AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Personality Disorders

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Personality disorders (PDs) are **enduring, pervasive patterns of inner experience and behavior** that deviate markedly from cultural expectations, manifest across multiple domains (cognition, affectivity, interpersonal functioning, impulse control), and cause clinically significant distress or functional impairment beginning in adolescence or early adulthood. The DSM-5-TR organizes 10 PD subtypes into three clusters: **Cluster A** (paranoid, schizoid, schizotypal — odd/eccentric), **Cluster B** (antisocial, borderline, histrionic, narcissistic — dramatic/impulsive), and **Cluster C** (avoidant, dependent, obsessive-compulsive — anxious/fearful). Borderline personality disorder (BPD) carries the greatest acute morbidity burden and the largest evidence base.[1]

ICD-10 Codes:

F60.0 Paranoid **F60.1** Schizoid **F60.2** Antisocial **F60.3** Borderline **F60.4** Histrionic **F60.5** Obsessive-compulsive **F60.6** Avoidant **F60.7** Dependent **F60.81** Narcissistic **F60.89** Other specific PDs **F60.9** Unspecified (avoid — see Section 5). **All F60.x codes map to HCC 153 (Personality Disorders), RAF 0.396 (CNA, CMS-HCC v28)**. Documentation must include a definitive diagnostic statement, reference to the enduring pattern since adolescence/early adulthood, functional impairment across ≥2 domains, and the specific subtype — not "consistent with" or "traits of."[2]

Prevalence: The prevalence of personality disorders in the United States is substantial, with the two largest nationally representative studies providing the most authoritative estimates. US-Specific Prevalence Data: The NESARC (National Epidemiologic Survey on Alcohol and Related Conditions), the largest US study (N = 43,093), found that **14.79%** (95% CI 14.08–15.50) of adult Americans —approximately **30.8 million people** — had at least one personality disorder. Individual subtype prevalences were: **Obsessive-compulsive PD: 7.88%** (most prevalent), **Paranoid PD: 4.41%; Antisocial PD: 3.63%; Schizoid PD: 3.13%; Avoidant PD: 2.36%; Histrionic PD: 1.84%; Dependent PD: 0.49%** (least prevalent).[3] BPD, narcissistic PD, and schizotypal PD were not assessed. The DSM-5-TR cites a review of epidemiological studies reporting median prevalences of **3.6% for Cluster A, 4.5% for Cluster B, 2.8% for Cluster C, and 10.5% for any PD.**[1]

HCC/RAF V28 Mapping

ICD-10 CODE[8]	HCC CATEGORY	RAF WEIGHT	DOCUMENTATION REQUIREMENT
F60.0 (Paranoid), F60.1 (Schizoid)	HCC 153 — Personality Disorders	0.396	**Cluster A (paranoid, schizoid)**. Document **pervasive distrust** (**F60.0**) or **detachment from social relationships with restricted emotional expression** (**F60.1**); enduring pattern since early adulthood. Paranoid PD is among the most prevalent in elderly
F60.2 (Antisocial)	HCC 153 — Personality Disorders	0.396	**Antisocial PD.** Document **pervasive disregard for and violation of others' rights; pattern present since age 15; patient must be ≥18 for diagnosis**. Higher prevalence in older men

ICD-10 CODE[8]	HCC CATEGORY	RAF WEIGHT	DOCUMENTATION REQUIREMENT
F60.3 (Borderline)	HCC 153 — Personality Disorders	0.396	**Borderline PD**. Document **instability of interpersonal relationships, self-image, and affects with marked impulsivity**; ≥5 of 9 DSM-5-TR criteria met. **Mood shifts reactive and hours-long — NOT cyclic days-to-weeks episodes** (key differentiator from Bipolar II)
F60.4 (Histrionic), F60.81 (Narcissistic)	HCC 153 — Personality Disorders	0.396	Histrionic (**F60.4**) and Narcissistic (**F60.81**). Document **excessive emotionality and attention-seeking** (**F60.4**) or **grandiosity, need for admiration, lack of empathy** (**F60.81**); both pervasive across contexts
F60.5 (Obsessive-compulsive), F60.6 (Avoidant), F60.7 (Dependent)	HCC 153 — Personality Disorders	0.396	Cluster C (obsessive-compulsive, avoidant, dependent). **F60.5 and F60.6** are **highly prevalent and tend to persist or intensify in later life**; document orderliness/perfectionism/control (**F60.5**), social inhibition with hypersensitivity to criticism (**F60.6**), or excessive need to be cared for (**F60.7**)
F60.89 (Other specified)	HCC 153 — Personality Disorders	0.396	**Other specific personality disorders** (e.g., passive-aggressive, depressive PD). Use when a specific subtype is documented but does not fit **F60.0–F60.81**. Maps to HCC 153 with full specificity
F60.9 (Unspecified)	HCC 153 — Personality Disorders	0.396	**AVOID — unspecified PD**. Carries the same RAF but auditors flag as inadequate documentation specificity. Use only if diagnosis is confirmed but subtype truly cannot be determined; pursue subtype clarification at next visit

ABBREVIATIONS: BPD = borderline personality disorder; CMS = Centers for Medicare & Medicaid Services; CNA = Community Non-Aged; DSM-5-TR = Diagnostic and Statistical Manual, 5th Edition, Text Revision; HCC = hierarchical condition category; PD = personality disorder; RAF = risk adjustment factor; v28 = CMS-HCC Model Version 28 RAF coefficients, HCC mapping, and base rate per CMS CY2026 sources. *RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model;11 values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year[5]

Risk-adjusted care resource allocation — MA base rate × RAF coefficient for HCC 153 (Personality Disorders): 0.396 (CNA segment, CY2026)

PERSONALITY DISORDERS (any F60.x subtype)
~$4,119

HCC 153 · RAF 0.396 · per active patient/year

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Diagnostics (older adults, at-risk population)

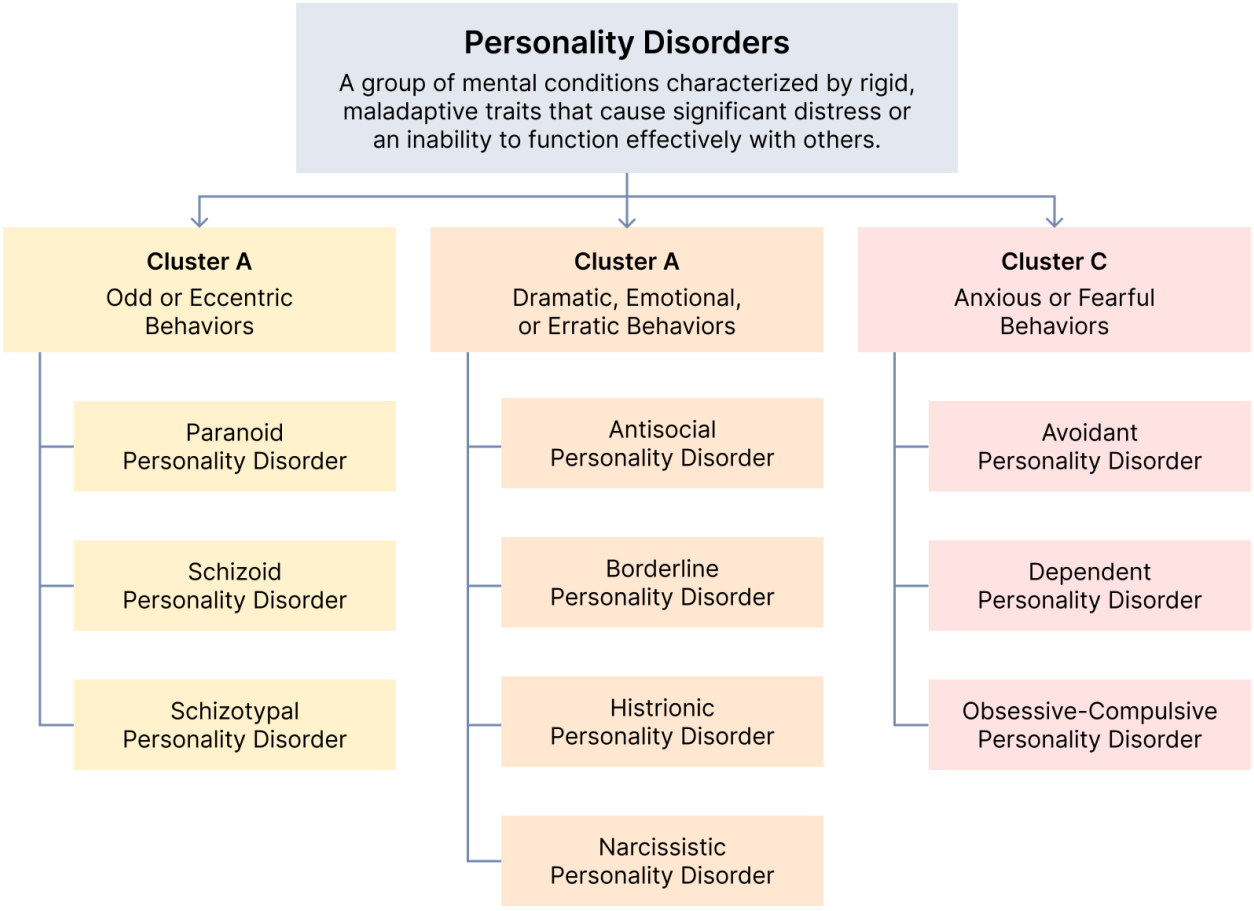
No Medicare-specific preventive screening benefit exists for personality disorders; coverage is limited to diagnostic and treatment services. The AWV is the principal opportunity to identify and document PDs — depression screening (G0444) is the most reliable gateway in primary care.

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Annual Wellness Visit (initial/ subsequent)	Covered Part B	Once initial then annually	G0438/ G0439	Primary opportunity to screen for and document PDs in Medicare beneficiaries. Pair with depression screening and SDOH inventory[4]
Depression screening (PHQ-2/ PHQ-9)	Covered annually under Medicare Part B	Annually at AWV; every 6 months if active PD; after each medication change	G0444	**Treatment-resistant or recurrent depression should prompt PD evaluation** — unrecognized PD is a likely contributor to poor depression remission outcomes (median ACO remission only **8.33–15.5%**)[4]
SAPAS-SR (brief PD screener)	Not separately billed under Medicare — integrate into AWV health-risk assessment	Once at suspicion; repeat as clinically indicated	— (no dedicated code; 96127 may apply per MA plan)	8-item self-report; **sensitivity 83%, specificity 80%** for any PD. Recommended as brief screener when PD suspected[5]
Geriatric-validated PD assessment (GPS or SIPP-SF)	Not separately billed; clinician time included in E/M	Once at suspicion in adults ≥65	—	GPS (**Gerontological Personality Disorders Scale**) and SIPP-SF (**Severity Indices of Personality Problems Short Form**) are validated for older adults; standard adult instruments may over- or under-diagnose in retired individuals or those with cognitive decline[6]

TEST	COVERAGE	FREQUENCY	CPT CODE	CLINICAL INDICATION
Psychiatric diagnostic evaluation	Covered Part B when PD suspected	Once at suspected diagnosis; repeat as clinically indicated	90791/90792	**Confirms DSM-5-TR criteria**, identifies subtype, and rules out mood, trauma, or substance-related differentials[6]
Psychiatric Collaborative Care Management	Covered Part B	Monthly	99492 (initial)/ 99493 (subsequent)/ 99494 (add-on)	Billable **PCP-led framework supporting integrated behavioral health** — the structural model VBC requires. ACOs with mental health quality measures in contracts are 15 percentage points more likely to implement collaborative care[7]

ABBREVIATIONS: AWV = Annual Wellness Visit; CPT = Current Procedural Terminology; E/M = evaluation and management; GPS = Gerontological Personality Disorders Scale; MA = Medicare Advantage; PD = personality disorder; PHQ = Patient Health Questionnaire; SAPAS-SR = Standardized Assessment of Personality – Abbreviated Scale, Self-Report; SDOH = social determinants of health; SIPP-SF = Severity Indices of Personality Problems Short Form

Personality Disorder Description



Description of each Personality Disorder

PERSONALITY DISORDER	DSM-5 CLUSTER	CLINICAL DESCRIPTION
Paranoid (F60.0)	A (Odd/Eccentric)	Pervasive **distrust and suspiciousness** of others, with a tendency to interpret others' motives as malevolent; suspects exploitation, harm, or deception without sufficient basis; reluctant to confide in others; reads hidden demeaning meanings into benign remarks; bears grudges persistently
Schizoid (F60.1)	A (Odd/Eccentric)	Pervasive **detachment from social relationships** and a restricted range of emotional expression; neither desires nor enjoys close relationships; chooses solitary activities; limited interest in sexual experiences; takes pleasure in few activities; lacks close friends; appears indifferent to praise or criticism; shows emotional coldness or flattened affect

