# INSURANCE IMPLICATIONS OF DSM-5

The upcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) has been developed to facilitate a seamless transition into immediate use by clinicians and insurers to maintain continuity of care. The new manual represents a step forward in more precisely identifying and diagnosing mental disorders.

To help ensure ease of use, *DSM-5* will continue to use statistical codes contained in the U.S. Clinical Modifications (CM) of the World Health Organization's (WHO's) *International Classification of Diseases* (*ICD*). The *ICD-9-CM* contains the internationally approved statistical codes for all medical diseases or disorders but does not contain detailed descriptions of how to diagnose these conditions. Below are frequently asked questions especially pertinent to insurers and clinicians.

## *Frequently Asked Questions*

**When can *DSM-5* be used for insurance purposes?**

Since *DSM-5* is completely compatible with the HIPAA-approved *ICD-9-CM* coding system now in use by insurance companies, the revised criteria for mental disorders can be used immediately for diagnosing mental disorders when it is released in May 2013. However, the change in format from a multi-axial system in *DSM-IV-TR* may result in a brief delay while insurance companies update their claim forms and reporting procedures to accommodate *DSM-5* changes.

**How will the previous multi-axial conditions be coded?**

*DSM-5* combines the first three *DSM-IV-TR* axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Although a single axis recording procedure was previously used for Medicare and Medicaid reporting, some insurance companies required clinicians to report on the status of all five *DSM-IV-TR* axes.

Contributing psychosocial and environmental factors or other reasons for visits are now represented through an expanded selected set of *ICD-9-CM* V-codes and, from the forthcoming *ICD-10-CM*, Z-codes. These codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between patients and their intimate partners). These conditions may be coded along with the patient's mental and other medical disorders if they are a focus of the current visit or help to explain the need for a treatment or test. Alternatively, they may be entered into the patient's clinical record as useful information on circumstances that may affect the patient's care.

**On October 1, 2014, the United States adopts *ICD-10-CM* as its standard coding system. How will diagnoses be coded then?**

*DSM-5* contains both *ICD-9-CM* codes for immediate use and *ICD-10-CM* codes in parentheses. The inclusion of *ICD-10-CM* codes facilitates a cross-walk to the new coding system that will be implemented on October 1, 2014 for all U.S. health care providers and systems, as recommended by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS). This feature will eliminate the need for separate training on *ICD-10-CM* codes for mental disorders that is now being offered for all other diseases/disorders by other medical societies and vendors to prepare for the 2014 implementation.

**With the removal of the multiaxial system in *DSM-5*, how will disability and functioning be assessed?**

The *DSM-5* includes separate measures of symptom severity and disability for individual disorders, rather than the Global Assessment of Functioning (GAF) scale that combined assessment of symptom severity, suicide risk, and social functioning into a single global assessment. This change is consistent with WHO recommendations to move toward a clear conceptual distinction between the disorders contained in the *ICD* and the disabilities resulting from disorders, which are described in the *International Classification of Functioning, Disability, and Health* (*ICF*).

The World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) is provided in Section III of *DSM-5* as the best current alternative for measuring disability, and various disorder-specific severity scales are included in Section III and online. The WHO-DAS 2.0 is based on the ICF and is applicable to patients with any health condition, thereby bringing *DSM-5* into greater alignment with other medical disciplines. While the WHO-DAS was tested in the *DSM-5* field trials and found to be reliable, it is not yet being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes.

**Sometimes different disorders or subtypes share the same diagnostic code. Is this an error?**

No. It is occasionally necessary to use the same code for more than one disorder. Because the *DSM-5* diagnostic codes are limited to those contained in the *ICD*, some disorders must share codes for recording and billing purposes. For example, hoarding disorder and obsessive-compulsive disorder share the same codes (ICD-9-CM 300.3 and ICD-10-CM F42).

Because there may be multiple disorders associated with a given ICD-9-CM or ICD-10-CM code, the DSM-5 diagnosis should be always be recorded by name in the medical record in addition to listing the code.

