Diagnosing Psychiatric Disorders: The Synchronization of DSM-5 and ICD-10-CM

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The two most widely used classification systems are ICD-10 and DSM. These systems are mutually influential. Recent diagnostic guides highlight the importance of an integrated approach to presenting problems in a patient-centered framework. Specifics here.

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Article Goal
This article provides an overview of the changes in DSM-5 and a review of how DSM-5 relates to ICD-10-CM.

Learning Objectives
At the end of this article, readers should be able to:
1. Describe the relationship of DSM-5 and ICD-10-CM.
2. Recognize how DSM-5 can translate into changes in clinical practice.
3. Analyze how changes occurring in mental health might impact mental health records, regulatory policies, and reimbursement models.

Target Audience
This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

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The publication of DSM-5 is the culmination of more than a decade-long revision of earlier versions of DSM. The importance of DSM is highlighted by its impact on the practice of psychiatry in the US and on psychiatric research throughout the world. The implications of a diagnostic and classification system are extensive. The role of a classification system has evolved from its early origin as a system to record causes of mortality to the current complex versions of taxonomies with a broad range of roles and functions used by multiple stakeholders.

International diagnostic classifications and guides

The two most widely used classification systems in psychiatry are the World Health Organization (WHO) International Classification of Diseases and Related Health Problems (ICD) and DSM. The ICD is one of the WHO’s Family of International Classifications (WHO-FIC). The ICD is usually updated every 10 years to reflect scientific advances in medicine and health sciences, enhance clinical and health system utility, and optimize public health usefulness. The ICD has its historical roots in the International Classification of Causes of Death, which was produced by the International Statistical Institute in 1893. The WHO produced the Sixth Revision of the ICD (then called International Classification of Diseases, Injuries and Causes of Death) in 1948. A separate section on mental disorders was included for the first time in ICD-6; Chapter V of the current ICD focuses on mental and behavioral disorders. Since its publication more than 60 years ago, DSM has become a standard reference for clinical psychiatric practice in the US. DSM-I was produced in 1952 as a national classification system for the American Psychiatric Association in conjunction with ICD-6. DSM-II was published in conjunction with ICD-8 in 1968. The lack of reliability of psychiatric diagnosis was a major concern for existing diagnostic systems. The Feighner criteria proposed criterion-based diagnosis in 1972 to enhance diagnostic reliability. These criteria were expanded in the Research Diagnostic Criteria, and this approach was adopted in DSM-III. The introduction of the notion of standardized nosology along with diagnostic criteria in 1980 with the publication of DSM-III constituted a major paradigm shift within DSM and psychiatric classification in general. The emphasis was placed on descriptive psychopathology and the use of specific diagnostic criteria for each mental disorder. The new standard significantly improved reliability of psychiatric diagnosis and enhanced communication among clinicians and other stakeholders.

Although the adoption of specific diagnostic criteria for mental disorders contributed to the extraordinary expansion in psychiatric research, it did not lead to similar advances in the validity of current nosological entities, and empirical work on the classification system itself has been relatively limited. Since 1980, DSM-III has been revised 4 times, DSM-III-R in 1987, DSM-IV in 1994, DSM-IV-TR in 2000, and most recently DSM-5 in May 2013. Attempts to synchronize ICD-10 (1992) and DSM-IV compromised the inclusion of a comprehensive diagnostic format by using a multiaxial system. ICD-10 included a research version with specified diagnostic criteria as well as a clinical guide version.

The process of updating the mental disorders chapter of ICD-11 is currently under way. It is expected that DSM-5 and the upcoming ICD-11 Chapter V will be synchronized as much as possible. Benefits of an optimized harmonization include easier clinical communication between the two systems and enhanced comparability of research findings and their applicability across national boundaries. An international treaty that mandates using the ICD coding system in the US also drives harmonization between the two systems. The currently used ICD-9-CM (US adaptation) will be replaced by ICD-10-CM in October 2014.

