present during a manic or depressive episode (DSM-5-TR 'with mixed features' specifier) | Code **F31.6x** when the current episode is mixed. Mixed features carry elevated suicide risk and often require antipsychotic + mood stabilizer combinations; avoid antidepressant monotherapy |

| TEST/MARKER | DIAGNOSIS CRITERION | NOTES |
|---|---|---|
| **Rapid cycling** | **≥4 mood episodes** (mania, hypomania, MDE, mixed) in a 12-month period | Associated with treatment resistance and higher morbidity. Review **antidepressant exposure**, thyroid status, substance use, and adherence. Prefer mood-stabilizer monotherapy or combination; avoid antidepressants as driver of cycling |

**ABBREVIATIONS:** CANMAT = Canadian Network for Mood and Anxiety Treatments; CMP = comprehensive metabolic panel; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; MDE = major depressive episode; MRI = magnetic resonance imaging; TSH = thyroid-stimulating hormone

### CLINICAL PEARL

**Universal Screening Requirement:** Prior to confirming a diagnosis of Unipolar Major Depressive Disorder (MDD), routinely screen for a lifetime history of mania or hypomania. Given the high prevalence of unrecognized bipolarity in "treatment-resistant" populations, this should be considered a standard of care for every new or returning depression encounter.
**The Diagnostic Pivot:** Integrate a high-yield, structured probe into the psychiatric review of systems: "Have you ever experienced a distinct period of persistently elevated or expansive mood, increased goal-directed energy, or a decreased need for sleep (e.g., feeling fully rested after only 3 hours)?" A positive response necessitates a formal shift in diagnostic trajectory, pharmacological strategy, and risk stratification.
**Avoid Antidepressant Monotherapy:** Exercise caution by withholding antidepressant monotherapy until a bipolar diathesis has been reasonably excluded. In patients with unrecognized Bipolar I or II, SSRI/SNRI monotherapy can act as a catalyst for iatrogenic mania, induce rapid cycling, or cause overall clinical destabilization.

## Common Oversights

From a risk-management perspective, identifying common monitoring oversights is critical for both patient safety and meeting the rigorous documentation standards required for high-acuity behavioral health care.[2,6,9]

| OVERSIGHT/SHORTCUT | WHY IT MATTERS — WHAT TO DO INSTEAD |
|---|---|
| **Initiating antidepressant monotherapy for a depressive episode without screening for lifetime mania/hypomania** | Antidepressant monotherapy in undiagnosed bipolar depression can precipitate manic or mixed switch, destabilize mood cycling, and carries no first-line evidence for bipolar depression. **Before any antidepressant,** ask about decreased-need-for-sleep episodes, family history of bipolar disorder, post-partum psychosis, prior treatment-resistant depression. In confirmed Bipolar I depression, first-line agents are lithium, quetiapine, lurasidone, or cariprazine — not SSRIs or SNRIs |

| OVERSIGHT/SHORTCUT | WHY IT MATTERS — WHAT TO DO INSTEAD |
|---|---|
| **Attributing new cognitive decline in an older adult with bipolar disorder to dementia without differential workup** | Cognitive impairment in OABD may reflect aging, episode-related impairment, **medication effects** (lithium, benzodiazepines, anticholinergics), or **progressive neurodegeneration** — trajectories differ and treatment differs. MoCA at baseline and annually; baseline neuropsychological testing when new cognitive complaints arise; medication review (Beers Criteria); differentiate from episode-driven impairment before diagnosing dementia |
| **Not reassessing lithium dose when an NSAID, ACEi/ARB, thiazide diuretic, or loop diuretic is started, changed, or stopped** | These agents reduce renal lithium clearance and raise serum levels rapidly — older adults with reduced renal reserve are especially vulnerable. At every medication change involving a lithium-interacting drug, **check a lithium level within 1–2 weeks, review renal function, and counsel the patient on signs of toxicity** (tremor, confusion, ataxia, GI upset). **Do not wait for the routine 3–6-month level** |
| **Discontinuing lithium abruptly (patient request, adherence concern, perceived side effect)** | Abrupt lithium discontinuation is **associated with** a r**ebound mania/suicide risk** materially higher than controlled taper. If discontinuation is necessary, **taper over weeks to months with close follow-up**; document the taper plan and the patient's baseline mood status. When adherence is the driver, address barriers (side effects, cost, beliefs) before abandoning the agent |
| **Conflating Bipolar II with MDD because 'hypomania didn't seem serious'** | Bipolar II carries functional impairment comparable to Bipolar I, elevated suicide risk, and distinct pharmacology — **antidepressant monotherapy is not first-line and can destabilize mood**. When hypomanic periods are present (decreased sleep + increased energy + goal-directed activity × ≥4 days), code F31.81 and initiate psychiatric referral for shared pharmacologic decision-making. 'Just depression' mislabels a chronic illness that shapes the patient's life |

**ABBREVIATIONS**: ACEi = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; Beers = American Geriatrics Society Beers Criteria; CANMAT = Canadian Network for Mood and Anxiety Treatments; GI = gastrointestinal; MDD = major depressive disorder; MoCA = Montreal Cognitive Assessment; NSAID = nonsteroidal anti-inflammatory drug; OABD = older adult with bipolar disorder; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor

## Key Differentials

Beyond symptom recognition, the diagnostic process must include a rigorous evaluation of key differentials, as various medical conditions and other psychiatric disorders can closely mimic the affective instability of bipolar disorder.[2,13,14]

| PRESENTATION | DIFFERENTIAL | KEY TESTS |
|---|---|---|
| **Depressive episode in a young adult with family history of bipolar disorder, post-partum psychosis, or treatment-resistant prior episodes** | Bipolar depression **vs** unipolar MDD. antidepressant monotherapy is **contraindicated** if bipolar | Structured interview (**MDQ + HCL-32** in high-pretest cases, then MINI or SCID or psychiatric referral); direct questions about decreased-need-for-sleep, family history, mood switches |
| **New-onset mania in an adult ≥60 with no prior psychiatric history** | **Secondary mania**: stroke, CNS tumor, frontotemporal dementia, thyrotoxicosis, steroid-induced, substance-induced | Brain MRI with attention to frontal/temporal regions; TSH, free T4; CMP; urine drug screen; medication review (steroids, dopamine agonists, interferon) |
| **Mood cycling with persistent functional impairment between episodes** | Bipolar disorder (I, II, cyclothymic) **vs** borderline personality disorder — may coexist | Longitudinal observation; mood diary; collateral history; **psychiatric evaluation** for DSM-5-TR criteria. Distinguish episode-driven from trait-level affective instability |
| **Mania + psychosis, first episode** | Bipolar I with psychotic features **vs** schizoaffective disorder vs primary psychotic disorder (e.g., schizophrenia, substance-induced psychosis) | **Psychiatric evaluation**; longitudinal course matters (mood-congruent vs mood-incongruent psychosis, duration of psychosis outside mood episode); urine toxicology; neuroimaging |
| **Recurrent brief mood oscillations with irritability, impulsivity, or substance use** | Cyclothymic disorder **vs** ADHD vs substance-induced mood disorder; may coexist with all three | Mood chart over weeks; ADHD screen; substance-use history; family history; neuropsychological testing if diagnostic clarity required |

**ABBREVIATIONS**: ADHD = attention-deficit/hyperactivity disorder; CMP = comprehensive metabolic panel; CNS = central nervous system; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; HCL-32 = Hypomania Checklist-32; MDD = major depressive disorder; MDQ = Mood Disorder Questionnaire; MINI = Mini International Neuropsychiatric Interview; MRI = magnetic resonance imaging; SAMe = S-adenosylmethionine; SCID = Structured Clinical Interview for DSM; TSH = thyroid-stimulating hormone

## Comorbidity Screening

In bipolar disorder, managing comorbidities is just as critical as mood stabilization, as the disease is a systemic condition with potential metabolic and cardiovascular risks.[11,12]

| CONDITION | PREVALENCE/ASSOCIATION | SCREENING APPROACH |
|---|---|---|
| **Cardiovascular disease (I25.x, I10, I50.x)** | **CV mortality drives 35–40% of excess deaths** in bipolar disorder; 1.5–2.5× CV risk vs general population | **Annual lipid panel, BP, glucose/HbA1c, ASCVD risk calculation**; counsel on smoking cessation, diet, activity; prefer metabolically neutral antipsychotics where possible |
| **Type 2 diabetes (E11.x) + metabolic syndrome** | Prevalence elevated by SGA exposure (especially olanzapine, quetiapine, risperidone); HEDIS SSD + SMD measures apply | Baseline + annual HbA1c, fasting glucose, lipids, weight/BMI; diabetes screen within 12 months (SSD, ages 18–64); **metabolic monitoring every 3–6 months during SGA titration** |
| **Substance use disorders (F10–F19)** | Co-occurrence common (**>40% lifetime**); worsens adherence, outcomes, and suicide risk | **Annual screen with AUDIT-C + single-item drug-use screen**; structured diagnostic interview when positive; integrated psychiatric-addiction treatment |
| **Anxiety disorders (F41.x, F40.x)** | Co-occurrence **~50% lifetime**; worsens episode severity and treatment response | **GAD-7 annually;** co-treat with mood stabilizer + evidence-based psychotherapy (CBT); avoid benzodiazepines as monotherapy in older adults (Beers) |
| **Cognitive impairment/ dementia (F06.7x, G30.x)** | **50–70%** of OABD have cognitive dysfunction; progressive-to-dementia trajectory in **18–40%** | **Baseline + annual MoCA**; neuropsychological testing if new complaints; brain imaging if rapid decline or focal deficits |