PERSONALITY DISORDER	DSM-5 CLUSTER	CLINICAL DESCRIPTION
Antisocial (F60.2)	B (Dramatic/ Erratic)	Pervasive **pattern of disregard for and violation of the rights of others**; failure to conform to social norms and lawful behavior; deceitfulness; impulsivity; irritability and aggressiveness; reckless disregard for safety of self or others; consistent irresponsibility; lack of remorse. **Requires evidence of conduct disorder before age 15**; diagnosis made at age ≥18
Borderline (F60.3)	B (Dramatic/ Erratic)	Pervasive **instability in interpersonal relationships, self-image, and affects with marked impulsivity**; frantic efforts to avoid real or imagined abandonment; alternating idealization and devaluation; identity disturbance; impulsivity in ≥2 self-damaging areas; recurrent suicidal behavior or self-harm; affective instability; chronic emptiness; inappropriate intense anger; transient stress-related paranoid ideation or dissociation
Histrionic (F60.4)	B (Dramatic/ Erratic)	Pervasive **excessive emotionality and attention-seeking**; uncomfortable when not the center of attention; inappropriately sexually seductive or provocative behavior; rapidly shifting and shallow emotions; uses physical appearance to draw attention; impressionistic and vague speech; self-dramatization; suggestible; considers relationships more intimate than they are
Obsessive-Compulsive (F60.5)	C (Anxious/ Fearful)	Pervasive **preoccupation with orderliness, perfectionism**, and mental/interpersonal control at the expense of flexibility and efficiency; preoccupied with details, rules, and lists; perfectionism interferes with task completion; excessively devoted to work; inflexible about morality; unable to discard worn-out objects; reluctant to delegate; miserly spending; rigidity and stubbornness. **Distinct from OCD** (**F42**)
Avoidant (F60.6)	C (Anxious/ Fearful)	Pervasive **social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation**; avoids occupational activities involving interpersonal contact due to fear of criticism or rejection; unwilling to engage unless certain of being liked; restrained in intimate relationships; preoccupied with being criticized; views self as socially inept or inferior; reluctant to take personal risks
Dependent (F60.7)	C (Anxious/ Fearful)	Pervasive and **excessive need to be taken care of, leading to submissive and clinging behavior and fears of separation**; difficulty making everyday decisions without excessive reassurance; needs others to assume responsibility; difficulty expressing disagreement; goes to excessive lengths to obtain nurturance; feels helpless when alone; urgently seeks new relationships when one ends

PERSONALITY DISORDER	DSM-5 CLUSTER	CLINICAL DESCRIPTION
Narcissistic (F60.81)	B (Dramatic/ Erratic)	Pervasive **grandiosity (in fantasy or behavior), need for admiration, and lack of empathy;** grandiose sense of self-importance; fantasies of unlimited success, power, or beauty; believes they are "special"; requires excessive admiration; sense of entitlement; interpersonally exploitative; lacks empathy; envious of others; arrogant behaviors or attitudes
Other Specified PD (F60.89)	Varies	Used when the individual's personality pattern meets the general criteria for a personality disorder but either: **(1)** traits of several different personality disorders are present without meeting full criteria for any specific one, or **(2)** the personality disorder is not included in the DSM-5 classification (e.g., passive-aggressive personality disorder)
Unspecified PD (F60.9)	Varies	Used when symptoms characteristic of a personality disorder are present but there is insufficient information to make a more specific diagnosis; appropriate as a provisional code when further evaluation is needed
Bipolar Disorder, Unspecified (F31.9)	N/A — Not a PD	This is a mood disorder, **NOT** a personality disorder. It is **frequently miscoded as a substitute for Borderline Personality Disorder** (BPD, **F60.3**) due to the shared "B" abbreviation and overlapping features such as mood instability and impulsivity. However, bipolar disorder involves discrete episodic mood states (mania/hypomania and depression), whereas BPD involves chronic interpersonal and identity instability. Miscoding as **F31.9** results in incorrect HCC mapping (HCC 55 vs. 153), inappropriate treatment planning, and inaccurate risk adjustment

ABBREVIATIONS: ASPD = antisocial personality disorder; AvPD = avoidant personality disorder; BD = bipolar disorder; BPD = borderline personality disorder; DPD = dependent personality disorder; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision; ED = emergency department; HCC = hierarchical condition category; HPD = histrionic personality disorder; NPD = narcissistic personality disorder; OCD = obsessive-compulsive disorder; OCPD = obsessive-compulsive personality disorder; PD = personality disorder; PD-TS = personality disorder, trait-specified; PD-U = unspecified personality disorder

AAVBC PERSPECTIVE

*Personality disorders are far more common in older adults than many clinicians realize, affecting **10–20%** of adults aged 65 and older in community settings and as many as **57.8%** of those in nursing home populations.[6] The prevailing clinical narrative frames personality disorders as conditions diagnosed in youth, but this assumption deserves scrutiny. In older adults, personality disorders frequently manifest through late-in-life behavioral changes, social dysfunction, or worsening of chronic medical conditions — presentations that may be*

overlooked or misattributed to other diagnoses.PCPs can meaningfully improve the diagnosis and care of personality disorders in older adults through several key strategies:

- ***Recognize the Red Flags in Primary Care:***

Patients with personality disorders often receive inadequate somatic health care due to three core barriers: difficulty expressing actual symptoms and needs, challenging interactions with professionals, and non-compliance with medical treatment and lifestyle advice. PCPs should ***consider*** *a personality disorder when encountering older patients with* ***unexplained patterns of treatment non-adherence, frequent interpersonal conflicts with staff, "doctor shopping," social isolation, or chronic medical conditions that worsen despite appropriate management.***

- ***Use Age-Appropriate Screening Tools:*** *Standard personality assessments were developed for younger adults and may lead to overdiagnosis or underdiagnosis in older populations. Three validated instruments have shown promise for older adults*
- ***Gerontological Personality Disorders Scale (GPS)*** *— a brief, feasible, and acceptable screening tool specifically designed for general practice settings, with items that older adults and informants find clearly phrased and non-confrontational*
- ***Severity Indices of Personality Problems–Short Form (SIPP-SF)*** *— demonstrated good age-neutrality and is useful for screening levels of personality functioning*
- ***Assessment of DSM-IV Personality Disorders (ADP-IV)*** *— another promising instrument for later-life assessment*

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Treatment-resistant depression or recurrent anxiety in an adult ≥65	Unrecognized PD is a likely **contributor to poor depression remission** outcomes — ACO median remission only **8.33%** (2017) to **15.5%** (2021), vs ~**53%** spontaneous remission without treatment. A new PD assessment is indicated when standard depression treatment underperforms[8]
Rapid, daily mood shifts triggered by interpersonal events (hours-long)	Pattern characteristic of borderline PD (**F60.3**) — frequently miscoded as Bipolar II (**F31.81**). Bipolar episodes last **days to weeks**, not hours, and are not reactive to interpersonal events
Pervasive distrust of clinicians or care team; refusal of standard care	Suggests paranoid PD (**F60.0**), the most prevalent PD in elderly. Often misattributed to early dementia. Document the **enduring pattern** vs episodic confusion to differentiate
Rigid orderliness, perfectionism, and control disrupting care planning	**Obsessive-compulsive PD** (**F60.5**) — the **most prevalent PD in older adults**. Patients may rigidly resist medication changes, deviate from regimens to maintain control, or escalate over minor schedule changes

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Symptom exacerbation triggered by life transition (retirement, bereavement, relocation to assisted living)	Life transitions are documented precipitants for PD symptom exacerbation or de novo presentation in later life — particularly in detachment-domain traits (avoidant PD) moving to communal nursing home environments
High-frequency ED utilization or recurrent psychiatric hospitalization	PD patients — especially BPD — are high utilizers of crisis services. **Recurrent ED utilization without clear medical or acute psychiatric cause** should prompt PD assessment, particularly when paired with chronic self-harm history
Non-adherence to chronic disease management out of proportion to capacity	Dependent, antisocial, histrionic, and narcissistic PD features independently predict higher medical resource utilization beyond what health status explains; PD-driven non-adherence drives diabetes, cardiovascular, and AMM Star measure underperformance
Self-harm in an adult ≥60	Self-harm in this age group carries a **67-fold increased risk of death by suicide** vs the general older population; older adults use more lethal methods and have higher case fatality. Any self-harm requires urgent psychiatric assessment[9]

ABBREVIATIONS: AMM = Antidepressant Medication Management; BPD = borderline personality disorder; ED = emergency department; PD = personality disorder

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
Life transitions (retirement, bereavement, relocation to assisted living)	Widely cited as precipitants for PD symptom exacerbation or unmasking in later life; detachment-domain traits decompensate in communal settings[1]	Ask about recent transitions at every AWV; integrate caregiver history. Proactive SDOH screening and community-resource referral protect against destabilization
Male sex	**Men have higher overall PD prevalence** in older adults, particularly antisocial and substance-related PDs[10]	Maintain a low threshold for PD screening in older men with **substance use disorder, chronic non-adherence**, or recurrent interpersonal conflict in care relationships

FACTOR	RISK SIGNAL	NOTES
Childhood adversity (when documented in history)	Umbrella review (2021): • emotional abuse OR 28.15 (**95%** CI 14.76–53.68) • emotional neglect OR 22.86; • any adversity OR 14.32; • physical abuse OR 9.30; • sexual abuse OR 7.95; • physical neglect OR 5.73 — all class II (highly suggestive) evidence for BPD[11]	Non-modifiable but essential context for trauma-informed care. Document where known and use to inform engagement strategy; avoid re-traumatization
Unmet health-related social needs (HRSNs)	Odds of severe loneliness rise incrementally with mental illness severity among MA beneficiaries; combination of mental illness + HRSNs amplifies stress and exacerbation risk[12]	Systematic HRSN screening (CMS AHC domains — food, housing, utilities, transportation, interpersonal violence)
Comorbid cognitive decline/early dementia	Older adults with PDs are significantly more likely than younger PD patients to carry comorbid dementia/delirium diagnoses; high neuroticism and low conscientiousness are associated with accelerated cognitive decline[13]	Phased personality assessment recommended; PD symptoms (**paranoia, emotional dysregulation)** may be **misattributed to dementia**, and early dementia may be missed when behavioral changes are attributed to longstanding PD
Polypharmacy and inappropriate prescribing	Off-label antipsychotics, benzodiazepines, and anticonvulsants for PD symptoms in elderly with dementia or fall history directly trigger DAE-Dementia and DAE-Falls Star measure penalties (MA performance **44.0–57.8%**)[14]	**Deprescribing** review at every PD-related visit; prioritize psychotherapy over pharmacotherapy. Mandatory medication reconciliation at AWV
Lower socioeconomic status/dual eligibility/LIS status	Dual-eligible/LIS MA enrollees with mental illness have 7.6 percentage-point lower 7-day post-discharge follow-up rates and incrementally worse performance on every behavioral health quality measure[14]	Document HRSNs; engage care coordinators and peer support; leverage MA supplemental benefits (NEMT, in-home services). Beginning with 2027 Star Ratings, CMS EHO4all reward will incentivize performance for this population

ABBREVIATIONS: AHC = Accountable Health Communities; AWV = Annual Wellness Visit; BPD = borderline personality disorder; CI = confidence interval; CMS = Centers for Medicare & Medicaid Services; DAE = Drug-Disease Avoidance in the Elderly; HRSN = health-related social need; LIS = low-income subsidy; MA = Medicare Advantage; NEMT = non-emergency medical transportation; OR = odds ratio; PD = personality disorder; SDOH = social determinants of health
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Diagnostic Thresholds

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
DSM-5-TR Section II general PD criteria[1]	**(A)** Enduring pattern of inner experience and behavior deviating from cultural expectations in ≥2 of cognition/affectivity/interpersonal functioning/ impulse control **(B)** inflexible and pervasive across contexts **(C)** clinically significant distress or impairment **(D)** stable and long-duration, onset traceable to adolescence/early adulthood **(E)** not better explained by another mental disorder **(F)** not attributable to substance or medical condition	**All six criteria required** for any **F60.x** diagnosis. Document each in the note. Stigma-avoidance omission is the most common documentation failure
DSM-5-TR Section II — BPD criterion threshold[15]	**≥5 of 9 polythetic criteria**: • frantic efforts to avoid abandonment; • unstable intense relationships; • identity disturbance; impulsivity in ≥2 self-damaging areas • recurrent suicidal/self-harm behavior • affective instability (hours-long mood shifts) • chronic emptiness; inappropriate intense anger • transient stress-related paranoid ideation or dissociation	Document the **number of criteria met**. Semistructured interviews achieve sensitivity **83–89%**, specificity **78–93%** for BPD
DSM-5-TR Section III — Alternative Model (AMPD)[7]	**Criterion A:** moderate or greater impairment (**≥2 on 0–4 scale**) in self-functioning (identity, self-direction) AND interpersonal functioning (empathy, intimacy) **Criterion B:** maladaptive traits in **≥1 of 5 domains** (negative affectivity, detachment, antagonism, disinhibition, psychoticism)	Dimensional model; AMPD retains only 6 of 10 categories. Informs clinical thinking; **ICD-10-CM F60.x codes remain required for US billing**
SAPAS-SR (brief screener)[16]	8-item self-report; cutoff ≥3 positive for any PD; **sensitivity 83%, specificity 80%**	Use as **triage tool** when PD is suspected; positive screen warrants structured psychiatric interview
IPDS (brief screener)[5]	Self-report; **sensitivity 77%, specificity 85%**	**Alternative brief screener**; same role as SAPAS-SR