An overview of DSM-5

Section I (DSM-5 Basics) consists of an introduction and guide to the use of the manual; Section II describes diagnostic criteria and codes with diagnostic and associated features; Section III includes emerging measures and models. The Appendix highlights changes from DSM-IV to DSM-5 and
contains glossaries of technical terms and cultural concepts as well as alphabetical and numerical listings of DSM-5 diagnoses and codes (according to ICD-9-CM and ICD-10-CM). A total of 22 broad diagnostic categories are described in “Diagnostic Criteria and Codes” (Section II). Detailed diagnostic criteria with coding and recording procedures as well as a list of specifiers are included for each specific disorder listed within a broad category. This is followed by a description of the essential elements and associated features that support the diagnosis, including prevalence, development, and course, as well as risk and prognostic factors. The latter are categorized as environmental, genetic, psychological, and course modifiers. Section II also includes culture- and gender-related diagnostic issues, suicide risk, and functional consequences. Differential diagnosis is briefly discussed, and the main disorder-related comorbidities are highlighted.

Section III (“Emerging Measures and Models”) includes tools and techniques helpful in clinical decision making and in understanding the cultural context of mental disorders as well as in identifying diagnostic conditions that merit further research. Level 1 is a cross-cutting symptom measure that serves as a review of systems across mental disorders, while the Level 2 severity measures (available online at www.psychiatry.org/dsm5) are intended to be used following Level 1 measures “to explore significant responses to the Level 1 screen.”

A severity scale for schizophrenia and the WHO Disability Assessment Schedule, Version 2 (WHODAS 2.0) are included. Used internationally, WHODAS 2.0 assesses functional capacity in 6 domains: understanding and communication, getting around, self-care, getting along with people, activities (household and school/work), and participation in society. Although it is time-intensive, WHODAS 2.0 allows for a standardized tracking method for disability progression or remission.

DSM-5 retains the brief culture-related diagnostic issues within the “Associated Features Supporting Diagnosis” section included in DSM-IV-TR; however, cultural formulation is expanded in Section III, which also includes the cultural formulation interview (CFI). The CFI presents a detailed guide for a culturally informed interview. The “Glossary of Cultural Concepts of Distress” is an additional entry in the Appendix.

Section III also contains proposed disorders for future studies, including an alternative model to diagnose personality disorders. Proposed categories that caused controversy during the development phase were Internet gaming disorder, caffeine use disorder, and suicidal behavior disorder. Other conditions for future studies, such as attenuated psychosis syndrome, depressive episodes with short-duration hypomania, persistent complex bereavement disorder, neurobehavioral disorder associated with prenatal alcohol exposure, and nonsuicidal self-injury, were seen as less problematic.

Key changes in DSM-5

Key changes in DSM-5 include deletion of the multiaxial format along with various degrees of changes within diagnostic categories. The multiaxial format, a conspicuous concept in both DSM-III and DSM-IV, has been deleted from DSM-5 because of limited use by clinicians. Clinical diagnoses—mental disorders, personality disorders, intellectual disability, and other medical conditions formerly listed on Axis I, II, and III in DSM-IV—are now listed together. A select set of the ICD-9-CM V codes and the new ICD-10-CM Z codes are used as a separate notation for psychosocial and contextual factors.

The Global Assessment of Functioning (GAF) scale (Axis V in DSM-IV) was eliminated from DSM-5 because it was deemed an inadequate measure of mental health disability. It was also seen as an insufficient method for assessing determinations of medical necessity for treatment required by managed care organizations or workers’ compensation programs. For clinical use, the WHODAS 2.0 is a more valid and useful instrument to assess disability. In addition to assessing specific areas of functioning, the WHODAS 2.0 provides severity rating on a scale of 1 to 5 that can be used to monitor change over time and to report disability data.

