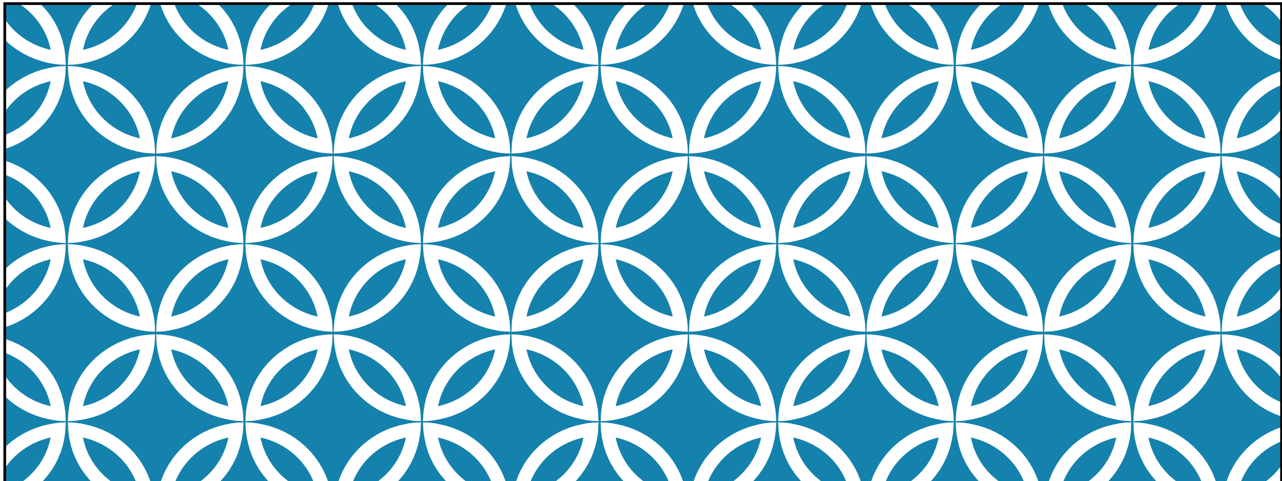


# SUMMARY FOR TRAINERS | DSM 5

## TIME FRAME

THE CHANGES ARE SUBSTANTIAL AND WILL REQUIRE PLANNING OVER THE LONGER TERM

DON'T TRY TO DO IT ALL AT ONCE BUT BUILD ON A SOLID PLAN FOR DIAGNOSTIC DOCUMENTATION AND CODING THAT RECOGNIZES THE CHANGES IN BOTH THE CLINICAL AND BUSINESS ENVIRONMENTS THAT ARE DEPENDENT ON DIAGNOSTIC ACCURACY

Remember you will not get claims paid after Oct 1 2015 without a current ICD 10 diagnosis. This is not automatic. It cannot be done without clinical input.

Make sure you train on your plan: e.g. July 1 to Oct 1- as people due for treatment plan review or annual assessment do diagnosis update. That leaves 9 months of consumers not changed.

# DSM 5 AND RELEVANCE

IMPORTANT TO MAKE SURE YOUR STAFF UNDERSTAND THE BIGGER PICTURE

MOVE TOWARD PROSPECTIVE PAYMENTS AND OTHER RISK BASED PAYMENTS BASED ON DIAGNOSES

APGS: NY MH AND SU SERVICES – DIAGNOSTIC WEIGHT APPLIED TO SPECIFIC SERVICE CODES

HEATLH HOMES –ESPECIALLY HIGH RISK OR CHRONIC HEALTH HOMES

CODING STRATEGY IS NOW STRATEGIC – THE BETTER YOU ARE AT IT, THE BETTER POSITIONING FOR DEVELOPING PROSPECTIVE OR OTHER BUNDLED RATES; GETTING THE INDIVIDUALS YOU SERVE, THE SERVICES THEY NEED, ETC.

# DEFINITION MENTAL DISORDER

DEFINITION OF A MENTAL DISORDER

CRITICAL THAT PROVIDERS UNDERSTAND THAT A DIAGNOSIS DOES NOT MEAN TREATMENT IS NECESSARY

UNSPECIFIED OR OTHER SPECIFIED - SITUATION IN WHICH INDIVIDUAL DOES NOT MEET FULL CRITERIA FOR A MORE SPECIFIC DIAGNOSIS BUT TREATMENT IS NECESSARY

IN BOTH CASES – DOCUMENTATION IS NECESSARY TO SUPPORT THE RECOMMENDATION FOR TREATMENT

# DEFINITION OF MENTAL DISORDER

…a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or development processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual.