TEST/MARKER	DIAGNOSIS CRITERION	NOTES
SCID-5-PD (gold-standard interview)[15]	Semistructured clinician-administered interview; sensitivity **83–89%**, specificity **78–93%** for BPD	**US clinical standard for definitive PD diagnosis** when brief screening is positive or clinical suspicion is high
Severity (ICD-11/ SIFS anchors)[17]	No PD severity threshold • **≥2.50 (severe**); • 1.90–2.49 moderate • 1.30–1.89 mild • 1.05–1.29 personality difficulty • 0–1.04 no PD	ICD-11 dimensional model is informational in US billing

ABBREVIATIONS: AMPD = Alternative Model for Personality Disorders; BPD = borderline personality disorder; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; ICD-10-CM = International Classification of Diseases 10th Revision Clinical Modification; ICD-11 = International Classification of Diseases 11th Revision; IPDS = Iowa Personality Disorder Screen; PD = personality disorder; SAPAS-SR = Standardized Assessment of Personality – Abbreviated Scale, Self-Report; SCID-5-PD = Structured Clinical Interview for DSM-5 Personality Disorders; SIFS = Self and Interpersonal Functioning Scale

CLINICAL PEARL: RULE OUT BIPOLAR

Reactive, hours-long mood shifts triggered by interpersonal events are **borderline personality disorder (F60.3)** — not Bipolar II **(F31.81)**. Cyclic episodes lasting days to weeks point to bipolar disorder; reactive episodes lasting hours and resolving with interpersonal repair point to BPD. **This is the single most clinically impactful differential in PD coding and drives the entire treatment pathway.**[18]

When standard adult PD screeners feel ill-fitted in a retired patient, use the **GPS or SIPP-SF** — instruments validated for older adults that account for age-appropriate criterion descriptors. Standard tools designed for working-age adults use employment, productivity, and interpersonal-system descriptors that overdiagnose or underdiagnose in retired or cognitively impaired older patients. When older adults with chronic depression are not responding to standard SSRI care, screen for underlying PD before escalating pharmacotherapy — unrecognized PD is a likely driver of treatment-resistant depression and poor remission outcomes.

Common Oversights

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD
Not screening for personality disorders in patients with recurrent ED visits, treatment non-adherence, or chaotic interpersonal patterns	Approximately **25% o**f primary care patients meet criteria for a personality disorder, yet it is seldom formally diagnosed — accounting for **5%** of psychiatric hospital admissions despite its prevalence; missed diagnosis leads to inappropriate treatment, chronicity of apparently acute disorders, and unrecognized suicide risk (lifetime **1.4–4.5%**)[19]
Diagnosing BPD based solely on self-harm or "difficult patient" behavior without structured assessment	Sensitivity of validated diagnostic instruments ranges **83–89%**, specificity **78–93%**; semistructured interviews (SCID-5-PD, SIDP-IV) or screening tools (MSI-BPD, PDQ-4+) should supplement clinical impression; stereotyped diagnosis based on self-harm alone misses the majority of personality disorder presentations[15]
Using F60.9 (unspecified) when specific personality disorder type can be documented	Specific ICD-10 codes (**F60.0 paranoid, F60.1 schizoid, F60.2 antisocial, F60.3 borderline, F60.4 histrionic, F60.5 anankastic, F60.6 anxious/avoidant, F60.7 dependent, F60.81 narcissistic**) document clinical specificity; unspecified codes flatten acuity and suppress risk-model accuracy[7]
Not assessing severity using the DSM-5 Alternative Model (AMPD) or ICD-11 dimensional framework	Both DSM-5 Section III and ICD-11 now classify personality disorders by severity level (mild, moderate, severe) based on impairment in self-functioning and interpersonal functioning; severity — not categorical type — is the strongest predictor of clinical outcomes and healthcare utilization[7]
Prescribing polypharmacy for BPD core symptoms without psychotherapy referral	**No medication class has been consistently effective for BPD** in RCTs; no FDA-approved pharmacotherapy exists for BPD; NICE guidelines recommend pharmacotherapy only for discrete severe comorbid disorders (e.g., MDD, severe anxiety), not core BPD symptoms; **78%** of BPD patients were on medications >**75%** of the time over 6 years, with **37%** on ≥3 drugs simultaneously[15]
Continuing benzodiazepines long-term in personality disorders	**Benzodiazepines** are associated with **substantially elevated psychiatric rehospitalization risk in BPD**; they can **worsen impulsivity and disinhibition**; NICE and NHMRC guidelines recommend against routine use; if prescribed in crisis, limit to ≤1 week[20,21]
Not documenting comorbid psychiatric diagnoses separately	BPD comorbidity rates: anxiety disorders **84.5%**, mood disorders **82.7%**, substance use disorders **78.2%**, PTSD **30.2%**, ADHD **33.7%**; each comorbidity requires its own ICD-10 code, treatment plan, and MEAT documentation — bundling under a single personality disorder code undertreats the patient[7]

OVERSIGHT/SHORTCUT	WHY IT MATTERS — WHAT TO DO INSTEAD

ABBREVIATIONS: AMPD = Alternative Model for Personality Disorders; BPD = borderline personality disorder; CBT = cognitive behavioral therapy; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; ED = emergency department; FDA = US Food and Drug Administration; HCC = Hierarchical Condition Category; ICD-10 = International Classification of Diseases, 10th Revision; ICD-11 = International Classification of Diseases, 11th Revision; MDD = major depressive disorder; MSI-BPD = McLean Screening Instrument for Borderline Personality Disorder; NHMRC = National Health and Medical Research Council (Australia); NICE = National Institute for Health and Care Excellence (UK); PD = personality disorder; PDQ-4+ = Personality Diagnostic Questionnaire, 4th Edition Plus; RCT = randomized controlled trial; SCID-5-PD = Structured Clinical Interview for DSM-5 Personality Disorders; SIDP-IV = Structured Interview for DSM-IV Personality Disorders

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
Hours-long, reactive mood shifts in response to interpersonal eventsHours-long, reactive mood shifts in response to interpersonal events	Borderline PD (**F60.3**) **vs** Bipolar II disorder (**F31.81**) Borderline PD (**F60.3**) **vs** Bipolar II disorder (**F31.81**)	Detailed mood timeline; BPD = hours and reactive, Bipolar II = days–weeks and episodic. SCID-5-PD or MDQ; family history. The most clinically impactful PD differential[22]
Late-onset emotional dysregulation, paranoia, or behavioral change after age 60	PD decompensation triggered by life transition **vs** early dementia **vs** delirium **vs** depression with psychotic features	Comprehensive geriatric assessment; MoCA; PHQ-9; **review of recent transitions** (bereavement, retirement, relocation); medication review. Phased personality assessment if cognitive impairment is present[7]
Pervasive distrust of clinicians and care team	Paranoid PD (**F60.0**) **vs** delusional disorder (**F22**) **vs** early dementia with paranoid featuresParanoid PD (**F60.0**) **vs** delusional disorder **(F22) vs** early dementia with paranoid features	**Enduring pattern** since early adulthood (PD) vs recent onset (delusional disorder, dementia); MoCA; collateral history; psychiatric evaluation[23]
Detachment, restricted affect, social isolation	Schizoid PD (**F60.1**) **vs** autism spectrum disorder **vs** avoidant PD (**F60.6**) **vs** depressionSchizoid PD (**F60.1**) **vs** autism spectrum disorder **vs** avoidant PD (**F60.6**) vs depression	**Lifelong pattern** (schizoid) vs developmental history (ASD) vs fear of evaluation (avoidant) vs episodic (MDD). Comprehensive history of social functioning across the lifespan

PRESENTATION	DIFFERENTIAL	KEY TESTS
Trauma-related symptoms misattributed to PD	PTSD (**F43.10**) **vs** complex PTSD **vs** BPD (**F60.3**) — overlapping features include affective instability, identity disturbance, dissociationPTSD (**F43.10**) **vs** complex PTSD **vs** BPD (**F60.3**) — overlapping features include affective instability, identity disturbance, dissociation	**Medical gaslighting risk**: BPD is sometimes misapplied to patients experiencing trauma or abuse, failing to differentiate reactive emotional distress from personality pathology. PCL-5 + trauma history; specialist consultation when overlap is unclear
Substance use disorder driving apparent PD features	PD with comorbid SUD **vs** substance-induced personality change **vs** PD with comorbid SUD **vs** substance-induced personality change	NESARC: antisocial and BPD show ORs 1.2–6.4 for co-occurring SUD; rule out substance-induced presentation before assigning **F60.x**; both diagnoses may be appropriate when criteria independently met.NESARC: antisocial and BPD show ORs 1.2–6.4 for co-occurring SUD; rule out substance-induced presentation before assigning **F60.x**; both diagnoses may be appropriate when criteria independently met[24]

ABBREVIATIONS: ASD = autism spectrum disorder; BPD = borderline personality disorder; MDD = major depressive disorder; MDQ = Mood Disorder Questionnaire; MoCA = Montreal Cognitive Assessment; PCL-5 = PTSD Checklist for DSM-5; PD = personality disorder; PHQ-9 = Patient Health Questionnaire 9-item; PTSD = post-traumatic stress disorder; SCID-5-PD = Structured Clinical Interview for DSM-5 Personality Disorders; SUD = substance use disorder
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Comorbidity Screening

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Major depressive disorder (F32.x/F33.x) **Major depressive disorder (F32.x/F33.x)**	Most common psychiatric comorbidity across all PDs in older adults; personality functioning dimensions (especially identity integration) are primary predictors of impaired wellbeing (partial η^2 = 0.36)[25]	PHQ-9 annually and after each medication change. Document **F32.1**/**F32.2**/**F33.1**/**F33.2** separately; treating depression alone without addressing underlying PD is insufficient. PHQ-9 annually and after each medication change. Document **F32.1**/**F32.2**/**F33.1**/**F33.2** separately; treating depression alone without addressing underlying PD is insufficient

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH
Suicidality/self-harm	Self-harm in adults ≥60 carries **67-fold increased risk of death by suicide** vs general older population; older adults use more lethal methods with higher case fatality and fewer warning signs[26]	Active screening at every visit during active PD treatment. **Any self-harm in an older PD patient requires urgent psychiatric assessment**. Document a written crisis prevention plan
Substance use disorders	NESARC: antisocial, borderline, histrionic, narcissistic PDs show **ORs 1.2–6.4** for co-occurring alcohol/SUD. In older adults, substance misuse is a risk factor for self-harm repetition[27]	**Screen for alcohol** at every visit (PD patients may underreport); document **F10.x**–**F19.x** when present. Integrated SUD and PD treatment is required.Screen for alcohol at every visit (PD patients may underreport); document **F10.x**–**F19.x** when present. Integrated SUD and PD treatment is required
Cognitive decline/ dementia	Older PD patients are significantly more likely than younger PD patients to carry comorbid dementia/delirium diagnoses; **antipsychotics carry FDA boxed warning for increased mortality (1.6–1.7× vs placebo) in dementia**[28]	Phased personality assessment if cognitive concern; MoCA at baseline and annually. Document cognitive baseline before any antipsychotic decision
Chronic somatic disease (diabetes, cardiovascular, COPD)	PD features independently predict higher medical resource utilization beyond what health status explains; PD-driven non-adherence is a primary driver of AMM, diabetes, and BP-control underperformance[29]	Integrated care teams; care coordinators monitor medication adherence and appointment attendance. Document the **somatic-psychiatric intersection**
Social isolation/ functional decline	**79%** of geriatric PD patients have ≥1 additional mental disorder; PDs impair social functioning and quality of life across all subtypes in older adults[25]	Annual SDOH screening (AHC tool); referral to community resources, peer support, in-home services as MA supplemental benefits allow
Anxiety disorders (F41.x)Anxiety disorders (F41.x)	Frequently comorbid; may dominate the clinical picture and mask the underlying PD pattern[30]	**GAD-7 annually**; **F41.x** coded separately. Does not map to V28 HCC but supports clinical record.GAD-7 annually; **F41.x** coded separately. Does not map to V28 HCC but supports clinical record

CONDITION	PREVALENCE IN THIS POPULATION	SCREENING APPROACH

ABBREVIATIONS: AHC = Accountable Health Communities; AMM = Antidepressant Medication Management; BP = blood pressure; COPD = chronic obstructive pulmonary disease; FDA = Food and Drug Administration; GAD-7 = Generalized Anxiety Disorder 7-item; HCC = hierarchical condition category; MA = Medicare Advantage; MDD = major depressive disorder; MoCA = Montreal Cognitive Assessment; NESARC = National Epidemiologic Survey on Alcohol and Related Conditions; OR = odds ratio; PD = personality disorder; PHQ-9 = Patient Health Questionnaire 9-item; SDOH = social determinants of health; SUD = substance use disorder

CLINICAL PEARL: STIGMA AS A DRIVER OF UNDERCODING

Personality disorder undercoding is not always a documentation gap, it may be a deliberate clinical choice. **Some clinicians avoid applying a PD diagnosis out of concern that the label will bias future providers or harm the patient.** This concern is understandable and well-intentioned but clinically counterproductive. Without an accurate diagnosis, treatment plans default to interventions that do not address the underlying condition, crisis utilization continues unchecked, and the patient's care trajectory remains fragmented. Accurate **F60.x** documentation is not a label, it is the clinical foundation for appropriate psychotherapy referral, crisis prevention planning, and care coordination across the treatment team.