**ABBREVIATIONS**: ASCVD = atherosclerotic cardiovascular disease; AUDIT-C = Alcohol Use Disorders Identification Test — Consumption; Beers = American Geriatrics Society Beers Criteria; BMI = body mass index; BP = blood pressure; CBT = cognitive behavioral therapy; CV = cardiovascular; GAD-7 = Generalized Anxiety Disorder-7; HbA1c = hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; MoCA = Montreal Cognitive Assessment; NSAID = nonsteroidal anti-inflammatory drug; OABD = older adult with bipolar disorder; PT = physical therapy; SGA = second-generation antipsychotic; SMD = diabetes monitoring; SSD = diabetes screening

## Staging/Severity Matrix

In addition to identifying the type of bipolar disorder, the stage and intensity of symptoms can help predict how to best protect the patients health over the long term.[9,13]

| STAGING SYSTEM | CRITERIA/VALUES | CLINICAL USE | DOCUMENTATION |
|---|---|---|---|
| **DSM-5-TR episode type** | Manic, hypomanic, depressed, mixed, in partial/full remission Estimated outcomes: Episode type determines first-line agent choice | **Drives ICD-10 selection** (**F31.x**); shapes pharmacology | 'Bipolar I, current episode manic, moderate (**F31.12**), without psychotic features.' |

| STAGING SYSTEM | CRITERIA/VALUES | CLINICAL USE | DOCUMENTATION |
|---|---|---|---|
| **Severity specifiers** | Mild, moderate, severe; with/without psychotic features; with mixed features; with rapid cycling; with peripartum onset; with anxious distress | ICD-10 and documentation accuracy; Guide urgency of intervention, hospitalization decisions, agent choice | 'Severe with psychotic features'; 'moderate with mixed features'; 'with rapid cycling' |
| **Young Mania Rating Scale (YMRS)** | 11 items scored 0–60<br>**≤12 remission**<br>**13–19 mild**<br>**20–25 moderate**<br>**≥26 severe**<br>MCID 6.9 | Gold standard clinician-rated measure to track manic/mixed episode trajectory and treatment response | 'YMRS 22 at baseline → 9 at week 6 (remission)' |
| **Montgomery-Åsberg Depression Rating Scale (MADRS) anchored to Clinical Global Impression-Severity (CGI-S) scale** | **Euthymic/Normal:** 0–6<br>**Subclinical/Borderline:**7–12<br>**Mild:**13–18<br>**Moderate:**19–23<br>**Marked:**24–36<br>**Severe:** 37–39<br>**Extreme≥:**40 | The MADRS is strictly a **depression scale**; it does not measure manic or hypomanic symptoms. In bipolar patients, standard antidepressant or rapid-acting therapies can trigger a manic "switch" or a mixed state. | 'MADRS 28 at baseline → 11 at week 8 (remission)'<br>Always pair the MADRS with a mania tracking tool like the **Young Mania** |
| **Clinical Frailty Scale (OABD ≥65)** | **CFS 1 (fit) → 9 (terminally ill);**<br>**≥5 = frail** | **Guides lithium dose ceiling**, SGA metabolic risk, tolerance, polypharmacy scrutiny<br>Frailty >chronological age in pharmacologic decisions in OABD | 'Bipolar I, in remission (**F31.73**), CFS 4 — vulnerable but not frail' |
| **Kupka staging/ functional** | Early (high remission potential) → late (persistent impairment, neurocognitive decline) | Conceptual; guides **long-term expectations** and **early-intervention emphasis** | 'Bipolar I, 15-year course, with residual functional impairment' |

**ABBREVIATIONS**: CANMAT = Canadian Network for Mood and Anxiety Treatments; CFS = Clinical Frailty Scale; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; HAM-D = Hamilton Depression Rating Scale; MADRS = Montgomery-Åsberg Depression Rating Scale; MBC = measurement-based care; MCID = minimum clinically important difference; OABD = older adult with bipolar disorder; SGA = second-generation antipsychotic; VBC = value-based care; YMRS = Young Mania Rating Scale

## DSM-5 Criteria for Bipolar Disorder

The DSM-5-TR defines three primary bipolar spectrum diagnoses — Bipolar I, Bipolar II, and Cyclothymic Disorder — each distinguished by episode type, duration, severity, and functional impact.[1]

| DIAGNOSIS | REQUIRED EPISODES | DURATION THRESHOLD | KEY SYMPTOM CRITERIA | SEVERITY/ FUNCTIONAL IMPACT | DISTINGUISHING FEATURES |
|---|---|---|---|---|---|
| **Bipolar I** | **≥1 lifetime manic episode**; depressive episodes common but not required | Manic episode **≥7 days** (or any duration if hospitalization required) | Manic criteria **(all must be met):** Elevated/ expansive/ irritable mood + increased energy/activity **≥3 associated symptoms** (≥4 if mood only irritable): grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, increased goal-directed activity, risky behavior | Marked impairment in social/ occupational functioning, **OR** hospitalization required, **OR** psychotic features present | Full manic episode emerging during antidepressant treatment that persists beyond physiological effect qualifies for Bipolar I diagnosis |
| **Bipolar II** | **≥1 hypomanic episode AND ≥1 major depressive episode**; **NO lifetime manic episode** | Hypomanic episode **≥4 consecutive days**; MDE ≥2 weeks | Hypomania: same symptom cluster as mania (≥3 symptoms, ≥4 if irritable only); MDE: depressed mood or anhedonia + ≥4 additional symptoms | Hypomania: unequivocal change observable by others but **NOT** severe enough for marked impairment or hospitalization; **if psychotic features present → reclassify as Bipolar I** | Depressive episodes predominate clinically (3:1 ratio vs. hypomania); most patients present during depression, not hypomania |

| DIAGNOSIS | REQUIRED EPISODES | DURATION THRESHOLD | KEY SYMPTOM CRITERIA | SEVERITY/ FUNCTIONAL IMPACT | DISTINGUISHING FEATURES |
|---|---|---|---|---|---|
| **Cyclothymic Disorder** | Numerous periods of hypomanic symptoms + depressive symptoms, neither meeting full episode criteria | **≥2 years** (≥1 year in children/ adolescents); **no symptom-free interval >2 months** | Subthreshold hypomanic and depressive **symptoms present ≥50% of the time** | Symptoms cause clinically significant distress or impairment; criteria for **full manic, hypomanic, or major depressive episode NEVER met** | **15–50% risk of conversion** to Bipolar I or II; often underdiagnosed |

## Severity Specifiers (Mild/Moderate/Severe) for Bipolar Disorder

For **manic episodes**, severity is based on the number of criterion symptoms, their intensity, and degree of functional disability:

- **Mild:** Minimum symptom criteria are met for a manic episode
- **Moderate:** Very significant increase in activity or impairment in judgment
- **Severe:** Almost continual supervision is required to prevent physical harm to self or others

For **major depressive episodes**, the same three-tier system applies:

- **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis; intensity is distressing but manageable; minor impairment in social or occupational functioning
- **Moderate:** Number of symptoms, intensity, and/or functional impairment are between "mild" and "severe"
- **Severe:** Number of symptoms substantially in excess of minimum; intensity is seriously distressing and unmanageable; marked interference with social and occupational functioning

**Available DSM-5-TR Specifiers (applicable to any episode type):**

- **With mixed features** — ≥3 symptoms of the opposite pole; antidepressant monotherapy contraindicated; elevated suicide risk
- **With rapid cycling** — ≥4 mood episodes in 12 months; associated with treatment resistance
- With psychotic features — mood-congruent or mood-incongruent; often requires inpatient care

- **With anxious distress** — higher suicide risk, longer illness duration, greater treatment nonresponse
- **With peripartum onset** — onset during pregnancy or within 4 weeks postpartum
- **With catatonia, with melancholic features, with atypical features, with seasonal pattern**

## Young Mania Rating Scale (YMRS)

The Young Mania Rating Scale (YMRS) is a clinician-administered, 11-item scale that grades manic symptom severity based on a clinical interview assessing the patient's condition over the preceding 48 hours. Each item has five explicitly defined severity levels (e.g., for elevated mood: **0** = absent, **1** = mildly elevated, **2** = definite subjective elevation, **3** = elevated/inappropriate, **4** = euphoric/laughing/singing). Ratings are based on both the patient's subjective report and the clinician's direct observation during the interview.

| ITEM | SCORING RANGE | WHAT IT ASSESSES |
|---|---|---|
| **1. Elevated mood** | 0–4 | Euphoria, optimism, self-confidence, cheerfulness |
| **2. Increased motor activity/ energy** | 0–4 | Psychomotor activation, restlessness, agitation |
| **3. Sexual interest** | 0–4 | Increased sexual drive, preoccupation, inappropriate behavior |
| **4. Sleep** | 0–4 | Decreased need for sleep (not insomnia) |
| **5. Irritability** | 0–8 | Hostility, anger, argumentativeness (double-weighted) |
| **6. Speech (rate and amount)** | 0–8 | Pressured speech, tangentiality, flight of ideas (double-weighted) |
| **7. Language-thought disorder** | 0–4 | Circumstantiality, distractibility, racing thoughts |
| **8. Content** | 0–8 | Grandiosity, hyper-religiosity, paranoia, delusions (double-weighted) |
| **9. Disruptive-aggressive behavior** | 0–8 | Threatening, assaultive, destructive behavior (double-weighted) |
| **10. Appearance** | 0–4 | Grooming, dress, overall presentation |
| **11. Insight** | 0–4 | Awareness of illness and need for treatment |

### ⚠ RED FLAG – EMERGENCY | CALL 911 OR ACTIVATE CRISIS RESPONSE

- Active suicidal intent or plan
- Suicide attempt in progress or recently completed
- Acute psychosis with impaired judgment or agitation threatening safety
- Catatonia
- Manic episode with dangerous behavior (driving recklessly, high-risk sexual behavior, aggression)
- Neuroleptic malignant syndrome or serotonin syndrome
- Severe lithium toxicity (confusion, ataxia, tremor, seizure)

### ⚠ RED FLAG – URGENT/RAPID EVALUATION (WITHIN 24–72 HOURS)

- New manic episode without immediate safety concern → stabilize outpatient if psychiatry coverage available
- Mixed features with suicidal ideation but no plan
- Antidepressant-induced mood switch
- First-episode psychosis with preserved judgment
- Rapid lithium level rise after NSAID/ACEi/thiazide change
- New cognitive decline in OABD with safety concern
- Medication-induced adverse effect (rash on lamotrigine → rule out Stevens-Johnson/TEN; pancreatitis on valproate)
- Post-psychiatric discharge bridge visit — FUH (Follow-Up After Hospitalization for Mental Illness) measure

## 3 MEAT DOCUMENTATION ESSENTIALS

Female patient, 42, established Bipolar I on lithium 900 mg/day and quetiapine 300 mg qhs for maintenance. Presents for follow-up. Past 2 weeks: decreased sleep (3–4 hours) without fatigue, increased project starts at work, irritability with family. YMRS 18. Lithium level 0.6 mEq/L (therapeutic). Prior notes: 'Bipolar disorder, continue meds.' No episode specification, no YMRS trend, no safety assessment documented.