# MORE FOCUS ON RISK

DSM 5 FOCUS ON RISK:

- PROVIDERS NEED TO UNDERSTAND THIS NEW EMPHASIS
  - SOME HARD CODED IN: E.G. SUBSTANCE USE DIAGNOSES INDICATE SEVERITY IN CODE; DEVELOPMENTAL DISABILITY ALWAYS BUT WITH NEW REQUIREMENTS; ETC.
  - SOME IN NEW SPECIFIERS –CRITICAL THESE BE CONSIDERED AND DOCUMENTED
  - SOME CONTINUING FROM DSM IV – ALSO REQUIRE CONSIDERATION AND DOCUMENTATION.
  - SOME SUGGEST ALTERNATIVE TREATMENT PLANNING AND INDIVIDUAL NOT LIKELY TO RESPOND TO USUAL TREATMENT
  - NOTE: DSM SAYS ALL SPECIFIERS ARE INDICATIVE OF GREATER RISK

# DIAGNOSES AND CURRENT CLINICAL PICTURE

HISTORICALLY DIAGNOSES DID NOT CHANGE

NOW THEY MUST:

- SEVERITY SPECIFIERS
- OTHER SPECIFIERS: ANXIOUS DISTRESS SPECIFIER REQUIRES ITS OWN SEVERITY SPECIFIER
- SPECIFIERS AND TREATMENT PLANNING - DO THEY MATCH?

IF NOT, WHY SHOULD PAYER, PAY?

- E.G. AN INDIVIDUAL WITH MEDICATION RESISTANT PSYCHOTIC SYMPTOMS KEEPS SAME SEVERITY SPECIFIER BUT CAN STILL GO FROM HOMELESS TO NOT HOMELESS –THIS CAN BE CODED USING Z CODES. PAYERS LOOKING FOR CHANGE.

# MULTI-AXIAL DX GONE

Individual with schizophrenia, moderate cannabis use disorder, high blood pressure, COPD, homeless, severe socio-economic problems, poor education, GAP 45

- 295.90 Schizophrenia (add specifiers )
- 304.30 Moderate Cannabis Use Disorder (severity indexed in code)
- I10 Hypertension
- J44.9 COPD
- Z59.0 Homelessness
- Z59.5 Extreme poverty
- Z55.0 Illiteracy or low level literacy

# HIGHEST LEVEL OF CERTAINTY

ANATOMY OF A DIAGNOSIS

- DIAGNOSIS –DSM and ICD both have coding guidelines. DSM addresses both ICD 9 and 10 guidelines
- SUB-TYPES: these are mutually exclusive – so instruction is to "specify whether" - e.g. delusional subtypes: jealous, persecutory, somatic, etc.
- SPECIFIERS: there are many of these and in some cases new and important specifiers.
  - Individual may have more than one – "specify if"
  - Information is relevant to treatment course and its descriptive features
- SEVERITY: form of specifier that is linked – still very loosely – to the level of support needed; course of the illness – "specify current severity"
- For now – coding strategy – what is important to capture and how will you do it? We will show later how some specifiers can be added into the diagnostic information in AVATAR.

# HIGHEST LEVEL OF CERTAINTY

TACKLING UN AND OTHER SPECIFIED

Other specified or unspecified

- Other specified: allows clinician to give reason IN NARRATIVE why does not meet criteria –with further versions of ICD will have ability to be specific through coding in some cases.
  - In some cases specific examples of when "other specified" could or should be used are given, e.g.
    - Persistent auditory hallucinations in the absence of other features
    - Short duration cyclothymia (less than 24 months)
- If not specified – use "unspecified diagnosis"
  - Use also when not sufficient information to make a more specific DX –payers are beginning to watch these and the length of time these stay in place now that "other specified" is available.

