Reviewing Diagnostic Coding for Mental Disorders

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Editor's note: This is the first part in a two-part series on diagnostic coding for mental healthcare. Part II will discuss the differences between DSM-IV and ICD-9-CM coding systems.

Coding and documentation and the development and implementation of an effective HIM compliance program have become critical issues for mental health information professionals. Although the coding principles for mental disorder diagnoses and services generally are not as complicated as those for medical specialties, there are some updates, issues, and challenges that warrant discussion.

ICD-9-CM vs. DSM-IV

Although mental health services and treatment may be rendered in different healthcare settings, all diagnoses submitted for billing are coded using either the International Classification of Diseases, 9th Revision, Fourth Edition (ICD-9-CM) or the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV), and which coding system to use depends on the third-party payer. Codes for the mental health diagnostic and therapeutic services and procedures are also submitted on claims using the American Medical Association's most current version of Current Procedural Terminology (CPT).

While ICD-9-CM is still not universally used as the diagnostic coding system for indexing or receiving reimbursement for all mental health services, it is generally used in medical facilities that offer both inpatient and outpatient mental health services and programs. The mental health professionals in all settings use the diagnostic criteria from the DSM-IV coding and classification system and nomenclature of mental disorders. It is essential that all HIM departments add the DSM-IV to their lists of coding resources in their compliance plans.

Coding professionals review patient records to determine coding specificity for mental health diagnoses. For example, if a psychiatrist documents a Major Depressive Disorder, the fourth and fifth digits, which indicate whether the depression is a single episode or recurrent and its severity, respectively, must be assigned. If the DSM code for a particular diagnosis is similar to that in the ICD-9-CM, then the ICD-9-CM diagnostic specificity should be based on the DSM-IV criteria for that diagnosis whenever possible. The coding professional should query the physician for the specificities.

In cases of substance abuse or dependence, the DSM-IV does not recognize the ICD-9-CM fifth digits as clinically significant. Here, the DSM-IV has chosen to use "0" as the fifth digit (defined in the ICD-9-CM as "unspecified") to maintain fifth-digit integrity with the ICD-9-CM. This issue can affect payment when the third-party payer will not accept an unspecified fifth digit. Adhering to these nuances in coding principles and diagnostic terminology is not a major concern to third-party payers; they are more concerned if there is appropriate documentation to substantiate the diagnosis and the medical necessity and appropriateness of the services provided.

HCFA Focuses on Psychiatric Partial Hospitalization

Psychiatric partial hospitalization claims have been subject to intensified medical review by HCFA's fiscal intermediaries since October 1, 1999. This concern is based on a review of Florida, Texas, Colorado, Pennsylvania, and Alabama claims conducted by the Office of the Inspector General (OIG). The OIG determined that more than 90 percent of 1997 community mental health center (CMHC) partial hospitalization program (PHP) claims did not meet Medicare coverage requirements. The two major findings were:

- there was no documented diagnosis of mental illness or a diagnosis that substantiated benefiting from a PHP

- the programs did not meet the program criteria required by the statute that defines partial hospitalization services

In September 1998, HCFA disclosed a 10-point CMHC initiative. The goal of this comprehensive plan was to correct these problems and improve HCFA's management of the CMHC benefit. One component of this initiative is an intensified medical review of CMHC PHP claims in the five states originally sampled to determine the types of billing errors and reduce payment error rates. It will also identify for HCFA those providers with questionable billing practices and utilization patterns. Specific documentation guidelines for partial hospitalization records are defined in this transmittal. The initial psychiatric evaluation/ program certification, treatment plan, and progress notes will be evaluated to help the FIs determine whether the services provided were accurate and appropriate.[1, 2]

Although a type of outpatient program, a partial hospitalization is really an intermediate step in psychiatric care. A patient may not require full-time hospitalization, but he or she still needs support, a planned therapeutic program, and intensive short-term daily treatment services not available through outpatient visits in a hospital-based or hospital-affiliated facility or a office.[3]

Mental Health Outpatient Documentation Practices

Because psychiatrists and other mental health professionals are providing outpatient care (without the necessary guidelines for documentation), their documentation practices might be more reflective of their office records than inpatient record documentation practices. In the past, it seemed to be a common practice of mental health professionals to document more when it was necessary to justify a more restrictive treatment environment due to accreditation standards and state statutes. They felt that a less restrictive treatment setting required less documentation.

Another issue to consider is patient confidentiality. The patient's right to privacy versus the information needed by third-party payers to justify treatment may present a problem for mental health providers. Mental health professionals are aware that a documented history of depression, even without treatment, may be interpreted as a pre-existing condition. Besides the purposeful scanty documentation to protect privacy, some therapists will use a less severe diagnosis such as Adjustment Disorder with Depressed Mood rather than Major Depressive Disorder to avoid "labeling the patient."

It is important to remember that third-party reviewers use the DSM-IV as a record review tool to evaluate the appropriateness of the diagnosis, the need for treatment, and intensity of service. They do not have to develop their own criteria sets. The DSM-IV clearly defines diagnostic criteria based on literature review and research. Used by all mental health professionals, the DSM-IV is a nomenclature that is "the language of psychiatry."

Diagnostic Coding by Mental Health Professionals

In private practices, mental health professionals are mostly coding with the DSM-IV for reimbursement. Because most of these code numbers have the same ICD-9-CM code numbers and all DSM-IV codes have recognizable ICD-9-CM code numbers, some third-party payers may not be aware that DSM-IV codes are being used. It seems to be acceptable if the diagnosis is written using the DSM-IV diagnostic terminology. If the record was reviewed, the reviewer would probably be evaluating the documentation versus diagnostic criteria for that particular DSM-IV diagnosis. Mental health professionals will use the ICD-9-CM if this code number differs from one in the DSM-IV only when mandated by a third-party payer. Some facilities and professionals have developed their own DSM-IV to ICD-9-CM crosswalks.

One psychiatrist questioned about diagnostic specificity said that if he selects a code that reflects the full extent of the diagnostic specificity, the corresponding diagnostic terminology does not have to reflect the same specificity. For example, if he codes 296.33, he can document Major Depressive Disorder as the diagnosis instead of Major Depressive Disorder, Recurrent, Severe without Psychotic Features. This is his type of diagnostic shorthand. This practice could create a problem for the coding professional when looking through the record for the specific documentation to support the code listed by the psychiatrist. Even if the code assignment is supported by the documentation in the record, it is a good compliance practice that the diagnostic code matches the appropriate diagnostic terminology. Michael B. First, MD, editor of text and criteria for the DSM-IV and editor of the DSM-IV-TR, agrees with this documentation practice. It is a fundamental principle of the DSM-IV recording procedure.

Diagnostic Specificity for Reimbursement

The major problem with coding mental health diagnoses is that a majority are reported without regard to full specificity upon program discharge. There are two approaches to this problem:

1. **Use what the encoder assigns.**

   Because all encoders can select a code number for even an unspecified diagnosis, a code can always be assigned. This is generally not a concern in busy HIM departments. The diagnosis of Major Depression is a typical example. When using the encoder, Major Depressive Disorder can be coded without noting any specifics as to the episode and its severity. Some encoders select 296.20. Technically, this is the ICD-9-CM code number for an Unspecified Major Depressive Disorder. It is also the code for a Major Depressive Disorder, Single Episode, Unspecified. When this practice was mentioned to several mental health professionals, they were very surprised by this default classification of some encoders. They usually know if the episode of the depression was single or recurrent and, sometimes, in haste, do not document it. They were not aware of its effect on the assignment of the code number.

2. **Review the patient record.**

   Medical/surgical facilities that have responsibility for mental health programs and services are submitting codes for billing using diagnostic ICD-9-CM codes although the healthcare professionals are using DSM-IV for diagnosing and documentation in the patient record. The professionals are doing their best to determine the diagnoses at program discharge. If the diagnosis does not specify a fourth or fifth digit, HIM professionals must review the charts to find this information. Unfortunately, due to increasing workloads in HIM departments and more severe coding specificity concerns in other medical specialties, the psychiatrists are generally not contacted unless the coder is unable to determine the diagnosis. Just because a patient has been readmitted to the facility for a treatment or is being treated again for a Major Depression does not necessarily mean that the patient is having a recurrent episode. There may have been chronic depression between readmissions to the facility or the depression may really be a single episode which fluctuates in severity.[4] Contact the psychiatrists for further clarification.

The HIM Professional's Responsibilities

The individual responsible for coding mental disorder diagnoses differs depending on the healthcare setting. In medical-based facilities with inpatient services, coding professionals usually provide the inpatient codes or at least review the coding selected by the clinicians. The organizational structure of a healthcare facility will determine whether the HIM department will assign codes for partial, day hospital, or outpatient clinic diagnoses. In a majority of facilities providing only mental health services, the mental health professionals are doing their own coding. When this situation occurs, these codes are often directly routed to the business office without undergoing quality review, even in some facilities with an HIM department. Due to the changes in reimbursement methods for outpatient services in mental health to number of visits, the actual DSM-IV diagnosis and the supporting documentation become very important. With HIM professionals assisting in the coding process, data quality will improve.

Regardless of the approach used to determine coding specificity, coding professionals also need to remember that psychiatric or substance-use diagnoses are not just an element to go into a database profile. These are vital pieces of information belonging to real people, and each has the potential to have a major effect on the healthcare services that these individuals receive, potential employment possibilities, and personal life experiences. This information should be as accurate as possible and determined by the clinician. In the current environment, data quality and coding are key factors in mental health reporting.

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Notes

1. Healthcare Financing Administration. Program Transmittal No. A-99-39. Available at http://www.hcfa.gov/pubforms/transmit/a993960.htm.

2. "FIs increase scrutiny of psych partial hospitalization claims." *Briefings on Coding Compliance Strategies* 2, no. 10 (1999): 1, 5.

3. American Medical Association. *CPT Assistant* 2, no. 2. Chicago, IL: American Medical Association, 1992, 24.

4. Correspondence and conversations with Michael B. First, MD.

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Albaum-Feinstein, Andrea. *DSM-IV Crosswalk: Guidelines for Mental Health Information*, 1999 Edition. Chicago, IL. American Health Information Management Association, 1999.

Albaum-Feinstein, Andrea. "A Health Information Manager's Perspective: Meeting the Challenge of Coding and Documentation." *Journal of Practical Psychiatry and Behavioral Health* 2, no. 3 (1996): 146-150.

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AHIMA's DSM-IV Crosswalk: Guidelines for Coding Mental Health Information, by Andrea L. Albaum-Feinstein, is available to members for $48 ($60 for nonmembers.) To order, call (800) 335-5535; fax orders to (312) 233-1500; or mail orders to AHIMA Dept. 77-97105, Chicago, IL 60678-7105. The product number is AC200299.

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