**MONITOR:** "42yo Female with Bipolar I Disorder. **Current Status:** Breakthrough hypomanic symptoms (**F31.12**). Sleep decreased to 3–4 hours/night without daytime fatigue. Functional impact: Increased irritability at home and excessive work productivity (project starts). **Labs:** Lithium level 0.6 mEq/L (therapeutic for maintenance, but sub-optimal for acute stabilization). Metabolic labs pending; weight stable on quetiapine."

**EVALUATE:** "**YMRS Score: 18** (Moderate Mania). Compared to baseline of 4, this represents a significant relapse in symptoms. Speech is pressured; mood is expansive/irritable. **Safety Assessment:** Denies suicidal/homicidal ideation. No psychosis noted. Financial judgment remains intact today, but irritability is straining familial relationships."

**ASSESS:** "**Bipolar I Disorder, Most Recent Episode Manic (Hypomanic), Moderate Severity (F31.12).** Symptoms likely driven by sub-optimal lithium level (<0.8 mEq/L) for current acuity. High risk for progression to full mania (**F31.2**) if circadian rhythms are not restored within 48–72 hours."

**TREAT:** **Medication Adjustment:** Increase Lithium Carbonate to 1200 mg/day (target level 0.8–1.0 mEq/L for acute stabilization). **Circadian Hygiene:** Counseled on "dark therapy" and strict 10 PM lights-out to restore sleep cycle. **Adherence Counseling:** Discussed the clinical risks of breakthrough episodes on long-term cognitive health. **Follow-Up:** Return in 7 days for repeat YMRS and Lithium level. Patient instructed to call immediately if hallucinations or extreme impulsivity develop.

## Clinical Documentation Elements

- **Specify episode:** State episode type, severity, psychotic features, mixed features, rapid cycling, peripartum onset, anxious distress. 'Bipolar I, current episode manic, moderate, without psychotic features (**F31.12**)' is complete. 'Bipolar disorder' alone is not
- **Include current data:** Current YMRS, MADRS, or PHQ-9; lithium level and date; weight/BMI; lipid panel; HbA1c; BP; adherence assessment; C-SSRS when indicated. 'YMRS 22 (baseline 8) — moderate manic episode; lithium level 0.7 mEq/L; BMI 29.' Measurement-based care reflects real clinical response
- **Link comorbidities:** Explicitly connect bipolar disorder to cardiovascular risk, diabetes, substance use, anxiety, cognitive impairment, and obesity. 'Bipolar I, in partial remission (**F31.73**), with type 2 diabetes (**E11.9**) — HbA1c 7.4% on quetiapine; considering transition to lurasidone.' Linkage shapes treatment and documentation
- **Document chronicity:** Bipolar disorder is chronic. Record age at onset, prior episodes (number and type), prior hospitalizations, prior medication trials and responses, current maintenance regimen, duration of current phase. 'History of' does **NOT** apply while active or on maintenance — use **F31.7x** (remission) with continued monitoring
- **Associated conditions:** List all active codes: **F31.x** (specific episode); **F41.1** (GAD); **F10.x** (alcohol use disorder); **F17.200** (nicotine dependence); **E11.x** (T2DM); **I25.x** (CAD); **E78.5** (dyslipidemia); **Z91.83** (adherence); **F06.7x** (neurocognitive disorder). Each carries independent clinical and documentation significance

## Reframing Common Documentation Shortcuts

| INSTEAD OF… | DOCUMENT… |
|---|---|
| **'Bipolar disorder — continue meds.'** | 'Bipolar I, in partial remission (**F31.73**) — YMRS 8, MADRS 11. Lithium 900 mg/day, level 0.7 mEq/L; quetiapine 300 mg qhs. Reviewed adherence (taking as prescribed), tremor (mild), metabolic labs (HbA1c 5.9%). Continue maintenance; next level + eGFR + TSH in 3 months' |
| **'Depression' in a patient with prior mania history** | 'Bipolar I, current episode depressed, moderate (**F31.32**). PHQ-9 15, MADRS 26. Not unipolar MDD. Initiating quetiapine XR 300 mg qhs (CANMAT first-line for bipolar depression). Antidepressant monotherapy avoided' |
| **'Bipolar, unspecified.'** | 'Bipolar I, current episode manic, moderate, without psychotic features (**F31.12**). YMRS 22. Decreased sleep × 10 days with increased goal-directed activity; no psychotic features; no safety concerns. Lithium increased to target level 0.8 mEq/L; quetiapine added 200 mg qhs. Psychiatric referral in 2 weeks.' |
| **'Lithium level 0.9, continue.'** | 'Lithium 900 mg/day; level 0.9 mEq/L (steady state). Ibuprofen 600 mg TID started by orthopedics 2 weeks ago — level previously 0.6 mEq/L. **Recheck level in 1 week**; counseled on tremor, confusion, ataxia as signs of toxicity. Consider acetaminophen or topical NSAID instead |
| **'Doing well' (in OABD patient)** | 'Bipolar I, in full remission (**F31.74**), 8 months post last episode. MoCA 26 (prior 28) — mild decline; pattern consistent with treatment-stable course. CFS 4. Lithium level 0.6 mEq/L (target 0.4–0.8 per ISBD for age 60–79). eGFR stable; TSH WNL. Continue maintenance; repeat MoCA in 6 months' |

**ABBREVIATIONS:** A&P = assessment and plan; CANMAT = Canadian Network for Mood and Anxiety Treatments; CFS = Clinical Frailty Scale; eGFR = estimated glomerular filtration rate; HbA1c = hemoglobin A1c; HCL-32 = Hypomania Checklist-32; ISBD = International Society for Bipolar Disorders; MADRS = Montgomery-Åsberg Depression Rating Scale; MDD = major depressive disorder; MDQ = Mood Disorder Questionnaire; MoCA = Montreal Cognitive Assessment; NSAID = nonsteroidal anti-inflammatory drug; OABD = older adult with bipolar disorder; PHQ-9 = Patient Health Questionnaire-9; qhs = every night at bedtime; TID = three times daily; TSH = thyroid-stimulating hormone; WNL = within normal limits; XR = extended release; YMRS = Young Mania Rating Scale
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

# 4 TREATMENT AND REFERRAL QUICK GUIDE

## Therapy Escalation Criteria

Moving from diagnosis to active management requires a **longitudinal treatment plan**, prioritizing the selection of agents that address the patient's specific phase of illness—whether acute mania, bipolar depression, or maintenance.[2,9,14,15]

| TRIGGER | ACTION |
|---|---|
| **Acute manic episode — moderate/severe, with or without psychotic features** | **Initiate first-line monotherapy or combination** per CANMAT 2023: lithium, quetiapine, valproate, aripiprazole, risperidone, paliperidone, asenapine, or cariprazine. Severe/psychotic features → antipsychotic + mood stabilizer combination; hospitalization if safety compromised. YMRS at baseline; reassess weekly during acute phase |
| **Acute bipolar depression — moderate/ severe** | **First-line** per CANMAT 2023 acute efficacy: olanzapine-fluoxetine (**56.7%** response), quetiapine (~**49%**), lurasidone (~**48.5%**), cariprazine (~**44.5%**), lamotrigine (~**44.4%**), olanzapine (~**44.3%**), lumateperone (~**42.4%**). Antidepressant monotherapy is **NOT** first-line. **MADRS at baseline; reassess every 2–4 weeks**[2] |
| **Maintenance — after first remission of Bipolar I** | **First-line maintenance** per CANMAT 2023: lithium, quetiapine, valproate, lamotrigine, asenapine, or aripiprazole; quetiapine, valproate, or aripiprazole may be combined with lithium or valproate. **Lithium carries an independent antisuicidal effect and is strongly considered when tolerable**. Duration: indefinite in Bipolar I after ≥2 episodes |
| **Treatment-resistant mania or depression** | **ECT consideration for severe, treatment-resistant, catatonic, or suicidal mania or depression**, or in pregnancy when safer than pharmacotherapy. Clozapine for treatment-resistant mania. Psychiatric specialty referral; consider tertiary bipolar program |
| **Post-psychiatric-hospitalization discharge** | **Follow-up visit within 7 days of discharge** (HEDIS FUH 7-day); second visit within 30 days (FUH 30-day) Medication reconciliation; safety plan; adherence assessment; measurement-based care; coordination with outpatient psychiatry |

