ICD-10-CM and DSM-5

What’s the point?

Positive effort to use the most accurate diagnosis to treat with the most effective and efficient treatments
First – a Little History
ICD-10 CM

- International Classifications of Diseases, Tenth Revision, Clinical Modifications
- Created and Maintained by the World Health Organization
- Released on January 1, 1999
- Being used by every country except the United States
- Mandated for use for all claiming activities by the Centers for Medicare and Medicaid services beginning October 1, 2015 (Oh – that’s today!)
More ICD History

- Each region or country can “customize” ICD-10 to meet their cultural needs
- ICD-10-CM is the Clinical Modifications approved for use in the U.S.
- Future History:
  - ICD-11 has now been delayed until 2018 – four years later than originally planned
DSM-5

- Diagnostic and Statistical Manual of Mental Disorders
- Created and Maintained by the American Psychiatric Association
- Released in May, 2013
- The standard classification of mental disorders used by mental health professionals
- A listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system
- Required by most licensing boards
What is the Relationship?

- Clinicians use DSM Methodology to identify the diagnoses.
- Decision Trees based on Symptomology lead the clinician to the appropriate Diagnoses.
- The diagnoses are then Coded using ICD-10-CM.
**DSM-5 Criteria**

**Major Depressive Episode**

Five or more of the following symptoms:
- Markedly diminished interest or ...
- Insomnia nearly every day
- Diminished ability to concentrate

With Psychotic features
In Partial Remission
In Full Remission

**ICD-10 Coding**

Bipolar I Disorder,
Current or most recent episode depressed,
In partial remission
F31.75
Differences between ICD and DSM

- Asperger’s and Autism
  - DSM-5 has consolidated Asperger’s Syndrome into the Autism Spectrum (F84.0)
  - ICD-10-CM continues to code Asperger’s and Pervasive Developmental Disorders as specific diagnoses
    - Asperger’s Disorder: F84.5
    - Other pervasive Dev Disorder: F84.8
    - Pervasive Dev Disorder, Unspec: F84.9
  - These 3 ICD-10 codes are on the DHCS Included List
Intensity Levels

- Unspecified, Acute and Chronic
  - ICD-10-CM uses these intensity levels for many diagnoses, for example:
    - PTSD unspecified F43.10
    - PTSD Acute F43.11
    - PTSD Chronic F43.12
  - DSM-5 only references F43.10
## Differences in Substance Use Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>ICD-10-CM Description</th>
<th>DSM-5 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.10</td>
<td>Alcohol abuse, uncomplicated</td>
<td>Alcohol use disorder, mild</td>
</tr>
<tr>
<td>F10.120</td>
<td>Alcohol abuse w/intoxication</td>
<td>None</td>
</tr>
<tr>
<td>F10.129</td>
<td>Alcohol abuse w/intox, unspec</td>
<td>Alcohol Intox, with mild use disorder</td>
</tr>
<tr>
<td>F10.20</td>
<td>Alcohol dependence, uncomp.</td>
<td>Alcohol Use disorder, moderate</td>
</tr>
<tr>
<td>F10.230</td>
<td>Alcohol dependence, with withdrawal, uncomplicated</td>
<td>None</td>
</tr>
<tr>
<td>F10.239</td>
<td>Alcohol dependence with withdrawal, unspecified</td>
<td>Alcohol withdrawal, without perceptual disturbances</td>
</tr>
<tr>
<td>F10.920</td>
<td>Alcohol use, unspecified, with intoxication, uncomplicated</td>
<td>None</td>
</tr>
<tr>
<td>F10.929</td>
<td>Alcohol use, unspecified with intoxication, unspecified</td>
<td>Alcohol intoxication, without use disorder</td>
</tr>
</tbody>
</table>
Implementation Strategies
Plan A: Implement ICD-10-CM Well in Advance

- Optionally, also implement DSM-5
- The Crosswalk from ICD-9 to ICD-10-CM is “Many-to-one”
- Update Diagnosis Reviews for all open clients well before October 1st
- EHR software will convert from ICD-10-CM back to ICD-9 to be able to submit claims for services performed prior to October 1st
- Avoids the necessity of updating 1000’s of Diagnoses on September 30th!
Plan B: Only Use Crosswalks