# HIGHEST LEVEL OF CERTAINTY

TACKLING UN AND OTHER SPECIFIED

UNSPECIFIED: WITH OPTION OF OTHER SPECIFIED APPEARS TO BE MORE TIME LIMITED
- NEW DIAGNOSES MAY BE AN OPTION FOR THOSE DIAGNOSED AS NOS RIGHT NOW
- MUST CONTINUE TO SUPPORT NEED FOR TREATMENT W/OUT SPECIFIC DIAGNOSIS JUST AS WOULD W/MORE SPECIFIC

OTHER SPECIFIED: CONSIDER HOW TO APPROACH IN DIAGNOSTIC CATEGORIES WHERE YOU HAVE MOST UNSPECIFIED
- INCLUDE IN TRAINING OR INDIVIDUAL TA
- MUST CONTINUE TO SUPPORT NEED FOR TREATMENT W/OUT SPECIFIC DIAGNOSIS

# REPLACEMENT DIAGNOSES

SOME DIAGNOSES DEVELOPED AS AN ALTERNATIVE TO CONCERNS ABOUT OVERUSE OF OTHER DIAGNOSES
- DISRUPTIVE MOOD DYSREGULATION DISORDER – POSSIBLE ALTERNATIVE FOR BIPOLAR DISORDER IN CERTAIN CHILDREN
  - HOW DOES THIS GET TACKLED – AGENCY OR INDIVIDUAL PROVIDER/PRESCRIBER?
  - DO YOU MEASURE NUMBERS?
  - OTHER ISSUES: MEDICATION, TREATMENT PLANNING, ETC
  - SLIDES 4-6 PART 2.
- SOCIAL PRAGMATIC COMMUNICATION DISORDER - POSSIBLE SUBSTITUTE FOR SOME CHILDREN CURRENTLY DIAGNOSED WITH PDD
  - SAME AS ABOVE
  - SLIDES 30-31, PART 1

# NEW DIAGNOSES

NEW DIAGNOSES/CO-MORBIDITIES NOT AS REPLACEMENTS

- TOTALLY NEW:
  - HOARDING DISORDER – SEE HANDOUT FOR NEW DIAGNOSES
  - PREMENSTRUAL DYSPHORIC DISORDER
- SPLITTING: REACTIVE ATTACHMENT DISORDER AND DISINHIBITED SOCIAL ENGAGEMENT DISORDER
- LUMPING: AUTISM SPECTRUM; PERSISTENT DEPRESSIVE DISORDER
- EXPANSION OF FORMERLY ADULT OR KIDS DISORDERS ACROSS THE AGE SPECTRUM – ADHD WELL KNOWN BUT ALSO SEPARATION ANXIETY AND OTHERS. NOTE READ DSM DISCUSSION ABOUT DEVELOPMENT AND COURSE
- IN SOME CASES ALLOWING CO-MORBIDITIES NOT PREVIOUSLY ALLOWED, PART 3, SLIDE 7, IED. NOTE IN SOME CASES WHERE COMORBIDS ALLOWED NOTE DSM ADVICE THAT THESE REQUIRE ADDITIONAL CLINICAL ATTENTION – HOW SHOWN IN TX PLAN?

# IMPLICATIONS OF CHANGING A DIAGNOSIS

Make sure you are clear about your policies for changing diagnoses. What notification/discussion/etc with consumer/family?

Should you have scripts for certain common changes, eg. Autism spectrum d/o

- ALL INDIVIDUALS WITH ONE OF THE LUMPED DIAGNOSES OTHER THAN A CURRENT DIAGNOSIS OF AUTISM SPECTRUM DISORDER WILL NEED TO CHANGE

Provide instruction for clinicians/case managers who have to deal with IEPs.

## CHANGES TO SUBSTANCE- RELATED AND ADDICTIVE DISORDERS DSM 5

**Substance Induced Disorders**

**Use to be:**

Major Depression

Opiate Dependence

**Now:**

1. Major Depression

   Opiate Use Disorder, Severe OR

2. Severe Opiate Use Disorder, with Opiate Induced Depressive D/O

## CHANGES TO SUBSTANCE- RELATED AND ADDICTIVE DISORDERS DSM 5

**Substance Induced Disorders**

Watch for coverage: will OMH cover these DX; what are OASAS expectations for treatment?

Remember in documentation if need to split and have independent MH diagnosis:

Criterion C: Disorder not better explained by an independent mental disorder. Evidence might include:

- Mental disorder preceded the substance/medication use
- Mental disorder persisted after substance/medication withdrawn (1 month); doesn't apply to persisting

Criterion E: Clinically significant distress or impairment

# SUBSTANCE USE DISORDERS

Don't let staff be confused by the crosswalks:

BECAUSE ICD 10 WAS PRE-DSM 5 STILL INCLUDES SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE – NOT SUBSTANCE USE WITH SEVERITY SPECIFIER

- MILD SUBSTANCE USE DISORDER = SUBSTANCE ABUSE
- MODERATE OR SEVERE USE DISORDER = SUBSTANCE DEPENDENCE
- See handout on Opioid Disorders – ICD 10

# NEURODEVELOPMENTAL DISORDERS

Use of charts for IDD/Autism Spectrum

Autism Spectrum changes: including changes to criteria and specifiers

Social/Pragmatic Communication Disorder: consider and use

ADHD – changes in examples, onset, severity index instructions, partial remission, can be co-morbid with autism.