**ABBREVIATIONS:** CANMAT = Canadian Network for Mood and Anxiety Treatments; CFS = Clinical Frailty Scale; ECT = electroconvulsive therapy; eGFR = estimated glomerular filtration rate; FUH = Follow-Up After Hospitalization for Mental Illness; HEDIS = Healthcare Effectiveness Data and Information Set; ISBD = International Society for Bipolar Disorders; MADRS = Montgomery-Åsberg Depression Rating Scale; MoCA = Montreal Cognitive Assessment; SGA = second-generation antipsychotic; TSH = thyroid-stimulating hormone; YMRS = Young Mania Rating Scale
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

## Progression of bipolar disorders and recommended pharmacological treatments

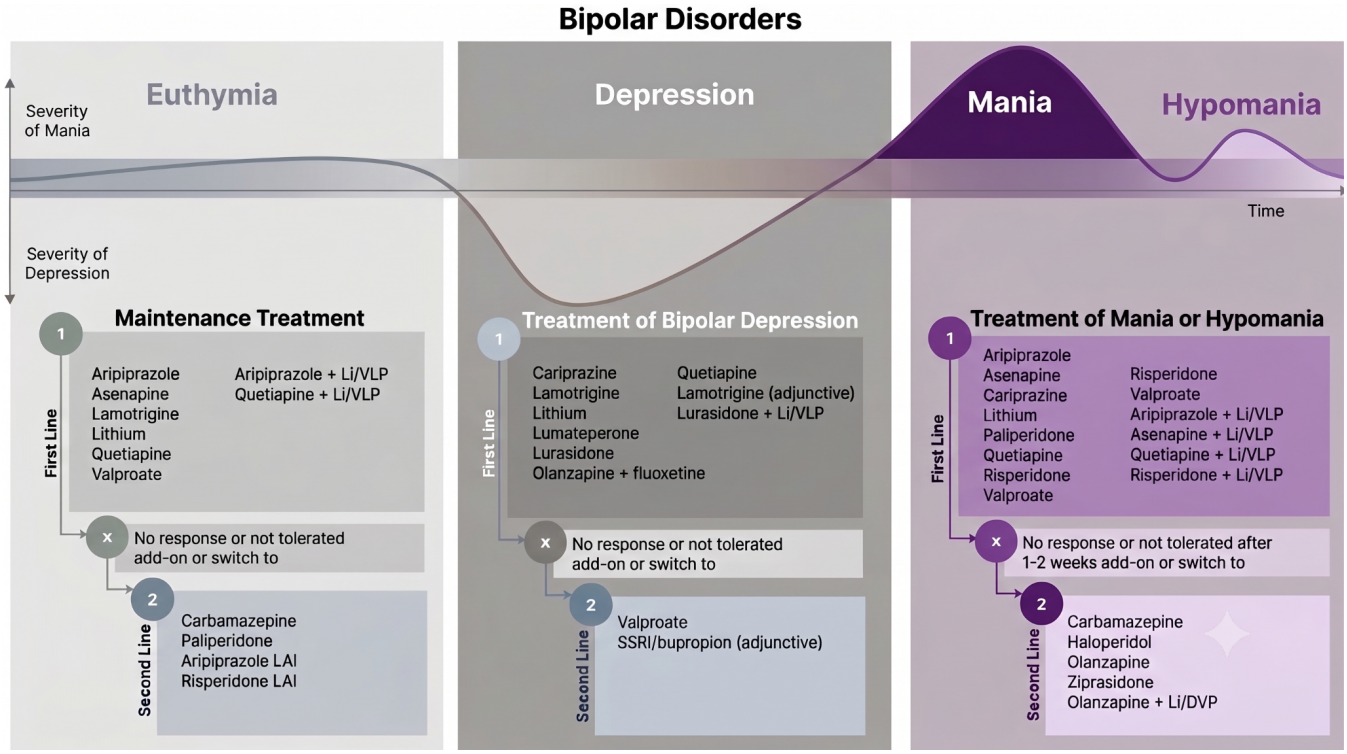


**Figure 1:** LAI, Long acting injectable. Li, Lithium; SSRI, Selective serotonin reuptake inhibitor; VLP, Valproate.

***Note:*** *Valproate should be avoided in patients of childbearing age due to its teratogenic risk and other significant side effects. Carbamazepine also increases the risk of neural tube defects but is used during pregnancy under certain circumstances (for example, when the pregnant parent needs to be treated for epilepsy). Lithium use during pregnancy has been associated with an increased risk of a particular type of cardiovascular birth defect called Ebstein anomaly. However, because this risk is quite low, lithium is sometimes continued at the lowest possible dose during pregnancy.*

## CANMAT/VA-DoD/ISBD/JACC/AFP Aligned Recommendations

The following are guideline-based recommendations for treatment approaches:[19–21]

| CATEGORY | RECOMMENDED AGENT/APPROACH | NOTES |
|---|---|---|
| **First-line acute mania (CANMAT 2023)** | Monotherapy: lithium, quetiapine, valproate, aripiprazole, risperidone, paliperidone, asenapine, cariprazine. Combination (Li or valproate + SGA) for severe/psychotic features | **Hospitalize if safety is compromised**. YMRS every 1–2 weeks. Avoid antidepressants during acute mania. Psychiatric referral expected |
| **First-line acute bipolar depression (CANMAT 2023)** | Olanzapine-fluoxetine, quetiapine, lurasidone, cariprazine, lamotrigine, olanzapine, lumateperone. **Response rates 42–57% at 6–8 weeks** | Antidepressant monotherapy is **NOT** first-line. MADRS every 2–4 weeks. Psychotherapy adjunct (CBT, IPSRT) |

| CATEGORY | RECOMMENDED AGENT/APPROACH | NOTES |
|---|---|---|
| **Maintenance (CANMAT 2023)** | First-line monotherapy: lithium, quetiapine, valproate, lamotrigine, asenapine, aripiprazole; combination: Li + quetiapine, Li + valproate, Li + aripiprazole | Indefinite in Bipolar I after **≥2** episodes. Lithium has an independent antisuicidal effect. Measurement-based care with YMRS + MADRS at each visit |
| **Electroconvulsive therapy (ECT)** | Severe, treatment-resistant, catatonic, or acutely suicidal mania or depression; pregnancy when pharmacotherapy risks outweigh ECT | **High response rates in refractory episodes**. Cognitive side effects; pre-ECT workup essential. Coordination with anesthesia and psychiatry |
| **Geriatric lithium dosing (ISBD 2019 Delphi)** | **Target:** 0.4–0.8 mEq/L in ages 60–79; 0.4–0.7 in ≥80. **Start low (150–300 mg/day)**, titrate slowly; steady-state level at 5–7 days | Review NSAIDs, ACEi/ARB, thiazides, loop diuretics at every visit. eGFR + TSH every 6 months. Abrupt discontinuation → rebound mania/suicide risk |

**ABBREVIATIONS:** ACEi = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; CANMAT = Canadian Network for Mood and Anxiety Treatments; CBT = cognitive behavioral therapy; ECT = electroconvulsive therapy; eGFR = estimated glomerular filtration rate; FFT = family-focused therapy; IPSRT = interpersonal and social rhythm therapy; ISBD = International Society for Bipolar Disorders; Li = lithium; MADRS = Montgomery-Åsberg Depression Rating Scale; NSAID = nonsteroidal anti-inflammatory drug; SGA = second-generation antipsychotic; TSH = thyroid-stimulating hormone; YMRS = Young Mania Rating Scale
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

### CLINICAL PEARL: SECOND GENERATION ANTIPSYCHOTICS FOR BIPOLAR DISORDER[2]

**Acute manic episodes** are often treated with **second-generation antipsychotics**, either alone or with lithium or valproate, because they can provide faster symptom control while a mood stabilizer reaches therapeutic effect. Commonly used options include **aripiprazole, asenapine, cariprazine, olanzapine, paliperidone, quetiapine, risperidone,** and **ziprasidone**. Lithium remains a core mood stabilizer but may take several days to show full clinical effect.

Long-term antipsychotic treatment requires monitoring for **weight gain, dyslipidemia, insulin resistance, hyperglycemia,** and hypertension. These changes may contribute to **metabolic syndrome**, especially in patients with baseline cardiometabolic risk. Metabolic risk varies by agent and is generally higher with olanzapine and lower with aripiprazole or ziprasidone.

## Non-Pharmacologic Treatment and Lifestyle Modification

Lifestyle modifications and non-pharmacological treatment can be very helpful in helping patients manage and cope with symptoms.[2]

| INTERVENTION | TARGET/RECOMMENDATION | NOTES |
|---|---|---|
| **Cognitive behavioral therapy (CBT) for bipolar disorder** | Reduces depressive relapse; improves medication **adherence** and coping | **8–20 sessions**; experienced therapist with bipolar-specific training; adjunct to pharmacotherapy, not replacement |
| **Family-focused therapy (FFT)** | **Reduces relapse**, improves family communication and medication adherence | **12–20 sessions** with patient + family; especially effective after an acute episode. Important for adolescents and young adults |
| **Interpersonal and social rhythm therapy (IPSRT)** | Stabilizes sleep-wake and social rhythms; **reduces episode recurrence** | Mood-charting and routine-stabilization approach; particularly relevant given sleep disruption as mania trigger |
| **Psychoeducation + early-warning-sign planning** | Reduces relapse by **20–30%** when delivered systematically | Can be individual or group; includes patient + family; covers diagnosis, medications, adherence, prodromes, crisis plan |
| **Sleep hygiene + circadian rhythm stabilization** | Targets **7–9 hours** at consistent times; avoid shift work, jet-lag patterns when possible | Monitor sleep diary; CPAP for comorbid OSA; avoid sedative-hypnotic dependence; address light exposure |

**ABBREVIATIONS:** AWV = annual wellness visit; CBT = cognitive behavioral therapy; CPAP = continuous positive airway pressure; FFT = family-focused therapy; IPSRT = interpersonal and social rhythm therapy; NAMI = National Alliance on Mental Illness; OSA = obstructive sleep apnea

## Non-Pharmaceutical Prevention Strategies

Primary prevention of bipolar disorder is not yet achievable, but secondary prevention such as preventing episode recurrence, suicide, and cardiometabolic morbidity is the central clinical goal.

