Understanding the Complexities of Coding for Mental Disorders

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Editor's note: This is the second part in a two-part series on diagnostic coding for mental healthcare.

Documentation differences between DSM-IV and ICD-9-CM continue to challenge coders in mental health settings. Efforts to minimize these differences are evident in current revisions. This article explores these differences, the complexities of the mental disorder coding process, and recent and future revisions of these coding systems.

Differences between DSM-IV and ICD-9-CM

Since 1993, the American Psychiatric Association (APA) has established a close working relationship with the National Center for Health Statistics (NCHS) in an attempt to keep clinical classification differences at a minimum.[1] Changes to reduce the differences between the ICD-9-CM and DSM-IV were included in the Oct. 1, 1994, *ICD-9-CM Official Authorized Addendum* and subsequent addenda. However, despite these joint efforts, there are still some differences:[2]

1) although most DSM-IV codes are recognizable ICD-9-CM codes, the diagnostic term associated with the DSM code is sometimes different from that associated with the ICD-9-CM code. Most of the differences in the diagnostic terms exist because the ICD-9-CM terms date back to the late 1970s. Although ICD-9-CM has been expanded, it has been impossible to add all the DSM diagnostic terms. Further, since the mid-1970s, the DSM has undergone three major revisions and each one has included updated diagnostic terms reflective of current psychiatric practice

2) other differences include diagnostic sequencing, fifth-digit subclassification, and some classification assignments

DSM-IV and ICD-9-CM Approaches to Principal Diagnosis

The diagnostic sequencing differences are inherent to the DSM-IV multiaxial assessment system. Although the DSM-IV and ICD-9-CM coding assignments may be the same, some differences remain with regard to identification of the principal diagnosis for inpatient services and reason for visit for outpatient services. There are five axes in the DSM-IV multiaxial system and each is listed in order from Axis I to V, regardless of which axis the principal diagnosis or reason for visit is listed. Using DSM-IV, multiaxial approach, the mental disorder diagnosis would usually be listed as the principal diagnosis or reason for the visit on Axis I unless a Personality Disorder or Mental Retardation on Axis II is the principal diagnosis or the reason for the visit. The first diagnosis listed on Axis I is assumed to be the principal diagnosis. If, however, the principal diagnosis is on Axis II, the phrase "principal diagnosis" is noted in parentheses. General medical conditions that affect the treatment or management of the patient are listed on Axis III and would rarely be considered for principal diagnosis or reason for visit.[3] However, it is possible that a psychiatrist who is also functioning as a primary care physician might list a principal diagnosis on Axis III.[4]

In ICD-9-CM, whether the general medical or physical condition is sequenced before the psychiatric or substance use disorder depends on the instructional note for that particular diagnostic category or subcategory. For example, the ICD-9-CM category 293 (equivalent for the DSM-IV diagnoses for Mental Disorders Due to General Medical Conditions) instructs the coder to "Code first the associated physical or neurological condition." For example, when using the multiaxial approach, coding the DSM-IV equivalent diagnosis for Delirium Due to Renal Failure, the mental disorder, Delirium Due to a General Medical Condition, 293.0, would be listed first on Axis I and the general medical condition of Renal Failure, 586, would be listed second on Axis III. When coding with the ICD-9-CM, Renal Failure, 586, would be listed first (as the associated physical condition) followed by the mental disorder of Delirium, 293.0.[5]

DSM-IV Revisions

1996 Coding Update

In 1996, the APA published a DSM-IV Coding Update. This included new diagnostic codes that were added to the Mental Disorder Chapter of the ICD-9-CM and elimination of codes that were out of date or no longer legitimate codes.[6] The DSM-IV manuals printed after October 1996 included these updates and had a special designation on their covers to indicate these were updated editions. All these changes were included in AHIMA's 1999 edition of the *DSM-IV Crosswalk: Guidelines Coding for Mental Health Information*.

DSM-IV-TR

In June of this year, the APA will publish the DSM-IV-TR (text revision), which will include all the 1996 and subsequent ICD-9-CM coding changes that have affected the DSM-IV coding and classification system. The text has also been revised based on a comprehensive literature review of psychiatric research published since 1992. With the exception of some minor corrections to a few of the criteria sets, no major changes were made to the criteria sets nor were any new categories added to or deleted from the manual. Appendix D, Annotated Listing of Changes in DSM-IV, will be replaced by an appendix that summarizes the text revisions. Appendices E, F, and G, ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders, will also be updated. Additionally, an appendix with the ICD-10-CM equivalent of the current DSM-IV diagnoses will be included. However, these diagnoses were not determined by the use of the ICD-10-CM coding principles and may not be found in the finalized alphabetical index and/or tabular list. Also included are expanded instructions for use of Axis V, Global Assessment of Functioning.[7]

Alzheimer's Dementia

When DSM-IV was published in May 1994, Alzheimer's Dementia was categorized to the same subtypes as in the 1993 ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, and 290.3. These were eliminated from the DSM classification in the DSM-IV-TR to make it consistent with the Alzheimer's Dementia coding change in 1993 in the ICD-9-CM and the impending ICD-10-CM.[8] Code 331.0 is assigned for Alzheimer's Disease and the Dementia is assigned to 294.1, the subcategory for "Dementias in conditions classified elsewhere." Of these two required codes, Alzheimer's Disease, 331.0, is sequenced first as the underlying etiology before the code for the Dementia, 294.1, or the manifestation code to fully describe the condition.[9] In contrast, using the DSM-IV multiaxial system, the Dementia would be listed on Axis I as the principal diagnosis or reason for the visit and the Alzheimer's Disease, the etiology of the underlying medical condition, would be listed on Axis III.

A Proposed Fifth Digit

In addition to accepting the change for Alzheimer's Dementia, the APA has proposed adding a fifth digit to code 294.1, "Dementia in conditions classified elsewhere," for consideration in the October 2000 *ICD-9-CM Addenda*. In addition to the severe cognitive impairment that is the hallmark of dementia, many individuals develop behavioral disturbances that require the clinical attention of a mental health professional.[10] The addition of a fifth digit would designate whether the dementia is without (294.10) or with (294.11) a behavioral disturbance. Behavioral symptoms include aggressive, combative, and violent behaviors and wandering off. A patient who has dementia without behavioral or cognitive symptoms would only exhibit symptoms related to cognitive impairments such as memory loss or aphasia.[12] (See "Committee Proposes ICD-9-CM Changes for 2001" in the March 2000 *Journal of AHIMA* for more details.)

Vascular Dementia

In the DSM-IV-TR, the code for this type of dementia will remain 290.40. Because it is becoming more prevalent as a diagnosis in our aging population, the APA has proposed it as subterm, under Dementia, in the Alphabetical Index of the 1CD-9-CM for the 2000 Addenda.[13]

Abuse and Neglect

In October 1996, major changes were added to clarify coding with regard to neglect, sexual, emotional, and physical abuse. Only some of these coding changes were recognized in the DSM-IV. (These changes are summarized in Chapter 5 of the 1999 edition of AHIMA's DSM-IV to ICD-9-CM Crosswalk; also refer to Coding Clinic 16, no. 3.) Those changes recognized in the DSM-IV were included in the 1996 update and will also be included in the updated DSM-IV classification in the DSM-IV-TR.

DSM-V

The publication of DSM-V depends on factors like research and the clinical perspective needed to update the diagnostic system. The publication of ICD-10-CM does not have to coincide. Presumably, ICD-10-CM will go into effect at least a few years prior to the publication of DSM-V, so DSM-IV-TR will be reprinted again with ICD-10-CM codes, and the "recording procedures" sections of the DSM-IV-TR text will be rewritten to reflect the new ICD-10-CM coding.[14]

Compliance Opportunities in Mental Health Settings

Mental health settings have just begun to address compliance issues, which offer a great opportunity for those HIM professionals who are not currently involved in the coding and documentation aspects at their facility to show their expertise. There are opportunities as well for in-service education. For diagnostic coding, complying with ICD-9-CM and DSM-IV-TR coding guidelines should be included. Although many challenges lie ahead, submitting accurate health information to the government, accreditation bodies, agencies, and third-party payers will benefit your facility, its clinicians and, most importantly, the patients for whom we are working together to provide optimal care services.

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Notes

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2. *Ibid*., pp. 12-13.
3. *Ibid*., pp. 13-15.
4. Correspondence and conversations with Michael B. First, MD, editor, DSM-IV-TR.
5. Albaum-Feinstein, pp. 26-27.
6. American Psychiatric Association. "Introduction." *DSM-IV Coding Update*. Washington, DC: American Psychiatric Association, 1996, p.v.
7. Michael B. First, MD.
8. *Ibid*.
9. Albaum-Feinstein, p. 26.
10. Michael B. First, MD.
11. ICD-9-CM Coordination and Maintenance Committee Meeting Minute Proposals, Nov. 12, 1999, p. 3. Available at www.cdc.gov/nchs/data/icdp1199.pdf.
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