Staging/Severity Matrix

The **Self and Interpersonal Functioning Scale (SIFS)** is a 24-item **self-report** questionnaire measuring personality pathology severity across four core components: identity, self-direction, empathy, and intimacy.

- **Scale range**: items from 0 (does not describe me at all) to 4 (describes me completely accurately) to evaluate overall impairment levels
- **Domain Scores:** Calculated by averaging or summing items corresponding to each of the four specific subscales (Identity, Self-Direction, Empathy, Intimacy)
- **Global Sum Score:** Combines all items to provide an overall indicator of general personality pathology severity. Higher scores reflect greater impairment in functioning
- **Severity Thresholds:** General score interpretations map onto functional impairment tiers (e.g., lower average scores indicate healthy or mild levels, while higher average scores reflect moderate to high personality dysfunction)

Core Elements Measured by SIFS:

- **Identity:** Experience of a unique self, clear boundaries, and accurate self-esteem regulation
- **Self-Direction**: Pursuit of coherent and meaningful short- or long-term goals and constructive internal standards
- **Empathy:** Appreciation and comprehension of others' experiences and experiences of different perspectives

- **Intimacy:** Depth and duration of connection with others, and the capacity for mutual closeness

SEVERITY	DEFINING CRITERIA[17]	ACTION REQUIRED
No PD/ Personality difficulty	**SIFS 0–1.04** (no PD) or **1.05–1.29** (personality difficulty); subthreshold maladaptive traits without enduring functional impairment	Document patterns for clinical continuity; ICD-11 6D11.5 "Personality Difficulty" is informational only — **no ICD-10-CM equivalent**; not codeable for US billing
Mild PD	**SIFS 1.30–1.89**; meets DSM-5-TR general PD criteria with limited functional impairment in 1–2 domains	**Outpatient psychotherapy first-line** (DBT, schema therapy, CBT); collaborative care management (CPT 99492–99494); document specific **F60.x** subtype
Moderate PD	**SIFS 1.90–2.49**; pervasive impairment across multiple domains; recurrent interpersonal conflict; functional disability	**Structured psychotherapy with care coordination**; **symptom-targeted pharmacotherapy** if needed (mood stabilizer, SSRI, SGA); psychiatric consultation. Document **F60.x** subtype + comorbidities
Severe PD	**SIFS ≥2.50**; severe impairment in self and interpersonal functioning; recurrent crisis utilization, self-harm, or hospitalization	Specialist eating-disorder–trained therapist or PD program (DBT, MBT, schema therapy); written crisis plan; close care coordination; **psychiatry-led management**; address suicidality and self-harm directly

ABBREVIATIONS: CBT = cognitive behavioral therapy; CPT = Current Procedural Terminology; DBT = dialectical behavior therapy; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; ICD-10-CM = International Classification of Diseases 10th Revision Clinical Modification; ICD-11 = International Classification of Diseases 11th Revision; MBT = mentalization-based therapy; PD = personality disorder; SGA = second-generation antipsychotic; SIFS = Self and Interpersonal Functioning Scale; SSRI = selective serotonin reuptake inhibitor

Clinical Severity Scale

SEVERITY LEVEL[1]	SELF AND IDENTITY	INTERPERSONAL FUNCTIONING	RISK AND HARM
Mild	**Struggles with decision-making or handling criticism**, but retains a coherent identity and reality testing	Relationships are affected, but the person can generally maintain social functioning despite some friction	Self-harm or harm to others is very uncommon
Moderate	Disturbance extends across multiple areas (e.g., self-concept and goal-setting), though some core capacities remain intact	**Notable difficulties in forming and sustaining relationships**. Capacity for empathy or moderation of behavior is impaired	Harm to self or others may occur but is typically moderate

SEVERITY LEVEL[1]	SELF AND IDENTITY	INTERPERSONAL FUNCTIONING	RISK AND HARM
Severe	**Profound disturbances**. Lacks a stable sense of self, displays rigid or chaotic self-concepts, and struggles with basic goals	Interpersonal relationships are heavily characterized by pervasive conflict, exploitation, or isolation	Serious risk of self-injury or violence. Severe occupational and social compromise

⚠ RED FLAG — URGENT ACTION[31]

- **Active suicidal ideation with plan or intent, or suicide attempt** — older adults with PDs use more lethal means and have higher case fatality than younger adults
- **Self-harm with medical injury requiring acute treatment** (self-poisoning is the most common method in older adults)
- **Acute psychotic decompensation** with loss of reality testing or command hallucinations. **Severe agitation or violence posing imminent danger** to self or others
- **Lithium level >2.0 mEq/L** (if prescribed) → withhold dose and obtain specialist consultation
    - **Note:** Lithium is not FDA-approved for personality disorders; its use in this context is off-label, though it may be considered on a case-by-case basis when mood instability or impulsivity is prominent and first-line approaches have been insufficient. Any off-label prescribing should be guided by individualized clinical judgment, informed consent, and close monitoring of serum levels and renal/thyroid function
- **New psychotropic + dementia or fall history** with acute deterioration → immediate medication review

⚠ RED FLAG — RAPID DECLINE[32]

- **New-onset suicidal ideation** without immediate plan — particularly in older men living alone or with recent bereavement → same-day or next-day specialist contact
- **Escalating self-harm behavior** or new self-harm in a patient without prior history → urgent psychiatric referral
- **Acute medication non-adherence for critical somatic conditions** (insulin, anticoagulants) driven by PD-related behavior → urgent care coordinator outreach
- **Sudden functional deterioration** not explained by medical illness in a known PD patient — may indicate decompensation triggered by life transition (loss of caregiver, move to assisted living)
- **New psychotropic drug-disease interaction identified** (e.g., benzodiazepine prescribed to PD patient with dementia or fall history) → deprescribe with psychiatry support

3 MEAT DOCUMENTATION ESSENTIALS

A 71-year-old retired teacher presents to her PCP three months after relocating to assisted living following her husband's death. She has a 30-year history of recurrent interpersonal conflict, two previous psychiatric hospitalizations in her 40s for self-harm, and chronic non-adherence to her diabetes regimen. Recent ED visit for an intentional overdose of acetaminophen (24 tablets) — medically cleared, discharged 5 days ago without outpatient follow-up scheduled. Vitals stable. PHQ-9 = 17. SAPAS-SR = 5 (positive). Patient describes "intense, shifting" emotions toward her new caregiver — "she's the only one who understands me" one day, "she's out to get me" the next. Mood shifts last hours, not days.

MONITOR: "**Borderline personality disorder (F60.3)** — meets ≥5/9 DSM-5-TR criteria: frantic efforts to avoid abandonment (recent relocation context), unstable intense relationships (caregiver dynamic), identity disturbance, recurrent self-harm behavior (acetaminophen overdose 5 days prior; two prior hospitalizations in 40s), affective instability (hours-long mood shifts, **NOT cyclic episodes lasting days–weeks**), chronic emptiness, inappropriate intense anger. Enduring pattern since early adulthood. **PHQ-9 17** (severe depression); **SAPAS-SR 5/8** positive. No outpatient mental health visit scheduled post-ED — **FUH-7 window closes in 2 days**."

EVALUATE: "Exam: alert, oriented; affect labile; mood shifts during visit from tearful to angry to engaged. No active suicidal plan today but reports passive ideation ("would not mind not waking up"). Recent overdose with stated intent. Comorbidities: **type 2 diabetes** (HbA1c 9.4%, last filled metformin 6 weeks ago); **major depressive disorder** with PHQ-9 17. **MoCA 27/30** (no cognitive impairment). **Bereavement** 6 months; **recent relocation** to assisted living 3 months; lives in single room without family contact. SDOH screening: social isolation, transportation barrier to outpatient psychiatry."

ASSESS: "**Borderline personality disorder (F60.3)** — DSM-5-TR criteria met with ≥5 of 9 polythetic features documented above; enduring pattern since early adulthood, currently exacerbated by bereavement and relocation. Co-occurring **moderate–severe major depressive disorder, recurrent (F33.2)** with PHQ-9 17. **Diabetes mellitus type 2, uncontrolled (E11.65)**

with PD-driven non-adherence — primary VBC concern. Recent self-harm 5 days prior — **Tier 2 red flag**. Trajectory: high crisis-utilization risk; FUH-7 window closing; written crisis plan absent. Plan transitions to integrated behavioral health via Psychiatric Collaborative Care Management."

TREAT: " **Same-day mental health visit scheduled today** to close FUH-7 window (psychiatric LCSW within practice, 90832); patient transported by care coordinator. **Psychiatric Collaborative Care Management initiated (CPT 99492)** — psychiatric consultant and behavioral health care manager; monthly billing going forward (99493). **Specialist referral** for DBT or schema therapy (BOOTS 2026 RCT: both produce substantial improvements with no significant differences on most outcomes); telehealth modality offered given mobility/transportation barrier. **Written crisis prevention plan** developed and signed; daughter listed as emergency contact; lock-box for medications. **Sertraline 25 mg daily** for comorbid MDD (start low in older adult; titrate to 50 mg in 2 weeks; serum sodium at 2 weeks per SIADH risk). **Avoid benzodiazepines and second-generation antipsychotics** absent compelling indication — DAE-Dementia/Falls measure exposure documented. Diabetes integrated into plan: care coordinator weekly check on metformin adherence; A1c repeat in 3 months. **Follow-up 1 week**; SDOH referrals (peer support, MA supplemental NEMT for ongoing psychiatry); next visit will include AWV (G0439) with PHQ-9, GPS, medication reconciliation."

Clinical Documentation Elements

- **Document DSM-5-TR criteria explicitly:** Name the **enduring pattern since early adulthood**, the **functional impairment in ≥2 domains** (cognition/affectivity/interpersonal functioning/impulse control), and — for BPD — **the number of polythetic criteria met (≥5/9)**. Without these elements the F60.x code is not supported
- **Name the specific subtype:** Use a specific **F60.0–F60.81** code (or **F60.89** when subtype does not fit). **Avoid F60.9** — same RAF but flagged by auditors as inadequate specificity. "Consistent with" and "traits of" are not codeable
- **Differentiate BPD from Bipolar II:** Document the **temporal pattern of mood shifts** — BPD = reactive, hours-long, triggered by interpersonal events; Bipolar II = cyclic episodes lasting days to weeks, not interpersonally triggered. This is the most clinically impactful PD documentation decision
- **Code comorbidities separately:** MDD (**F32.x/F33.x**), anxiety (**F41.x**), SUD (**F10.x–F19.x**), cognitive impairment (**G31.84/F03.x**), suicidality, self-harm. Each carries independent clinical and (where applicable) HCC implications. Treating depression alone without naming the PD is insufficient
- **Document life transitions and triggers:** Document bereavement, retirement, relocation, loss of caregiver — these are precipitants for PD exacerbation in older adults and shape the care plan. Trigger documentation supports trauma-informed care and Stage 3 review
- **Document the written crisis prevention plan:** Individual crisis plans should be developed for all PD patients to prevent iatrogenic effects of emergency service use. Note the plan, the emergency contact, and the patient's signed acknowledgment