Practical strategies in primary care and psychiatry:

- Maintain stable pharmacotherapy adherence (**PDC (proportion of days covered) ≥80%** for antipsychotics, per HEDIS SAA, is associated with fewer hospitalizations)
- Psychosocial intervention (CBT, family-focused therapy, IPSRT) to stabilize sleep-wake rhythms
- Aggressive cardiovascular risk management (BP, lipids, glucose, smoking cessation)
- Substance-use screening and treatment
- Post-psychiatric-discharge follow-up within 7 days (HEDIS FUH) to reduce readmission and suicide
- Lithium — with its independent antisuicidal effect — offered as first-line maintenance when tolerable

## Medication Safety and Dose Adjustments

| AGENT/ CLASS | INTERACTION | ADJUSTMENT | MONITORING |
|---|---|---|---|
| **Lithium**[16] | + NSAIDs (ibuprofen, naproxen, celecoxib) — scheduled or PRN → increased serum level and toxicity risk **Risk: HIGH** | Prefer acetaminophen, topical NSAIDs, duloxetine for chronic pain. If NSAID essential, recheck lithium level within 1–2 weeks; adjust dose | Lithium level 1–2 weeks after NSAID initiation/change; renal function; tremor, confusion, ataxia as toxicity signs |
| **Lithium**[16] | + ACE inhibitors/ARBs/thiazide/ loop diuretics Blood volume contraction and altered sodium handling raise serum lithium; effect amplified in older adults with reduced renal reserve **Risk: HIGH** | Check lithium level within 1–2 weeks of any change; **reduce lithium dose 25–50%** when initiating these agents in older adults | Level; renal function; BP; signs of toxicity; hydration status |
| **Valproate**[17] | + Lamotrigine Valproate inhibits lamotrigine glucuronidation → **2–3×** increased lamotrigine levels and Stevens-Johnson/TEN risk **Risk: HIGH** | Halve lamotrigine titration rate and target dose when on valproate; follow package titration for valproate-comedication | Rash surveillance; LFTs; platelets; clinical monitoring for mucocutaneous signs |
| **Second-generation antipsychotics (olanzapine, quetiapine, risperidone)** | Metabolic burden (weight gain, dyslipidemia, diabetes) Multiple receptor mechanisms (H1, 5-HT2C) driving weight and metabolic changes **Risk: MODERATE–HIGH** | Prefer aripiprazole, lurasidone, cariprazine when metabolically sensitive; switch protocols if metabolic decompensation | Weight/BMI, fasting glucose or HbA1c, lipids at baseline, 12 weeks, annually (HEDIS SSD, SMD, SMC) |
| **Clozapine**[18] | Agranulocytosis; myocarditis; seizure; metabolic Idiosyncratic hematologic and cardiac effects **Risk: HIGH** | REMS program enrollment; weekly ANC × 6 months, biweekly × 6 months, monthly thereafter; baseline + periodic troponin/CRP/ ECG in first 4–8 weeks | ANC per REMS; troponin/CRP/ECG at baseline and during early titration; metabolic monitoring |

| AGENT/ CLASS | INTERACTION | ADJUSTMENT | MONITORING |
|---|---|---|---|
| **Carbamazepine**[19] | Cytochrome P450 enzyme induction (3A4, 1A2, 2C9) Lowers levels of many co-administered drugs including oral contraceptives, warfarin, lamotrigine, quetiapine, valproate **Risk: MODERATE–HIGH** | Review all concurrent medications at initiation; coordinate with prescribers; advise on non-oral contraception | Drug levels when applicable; LFTs; CBC (aplastic anemia, agranulocytosis risk); $Na^+$ (SIADH) |
| **SSRIs/SNRIs in bipolar disorder (when cautiously used per psychiatry)**[20] | Risk of mood switch, rapid cycling induction Serotonergic and noradrenergic effects may destabilize mood in bipolar diathesis **Risk: HIGH (avoid as monotherapy)** | **Do NOT initiate antidepressant monotherapy in bipolar disorder;** if indicated, only with mood-stabilizer coverage and psychiatric oversight; monitor for switch | Mood tracking, YMRS at follow-up; discontinue if switch occurs |

**ABBREVIATIONS:** ACE = angiotensin-converting enzyme; ANC = absolute neutrophil count; ARB = angiotensin receptor blocker; BMI = body mass index; BP = blood pressure; CBC = complete blood count; CRP = C-reactive protein; ECG = electrocardiogram; HbA1c = hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; LFT = liver function test; $Na^+$ = sodium; NSAID = nonsteroidal anti-inflammatory drug; PRN = as needed; REMS = Risk Evaluation and Mitigation Strategy; SIADH = syndrome of inappropriate antidiuretic hormone; SMC = CV monitoring; SMD = diabetes monitoring; SNRI = serotonin-norepinephrine reuptake inhibitor; SSD = diabetes screening; SSRI = selective serotonin reuptake inhibitor; TEN = toxic epidermal necrolysis; YMRS = Young Mania Rating Scale
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

## When to Refer

To minimize ER visits and inpatient admissions, workflow should include clear triggers for specialty referral, such as rapid cycling or lithium toxicity risk, ensuring that high-acuity patients receive the appropriate level of psychiatric oversight.[14]

| CRITERION | SPECIALIST | URGENCY |
|---|---|---|
| **First manic episode; suspected Bipolar I diagnosis** | Psychiatry (outpatient or inpatient depending on severity) | **Immediate** — hospitalization if safety compromised; outpatient psychiatric consultation within days if stable. Mood stabilizer initiation should not wait for specialty visit if indicated |
| **Suspected bipolar depression in a patient previously on antidepressant monotherapy — especially with history suggestive of prior hypomania** | Psychiatry | Within **2–4 weeks**; sooner if antidepressant-induced switch or acute safety concern. Stop antidepressant monotherapy pending specialist decision |

| CRITERION | SPECIALIST | URGENCY |
|---|---|---|
| **Treatment resistance: failure of ≥2 adequate first-line agents** | Psychiatry (tertiary bipolar program if available) | Within **4–6 weeks**. Consider ECT, clozapine, combination strategies, and reassessment of diagnosis (secondary mania, substance-induced, misdiagnosed) |
| **Acute suicidal ideation with plan or intent; recent suicide attempt** | Emergency psychiatric evaluation (911/crisis line/ED) | **IMMEDIATE.** Safety plan; remove access to lethal means; do not send home without psychiatric disposition. |
| **Post-psychiatric-hospitalization discharge** | Outpatient psychiatry + primary care | Within **7 days of discharge** (HEDIS FUH 7-day); second visit within 30 days. Medication reconciliation; safety plan; adherence; labs |
| **Older adult with bipolar disorder + new cognitive decline, frailty progression, or polypharmacy concerns** | Geriatric psychiatry + primary care; neuropsychology if diagnostic clarity needed | Within **4–6 weeks**. Include MoCA, CFS, medication list, recent labs, collateral history |

**ABBREVIATIONS:** CFS = Clinical Frailty Scale; ECT = electroconvulsive therapy; ED = emergency department; FUH = Follow-Up After Hospitalization for Mental Illness; HEDIS = Healthcare Effectiveness Data and Information Set; MoCA = Montreal Cognitive Assessment

## Follow-Up Timing

Once the patient is stabilized on a therapeutic regimen, the focus shifts to **long-term follow-up timing**, which is governed by both clinical stability and the strict surveillance windows mandated by national quality standards.[14,15,21]

| STAGE/ CATEGORY | FREQUENCY | LABS/ASSESSMENTS TO MONITOR |
|---|---|---|
| **Initial bipolar diagnosis visit** | **Day 0**; psychiatric referral within **1–2 weeks** | DSM-5-TR criteria documented; YMRS, MADRS, PHQ-9, C-SSRS; pre-treatment labs (Cr/eGFR, TSH, Ca, HbA1c, lipids, ECG); mood stabilizer initiation as indicated; safety plan; psychoeducation |
| **Acute manic/ mixed episode management** | Every **1–2 weeks** during acute phase; daily contact if outpatient stabilization | YMRS; medication tolerability; adherence; safety; **lithium level every 5–7 days during titration**; SGA metabolic panel at 12 weeks; sleep pattern |
| **Acute bipolar depression management** | Every **2–4 weeks** during acute phase | MADRS, PHQ-9; C-SSRS every visit; medication tolerability; adherence; monitor for mood switch; suicide risk reassessment |

| STAGE/ CATEGORY | FREQUENCY | LABS/ASSESSMENTS TO MONITOR |
|---|---|---|
| **Maintenance (stable remission)** | Every **3 months** routine; more often if recent instability or titration | YMRS, MADRS, PHQ-9 quarterly; **lithium level every 3–6 months**; eGFR + TSH every 6 months; SGA metabolic labs annually; medication reconciliation every visit |
| **Post-psychiatric-hospitalization transition** | Within **7 days** (HEDIS FUH-7); second visit within 30 days (HEDIS FUH-30) | Medication reconciliation; adherence; **safety plan**; labs per agent; follow-up psychiatric appointment scheduled; communication with discharging team |
| **OABD (≥65) maintenance** | Every **3 months**; more often if frail or on lithium with interacting medications | Lithium level (target 0.4–0.8 age 60–79; 0.4–0.7 ≥80); eGFR + TSH every 6 months; annual MoCA, CFS; medication review with Beers Criteria; fall/orthostasis screen |