- Specifier allows for continued treatment even though full criteria not met (Partial Remission)

# SCHIZOPHRENIA SPECTRUM

New assessment measures for symptoms severity- not required but useful – very heterogeneous clinical pictures acknowledged

- **Hallucinations**
- **Delusions**
- **Disorganized speech**
- Abnormal psychomotor behavior
- Negative symptoms
- Impaired cognition
- Depression
- Mania

New specifiers after one year of disorder

Elimination of subtypes in schizophrenia but changes in criteria

# BIPOLAR DISORDERS

With anxious distress

Emphasis on changes in activity and energy not just mood in order to see if earlier identification can be achieved

New disorder in Depressive Disorders to reduce numbers of kids diagnosed with bipolar – Disruptive Mood Dysregulation Disorder

Differences in hard coding Bipolar I and II

Severity index

Expectations re: other specifiers

# DEPRESSIVE DISORDERS

Disruptive Mood Dysregulation Disorder

Anxious distress specifier

Bereavement exclusion: gone/risk

Persistent Depressive Disorder (Dysthymia and Chronic Major Depressive D/O combined

Premenstrual Dysphoric Disorder

# ANXIETY DISORDERS

Requirement gone that patient over 18 had to recognize that fear was unreasonable or excessive

6 month duration necessary to diagnose

Separation anxiety disorder and adults

Phobias – note additional codes if multiples, ICD 10 codes are specific

Panic Disorder and Agoraphobia unlinked

Panic attacks used as specifier for other mental illnesses

## OBSESSIVE COMPULSIVE DISORDERS

Hoarding new

Excoriation disorder new

Insight specifier –new and important

- Note: with body dysmorphic d/o – if delusional – just this diagnosis, not delusional disorder too or other psychotic disorder

Tic specifier

## TRAUMA AND STRESSOR RELATED DISORDER

Split: reactive attachment and disinhibited social engagement

New requirement in diagnosing that you specify how qualifying event experienced

- Subjective reaction criteria no longer require fear or horror

Adjustment disorder: new specifiers – acute and persistent

PTSD: criteria for below 6 years and 6 and above

PTSD and Acute stress: symptoms clusters are reorganized and new added

## DISSOCIATIVE DISORDERS

Symptoms of disruption can be reported by patient as well as observed

Gaps in recall can be for everyday and not just traumatic events

Derealization and depersonalization lumped

## SOMATIC SYMPTOM

Think about training on these once determine if covered. May be secondary diagnosis requiring additional clinical attention.

Somatic symptom disorder – can cause considerable distress and impaired functioning

- One somatic symptom only
- Less emphasis on medically unexplained symptoms (MUS) and more on impact in addition to abnormal thoughts, feelings, and behaviors in response to symptoms

Illness anxiety disorder: new

Psychological factors affecting other medical conditions: new

## EATING AND FEEDING DISORDERS

Avoidant/Restrictive Food intake Disorder: new

Anorexia: changes to criteria; changes to how low weight measured

Bulimia: reduction in frequency of binging and purging

Binge Eating Disorder: new

## ELIMINATION DISORDERS

Nothing new

## SLEEP WAKE DISORDERS

Very complicated

Symptoms noted but often diagnosed by specialist

Basic determination of existence and need to refer:

- Insomnia
- Excessive daytime sleepiness
- Disturbed mentation or behavior while sleeping
- Sleeping at wrong times

## SEXUAL DYSFUNCTION

6 months duration required

Lumping of some diagnoses:

- Female Sexual Interest/Arousal Disorder
- Genito-pelvic pain/penetration disorder

Sexual aversion: gone

# GENDER DYSPHORIA

Single diagnosis – no longer a sexual dysfunction

Other gender not other sex

Separate criteria kids and adolescents/adults

New post-transition specifier to allow continued mental health treatment

# DISRUPTIVE, IMPULSE CONTROL

ODD: note 4 changes including new criteria with changes to frequency, intensity; severity rating

IED: 2 new types of outbursts; new co-morbidities (IED requires independent clinical attention)

Conduct Disorder: new, important specifier – "with limited prosocial emotions"

## SUBSTANCES/ADDICTIVE

Added gambling d/o to this Chapter

Added cannabis withdrawal

Added caffeine withdrawal

Now use disorders, not abuse and dependence

ICD 10 coding changes significant

## NEUROCOGNITIVE

Lots new clinical sub-types

Chart needed to diagnose

Probable major and possible major – see coding update in March 2014

Mild – new

## PERSONALITY DISORDERS

Not much new

See Chapter 3 for discussion about alternative approach to diagnosing

No longer Axis II – may help with some payers

## PARAPHILIC D/O

Differentiation between paraphilia and paraphilic disorder

Name changes as a result

New specifiers:

- In controlled environment
- In remission!