**The names of some DSM-5 disorders do not match the names of the ICD disorders, even though the code is the same. Can you explain this?**

Because the DSM-5 diagnostic codes are limited to those contained in the ICD, new DSM-5 disorders were assigned the best available ICD codes. The names connected with these ICD codes sometimes do not match the DSM-5 names. For example, DSM-5 disruptive mood dysregulation disorder (DMDD) is not listed in the ICD. The best ICD-9-CM code available for DSM-5 use was 296.99 (other specified episodic mood disorder). For ICD-10-CM the code will be F34.8 (other persistent mood [affective] disorders). Please refer to the table below for other examples. APA will be working with CDC-NCHS and CMS to include new DSM-5 terms in the ICD-10-CM, and will inform clinicians and insurance companies when modifications are made.

Because DSM-5 and ICD disorder names may not match, the DSM-5 diagnosis should always be recorded by name in the medical record in addition to listing the code.

| DSM-5 Disorder | DSM-5/ICD-9-CM Code (in use through September 30, 2014) | ICD-9-CM Title | DSM-5/ICD-10-CM Code (in use starting October 1, 2014) | ICD-10-CM Title |
|---|---|---|---|---|
| Social (pragmatic) communication disorder | 315.39 | Other developmental speech or language disorder | F80.89 | Other developmental disorders of speech and language |
| Disruptive mood dysregulation disorder | 296.99 | Other specified episodic mood disorder | F34.8 | Other persistent mood [affective] disorders |
| Premenstrual dysphoric disorder | 625.4 | Premenstrual tension syndromes | N94.3 | Premenstrual tension syndrome |
| Hoarding disorder | 300.3 | Obsessive-compulsive disorders | F42 | Obsessive-compulsive disorder |
| Other specified obsessive compulsive and related disorder | 300.3 | Obsessive-compulsive disorders | F42 | Obsessive-compulsive disorder |
| Unspecified obsessive compulsive and related disorder | 300.3 | Obsessive-compulsive disorders | F42 | Obsessive-compulsive disorder |
| Excoriation (skin picking) disorder | 698.4 | Dermatitis factitia [artefacta] | L98.1 | Factitial dermatitis |
| Binge eating disorder | 307.51 | Bulimia nervosa | F50.8 | Other eating disorders |

**How are *DSM-5* and *ICD* related?**

*DSM-5* and the *ICD* should be thought of as companion publications. *DSM-5* contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The *ICD* contains the code numbers used in *DSM-5* and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.

The following URL contains the CMS response to a Frequently Asked Question (FAQ) about the relationship between *DSM* and *ICD-9-CM*: (https://questions.cms.gov/faq.php?id=5005&faqId=1817). This response will be updated to reflect the transition to *DSM-5* as soon as it is released.

**How is information from *DSM-5* used?**

*DSM-5* is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. Clinicians use *DSM-5* diagnoses to communicate with their patients and with other clinicians, and to request reimbursement from insurance organizations. *DSM-5* diagnoses may also be used by public health authorities for compiling and reporting morbidity and mortality statistics.

Another important role of *DSM* is to establish diagnoses for research on mental disorders. Only by having consistent and reliable diagnoses can researchers determine the risk factors and causes for specific disorders, and determine their incidence and prevalence rates.

**Can clinicians continue to use the *DSM-IV-TR* diagnostic criteria?**

Clinicians may use *DSM-5* in their practices starting in May, when the manual is released. However, there may be brief delays while insurance companies update their claim forms and reporting procedures to accommodate *DSM-5* changes, and clinicians should use *DSM-IV-TR* diagnoses and codes when required by a specific company. Transition details are still being developed with CDC-NCHS, CMS, and private insurance agencies. The APA is working with these groups with the expectation that a transition to DSM-5 by the insurance industry can be made by December 31, 2013.

As part of the transition to *DSM-5*, there will also need to be updates of questions in board certification examinations and quality assessments for medical record reviews. APA will be providing periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available.

*DSM* is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish *DSM-5* in 2013, culminating a 14-year revision process. For more information, go to www.*DSM5*.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org and www.healthyminds.org.