**ABBREVIATIONS:** Beers = American Geriatrics Society Beers Criteria; CFS = Clinical Frailty Scale; C-SSRS = Columbia Suicide Severity Rating Scale; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision; ECG = electrocardiogram; eGFR = estimated glomerular filtration rate; FUH = Follow-Up After Hospitalization for Mental Illness; HbA1c = hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; MADRS = Montgomery-Åsberg Depression Rating Scale; MoCA = Montreal Cognitive Assessment; OABD = older adult with bipolar disorder; PHQ-9 = Patient Health Questionnaire-9; SGA = second-generation antipsychotic; TSH = thyroid-stimulating hormone; YMRS = Young Mania Rating Scale
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

## Comorbidity Management

Once the acute mood episode is controlled, co-occurring conditions should be managed, as untreated anxiety, substance use, or metabolic syndrome can undermine the prescribed mood-stabilizing regimen.[2,9,14,22]

| COMORBIDITY | APPROACH | CAUTION |
|---|---|---|
| **Cardiovascular disease + dyslipidemia (I25.x, E78.5)** | Aggressive lipid, BP, glucose management; statin per ASCVD risk; smoking cessation; prefer metabolically neutral SGAs (aripiprazole, lurasidone, cariprazine) | CV mortality is the leading cause of excess death in bipolar disorder — **do not defer CV primary prevention** |
| **Type 2 diabetes (E11.x) + metabolic syndrome** | **Metformin first-line**; GLP-1 where appropriate; SGLT-2 if CV/renal indication; HEDIS SSD + SMD apply | **Avoid olanzapine/quetiapine when diabetes poorly controlled**; switch to aripiprazole/lurasidone/cariprazine if possible |
| **Substance use disorders (F10–F19)** | Integrated psychiatric-addiction treatment; naltrexone/acamprosate for AUD; buprenorphine for OUD; bupropion or NRT for nicotine | Bupropion lowers seizure threshold — avoid in uncontrolled bipolar if not on mood stabilizer. Substance use worsens adherence and cycling |

| COMORBIDITY | APPROACH | CAUTION |
|---|---|---|
| **Anxiety disorders (F41.x, F40.x)** | Mood stabilizer + evidence-based CBT; **SSRIs cautiously** and only with mood-stabilizer coverage per psychiatric plan | Avoid benzodiazepines as chronic monotherapy, especially in OABD (Beers). **Monitor for switch with SSRI** |
| **Cognitive impairment/ dementia (F06.7x, G30.x)** | **Differentiate episode-related from progressive impairment**; medication review (lithium, anticholinergics, benzodiazepines); cognitive-supportive care. | **Do not attribute new decline to dementia without workup**; MoCA + neuropsych when indicated; avoid abrupt lithium discontinuation on cognitive concerns alone |
| **Chronic pain + polypharmacy** | **Non-NSAID pain strategies in lithium patients** (acetaminophen, duloxetine, topical, PT, CBT-pain); avoid long-term opioids | NSAIDs, ACEi/ARB, thiazides, loop diuretics raise lithium levels — **check level within 1–2 weeks of any change** |

**ABBREVIATIONS:** ACEi = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; ASCVD = atherosclerotic cardiovascular disease; AUD = alcohol use disorder; Beers = American Geriatrics Society Beers Criteria; BP = blood pressure; CBT = cognitive behavioral therapy; CV = cardiovascular; GLP-1 = glucagon-like peptide-1; HEDIS = Healthcare Effectiveness Data and Information Set; MoCA = Montreal Cognitive Assessment; NRT = nicotine replacement therapy; NSAID = nonsteroidal anti-inflammatory drug; OABD = older adult with bipolar disorder; OUD = opioid use disorder; PT = physical therapy; SGA = second-generation antipsychotic; SGLT-2 = sodium-glucose cotransporter-2; SMD = diabetes monitoring; SSD = diabetes screening; SSRI = selective serotonin reuptake inhibitor
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

## Cost-Smart Options

| BRAND (EST. COST) | GENERIC/ALTERNATIVE (EST. COST) | EST. SAVINGS | COST-SMART TIP[21,23] |
|---|---|---|---|
| **Lithium carbonate ER (branded)** | Lithium carbonate IR/ER generic — widely available, low-cost Lithobid ($120–$180)Lithium Generic ($10–$40) | Generic lithium is among the most cost-effective psychotropics (~$100+) | Lithium has independent antisuicidal effect and first-line maintenance evidence. In patients tolerating lithium, it is both clinically preferred and cost-effective. Counsel on hydration, diet, NSAID avoidance |
| **Quetiapine XR (Seroquel XR)** | Quetiapine IR generic — dosing requires bid scheduling rather than qhs for equivalent exposure Seroquel XR ($500+)Quetiapine IR ($7–$15) | Meaningful monthly savings vs branded XR 500$+/month | IR generic is appropriate for most patients; XR branded if adherence favors once-daily dosing. Monitor metabolic parameters regardless of formulation |

| BRAND (EST. COST) | GENERIC/ALTERNATIVE (EST. COST) | EST. SAVINGS | COST-SMART TIP[21,23] |
|---|---|---|---|
| **Lurasidone (Latuda)** | Now available generic (2023+) — lurasidone generic<br>Latuda ($1,400+)Lurasidone Generic ($18–$30) | Substantial with generic availability ($1,470) | Metabolically favorable SGA for bipolar depression and maintenance; take with ≥350 kcal meal for absorption. Covered on most Part D formularies post-generic |
| **Cariprazine (Vraylar)** | No generic as of 2026 — brand-only<br>Vraylar ($1,200+) | Full brand cost; Part D formulary placement variable | CANMAT 2023 first-line for acute bipolar depression and mania.[12] Prior authorization may require documentation of failure on generic first-line alternatives |
| **Lamotrigine XR (Lamictal XR)** | Lamotrigine IR generic — requires bid dosing<br>$8 – $25 (generic)<br>Lamictal ($450+) | Meaningful vs XR branded<br>~$400 savings | **Slow titration essential** — Stevens-Johnson/TEN risk with rapid escalation, doubled with concurrent valproate. Counsel on rash; patient handout |
| **Valproate ER (Depakote ER)** | Valproate DR or IR generic<br>$12 – $35<br>Depakote ($300+) | (~$275) | Hepatotoxicity and teratogenicity (neural tube defects) — avoid in women of reproductive potential when alternatives are acceptable; baseline + periodic LFTs and platelets |

**ABBREVIATIONS:** bid = twice daily; CANMAT = Canadian Network for Mood and Anxiety Treatments; DR = delayed release; ER = extended release; IR = immediate release; LFT = liver function test; qhs = every night at bedtime; SGA = second-generation antipsychotic; TEN = toxic epidermal necrolysis; XR = extended release
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

## Patient Education and Adherence

### 1. Barriers to Adherence: The "Why"

Effective patient education must address the specific psychological and physical hurdles unique to this condition:

- **Anosognosia:** A neurological "lack of insight" where the patient truly believes they are well during a manic or hypomanic phase
- **The "Loss of Magic":** Patients may miss the productivity and euphoria of hypomania and view medication as a "creative anchor"
- **Weight Gain and Body Image:** Especially with SGAs, metabolic side effects are a top reason for sudden discontinuation
- **Cognitive Blunting:** The lethargic feeling or slowed processing speed often attributed to lithium or high-dose antipsychotics

### 2. The "Rule of Thirds" Education Strategy

When counseling patients, use this framework to set realistic expectations and reduce the risk of non-adherence in the first 90 days:

| THE TIMELINE | WHAT THE PATIENT SHOULD KNOW |
|---|---|
| **Days 1–14** | Focus is purely on **safety and side effects** (sedation, GI upset). Therapeutic mood benefits are rarely felt yet |
| **Weeks 3–6** | The "Partial Response" phase. Sleep should improve first; mood stability follows. Warning: This is the highest risk for suicidal ideation as energy returns before mood lifts |
| **Month 3+** | **Maintenance Education.** The "I feel fine, I don't need this anymore" phase. Explain that the medication is a "shield," not a "cure" |

### 3. Practical Tools for the Primary Care/Psych Clinic

- **Life Charting:** Encourage patients to use apps (like eMoods or Daylio) to track sleep and mood. Visualizing the "peaks" being flattened by medication provides evidence of success
- **Circadian Hygiene:** Educate that **sleep is a medication.** A single "all-nighter" can trigger a manic switch regardless of pharmaceutical compliance
- **The "No-Blame" Contract:** Establish a protocol where the patient agrees to call the office *before* stopping a medication if they hate the side effects, rather than just quitting

#### AAVBC PERSPECTIVE

*Managing bipolar disorder requires a strong, collaborative therapeutic alliance that recognizes the long-term demands of treatment. Effective care depends on continued medication adherence during euthymic periods, routine metabolic monitoring for patients receiving second-generation antipsychotics, and regular lithium level assessment—particularly after starting NSAIDs, ACE inhibitors, or thiazide diuretics.*[2]
***Beyond clinical management,*** *address the substantial psychosocial burden, including systemic* ***stigma****, occupational instability, caregiver strain, and the financial burden associated with high-cost SGAs (e.g., cariprazine, lumateperone, lurasidone).* ***Shared decision-making*** *should explicitly recognize these challenges, integrating family or caregivers when appropriate, and* ***prioritizing a treatment intensity matched to the patient's clinical frailty rather than chronological age****. Comprehensive documentation of patient values, social supports, and specific adherence barriers is essential to transition from a theoretical treatment plan to a sustainable model of care.*

