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 <u>except</u> 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

Code	ICD-10-CM Description	DSM-5 description
F10.10	Alcohol abuse, uncomplicated	Alcohol use disorder, mild
F10.120	Alcohol abuse w/intoxication	None
F10.129	Alcohol abuse w/intox, unspec	Alcohol Intox, with mild use disorder
F10.20	Alcohol dependence, uncomp.	Alcohol Use disorder, moderate
F10.230	Alcohol dependence, with withdrawal, uncomplicated	None
F10.239	Alcohol dependence with withdrawal, unspecified	Alcohol withdrawal, without perceptual disturbances
F10.920	Alcohol use, unspecified, with intoxication, uncomplicated	None
F10.929	Alcohol use, unspecified with intoxication, unspecified	Alcohol intoxication, without use disorder

Implementation Stratagies

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

For Example…

Description	ICD-9	ICD-10
Paranoid Schizophrenia	295.30	F20.0
Schizophrenia Disorganized type/Hebephrenic Schizophrenia	295.10	F20.1
Catatonic Schizophrenia	295.20	F20.2
Undifferentiated Schizophrenia	295.90	F20.3
Post- Schizophrenic Depression (Not on Included list)	295.90	F20.4
Residual Schizophrenia	295.60	F20.5
Simple Schizophrenia (Not on Included list)	295.90	F20.6
Other Schizophrenia (Not on Included list)	295.90	F20.8
Schizophrenia, unspecified	295.90	F20.9
Schizophreniform Disorder	295.40	F20.81

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

Another Example…

Description	ICD-9	ICD-10
Schizoaffective disorder, manic type	295.70	F25.0
Schizoaffective disorder, depressive type	295.70	F25.1
Schizoaffective disorder, mixed type	295.70	F25.2
Other Schizoaffective disorders	295.70	F25.8
Schizoaffective disorder, unspecified	295.70	F25.9

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 <u>not</u> 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?

- DSM-IV? DSM-5? ICD-10 "Bluebook"? ICD-10 "Tabular Index"
- 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, <u>not</u> 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 <u>observations</u> and request assistance from an LPHA if any changes seem appropriate

Questions