Reframing Common Documentation Shortcuts

INSTEAD OF…	DOCUMENT…
"Personality issues"/"difficult patient"	"**Borderline personality disorder (F60.3)** — meets ≥5/9 DSM-5-TR criteria; enduring pattern since early adulthood; functional impairment across interpersonal and affective domains" — name the diagnosis with specific subtype
"Mood disorder" (when pattern is BPD)	If mood shifts are **reactive and hours-long**, document "**Borderline personality disorder (F60.3)** — affective instability reactive and hours-long, NOT cyclic episodes lasting days–weeks; differentiated from Bipolar II"
"Personality disorder, unspecified"	Replace **F60.9** with the specific subtype: **F60.0** paranoid, **F60.1** schizoid, **F60.2** antisocial, **F60.3** borderline, **F60.4** histrionic, **F60.5** OCPD, **F60.6** avoidant, **F60.7** dependent, **F60.81** narcissistic, **F60.89** other specific
"Patient is non-compliant"	"PD-driven non-adherence — **F60.x** feature; documenting integrated behavioral health plan (Psychiatric Collaborative Care Management CPT 99492) and care coordinator weekly contact for chronic disease adherence"
"Consistent with personality disorder"/"traits of"	Replace with a **definitive diagnostic statement**: "Patient meets DSM-5-TR criteria for [specific subtype]" — coders cannot assign **F60.x** from "consistent with" or "traits of"
"Anxiety/depression, ongoing"	If criteria for PD are also met, code **both**: "**Borderline personality disorder (F60.3)** and **moderate–severe MDD, recurrent (F33.2)**" — stigma-avoidance omission of the PD undercodes HCC 153 and distorts risk stratification
"Pt scheduled for follow-up"	Document the **specific FUH-7 plan**: "Outpatient MH visit scheduled within 7 days post-discharge with [named clinician], modality [in-person/telehealth], transportation [confirmed/coordinated]"

ABBREVIATIONS: BPD = borderline personality disorder; CPT = Current Procedural Terminology; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; FUH-7 = Follow-Up After Hospitalization for Mental Illness, 7-day; HCC = hierarchical condition category; MDD = major depressive disorder; MH = mental health; OCPD = obsessive-compulsive personality disorder; PD = personality disorder

DOCUMENTATION REMINDER IS COMPREHENSIVE CODING

In CMS-HCC V28, all F60.x personality disorder codes map to **HCC 153 (Personality Disorders), RAF 0.396 (CNA segment)**. Documentation requires (a) a definitive diagnostic statement with the specific subtype, (b) evidence of the enduring pattern since adolescence/early adulthood, (c) functional impairment across ≥2 domains, and (d) MEAT documentation at least annually. Stigma-avoidance omission (coding only the comorbid F32.x/F41.x) is the primary documentation failure and leaves the patient without access to integrated care support.

4 TREATMENT AND REFERRAL QUICK GUIDE

Therapy Escalation Criteria

No medications are FDA-approved for personality disorders. Pharmacotherapy targets comorbid symptoms (depression, anxiety, impulsivity, psychosis). In elderly patients, polypharmacy risk, falls risk, and anticholinergic burden must guide every prescribing decision. Avoid antipsychotics for behavioral dysregulation in elderly patients unless necessary(high sedation/fall risk).

TRIGGER	ACTION
Suspected PD at AWV (SAPAS-SR ≥3 or clinical suspicion)[1]	Confirm DSM-5-TR criteria via structured psychiatric interview (SCID-5-PD preferred); document specific subtype, functional impairment, and enduring pattern
Confirmed PD, mild–moderate severity, no acute crisis[33]	Outpatient psychotherapy: **DBT or schema therapy** (both substantial improvements). Consider **Psychiatric Collaborative Care Management (CPT 99492–99494)** — billable framework supporting integrated behavioral health
Older adult (≥60) with confirmed PD	Geriatric-adapted psychotherapy: **group schema therapy + psychomotor therapy**
Symptom-domain–driven pharmacotherapy consideration[25]	No FDA approval. Mood stabilizers (lamotrigine, valproate, lithium) for impulsivity/anger; SGAs (aripiprazole, quetiapine) for cognitive-perceptual symptoms ; SSRIs only for comorbid MDD/GAD (PD-specific effect minimal). **All SMDs from general adult populations — no elderly-specific RCTs**
Antipsychotic or BZD prescribing in elderly PD patient	**Check for comorbid dementia OR fall history first**. If present, prescribing counts against DAE-Dementia (MA **48.0–57.8%**) and DAE-Falls (**44.0–55.1%**) Prioritize psychotherapy; document explicit clinical rationale if proceeding[34]

TRIGGER	ACTION
Crisis: self-harm, suicidality, or acute decompensation[31]	Emergency psychiatric assessment; written crisis prevention plan; close coordination with psychiatry. **Self-harm in adult ≥60 carries 67-fold increased suicide risk** vs general older population — escalate aggressively
Post-psychiatric-hospitalization discharge	**Schedule the FUH-7 visit BEFORE or AT discharge**. Use care coordinators/telehealth to close the window. Suicide risk in the first week post-discharge is 2,950 per 100,000 person-years[35]

ABBREVIATIONS: APA = American Psychiatric Association/American Psychological Association; AWV = Annual Wellness Visit; BPD = borderline personality disorder; BZD = benzodiazepine; CPT = Current Procedural Terminology; DAE = Drug-Disease Avoidance in the Elderly; DBT = dialectical behavior therapy; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; FUH-7 = Follow-Up After Hospitalization for Mental Illness, 7-day; GAD = generalized anxiety disorder; MA = Medicare Advantage; MDD = major depressive disorder; PD = personality disorder; RCT = randomized controlled trial; SAPAS-SR = Standardized Assessment of Personality – Abbreviated Scale, Self-Report; SCID-5-PD = Structured Clinical Interview for DSM-5 Personality Disorders; SGA = second-generation antipsychotic; SMD = standardized mean difference; SSRI = selective serotonin reuptake inhibitor; ST = schema therapy; STEPPS-OA = Systems Training for Emotional Predictability and Problem Solving for Older Adults; TAU = treatment as usual
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Specific Treatments for Each PD

See table below for guidance on how to manage each personality disorder, taking into consideration patient-specific factors (i.e. family support, financial stability, accessibility).[7,33,36,37]

PERSONALITY DISORDER	FIRST-LINE PSYCHOTHERAPY	ADJUNCTIVE PHARMACOTHERAPY (SYMPTOM-TARGETED)	KEY CLINICAL CAVEATS
Paranoid PD	**Supportive psychotherapy**; CBT; building therapeutic alliance is the primary challenge — **avoid confrontational approaches**	Antidepressants (SSRIs for comorbid anxiety/depression); low-dose atypical antipsychotics (aripiprazole, risperidone) for transient paranoid ideation	No RCTs exist; self-perpetuating suspiciousness makes engagement extremely difficult; schema-focused therapy showed benefit in a mixed PD RCT
Schizoid PD	Supportive psychotherapy; social skills training; gradual exposure to interpersonal engagement	**No pharmacotherapy** evidence; no medications recommended per Merck Manual; treat comorbid depression/anxiety per standard guidelines if present	Least studied PD; patients rarely seek treatment voluntarily; group therapy may be counterproductive initially; therapeutic alliance building requires patience with emotional detachment

PERSONALITY DISORDER	FIRST-LINE PSYCHOTHERAPY	ADJUNCTIVE PHARMACOTHERAPY (SYMPTOM-TARGETED)	KEY CLINICAL CAVEATS
Schizotypal PD	Supportive psychotherapy; social skills training; CBT for anxiety management	**Atypical antipsychotics for cognitive-perceptual symptoms** (ideas of reference, magical thinking, paranoid ideation)	Classified in ICD-10 under schizophrenia spectrum (F21) rather than PD cluster; overlaps with schizoid but distinguished by cognitive-perceptual distortions; low-dose risperidone showed benefit in small trials
Antisocial PD	CBT (group format preferred, especially with comorbid SUD); contingency management; multisystemic therapy for adolescents with conduct disorder	Antidepressants (SSRIs) for impulsive aggression; mood stabilizers (lithium, valproate) for affective instability and aggression; treat comorbid SUD aggressively **Note lithium valproate is considered off label for personality disorder*	Treatability is controversial; patients rarely self-refer; **best evidence is for CBT in group format combined with SUD treatment**; early intervention in adolescent conduct disorder may prevent adult ASPD
Borderline PD	General psychiatric management and structured clinical management; supportive psychotherapy; DBT (most studied); MBT; transference-focused psychotherapy; schema-focused therapy; STEPPS	Mood stabilizers (lamotrigine, topiramate) for mood symptoms, impulsivity, anxiety; atypical antipsychotics for transient psychotic symptoms, mood regulation, anger; antidepressants (not harmful but limited efficacy); **avoid benzodiazepines and stimulants**	No FDA-approved medications; NICE: **do not use pharmacotherapy for core BPD symptoms**; topiramate 200–250 mg/day highest LoE for hostility/ anger per network meta-analysis; well-organized standard care produces outcomes comparable to specialized therapies in some trials
Histrionic PD	Psychodynamic psychotherapy; schema-focused therapy (RCT evidence in mixed PD samples)	**No medications recommended**; SSRIs for comorbid depression/anxiety; avoid benzodiazepines	Among the least studied PDs; no RCTs exist specifically for histrionic PD; set clear boundaries around attention-seeking behavior; therapeutic relationship management is key

PERSONALITY DISORDER	FIRST-LINE PSYCHOTHERAPY	ADJUNCTIVE PHARMACOTHERAPY (SYMPTOM-TARGETED)	KEY CLINICAL CAVEATS
Obsessive-Compulsive PD	Psychodynamic psychotherapy; CBT; cognitive and psychodynamic treatments show medium-to-large effects for Cluster C disorders	Antidepressants (SSRIs)	Distinct from OCD (**F42**) — OCPD is ego-syntonic; no randomized psychotherapy trials exist specifically for OCPD; no established pharmacotherapy guidelines
Avoidant PD	Psychodynamic psychotherapy; supportive psychotherapy; CBT (strongest evidence; superior to psychodynamic in one RCT); metacognitive interpersonal therapy + MBT group	Antidepressants (MAOIs, SSRIs); anxiolytics — extrapolated from social anxiety disorder evidence; WFSBP suggests social phobia data may apply	Significant overlap with social anxiety disorder but AvPD involves broader self-concept impairment; CBT with graduated exposure is most evidence-supported
Dependent PD	Psychodynamic psychotherapy; CBT; schema-focused therapy; focus on building autonomy and self-efficacy	Antidepressants (MAOIs, SSRIs) for comorbid depression/ anxiety; avoid benzodiazepines (dependency risk)	**Termination of therapy itself can be a therapeutic challenge — plan gradual tapering of session frequency**; cognitive restructuring of dependency schemas is central
Narcissistic PD	Psychodynamic psychotherapy (transference-focused psychotherapy most prominent); MBT; metacognitive interpersonal therapy; schema-focused therapy (most robust support base per recent review); unified protocol (transdiagnostic CBT)	**No medications recommended**; SSRIs for comorbid depression; mood stabilizers for affective instability; no evidence for any medication targeting core narcissistic pathology	No RCTs have compared active treatments head-to-head; high dropout rates; must address both grandiose and vulnerable presentations; comorbid conditions often do not improve until NPD is directly addressed

PERSONALITY DISORDER	FIRST-LINE PSYCHOTHERAPY	ADJUNCTIVE PHARMACOTHERAPY (SYMPTOM-TARGETED)	KEY CLINICAL CAVEATS

ABBREVIATIONS: ASPD = antisocial personality disorder; AvPD = avoidant personality disorder; BPD = borderline personality disorder; CBT = cognitive behavioral therapy; DBT = dialectical behavior therapy; FDA = US Food and Drug Administration; ICD-10 = International Classification of Diseases, 10th Revision; LoE = level of evidence; MAOIs = monoamine oxidase inhibitors; MBT = mentalization-based treatment; NICE = National Institute for Health and Care Excellence; NPD = narcissistic personality disorder; OCD = obsessive-compulsive disorder; OCPD = obsessive-compulsive personality disorder; PD = personality disorder; RCT = randomized controlled trial; SSRIs = selective serotonin reuptake inhibitors; STEPPS = Systems Training for Emotional Predictability and Problem Solving; SUD = substance use disorder; WFSBP = World Federation of Societies of Biological Psychiatry
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Non-Pharmacologic Treatment and Lifestyle Modification

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Scheduled regular (non-crisis) visits[38]	**Fixed-interval visits** regardless of acute symptoms; clear expectations; consistent care team	**Reduces iatrogenic crisis utilization**; addresses interpersonal patterns (avoidance, suspicion) that drive engagement failure. **Consistent assignment avoids splitting**
Written crisis prevention plan[36]	Developed for all PD patients; **identifies triggers, coping steps, emergency conta**ct, lock-box for medications	Stepped care with **reliable pathways prevents iatrogenic ED use**; key recommendation in international guideline synthesis
Family/caregiver psychoeducation[39]	**Empathy, non-judgmental attitud**e, avoidance of high expressed emotion, no blame or overprotection	Significant reduction in caregiver emotional stress
Telehealth-based psychotherapy and care coordination[40]	**Video psychotherapy**, telephone care coordinator check-ins, asynchronous messaging	Overcomes mobility and avoidance barriers; particularly valuable for detachment-domain (avoidant, schizoid) patients. **No PD-specific telehealth RCTs in older adults published to date** — clinical judgment territory
SDOH screening and community-resource referral[41]	CMS AHC tool annually (food, housing, utilities, transportation, interpersonal violence)	SDOH-informed care coordination improves patient well-being and reduced food/housing barriers in community health center