## Quality Metrics Tie-In

| MEASURE (MY2026)[24] | STANDARD | APPLICABILITY TO SCHIZOPHRENIA |
|---|---|---|
| **HEDIS SSD: Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder on Antipsychotic Therapy** | **Denominator:** enrollees 18–64 with schizophrenia, schizoaffective disorder, or bipolar disorder dispensed an antipsychotic; Numerator: glucose or HbA1c test during measurement year<br>**Exclusions:** hospice | Type 2 diabetes incidence is 1.5–2.5× higher in bipolar disorder; SGAs (especially olanzapine, clozapine) and mood stabilizers (lithium, valproate) both drive metabolic dysregulation; national Medicaid benchmark ~79–89% screening rate; ADA 2026 recommends screening at baseline, 12–16 weeks post-antipsychotic initiation, and annually thereafter[25] |
| **HEDIS FUH: Follow-Up After Hospitalization for Mental Illness** | **Denominator:** enrollees ≥6 with inpatient discharge for mental illness; Numerator: outpatient mental health visit within 7 days (FUH-7) or 30 days (FUH-30) of discharge<br>**Exclusions:** hospice, transfers, planned readmissions | Suicide rate in the first week post-discharge is ~2,950/100,000 person-years; 7-day follow-up reduces suicide risk (HR 0.82) and is associated with greater medication adherence and lower readmission; national Medicaid benchmark only ~34% at 30 days for SMI; schedule PCP or psychiatry visit before discharge; bipolar patients with recent manic episodes require mood-stabilizer level verification within 7 days[26] |
| **HEDIS DMS-E: Utilization of the PHQ-9 to Monitor Depression Symptoms** | **Denominator:** enrollees ≥12 with diagnosis of major depression or dysthymia AND elevated PHQ-9 ≥10<br>**Numerator:** follow-up PHQ-9 documented | — |

**ABBREVIATIONS:** AAVBC = American Academy of Value-Based Care; ASCVD = atherosclerotic cardiovascular disease; CANMAT = Canadian Network for Mood and Anxiety Treatments; CV = cardiovascular; FUH = Follow-Up After Hospitalization for Mental Illness; HbA1c = hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; LDL-C = low-density lipoprotein cholesterol; MH = mental health; PCP = primary care provider; PDC = proportion of days covered; SAA = Adherence to Antipsychotic Medications; SGA = second-generation antipsychotic; SMC = CV monitoring; SMD = diabetes monitoring; SSD = diabetes screening

# 5 CODING REMINDERS AND CASE EXAMPLES

## Documentation Specificity

- **Stage/Severity:** Specify episode type AND severity AND psychotic features explicitly. For Bipolar I: current episode manic (**F31.1x / F31.2**), depressed (**F31.3x–F31.5**), mixed (**F31.6x**), or in remission (**F31.7x**); severity mild/moderate/severe; with or without psychotic features. Document YMRS or MADRS score where assessed (remission <12; MADRS severe ≥33; YMRS severe ≥26). Link functional impact (work, home, self-care, driving), Clinical Frailty Scale where applicable, and hospitalization history
- **Etiology:** Use the most specific **F31.x** code supported by the clinical picture. All **F31.x** map to HCC 154 (RAF ~0.351, CMS-HCC V28) — but episode specificity is essential for continuity of care and accurate complexity representation. **F31.9** (unspecified) should be replaced with the specific subtype (manic, depressed, mixed, remission) once the picture is defined; **F31.81** = Bipolar II (requires hypomania + MDE without full mania)
- **Current status:** Most recent mood state, YMRS/MADRS/PHQ-9/GAD-7 score as applicable, current regimen (lithium level, valproate level, SGA dose), metabolic panel (BMI, A1c, lipids, waist circumference), CV risk assessment, and any recent hospitalization or ED visit. For patients on lithium: most recent level (target 0.6–1.0 mEq/L general adult; 0.4–0.8 ages 60–79; 0.4–0.7 ≥80 per ISBD 2019 Delphi), Cr/eGFR, TSH, and Ca. For patients on SGAs: HEDIS SSD/SMD/SMC status
- **Associated conditions:** Substance use disorder (**F10–F19**; ~40% co-occurrence), generalized anxiety (**F41.1**), PTSD (**F43.10**), MDD history (**F33.x** — now reframed as bipolar depression), T2DM (**E11.x**), HTN (**I10**), dyslipidemia (**E78.x**), cardiovascular disease (**I25.x**), obesity (**E66.x**), and OSA (**G47.33**). Each carries independent clinical and documentation significance — **link each to bipolar disorder explicitly** in the A&P ('T2DM — exacerbated by SGA metabolic burden; switch from olanzapine to aripiprazole being considered'). — **bipolar depression is pharmacologically distinct from unipolar** and must be documented as such
- **Chronicity:** Date of bipolar disorder diagnosis (or best estimate — average 12–15 year delay from first mood symptoms), duration on current regimen, prior trials and responses (lithium, valproate, lamotrigine, SGAs, ECT), episode pattern (rapid cycling Y/N), seasonal pattern, and longitudinal mood chart if available. Bipolar disorder is chronic — 'history of' coding does **NOT apply** while the patient **remains on maintenance therapy or requires surveillance.** Use **F31.7x** (partial/full remission) when an active episode is absent; continue HCC-bearing **F31.x** coding indefinitely

## Annual Clinical Review and Confirmation

- **Annual review:** All **F31.x** codes map to HCC 154 and must be reassessed face-to-face or via synchronous audio-video telehealth each payment year. **Update** episode type, severity, psychotic features, remission status, current regimen, lithium/valproate levels where applicable, metabolic monitoring (HEDIS SSD/SMD/SMC), HEDIS SAA adherence (PDC ≥80% for ≥8 months), and functional status
- **Visit modality:** In-person or video telehealth with meaningful evaluation qualifies. **Document mood** state (YMRS/MADRS/PHQ-9/GAD-7 where assessed), recent **hospitalizations**, medication **adherence** and **tolerability**, **metabolic parameters**, **substance use**, and **suicide risk** assessment. FUH (7/30-day post-discharge follow-up) after any psychiatric hospitalization
- **Clinical context:** Under CMS-HCC V28, all **F31.x** codes map to HCC 154 at RAF ~0.351. **F31.9** (unspecified) is acceptable only when specificity is not yet determinable — replace with the specific episode type once defined. s H-1 (episode specificity) and H-2 (bipolar depression **distinct from unipolar**) are central to annual review. Continuity of the clinical record matters more than any individual code
- **Avoid rollover**: Do not copy last year's bipolar note forward without updating episode type, severity, current regimen, level/lab monitoring, metabolic status, HEDIS measures, substance use, adherence barriers, and suicide risk. Mood state, frailty, caregiver availability, and goals of care shift — reassess at each annual visit and after any psychiatric hospitalization

## Good Documentation is Comprehensive Coding

| EHR SHORTCUT/RISK | PREFERRED DOCUMENTATION LANGUAGE |
|---|---|
| **Carrying 'bipolar disorder' into the A&P without episode specificity** | 'Bipolar I, current episode manic, moderate, without psychotic features (**F31.12**), YMRS 22, addressed at today's visit.' Never just 'bipolar disorder.' Episode specificity is the condition for accurate HCC 154 documentation |
| **Coding depression (F32.x/ F33.x) in a patient with known lifetime mania** | 'Bipolar I, current episode depressed, moderate (**F31.32**). Prior manic episode 2023 (**F31.12**). MADRS 26. Initiating quetiapine 300 mg qhs (CANMAT first-line for bipolar depression).' Antidepressant monotherapy is not first-line; document the rationale when used |
| **Using F31.9 when episode type is documentable** | 'Bipolar I, current episode manic, moderate, without psychotic features (**F31.12**)' or 'Bipolar I, in partial remission (**F31.73**).' Replace **F31.9** with specificity once episode type is defined |
| **Omitting the lithium level at a maintenance visit** | 'Lithium 900 mg/day; level 0.7 mEq/L on 2026-04-10 (target 0.6–0.8 age 58); eGFR 72; TSH 2.1; no interacting medications added since last visit.' The level is the evidence of active management |

| EHR SHORTCUT/RISK | PREFERRED DOCUMENTATION LANGUAGE |
|---|---|
| **'Stable' as the only entry for a maintenance visit** | 'Bipolar I, in full remission (**F31.74**), 14 months post last episode. YMRS 4, MADRS 6, PHQ-9 3. Lithium 900 mg, level 0.6 mEq/L; eGFR 74; TSH 1.8. Metabolic labs WNL. Adherence is good. Continue maintenance; next level in 3 months' |
| **No post-hospitalization follow-up documentation** | 'Follow-up within 5 days of psychiatric discharge (HEDIS FUH-7 met). Medication reconciliation completed; discharge lithium 600 mg BID reviewed; outpatient psychiatry scheduled in 10 days; safety plan reviewed; level scheduled in 1 week' |

**ABBREVIATIONS:** A&P = assessment and plan; BID = twice daily; CANMAT = Canadian Network for Mood and Anxiety Treatments; CFS = Clinical Frailty Scale; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; FUH = Follow-Up After Hospitalization for Mental Illness; HCC = Hierarchical Condition Category; HEDIS = Healthcare Effectiveness Data and Information Set; ISBD = International Society for Bipolar Disorders; MADRS = Montgomery-Åsberg Depression Rating Scale; MoCA = Montreal Cognitive Assessment; NSAID = nonsteroidal anti-inflammatory drug; PHQ-9 = Patient Health Questionnaire-9; qhs = every night at bedtime; TSH = thyroid-stimulating hormone; WNL = within normal limits; YMRS = Young Mania Rating Scale

## EHR Workflow Tips

- **[EHR TIP — Annual Check]** Annual Wellness Visit — reassess all **F31.x** codes face-to-face or via synchronous video telehealth each payment year. Update episode type, severity, validated measures, lithium/metabolic labs, and functional status (MoCA, CFS in ≥65)
- **[EHR TIP — Problem List]** Surface patients with active **F31.x** without documented episode type (i.e., **F31.9**) — these are candidates for specificity upgrade. Surface patients on SGAs without HbA1c/lipids in the past year — these are HEDIS SSD/SMD gap candidates
- **[EHR TIP — Problem List]** Active problem list entries for bipolar disorder should read: "Bipolar I, current episode [manic/depressed/mixed]" or "Bipolar I, in [partial/full] remission" — never "history of bipolar disorder" while on maintenance therapy. Include validated-measure scores if used for MBC
- **[EHR TIP — Referral]** Referral letters should include: episode type + severity, YMRS/MADRS trend, current medications and levels, comorbidities with ICD-10 codes, prior treatment trials and responses, psychosocial status, safety plan status, and insurance/formulary detail
- **[EHR TIP — Workflow]** PH protocol — auto-generate follow-up visit within 7 days of discharge for PH-related admission. Include medication reconciliation, volume status assessment, risk restratification, and care coordinator contact in the visit template

## Brief Case Examples

**SUCCESS: COMPREHENSIVE DOCUMENTATION**

**Scenario:** 74-year-old with Bipolar I Disorder, currently stable on Lithium, but showing signs of early cognitive decline (MoCA 22) and renal strain (eGFR 48).