- Crosswalk from DSM-IV to ICD-9
  - This one is easy, it is always a one-to-one crosswalk
- Then crosswalk from ICD-9 to ICD-10-CM
  - This part of the crosswalk process is not so easy
  - Many of the ICD-9 to ICD-10-CM crosswalks are one-to-many
- Survey Says...
  - 65% of the respondents to our survey indicated they were going to depend on a crosswalk
  - There is risk associated with this plan
<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid Schizophrenia</td>
<td>295.30</td>
<td>F20.0</td>
</tr>
<tr>
<td>Schizophrenia Disorganized type/Hebephrenic</td>
<td>295.10</td>
<td>F20.1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catatonic Schizophrenia</td>
<td>295.20</td>
<td>F20.2</td>
</tr>
<tr>
<td>Undifferentiated Schizophrenia</td>
<td>295.90</td>
<td>F20.3</td>
</tr>
<tr>
<td>Post- Schizophrenic Depression (Not on Included list)</td>
<td>295.90</td>
<td>F20.4</td>
</tr>
<tr>
<td>Residual Schizophrenia</td>
<td>295.60</td>
<td>F20.5</td>
</tr>
<tr>
<td>Simple Schizophrenia (Not on Included list)</td>
<td>295.90</td>
<td>F20.6</td>
</tr>
<tr>
<td>Other Schizophrenia (Not on Included list)</td>
<td>295.90</td>
<td>F20.8</td>
</tr>
<tr>
<td>Schizophrenia, unspecified</td>
<td>295.90</td>
<td>F20.9</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
<td>295.40</td>
<td>F20.81</td>
</tr>
</tbody>
</table>

Note that 295.90 crosswalks to 5 different ICD-10-CM codes, 3 of which are **not** on the DHCS included list.
Another Example...

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoaffective disorder, manic type</td>
<td>295.70</td>
<td>F25.0</td>
</tr>
<tr>
<td>Schizoaffective disorder, depressive type</td>
<td>295.70</td>
<td>F25.1</td>
</tr>
<tr>
<td>Schizoaffective disorder, mixed type</td>
<td>295.70</td>
<td>F25.2</td>
</tr>
<tr>
<td>Other Schizoaffective disorders</td>
<td>295.70</td>
<td>F25.8</td>
</tr>
<tr>
<td>Schizoaffective disorder, unspecified</td>
<td>295.70</td>
<td>F25.9</td>
</tr>
</tbody>
</table>

Note that all of the ICD-9 codes are the same – but there are 5 different ICD-10-CM codes!
SUD Examples (ICD-9 to ICD-10)

- DSM-5 says:
  - 305.00 -> F10.10 (Alcohol use disorder, Mild)
  - 303.90 -> F10.20 (Moderate)
  - 303.90 -> F10.20 (Severe)

- ICD-10 says:
  - F10.10 could be 305.00, 305.01, 305.02 or 305.03
    - Alcohol Abuse unspecified, continuous, episodic or in remission
Another SUD Example

- **DSM-5 says:**
  - 291.81 (Alcohol withdrawal) ->
    - F10.239 (without perceptual disturbances) or
    - F10.232 (with perceptual disturbances)

- **ICD-10-CM says:**
  - 291.81 -> F10.239 (alcohol dependence with withdrawal)
  - F10.232 is not on the DHCS Included list
Plan C: Implement DSM-5 in Advance and crosswalk to ICD-10-CM

- This is similar to Plan A
- Specific implementation of this depends on the EHR software you are using
- Once an ICD-10-CM Diagnosis is entered into your system (based on a DSM-5 Diagnosis), it should be able to submit claims using the equivalent ICD-9 Diagnosis for services performed prior to October 1st
What does this mean?

- Crosswalks from ICD-9 to ICD-10-CM cannot solve the entire riddle
- Clinicians will need to be trained in both DSM-5 and ICD-10-CM
- As stated at the beginning of this presentation, DSM-5 can (and should) be used to determine what diagnosis to select
- The Clinician will then need to translate their conclusion into the most appropriate ICD-10CM code
Why go to all this trouble?

- Why not just select the most generic of the ICD-10 Codes?
- Clinically – The whole point of ICD-10 is to provide more information about the client’s condition
- Without the details of the diagnosis, incorrect clinical decisions are likely
- More and more we need to share key clinical information with other providers – ICD-10-CM provides a common language
- Fiscally – Auditors could disallow services if the Diagnoses does not align with the intervention described in the Progress Note
For Example

- F20.0 (Paranoid Schizophrenia) was specified as the Diagnosis
- The Progress Note clearly indicated the client was in Complete Remission
- The Auditor could disallow the service by saying that the Diagnosis should have been F20.05 (Paranoid Schizophrenia, Complete Remission)
However...