Transvestic disorder: men and women

# OTHER MENTAL DISORDERS

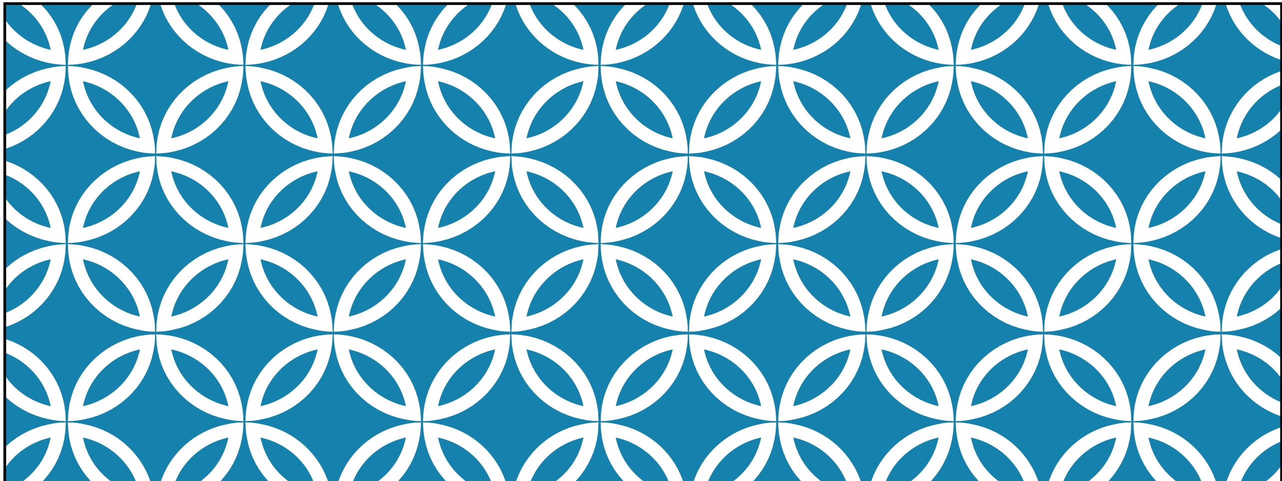
No change

# CONDITIONS FOR FURTHER STUDY

Use of other specified

Some interesting ones:

- Neurobehavioral d/order due to prenatal alcohol exposure
- Suicidal behavior disorder
- Non-suicidal self injury
- Others



# CODING

Using your crosswalk

## CODING THE DIAGNOSIS

DSM 5 and ICD 9

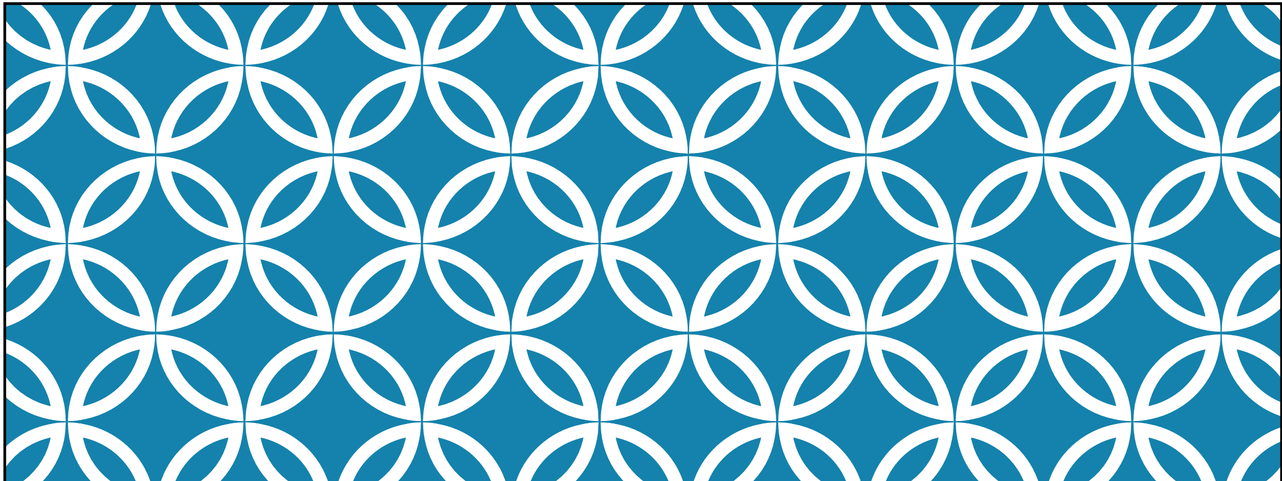
There is an ICD 9 code for each DSM 5 diagnosis –however some diagnoses may use the same code because a more specific code not available. Orgs need to figure out how to manage this issue and how it will affect any data mining – e.g. full narrative description in assessment? SEE HANDOUT