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Function-oriented goals over symptom scores[36]	Daily living, social engagement, chronic disease adherence — reframe recovery beyond DSM-5-TR criteria alone	Standard guidelines focus on symptom reduction; but **should focus on functioning, quality-of-life, and reduction of high-cost utilization.** Particularly important in older adults
MA supplemental benefits (NEMT, in-home services, peer support)[42]	Leverage available MA supplemental benefits to overcome engagement barriers	**Critical for socially isolated and mobility-limited PD patients**

ABBREVIATIONS: ACO = accountable care organization; AHC = Accountable Health Communities; BPD = borderline personality disorder; CMS = Centers for Medicare & Medicaid Services; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; ED = emergency department; MA = Medicare Advantage; MH = mental health; NEMT = non-emergency medical transportation; PD = personality disorder; QI = quality improvement; RCT = randomized controlled trial; SDOH = social determinants of health; VBC = value-based care

Medication Safety and Dose Adjustments

DRUG/CLASS	INTERACTION/ CONTRAINDICATION	CLINICAL ACTION
Second-generation antipsychotics + dementia[43]	**FDA boxed warning** — **increased mortality** (1.6–1.7× vs placebo) **in elderly** with dementia-related psychosis. Directly triggers DAE-Dementia Star measure penalty	**Contraindicated** absent compelling indication; document explicit risk-benefit if used. Prioritize psychotherapy. Reserve for refractory cases with psychiatry co-management
Antipsychotics or benzodiazepines + fall history[44]	**CNS depression, sedation, orthostasis → falls**; triggers DAE-Falls Star measure penalty	**Avoid**; **Beers** Criteria listed. Address withdrawal concerns with psychiatry. If unavoidable, document rationale and fall-prevention plan
Lithium + NSAIDs/ ACE inhibitors/ thiazides	Reduced renal lithium clearance → toxicity (narrow therapeutic index); NSAIDs common in arthritis comorbidity	Avoid combination; if NSAID needed, **monitor lithium level within 5 days**; consider acetaminophen alternative. Educate patient on signs of lithium toxicity (tremor, GI upset, confusion)
Valproate + warfarin[45]	Valproate displaces warfarin from protein binding and inhibits metabolism → **INR rise 25–50%** and bleeding risk	Monitor INR weekly when initiating or changing valproate dose; counsel on bleeding warning signs
Lamotrigine + valproate[45]	Valproate doubles lamotrigine plasma levels → toxicity (dizziness, ataxia, diplopia, Stevens-Johnson risk)	If co-prescribed, **halve the lamotrigine dose**; slow titration even more important; baseline LFTs

DRUG/CLASS	INTERACTION/ CONTRAINDICATION	CLINICAL ACTION
QTc-prolonging antipsychotic + other QTc-prolonging agent (azithromycin, fluoroquinolone, ondansetron)[46]	Additive QTc prolongation → torsades de pointes risk, especially at higher doses in elderly	Avoid combination when possible; baseline ECG if unavoidable; cardiology consultation if QTc >450 ms
SSRIs + NSAIDs/ anticoagulants[47]	Additive platelet effect → upper GI bleeding risk; OR for UGIB ~3× with SSRI + NSAID	Add PPI if NSAID co-administration unavoidable; counsel on bleeding warning signs
SSRIs in older adult[48]	**Hyponatremia/SIADH risk, fall**s, GI bleeding with concurrent anticoagulants/NSAIDs	Start at half adult dose; **serum sodium at 2 weeks** post-initiation and after each dose change. Document falls-prevention review

ABBREVIATIONS: ACE = angiotensin-converting enzyme; CNS = central nervous system; DAE = Drug-Disease Avoidance in the Elderly; ECG = electrocardiogram; FDA = Food and Drug Administration; GI = gastrointestinal; INR = international normalized ratio; LFT = liver function test; NSAID = non-steroidal anti-inflammatory drug; OR = odds ratio; PPI = proton pump inhibitor; QTc = corrected QT interval; SIADH = syndrome of inappropriate antidiuretic hormone; SSRI = selective serotonin reuptake inhibitor; UGIB = upper gastrointestinal bleeding
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**.

When to Refer

CRITERION[7,37]	SPECIALIST	URGENCY
Active suicidal ideation with plan or intent; suicide attempt; self-harm with medical injury	Emergency Department + psychiatric safety planning	**Immediate**
Acute psychotic decompensation or severe agitation/violence	Emergency Department + psychiatry	**Immediate**
New-onset suicidal ideation without immediate plan in older PD patient	Geriatric psychiatry	**Urgent (same-day or next-day)**
Post-psychiatric-hospitalization discharge (FUH-7 window)	Outpatient mental health visit (any qualifying MH clinician)	**Within 7 days of discharge**
New PD diagnosis suspected in older adult with treatment-resistant depression/anxiety	Geriatric psychiatry for structured personality assessment	**Expedited (within days)**

CRITERION[7,37]	SPECIALIST	URGENCY
BPD or severe PD requiring DBT, schema therapy, or MBT	Specialized PD program or psychiatric clinician trained in evidence-based PD psychotherapy	**Urgent (within 2 weeks)**
Persistent non-adherence to chronic disease management despite standard interventions	Psychiatric Collaborative Care Management (CPT 99492–99494) + care coordinator	**Routine (within 4 weeks)**
Caregiver burnout or breakdown in social support	Social work + family psychoeducation	**Routine**

ABBREVIATIONS: BPD = borderline personality disorder; CPT = Current Procedural Terminology; DBT = dialectical behavior therapy; FUH-7 = Follow-Up After Hospitalization for Mental Illness, 7-day; MBT = mentalization-based therapy; MH = mental health; PD = personality disorder

Follow-Up Timing

STAGE/CATEGORY	FREQUENCY[38]	LABS TO MONITOR
Active PD, mild–moderate severity	**Every 4–6 weeks while in active treatment; monthly once stable**	PHQ-9, safety assessment, medication review (Beers Criteria), functional status (GPS/SIPP-SF), SDOH screen at AWV
Active PD, severe — recurrent crises or self-harm history	**Every 2–4 weeks**; co-managed with psychiatry; monthly Psychiatric Collaborative Care Management (CPT 99493)	PHQ-9, safety assessment at every visit; written crisis plan review; medication reconciliation
Post-psychiatric-hospitalization	**7-day visit** (FUH-7 window) and **30-day visit** (FUH-30 window); then **every 2 weeks for 3 months**	Symptom severity, safety assessment, medication reconciliation post-discharge (MRP), care coordination notes
Pharmacotherapy initiation (any agent)	**Baseline labs; 2-week safety check; 4–6 week response check; then per agent**	SSRI: serum sodium at 2 weeks. Lithium: level at 1 week post-initiation and 1 week post-dose change, then every 3–6 months; renal/thyroid every 6 months. Valproate: hepatic at 1, 3, 6 months. Antipsychotic: metabolic + ECG (QTc)
Stable in treatment	**Quarterly to semi-annually**; annual reconfirmation of **F60.x** at AWV	PHQ-9, GPS/SIPP-SF, medication review, SDOH screen

STAGE/CATEGORY	FREQUENCY[38]	LABS TO MONITOR
Comorbid MDD on SSRI	**2 weeks after initiation, 6 weeks, then quarterly**	PHQ-9, serum sodium, suicidality screen, medication tolerability

ABBREVIATIONS: AWV = Annual Wellness Visit; CPT = Current Procedural Terminology; ECG = electrocardiogram; FUH = Follow-Up After Hospitalization for Mental Illness; GPS = Gerontological Personality Disorders Scale; MDD = major depressive disorder; MRP = Medication Reconciliation Post-Discharge; PD = personality disorder; PHQ-9 = Patient Health Questionnaire 9-item; QTc = corrected QT interval; SDOH = social determinants of health; SIPP-SF = Severity Indices of Personality Problems Short Form; SSRI = selective serotonin reuptake inhibitor
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Comorbidity Management

No FDA-approved pharmacotherapy exists for any personality disorder. Medications are used only to manage discrete comorbid conditions — such as major depression, anxiety, or transient psychotic features — not the personality disorder itself. When prescribed, SSRIs or low-dose antipsychotics target these co-occurring symptoms rather than core personality pathology.

COMORBIDITY	APPROACH	CAUTION
Major depressive disorder	Most common psychiatric comorbidity across all PDs in older adults. PHQ-9 at every visit during active treatment; SSRI for comorbid MDD (start at half adult dose)[48]	Code **F32.x**/**F33.x** separately (**F32.1**/**F32.2**/**F33.1**/**F33.2** → HCC 155 if mod/severe without psychosis; **F32.3**/**F33.3** → HCC 152). Treating depression alone without naming the PD is insufficient
Suicidality/self-harm	Active screening every visit; written crisis plan; **self-harm in adult ≥60 carries 67-fold suicide risk** vs general older population[9]	Older adults use more lethal methods with higher case fatality. Document plan, intent, means access, emergency contact, lock-box for medications
Substance use disorder)	NESARC: **ORs 1.2–6.4** for SUD with antisocial, borderline, histrionic, narcissistic PDs. Integrated SUD + PD treatment[27]	Code **F10.x**–**F19.x** separately. PD patients may underreport — screen at every visit. SUD raises self-harm repetition risk in older adults
Cognitive decline/ dementia	Phased personality assessment if cognitive concern; MoCA baseline and annually[49]	**Antipsychotic FDA boxed warning** in dementia-related psychosis directly triggers DAE-Dementia Star penalty. Document cognitive baseline before any antipsychotic decision
Chronic somatic disease — diabetes, CVD, COPD	**PD features predict higher medical resource utilization independent of health status**; PD-driven non-adherence drives AMM/diabetes/BP-control underperformance	Integrated care teams; care coordinators monitor adherence. Document the somatic-psychiatric intersection in every PD visit

COMORBIDITY	APPROACH	CAUTION
Social isolation/ functional decline	**79% of geriatric PD patients have ≥1 additional mental disorder**; PDs impair social functioning across all subtypes[25]	SDOH screening annually; community-resource referral; MA supplemental benefits (NEMT, peer support, in-home services)
Anxiety disorders	Frequently comorbid; GAD-7 annually; SSRI may help when comorbid	Code **F41.x** separately; does NOT map to V28 HCC but supports clinical record

ABBREVIATIONS: AMM = Antidepressant Medication Management; BP = blood pressure; BPD = borderline personality disorder; CVD = cardiovascular disease; COPD = chronic obstructive pulmonary disease; DAE = Drug-Disease Avoidance in the Elderly; FDA = Food and Drug Administration; GAD-7 = Generalized Anxiety Disorder 7-item; HCC = hierarchical condition category; MA = Medicare Advantage; MDD = major depressive disorder; MoCA = Montreal Cognitive Assessment; NEMT = non-emergency medical transportation; NESARC = National Epidemiologic Survey on Alcohol and Related Conditions; OR = odds ratio; PD = personality disorder; PHQ-9 = Patient Health Questionnaire 9-item; SDOH = social determinants of health; SSRI = selective serotonin reuptake inhibitor; SUD = substance use disorder
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

AAVBC PERSPECTIVE

From a value-based care standpoint, personality disorders present a unique challenge: there is no FDA-approved pharmacotherapy specific for any personality disorder, meaning medication costs should be limited to managing discrete comorbidities (depression, anxiety, transient psychosis) rather than the personality disorder itself.

Off-label polypharmacy, particularly long-term benzodiazepines and antipsychotics in elderly patient, generates cost without evidence of benefit.

***Psychotherapy is the highest-value intervention**. Structured modalities (DBT, MBT, CBT) reduce self-harm, ED utilization, psychiatric readmissions, and inpatient days — all high-cost drivers in this population. Investing in psychotherapy referral and engagement tracking is therefore the most cost-effective strategy: it addresses the root drivers of utilization while avoiding the metabolic, fall, and rehospitalization risks associated with unnecessary pharmacotherapy in older adults.*

Every PD-related visit should document active psychotherapy status, comorbidity-only medication rationale, and deprescribing review to align clinical care with quality measure performance and total cost-of-care reduction.

Abbreviations: DBT = Dialectical Behavior Therapy, MBT = Mentalization-Based Therapy, CBT = Cognitive Behavioral Therapy

Patient Education and Adherence

Unlike conditions where a single screening test or decision aid anchors the educational encounter, PD education must first overcome the clinician's own reluctance to disclose the diagnosis — yet disclosure and psychoeducation are explicitly recommended as foundational to building therapeutic alliance and motivating psychotherapy engagement. **Patients should be informed that effective psychotherapies exist and that medications are appropriate** only for treating discrete comorbid disorders or acute crises, not core personality pathology.

The educational challenge is compounded in older adults, where standard diagnostic language (employment disruption, relationship instability) may not map onto the lived experience of a retired, widowed, or institutionalized patient, and where comorbid cognitive impairment, physical illness, and polypharmacy make disentangling PD symptoms from medical conditions substantially more difficult.