- When DHCS published their ICD-10 Included list, F20.05 is **not** on the list!
- Therefore, this will not be an audit issue, but is an issue of using appropriate Diagnoses to describe the client’s condition
Psychosocial and Contextual Factors
DSM-5 has eliminated the Axis Concept

- Now, all disorders and conditions are reported in one place except for Psychosocial and Contextual Factors
- These used to be reported on Axis IV
- Although there were many Axis IV diagnoses codes (primarily “V” codes), there are now 100’s of Psychosocial and Contextual Factor codes
- These are now located in chapter 21 of the ICD-10-CM codes and are referred to as “Z” codes
How should these be used?

- One solution – identify the Axis IV codes used the most and create a crosswalk of these conditions to the new “Z” codes
  - Some examples:
    - Z55.9  Academic or Educational Problem
    - Z59.9  Unspecified housing or economic problem
    - Z71.89  Marital and Partner Problems
    - Z71.891  Sibling Relational Problem
How significant are these?

- Could be a temptation to spend time to pick the very best, most specific code from the 100’s available
- Do not yield to this temptation!
  - None of these codes play a role in determining Medical Necessity and none of them are on the Included list
- If it is important to document that a client has one of these factors, they can be included as a Psychosocial and Contextual Factor
- They can also be documented in the client’s assessment, which might be even more appropriate
How to document a Diagnosis Selection?
What should be the Basis for Diagnosis Documentation?

- Clinicians are currently familiar with documenting Dx selections with DSM-IV
- New clinicians are being trained in DSM-5
- Licensing Boards all require DSM-5
- Not everyone can implement DSM-5 at the same time
- No one trains to or is familiar with the ICD-10 “Bluebook”
- The “Bluebook” is based on the International version of ICD-10, not on ICD-10-CM
- The “Bluebook” is 10 years out of date
Differences - Schizophrenia

- The DSM-5 manual contains 20+ pages
  - Includes a list of specific sets of symptoms to reference
    - For example: 2 or more of Delusions, Hallucinations, Disorganized Speech, Disorganized or Catatonic behavior, diminished emotional expression, diminished levels of life functioning, etc.
    - Is very specific: “At least 2 Criterion A symptoms must be present for a significant portion of time...” and “Schizophrenia involves impairment in one of more major areas of functioning.”
Differences - Schizophrenia

- The ICD-10 “Bluebook” only has one page
  - It states: “The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety...”
  - It only lists 3 “common” symptoms – Delusions of persecution, hallucinatory voices, hallucinations of smell or taste
Grace Period

- For Audit purposes, DHCS should define a Grace Period
- The Grace Period should run from October 1, 2015 to April 1, 2016
- During the Grace Period, DHCS Auditors should accept supportive documentation based on either DSM-IV or DSM-5
- For obvious reasons, the ICD-10 “Bluebook” should not be considered a choice
Workflow Impact
In the Past...

- It is not unusual for a Client to be diagnosed at their initial assessment and for that Diagnosis to remain in effect for many years.
- If the Client has a crisis or is admitted to an inpatient unit, they will likely get a new diagnosis.
- Sometimes, the diagnosis is updated during the annual reassessment.
- ICD-9 and DSM-IV diagnoses were generic enough to allow this.
In the Future...

- Both DSM-5 and (especially) ICD-10-CM are much more specific.
- Both clinically and to meet documentation standards, diagnoses should be at least reviewed at each clinical encounter.
- Primary Care includes a Diagnosis at each patient encounter – Behavioral Health should consider the same protocol.
- Staff performing Rehab Services and Case Management Services are typically not licensed and therefore cannot Diagnose.
What Could (Should?) Change?

- Anytime a Medication, Counseling or Therapy Service is provided, the LPHA providing the service should (at a minimum) review current Diagnoses.
- Anytime a client is admitted to or discharged from an inpatient setting, their Diagnoses should be reviewed and updated.
- Anytime a Rehab or Case Management Service is provided, the staff person should make Diagnoses observations and request assistance from an LPHA if any changes seem appropriate.
Questions