- DSM 5 used the ICD 9 code that most specifically matched the DSM diagnosis.

PROBLEM: YOU ARE BEING ASKED TO CODE TO ICD 10

Not synched to DSM 5 at this time.

Current advice is to use the DSM 5 and crosswalk to ICD 10 – closest approximation you can get without using a diagnosis that is inaccurate or no longer exists in DSM 5



# UTILIZATION MANAGEMENT

Using UM to assist in the transition.

- Should look at integrity of the current diagnosis.
  - Is it supported by the documentation? Does it appear that another diagnosis should be given instead? Does it appear that another, more specific diagnosis would be warranted? (watching unspecified in particular)
    - Are charts used appropriately for IDD, Neurocognitive?
  - Does it reflect current levels of distress and impact on functionality? If not is person in right level of care?
  - Are appropriate specifiers being used?
  - Are there disagreements about diagnoses? How can they be reconciled?
  - Are medical and other diagnoses needed to support eligibility – HARP, HCBS, etc supported?
- See Grassley article on Medicare A fraud and abuse

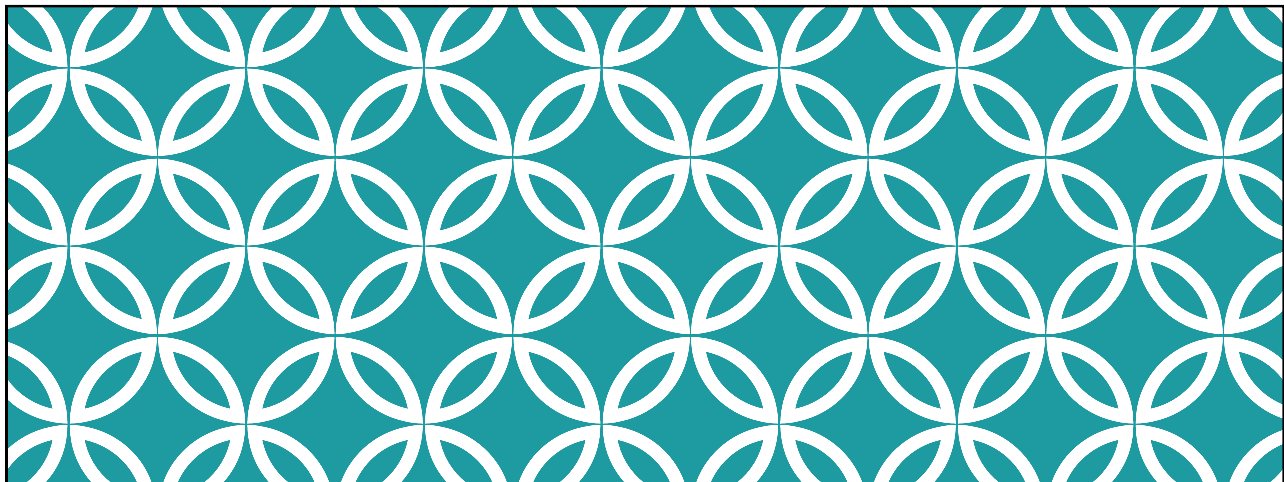
# UM ROLE IN SUPPORTING DX

FINALLY:

Training:
- Break into smaller pieces
- Have internal experts for resources for staff
- Focus clarity and comfort on the ones you use the most

Tracking:
- Watch use of any of the new diagnoses
- Track replacements
- Consumer complaints about diagnosis changes – any unintended consequences

# DEVELOP A STRATEGY



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THANK YOU!