The DSM multiaxial system was praised for its clinical utility because it provided a comprehensive and systematic evaluation of the patients’ presenting problems, integrating a bio-psycho-social approach. DSM-5 does not present an alternative conceptualization to the multiaxial approach to diagnosis. Despite multiple proposed categorical or dimensional changes, only a few were adopted in the final version of DSM-5. One of the major proposals rejected was the revision of the hybrid categorical-dimensional model for personality disorders. Implementation of this proposed new model by October 2014 would probably have imposed significant burden on clinical practice and the research community and would have required a revision of academic curriculums for residency programs and clinical practice guidelines. Instead, this model was included in Section III for further research.
Changes in terminology included deletion of terms that have been a mainstay of mental health vocabulary for nearly a quarter century. Some terms were deleted as an attempt to reduce stigma (eg, mental retardation, developmental disorder, stuttering, reading disorder, and mathematics disorder), others because of lack of validity (eg, autism, Asperger syndrome, schizophrenia subtypes), and still others as an attempt to simplify the nomenclature and make a smoother transition toward the style used in ICD-10 coding (eg, hair pulling disorder, skin picking disorder). There were few changes in diagnostic groupings. Mood disorders are streamlined into separate broad categories of bipolar and related disorders and depressive disorders. Obsessive-compulsive and related disorders are separated from anxiety disorders as a separate broad category. Similarly, PTSD is regrouped with trauma- and stress-related disorders and separated from anxiety disorders. Substance use disorders are restructured by combining both abuse and dependence diagnoses. For the first time, DSM includes a behavioral addiction disorder—gambling disorder—within the substance-related and addictive disorders group.

DSM-5 also introduced completely new categories based on the extensive research published over the past decade. Major and mild neurocognitive disorders have attracted much attention. Concerns were expressed about the potential for over-diagnosing mental illness. On the other hand, the inclusion of these categories was considered to be in alignment with current neurobiological models and also would allow for early intervention. Other noteworthy categories are agoraphobia—which can now be diagnosed without the presence of panic attacks—and disruptive mood dysregulation disorder. The latter raised criticism in the media, and opinions will likely continue to diverge. Advocates emphasized that this new category will reduce the overuse or misdiagnosis of bipolar disorder in children and adolescents, whereas its opponents fear that more children will gain a mental health diagnosis given the rather minimal and vague criteria required.

Several new disorders added in DSM-5 also caused controversy because of their potential impact on the prevalence of mental disorders: premenstrual dysphoric disorder, hoarding disorder, skin picking disorder, pain disorder, and binge eating disorder. It was agreed that identification of binge eating disorder would provide the possibility of early treatment and intervention to prevent further morbidity and progression to bulimia or anorexia. Concerns were expressed about potential over-diagnosis and for increasing the rate of psychiatric diagnoses in the US. Similar concerns were voiced over making the age criterion less restrictive for certain disorders, thus allowing the expansion of the diagnosis to more patients (eg, autism spectrum disorder, ADHD, feeding and eating disorders).

Clinical practice and research criteria will be influenced by the revisions that occurred in the specific diagnostic criteria for schizophrenia, bipolar disorder, and PTSD. The removal of bereavement as an exclusion criterion for MDD when the duration of symptoms is less than 2 months after the death of a loved one will also impact clinical practice and research. Bipolar disorders now are in a category of their own, and mixed episode is eliminated. All major subtypes for schizophrenia are deleted: 2 symptoms are now required instead of 1 from the quad of delusions, hallucinations, and disturbed speech and behaviors. DSM-5 also eliminates the special attribution of bizarre delusions and first-rank auditory hallucinations in diagnosing schizophrenia. Similarly, the requirement of non-bizarre delusions is eliminated for delusional disorder, and shared delusional disorder is no longer a separate entity. For PTSD, the subjective experience criterion is removed and now there are 4 instead of 3 distinct clusters (re-experiencing, avoidance, negative cognition, and arousal).

DSM-5 stands out for the introduction of several new specifiers, which will allow for more accurate coding and assist practitioners during the transition to ICD-10-CM. They are all significant, because they trigger a shift in clinical reasoning. Mixed criteria can now be applied for all types of mood episodes (depression, hypomania, mania), anxious distress can be listed for all depressive and bipolar disorders, and catatonia can be coded with any other specified disorder. Panic attacks are categorized as expected or unexpected and can be listed as specifiers with any other DSM-5 diagnosis. To simplify the nomenclature, DSM-5 introduced similar specifiers for all mental health conditions (panic attacks, catatonia) and deleted criteria that were causing ambiguity. (See the Table for examples of coding.)