**Documentation:** "Bipolar I disorder, currently in partial remission (**F31.73**). Stable on Lithium 300 mg BID; serum level 0.5 mEq/L (5/10/26). Complications: CKD Stage 3a (**N18.31**) secondary to long-term lithium; eGFR 48. Cognition: MoCA 22/30 (5/18/26) indicating mild cognitive impairment; CFS 4. Plan: Continue current dose; monitor renal function q3 months. Neurology referral for cognitive baseline. MEAT documented."

**Outcome:** HCC 154 (Bipolar) (RAF: 0.351) + HCC 127 (CKD 3a) (RAF: 0.127). Combined RAF: 0.478 ~ $4972.31/year.

### PITFALL: INSUFFICIENT DOCUMENTATION

**Documentation as written:** "Bipolar disorder. On lithium and quetiapine. Stable. No recent episodes." Coded as **F31.9** (Bipolar disorder, unspecified). No episode type (I vs II) specified. No current state (manic/depressive/remission). No rating scales (YMRS/PHQ-9). No metabolic or renal monitoring documented."

**Consequence:** "**F31.9** maps to **HCC 154**, but unspecified status fails to document the true Severity of Illness (SOI) and Risk of Mortality (ROM). Without specifying the current phase (e.g., Remission vs. Active Episode), treatment appropriateness for quetiapine titration cannot be verified. Lack of laboratory data (eGFR/TSH/HbA1c) means iatrogenic risks—such as lithium-induced nephrotoxicity or SGA-induced metabolic syndrome—are unaddressed. Documentation does not demonstrate **MEAT** (Monitor, Evaluate, Assess, Treat) or support medical necessity for complex polypharmacy."

**RAF Impact:** 0.351 decrease in Risk Adjustment Factor (RAF). Potential clawback of ~$3,650/year.

**Fix:** "Bipolar I Disorder, currently in **partial remission, most recent episode manic (F31.73)**. Patient stable but requires vigilant monitoring due to **CKD Stage 3a (N18.31)** secondary to long-term lithium use (**T43.505A**). **YMRS** today: 4; **PHQ-9**: 6. Lithium level 0.6 mEq/L (5/2026) with eGFR 48 (declining at 2 mL/min/year). **SGA Monitor:** HbA1c 5.9% (Prediabetes, **R73.03**) on quetiapine 300 mg QHS. Adherence is 90% per pharmacy fill data (**SAA metric**). Plan: Maintain current regimen; start Metformin 500 mg daily for weight/glucose stabilization; repeat renal panel in 3 months. Safety plan updated; no SI/HI."

## REFERENCES

1.Edition F. Diagnostic and statistical manual of mental disorders. *Am Psychiatr Assoc*. 2013;21(21): 591-643.

2.Nierenberg AA, Agustini B, Köhler-Forsberg O, et al. Diagnosis and treatment of bipolar disorder: a review. *Jama*. 2023;330(14):1370-1380.

3.Bipolar Disorders - Mental Health. Merck Manual Consumer Version. Accessed May 19, 2026. https://www.merckmanuals.com/home/mental-health-disorders/mood-disorders/bipolar-disorders

4.Furukawa TA. Assessment of mood: guides for clinicians. *J Psychosom Res*. 2010;68(6):581-589. doi: 10.1016/j.jpsychores.2009.05.003

5.Harvey AG. Sleep and circadian rhythms in bipolar disorder: seeking synchrony, harmony, and regulation. *Am J Psychiatry*. 2008;165(7):820-829.

6.Goldberg JF, Truman CJ. Antidepressant-induced mania: an overview of current controversies. *Bipolar Disord*. 2003;5(6):407-420.

7.Sajatovic M, Strejilevich SA, Gildengers AG, et al. A report on older-age bipolar disorder from the International Society for Bipolar Disorders Task Force. *Bipolar Disord*. 2015;17(7):689-704.

8.Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and meta-analysis. *Am J Psychiatry*. 2016;173(2):117-127.

9.McIntyre RS, Berk M, Brietzke E, et al. Bipolar disorders. *Lancet Lond Engl*. 2020;396(10265): 1841-1856. doi:10.1016/S0140-6736(20)31544-0

10.Griswold KS, Pessar LF. Management of bipolar disorder. *Am Fam Physician*. 2000;62(6):1343-1353.

11.Hunt GE, Malhi GS, Lai HMX, Cleary M. Prevalence of comorbid substance use in major depressive disorder in community and clinical settings, 1990–2019: Systematic review and meta-analysis. *J Affect Disord*. 2020;266:288-304.

12.Correll CU, Solmi M, Veronese N, et al. Prevalence, incidence and mortality from cardiovascular disease in patients with pooled and specific severe mental illness: a large-scale meta-analysis of 3,211,768 patients and 113,383,368 controls. *World Psychiatry*. 2017;16(2):163-180. doi:10.1002/wps.20420

13.Administration SA and MHS. Table 12, DSM-IV to DSM-5 Bipolar I Disorder Comparison. June 2016. Accessed May 19, 2026. https://www.ncbi.nlm.nih.gov/books/NBK519712/table/ch.t8/

14.Yatham LN, Kennedy SH, O'Donovan C, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the management of patients with bipolar disorder: consensus and controversies. *Bipolar Disord*. 2005;:5-69.

15.Keramatian K, Chithra NK, Yatham LN. The CANMAT and ISBD guidelines for the treatment of bipolar disorder: summary and a 2023 update of evidence. *Focus*. 2023;21(4):344-353.

16.DailyMed - LITHIUM solution. Accessed July 6, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e95036c7-542a-437a-969b-f95f6f949f84

17.DailyMed - DIVALPROEX SODIUM- divalproex sodium tablet, film coated, extended release. Accessed July 10, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e8e954d4-54e3-491c-867c-b3b656b70f

18.DailyMed - CLOZAPINE tablet. Accessed July 10, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5021d643-32d2-4167-b5d8-90870e68a787

19.DailyMed - CARBAMAZEPINE tablet. Accessed July 10, 2026. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=25cca2b1-9020-4d8a-bc22-b8063e57f9e

20.Pacchiarotti I, Bond DJ, Baldessarini RJ, et al. The International Society for Bipolar Disorders (ISBD) task force report on antidepressant use in bipolar disorders. *Am J Psychiatry*. 2013;170(11): 1249-1262. doi:10.1176/appi.ajp.2013.13020185

21.Carvalho AF, Firth J, Vieta E. Bipolar Disorder. Ropper AH, ed. *N Engl J Med*. 2020;383(1):58-66. doi: 10.1056/NEJMra1906193

22.Goldfarb M, De Hert M, Detraux J, et al. Severe mental illness and cardiovascular disease: JACC state-of-the-art review. *J Am Coll Cardiol*. 2022;80(9):918-933.

23.Marzani G, Neff AP. Bipolar disorders: evaluation and treatment. *Am Fam Physician*. 2021;103(4): 227-239.

24.Centers for Medicare & Medicaid Services. Medicare 2026 Part C & D Star Ratings Technical Notes. Published online 2025. https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data

25.Liu G, Zhang X, Huo X, Li W. Prevalence, Influencing Factors, and Clinical Characteristics of Cognitive Impairment in Elderly Patients With Schizophrenia. *Front Psychiatry*. 2022;:910814. doi:10.3389/fpsyt.2022.910814

26.Arnold MJ. Management of first-episode psychosis and schizophrenia: guidelines from the VA/DoD. *Am Fam Physician*. 2024;109(5):482-483.

## Medical Disclaimer

The information provided by the American Academy of Value-Based Care (AAVBC) in this document, including but not limited to coding guidance, and related content, is intended for educational and informational purposes only. This content is designed to assist healthcare providers, organizations, and professionals in understanding and applying Value-Based Care principles, practices, and regulatory compliance standards.

AAVBC does not provide legal, clinical, or medical advice. The content presented should not be interpreted or relied upon as specific legal, medical, clinical, or professional guidance. While efforts are made to ensure the accuracy and currency of the information provided, AAVBC does not guarantee that the materials presented are complete, comprehensive, or without error.

Providers and healthcare professionals must independently evaluate all content and guidance presented herein in the context of applicable laws, regulations, clinical guidelines, payer policies, patient-specific conditions, and contraindications. Any treatments, procedures, diagnostic approaches, medications, or strategies discussed are illustrative and should not be directly applied without a thorough and independent review of current, evidence-based clinical resources, and regulatory requirements.

For coding, documentation, utilization management, quality measures (including STAR ratings), and compliance matters, users are responsible for consulting official guidelines issued by regulatory bodies, including but not limited to the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), relevant state agencies, and other authoritative entities.

AAVBC expressly disclaims liability for any loss, claim, or damages arising directly or indirectly from the use or reliance on information provided in this document. Users should consult their organization's legal counsel, compliance officer, or qualified professional advisor for advice specific to their situation. By accessing and using this document, you agree to AAVBC's terms and acknowledge that the use of the content is at your own risk and discretion.