Family and caregiver psychoeducation is equally critical: Group psychoeducation for family members of BPD patients — emphasizing empathy, non-judgmental attitudes, and avoidance of high expressed emotion — can significantly reduced caregiver emotional stress.[50] Most people with personality disorders do not receive evidence-based treatment, even when effective brief interventions exist, because the number of affected individuals far outweighs the number of trained clinicians — **making PCP-level psychoeducation and motivational engagement toward psychotherapy referral the single most scalable intervention available.**

DOCUMENTATION REMINDER — PATIENT EDUCATION

Document patient education provided: named diagnosis with specific **F60.x** subtype, treatment plan (psychotherapy first-line; pharmacotherapy symptom-targeted only), red-flag symptoms requiring urgent contact, written crisis prevention plan, family/caregiver involvement plan, and 24-hour emergency contact. EHR template: "Education provided on [specific F60.x subtype] diagnosis, evidence-based treatment plan (DBT/schema therapy/MBT), and red-flag symptoms. Crisis plan reviewed and signed. Family invited to next visit for psychoeducation. Patient verbalized understanding."

Quality Metrics Tie-In

MEASURE (MY2026)[2]	STANDARD	APPLICABILITY TO PERSONALITY DISORDERS
HEDIS COA: Care for Older Adults — Medication Review	**Denominator:** MA/SNP enrollees ≥66, continuously enrolled **Numerator:** 2 sub-measures documented annually: (1) functional status assessment, (2) medication review **Exclusions:** hospice, ESRD	Polypharmacy is common in PD patients — off-label antipsychotics, benzodiazepines, anticonvulsants, and SSRIs all require reconciliation. Medication review should reconcile Beers Criteria PIMs, anticholinergic burden, fall-risk agents, and crisis-trigger medications[44]
HEDIS COA: Care for Older Adults — Functional Status Assessment	**Denominator:** enrollees ≥66 **Numerator:** functional status assessment documented annually; **Exclusions:** hospice, ESRD	GPS (Gerontological Personality Disorder Scale; sensitivity 90.1%, specificity 67.1%) and SIPP-SF (Severity Indices of Personality Problems–Short Form) directly satisfy this sub-measure and are validated for older adults aged 60–85. Document at every visit to track functional trajectory and guide treatment intensity decisions. Standard adult PD screeners may overdiagnose or underdiagnose in retired or cognitively impaired older patients[6]

MEASURE (MY2026)[2]	STANDARD	APPLICABILITY TO PERSONALITY DISORDERS
HEDIS DAE: Avoidance of Drug-Disease Interactions — Dementia	**Denominator:** enrollees ≥65 with dementia; **Numerator:** received ambulatory prescription for potentially harmful medication (antipsychotics, benzodiazepines, anticonvulsants, antidepressants) — lower is better **Exclusions:** hospice	**Older PD patients are significantly more likely than younger PD patients to carry comorbid dementia diagnoses**. Off-label antipsychotics and benzodiazepines for PD symptoms in elderly with dementia directly trigger this measure.Prioritize psychotherapy over pharmacotherapy; document explicit clinical rationale if prescribing[28]
HEDIS DAE: Avoidance of Drug-Disease Interactions — History of Falls	**Denominator:** enrollees ≥65 with history of falls **Numerator:** received ambulatory prescription for potentially harmful medication (anticonvulsants, antipsychotics, benzodiazepines, SSRIs, SNRIs, opioids) — lower is better **Exclusions:** hospice	Sedating psychotropics prescribed for PD symptoms (benzodiazepines, quetiapine, olanzapine) increase fall risk in elderly. MA performance: **44.0–55.1%** avoidance rate. NICE and NHMRC guidelines recommend against routine benzodiazepine use in PD; if prescribed in crisis, limit to ≤1 week[14]
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; **Exclusions:** hospice, transfers, planned readmissions	PD patients — **especially BPD** — are high utilizers of crisis services and psychiatric hospitalization. Suicide risk is highest in the first week post-discharge (2,950 per 100,000 person-years); patients who died in this window were more likely to have a primary diagnosis of personality disorder. Schedule PCP or psychiatry visit **BEFORE** discharge; national Medicaid benchmark only ~34% at **30 days**[35]
HEDIS AMM: Antidepressant Medication Management (Acute + Continuation Phase)	**Denominator:** enrollees ≥18 with new depression diagnosis who initiated antidepressant **Numerator:** remained on antidepressant ≥84 days (acute) or ≥180 days (continuation) **Exclusions:** hospice	**Depression is the most common psychiatric comorbidity across all PDs** in older adults. PD-driven non-adherence is a primary driver of AMM underperformance. Treating depression alone without addressing underlying PD is insufficient — unrecognized PD is a likely contributor to treatment-resistant depression and poor remission outcomes[8]

MEASURE (MY2026)[2]	STANDARD	APPLICABILITY TO PERSONALITY DISORDERS
HEDIS IET: Initiation and Engagement of Substance Use Disorder Treatment	**Denominator:** enrollees ≥18 with new SUD diagnosis; **Numerator:** initiated treatment within 14 days (initiation) **or** had ≥2 additional services within 34 days of initiation (engagement); **Exclusions:** hospice	NESARC data show antisocial, borderline, histrionic, and narcissistic **PDs have ORs 1.2–6.4 for co-occurring alcohol/SUD.** In older adults, substance misuse is a risk factor for self-harm repetition. Integrated SUD and PD treatment is required — screen for alcohol at every visit (AUDIT-C); document **F10.x–F19.x** when present[27]
HEDIS DMS-E: Utilization of the PHQ-9 to Monitor Depression Symptoms	**Denominator:** enrollees ≥12 with diagnosis of MDD **or** dysthymia AND elevated PHQ-9 ≥10 **Numerator:** follow-up PHQ-9 documented within 4–8 months of index elevated score **Exclusions:** hospice	**79% of geriatric PD patients have ≥1 additional mental disorde**r; depression dominates the clinical picture. PHQ-9 at every visit; follow-up PHQ-9 within 4–8 months if ≥10. Personality functioning dimensions (especially identity integration) are primary predictors of impaired wellbeing (partial $\eta^2 = 0.36$)[9]
HEDIS ACP: Advance Care Planning	**Denominator:** enrollees ≥66 **Numerator:** advance care plan or surrogate decision-maker documented, **OR** documentation that ACP was discussed but patient declined **Exclusions:** hospice	Initiate while decisional capacity is intact — anosognosia and cognitive decline may complicate future decision-making; ACP should address crisis management wishes and surrogate designation. CPT 99497/99498 billable during AWV with no copay
HEDIS PCR: Plan All-Cause Readmissions	**Denominator:** enrollees ≥18 with acute inpatient discharge **Numerator:** unplanned readmission within 30 days (lower is better); **Exclusions:** planned readmissions, hospice, psychiatric (note: psychiatric exclusion varies by program)	PD patients (especially BPD) have **high psychiatric readmission rates** driven by recurrent suicidal crises, self-harm episodes, affective instability, and interpersonal conflict — with BPD patients showing 30-day psychiatric readmission rates significantly higher than other diagnostic groups, and repeat self-harm in adults ≥60 carrying a 67-fold increased suicide risk compared to the general older population[9,15]

MEASURE (MY2026)[2]	STANDARD	APPLICABILITY TO PERSONALITY DISORDERS

ABBREVIATIONS: ACP = advance care planning; AMM = antidepressant medication management; AUDIT-C = Alcohol Use Disorders Identification Test–Consumption; AWV = annual wellness visit; BPD = borderline personality disorder; COA = care for older adults; CPT = Current Procedural Terminology; DAE = avoidance of drug-disease interactions; DMS-E = utilization of the Patient Health Questionnaire-9 (PHQ-9) to monitor depression symptoms; ED = emergency department; ESRD = end-stage renal disease; FSH = functional status assessment; FUH = follow-up after hospitalization for mental illness; FUH-7 = follow-up within 7 days of hospitalization; FUH-30 = follow-up within 30 days of hospitalization; GPS = Gerontological Personality Disorder Scale; HEDIS = Healthcare Effectiveness Data and Information Set; IET = initiation and engagement of substance use disorder treatment; MA = Medicare Advantage; MDD = major depressive disorder; NESARC = National Epidemiologic Survey on Alcohol and Related Conditions; NHMRC = National Health and Medical Research Council; NICE = National Institute for Health and Care Excellence; OR = odds ratio; PCP = primary care provider; PCR = plan all-cause readmissions; PD = personality disorder; PHQ-9 = Patient Health Questionnaire-9; PIM = potentially inappropriate medication; SIPP-SF = Severity Indices of Personality Problems–Short Form; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; SUD = substance use disorder.

QUALITY OUTCOME

No HEDIS, MIPS, or CMS Star Rating measure currently targets personality disorder diagnosis, treatment, or outcomes directly — a recognized gap in the measurement framework. Adjacent measures (FUH, AMM, DAE-Dementia, DAE-Falls, Depression Screening) are clinically meaningful for PD populations and should be documented at the relevant care transitions.

DOCUMENTATION REMINDER

Document the named diagnosis with **specific F60.x subtype** (e.g., "**borderline personality disorder (F60.3)**, ≥5/9 DSM-5-TR criteria met, enduring pattern since early adulthood, functional impairment across interpersonal and affective domains") — not "personality issues" or **F60.9**. For BPD, document the **reactive, hours-long mood-shift pattern** to differentiate from Bipolar II. Code comorbid MDD, anxiety, SUD, cognitive impairment separately. Document the written crisis prevention plan. Schedule the FUH-7 visit **BEFORE** or **AT** discharge from any psychiatric hospitalization.

5 CODING REMINDERS AND CASE EXAMPLES

Documentation Specificity

- **Subtype specificity:** Use a **specific F60.0–F60.81 code** (or **F60.89** when the subtype does not fit those categories). The cluster letter (A/B/C) is not codeable — name the disorder. "Personality issues," "personality difficulties," and "traits of" do not support an **F60.x** code
- **Avoid F60.9 (unspecified): F60.9** carries the **same RAF (0.396)** as specific codes but signals inadequate documentation. Risk-adjustment auditors flag **F60.9** as a marker of

insufficient clinical specificity. Use only when a specific subtype truly cannot be determined; pursue clarification at the next visit

- **BPD (F60.3) vs Bipolar II (F31.81):** The most clinically impactful PD differential. **BPD mood shifts are reactive and hours-long**; **Bipolar II episodes last days to weeks** and are not interpersonally triggered. Document the temporal pattern explicitly. Diagnostic substitution drives both undercoding of HCC 153 and inappropriate treatment escalation
- **Multiple PDs may co-occur:** High co-occurrence is well-documented (e.g., **F60.3** and **F60.5**). When multiple PD subtypes independently meet DSM-5-TR criteria, **each should be coded separately** to reflect the full clinical picture
- **F60.9 vs F60.89: F60.89** (other specific PDs) is preferred over **F60.9** when a specific PD pattern is documented but does not fit **F60.0**–**F60.81** (e.g., passive-aggressive, depressive PD). **F60.89** maps to HCC 153 with full documentation credit; **F60.9** is the unspecified fallback
- **Older adult coding trap:** Clinicians frequently attribute PD symptoms in older adults to **"cognitive decline" or "aging,"** systematically undercoding **F60.x** in the 65+ population. Obsessive-compulsive PD (**F60.5**) and paranoid PD (**F60.0**) are the most prevalent PDs in elderly. Differentiate enduring pattern (PD) from recent onset (dementia, delirium)
- **Stigma-avoidance omission:** Coding only the comorbid depression (**F32.x**/**F33.x**) or anxiety (**F41.x**) and omitting the PD is the **primary documentation gap**. Withholding the diagnosis perpetuates stigma, undercodes HCC 153, and leaves the patient without integrated care supports
- **Annual reconfirmation required:** PD must be reassessed and recoded once per calendar year via face-to-face or synchronous audio-video encounter, with **MEAT documented by 12/31**. HCC 153 documentation is forfeited if the diagnosis does not appear on a qualifying encounter that year

Annual Clinical Review and Confirmation

- **Annual review:** PDs must be reassessed once per calendar year via face-to-face or synchronous audio-video encounter, with **MEAT documented by 12/31**. Telephone-only encounters are insufficient where structured psychiatric evaluation is required
- **Visit modality:** In-person or video telehealth qualify. Brief screeners (SAPAS-SR, IPDS) and the GPS can be administered via video; SCID-5-PD interview is preferred in-person but can be conducted via video for older adults with mobility barriers
- **HCC context:** All **F60.x** codes map to **HCC 153 (Personality Disorders) — RAF 0.396 (CNA segment)**. Documentation is not complete when (a) absent diagnosis on the encounter, (b) coding only the comorbid **F32.x**/**F41.x** and omitting the PD, or (c) coding the PD on a non-qualifying encounter (e.g., telephone only)

- **Subcode reconfirmation:** If clinical picture has changed (e.g., dominant pattern previously coded as **F60.6** [avoidant] now better described as **F60.3** [borderline] after new self-harm episodes), update the specific **F60.x** subcode. Maintain a **definitive diagnostic statement** in every visit during active treatment
- **Validated severity/functioning measure:** Document **PHQ-9 score**, **safety assessment**, and — when available — **GPS or SIPP-SF score** at every encounter during active treatment. Generic "stable" or "improving" without anchoring values does not satisfy MEAT

Good Documentation is Comprehensive Coding

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE
"Personality issues"/"difficult patient"	"**Borderline personality disorder (F60.3)**, ≥5/9 DSM-5-TR criteria met (affective instability with reactive hours-long mood shifts; identity disturbance; recurrent self-harm; frantic efforts to avoid abandonment; chronic emptiness). Enduring pattern since early adulthood. Functional impairment across interpersonal and affective domains"
"Mood swings"	If reactive and hours-long: "**Borderline personality disorder (F60.3)** — affective instability reactive to interpersonal events, mood shifts last hours and resolve with interpersonal repair; **NOT cyclic episodes lasting days–weeks** (differentiated from Bipolar II)"
"Personality disorder, unspecified" (F60.9)	Replace with the specific subtype: "**Obsessive-compulsive personality disorder (F60.5)** — pervasive preoccupation with orderliness, perfectionism, and control disrupting medication regimen adherence; enduring pattern since early adulthood; most prevalent PD in elderly"
"Anxiety and depression, ongoing"	When PD criteria are also met: "**Avoidant personality disorder (F60.6)** with comorbid **moderate major depressive disorder, recurrent (F33.1)** and **generalized anxiety disorder (F41.1)**" — code each separately; PD is not subordinate to the mood/anxiety diagnosis
"Patient is non-compliant"/"non-adherent"	"PD-driven non-adherence — **F60.3 (BPD)** feature: chronic emptiness and impulsivity contributing to inconsistent medication-taking. Plan: weekly care coordinator outreach; pill box review at each visit; Psychiatric Collaborative Care Management (99492)"
"In remission"	PDs do not "remit" in the medication sense. If patient has stabilized: "**Borderline personality disorder (F60.3), in stable phase, active in treatment** — DBT ongoing, no self-harm episodes in past 12 months, PHQ-9 trended 17 → 6." Continue F60.3 coding while engaged in care
"Consistent with PD"/"rule out PD"	Once criteria are met, document a **definitive diagnostic statement**: "Patient meets DSM-5-TR criteria for [specific **F60.x** subtype]" — coders cannot assign F60.x from "consistent with" or "rule out"

EHR SHORTCUT/RISK	PREFERRED DOCUMENTATION LANGUAGE

ABBREVIATIONS: BPD = borderline personality disorder; DBT = dialectical behavior therapy; DSM-5-TR = Diagnostic and Statistical Manual 5th ed Text Revision; PD = personality disorder; PHQ-9 = Patient Health Questionnaire 9-item

EHR Workflow Tips

- **[EHR TIP — Smartphrase] .PDVISIT** auto-populates: specific **F60.x** subtype with documentation of the enduring pattern since early adulthood; DSM-5-TR criteria checklist (for BPD: count of polythetic criteria met out of 9); PHQ-9 score; SAPAS-SR or GPS score if performed; safety assessment with suicidality screen; written crisis prevention plan status; current psychotherapy (DBT/schema therapy/MBT/CBT); current medications with rationale and DAE-Dementia/DAE-Falls exposure flagged; comorbidity tags (MDD, anxiety, SUD, cognitive impairment); next visit and care coordinator outreach plan
- **[EHR TIP — Smartphrase] .PDMEAT** pre-structures all four MEAT elements: MONITOR (PHQ-9 trend, safety assessment frequency, GPS/SIPP-SF if performed, behavior log of self-harm or crisis utilization, medication tolerability); EVALUATE (DSM-5-TR criteria evidence, specific **F60.x** subtype features, functional impairment domains affected, comorbidities); ASSESS (definitive diagnostic statement, trajectory, life-transition triggers, FUH-7 status if post-discharge); TREAT (numbered: psychotherapy with named modality and clinician, pharmacotherapy with rationale and dose, written crisis plan, family/caregiver involvement, FUH-7 scheduling, SDOH referrals)
- **[EHR TIP — Smartphrase] .PDESCALATE** documents the escalation decision: current treatment, escalation trigger (specific clinical event — e.g., "new self-harm with acetaminophen ingestion 5 days prior; no FUH-7 scheduled"), action taken (e.g., "same-day MH visit to close FUH-7 window; Psychiatric Collaborative Care Management initiated CPT 99492; specialist DBT referral with telehealth modality"), guideline alignment (APA 2024 / NICE CG78 / BOOTS 2026), and referral status
- **[EHR TIP — Alert]** Configure a **gap alert** to fire at scheduling when: any patient with **F60.x** diagnosis has no PHQ-9 in past 12 months, no annual F60.x reconfirmation in current calendar year, or a recent psychiatric inpatient discharge without scheduled outpatient MH visit (FUH-7/FUH-30 risk). Configure a **DAE alert** to fire at prescription order when antipsychotic, benzodiazepine, anticonvulsant, or antidepressant is ordered for a patient ≥65 with documented dementia or fall history
- **[EHR TIP — Order Set] PD Initial Workup** order set: PHQ-9, SAPAS-SR, GPS (older adult), MoCA (if cognitive concern), CBC, CMP, TSH, comprehensive medication review, SDOH screen (CMS AHC tool). **Psychiatric Collaborative Care Management** order set: 99492 initial month code; 99493 monthly add-on; psychiatric consultant and behavioral health care manager identified by name. **Post-Hospitalization Bundle** order set (PD patients): FUH-7 visit scheduled with named MH clinician, transportation confirmed, MRP (Medication Reconciliation Post-Discharge) within 30 days, crisis plan reviewed

Brief Case Examples

SUCCESS: COMPREHENSIVE DOCUMENTATION

SCENARIO: A 72-year-old woman presents at AWV with treatment-resistant depression (two SSRI trials without remission), four home health aides dismissed in 18 months, and three ED visits for "panic attacks" without medical cause. Daughter reports lifelong pattern of unstable relationships, chronic emptiness, and hours-long reactive mood shifts triggered by perceived abandonment. PHQ-9 = 18; MoCA = 26/30; AUDIT-C = 2 (negative). History of self-poisoning at age 58.

Documentation: "Borderline personality disorder, severe (**F60.3**) — SCID-5-PD [date]: 7/9 DSM-5-TR criteria met (abandonment avoidance, unstable relationships, identity disturbance, affective instability, chronic emptiness, intense anger, transient paranoid ideation). Enduring pattern since early adulthood; not better explained by bipolar II (mood shifts reactive/hours-long, not episodic days-to-weeks — **F31.81** ruled out). SIPP-SF: moderate-to-severe impairment. Concurrent: recurrent MDD moderate (**F33.1**), PHQ-9 = 18; GAD (**F41.1**); former self-harm (**T14.91XS**); HTN (**I10**); T2DM (**E11.9**); bilateral knee OA (**M17.0**). GPS administered; MoCA 26/30 (cognitive baseline). **Beers review:** lorazepam PRN discontinued (BZD contraindicated in BPD per NICE CG78). **Meds:** sertraline 100 mg (continued for MDD; not escalated — limited BPD efficacy), lisinopril 10 mg, metformin 1000 mg BID. **Crisis plan completed:** triggers, coping steps, ED-avoidance pathway. **Referrals:** DBT program (expedited, 2 weeks); geriatric psychiatry; CoCM initiated (CPT 99492). **SDOH:** AHC tool — transportation barrier → NEMT activated. ACP (CPT 99497): surrogate designated, full code, crisis preferences documented. Return 4 weeks for PHQ-9, crisis plan review, DBT engagement — sooner for self-harm urge or suicidal ideation."

Outcome: HCC 153 (**F60.3**, SCID-5-PD confirmed with criterion count); HCC 155 (**F33.1**, PHQ-9 = 18); lorazepam deprescribing supports DAE-Falls/DAE-Dementia; GPS/SIPP-SF satisfy COA Functional Status; medication reconciliation satisfies COA Medication Review; ACP satisfies COA Advance Care Planning; PHQ-9 with follow-up plan satisfies MIPS #134 and triggers DMS-E; AUDIT-C satisfies MIPS #431; DBT referral addresses first-line evidence-based treatment; CoCM (CPT 99492) creates billable integrated behavioral health framework. Every MEAT element present: structured interview with criteria count, validated instruments with scores, specific F60.x with ruled-out differentials, coded comorbidities with active management, crisis plan, SDOH screening with intervention, follow-up interval with return criteria.

⚠ PITFALL — GENERIC "PERSONALITY ISSUES" WITH COMORBID DEPRESSION CODED ALONE

Documentation as written: "Personality disorder, anxious/depressed. Difficult patient. Refilling sertraline. F/u 3 months." Coded as **F60.9**. Patient is a 72-year-old woman with a documented 40-year history of unstable relationships, chronic emptiness, and recurrent self-harm (last episode 8 months ago). PHQ-9 score of 18 from last visit not referenced. Psychiatry consultation 6 months ago diagnosed borderline personality disorder with comorbid MDD, recurrent, moderate — but neither diagnosis appears on the PCP problem list. Type 2 diabetes with nephropathy (last HbA1c 9.1%) carried as **E11.9** (without complications). Sertraline 200 mg daily prescribed without documented psychotherapy referral. No safety plan on file. No Beers Criteria review documented despite concurrent lorazepam 1 mg TID.

Consequence: F60.9 (unspecified personality disorder) flattens clinical specificity when psychiatry has already confirmed **F60.3** (borderline). "Difficult patient" is a stigmatizing label that substitutes for diagnostic precision and provides no clinical utility. Sertraline at maximum dose for "core BPD symptoms" without psychotherapy referral contradicts NICE CG78 guidance — no medication is FDA-approved for BPD, and pharmacotherapy without psychotherapy for core symptoms is a documented pitfall. PHQ-9 of 18 (moderately severe depression) not coded as **F33.1** (MDD,

recurrent, moderate) misses a distinct HCC 155 diagnosis requiring its own treatment plan. Lorazepam TID in a 72-year-old with BPD and fall risk directly triggers DAE-Falls Star measure penalty and contradicts NICE/NHMRC recommendations against routine benzodiazepine use in PD. Diabetes coded as **E11.9** when nephropathy is present misses HCC 18/19 specificity. The record understates both psychiatric and medical complexity while simultaneously exposing the plan to quality measure penalties.

RAF Impact: F60.9 maps to HCC 153 but documentation is incomplete when specific subtype is documented elsewhere in the chart. Missing **F33.1** loses HCC 155 (RAF 0.309). **E11.9** without complication specificity (**E11.22** for nephropathy) loses HCC 18/19. Benzodiazepine prescribing without documented Beers review and clinical rationale counts against DAE measures (MA performance **44.0–57.8%**).

Fix: Update problem list and assessment: "Borderline personality disorder (**F60.3**), confirmed by structured psychiatric assessment (Dr. [Name], [date]); DSM-5-TR criteria: 7 of 9 met (abandonment fears, unstable relationships, identity disturbance, impulsivity, recurrent self-harm, affective instability, chronic emptiness); severity moderate per AMPD Level of Personality Functioning Scale. **Comorbid:** MDD, recurrent, moderate (**F33.1**), PHQ-9 = 18 today; type 2 diabetes with diabetic nephropathy (**E11.22**), HbA1c 9.1%. **Current medications:** sertraline 200 mg daily — prescribed for comorbid MDD, **NOT** core BPD symptoms per NICE CG78. Lorazepam 1 mg TID — Beers Criteria flagged, taper plan initiated today (reduce to BID × 2 weeks, then daily × 2 weeks, then discontinue; psychiatry co-managing). **Safety plan:** written crisis prevention plan reviewed and updated today — triggers identified, emergency contacts confirmed, means restriction counseled. **Psychotherapy referral:** DBT program referral placed [date]; patient agreeable. Functional status: GPS administered, score [X]. SDOH screen completed at AWV. Assessment: BPD with comorbid MDD and poorly controlled diabetes = (1) DBT referral for primary PD treatment; (2) continue sertraline for MDD, recheck PHQ-9 in 4–8 weeks per HEDIS DMS-E; (3) taper lorazepam per Beers/NICE; (4) endocrinology referral for HbA1c 9.1% with nephropathy; (5) safety plan on file, no active SI today. Return 2 weeks for lorazepam taper check and safety reassessment, or sooner for any self-harm urge,suicidal ideation, or medication adverse effect."

Coding after fix: F60.3 (borderline PD → HCC 153) + **F33.1** (MDD recurrent moderate → HCC 155) + **E11.22** (T2DM with nephropathy → HCC 18/19) + Beers review documented (DAE-Falls protection) + safety plan on file + psychotherapy referral placed = full clinical picture preserved with specificity, quality measure compliance, and appropriate RAF.

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