**Impact of DSM-5 and ICD-10-CM**

From a broader international health care harmonization perspective, there seems to be a clear advantage to aligning DSM-5 with the ICD system used in more than 110 countries. Ideally, this should contribute to higher statistical data validity across nations regarding morbidity and mortality; enhanced ability to conduct public health surveys; and implementation of data-driven, large-scale preventive models. Practically, however, there will be an immediate effect on mental health services and significant additional financial burdens on the health care system.
For successful implementation, adaptation will be required from all major stakeholders. On a macro level, these include managed care organizations, insurance providers, and health care technology companies; the micro level includes mental health practitioners and researchers. All the operational changes require a complex array of policy and contracting revisions, significant capital investments, and updated electronic systems capable of handling the ICD-10-CM 7-digit requirements. For clinicians, this may translate into improved clinical documentation to support higher granularity of coding, revised staffing models to assist with more complex billing and coding processes, and updated mechanisms to obtain authorization of mental health services. Perhaps one of the most challenging facets will be the revision and implementation of innovative payment models related to ICD-10-CM coding practices.

The trend to simplify nomenclature was criticized by many mental health professionals. However, it will likely be welcomed by multidisciplinary teams and physician extenders who have no mental health training but will now be required to have a greater degree of involvement in behavioral health documentation given the stipulations of the Affordable Care Act. In addition, managed care organizations are in the process of revising their medical necessity criteria based on the new DSM-5 single-axis model and the new ICD Z codes that are derived from information contained in the previous axis IV (psycho-social and environmental factors) that will likely generate new algorithms for authorizing mental health services.

For behavioral health services, the widespread national health care changes are especially complex, because of the major HIPAA 5010 revisions in January 2012 and Current Procedural Terminology (CPT) coding changes in January 2013. Many providers and organizations are still adjusting to these and now face implementation of DSM-5 and ICD-10-CM. As with all previous operational changes in health care, a drop in productivity is to be expected, which can be especially challenging for behavioral health organizations that already struggle with lower rates of reimbursement. Another important element specific for mental health services is maintaining patient privacy in light of increased documentation requirements and emphasis on multidisciplinary interventions as integrated, patient-centered models of care are becoming increasingly timely with the upcoming changes in the delivery of health care beginning January 2014.

Conclusion

The two most widely used classification systems are ICD-10 and DSM. These systems are mutually influential. For example, ICD-10 included 2 major features—the multiaxial format and the diagnostic criteria—that were adopted by DSM-III. Recent diagnostic guides highlight the importance of an integrated approach to presenting problems in a patient-centered framework. Compared with other classification systems and guides, DSM-5 is the only one that does not offer a comprehensive integrated formulation of presenting problems.

The overall structure and content of DSM-5 does not differ in vast ways from its predecessors, which may help in its implementation. The availability of Level 1 and Level 2 measures should improve diagnostic precision in busy clinical practices. New categories and changes in certain diagnostic criteria may also affect research and estimated rates of psychiatric disorders in the community. In addition, the emphasis on symptoms, metrics, and criteria should enhance precision in diagnosing psychopathology; however, it may need to be complemented with assessment models attuned to better respond to the complexities and needs of the patient. The availability of the cultural formulation and of the CFI provides an opportunity for enhanced care by emphasizing the patient’s uniqueness. The assessment of disability using the WHODAS 2.0 represents an improvement compared with GAF as an assessment of disability.

The practicality of applying all the suggested instruments and measures in busy clinical practices remains to be evaluated. Simplifying the added specifiers and course modifiers and using ICD-10-CM coding may facilitate the implementation of DSM-5 despite the challenging and complex web of coding requirements.
Disclosures:

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References:


Links: