DSM-5 Diagnoses: Best Practices

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Mountain Plains (HHS Region 8)

MHTTC Mental Health Technology Transfer Center Network

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered/ trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Objectives

- After the presentation, the participant will:
- 1) identify primary elements in DSM-5 diagnoses
- 2) have an understanding of necessary documentation
- 3) be able to identify some differences in payer practices.

“Behavioral Health”

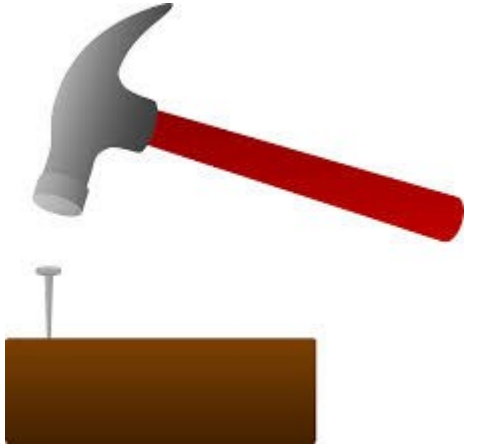
- A term used to include issues pertaining to both mental health and substance use

Why is this an issue?

- **67% of individuals with a behavioral health disorder** do not get behavioral health treatment[1]
- **30-50% of referrals** to behavioral health from primary care don't make first appt[2,3]
- Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients[4] due to:
  - Shortages of mental health care providers
  - Health plan barriers
  - Lack of coverage or inadequate coverage
- **Depression goes undetected** in >50% of primary care patients[5]
- **Only 20-40% of patients improve** substantially in 6 months without specialty assistance[6]

Sources: [1]Kessler et al., NEJM. 2005;352:515-23. [2]Fisher & Ransom, Arch Intern Med. 1997;6:324-333. [3]Hoge et al., JAMA. 2006;95:1023-1032. [4]Cunningham, Health Affairs. 2009; 3:w490-w501. [5]Mitchell et al. Lancet, 2009; 374:609-619. [6]Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Meds



- It's been estimated that:
- Between 15-20% of Americans take a psychotropic medication
- Between 75-80% of such medications are prescribed by non-psychiatric prescribers.

Meds

- While clearly psychotropic medications can be helpful, anti-depressants should typically be reserved for moderate-severe depression

- There are black box warnings for some medications, including certain sleep medications, anti-psychotics in certain elderly populations, and antidepressants in youth.

- For many individuals with depression and anxiety, one of the most useful treatments is cognitive behavioral therapy (CBT).

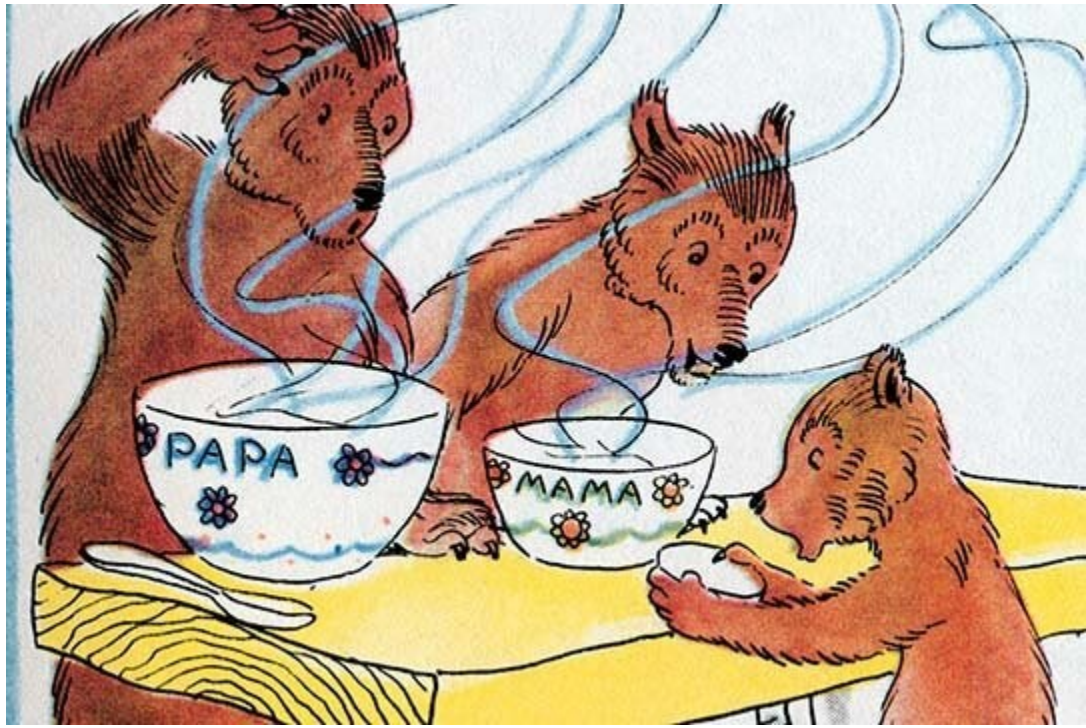
Variables re: managing behavioral health in primary care settings

- Emergent
- Urgent
- Routine/Chronic Disease Management*

- Illness/Behavior
- Severity/Complexity
- Supports

Clinician's dilemma in a fast-paced setting:

- Not over-diagnosing
- Not under-diagnosing
- Not missing what else this might be…



Risks of mis-diagnosis (even if they check most boxes…)

- Wrong treatment
- Delay in “right” treatment
- Reimbursement issues
- Other

Pressures

- Payment pressures to firmly diagnose (on the first visit!)
- Incentives to do what's expeditious, vs. "right".
- In primary care, disincentive to open-up the behavioral health "can of worms"…

One of the issues….

- We got lazy…
  - “Not otherwise specified” (NOS)

Many Integrated Care Models, However…

- Behavioral Health in Primary Care. (By far the most common)
- Primary Care in Mental Health
- Primary Care in Behavioral Health

Integration: An Evolving Relationship

Consultative Model

- Psychiatrists sees patients in consultation in his/her office – away from primary care

Co-located Model

- Psychiatrist sees patients in primary care

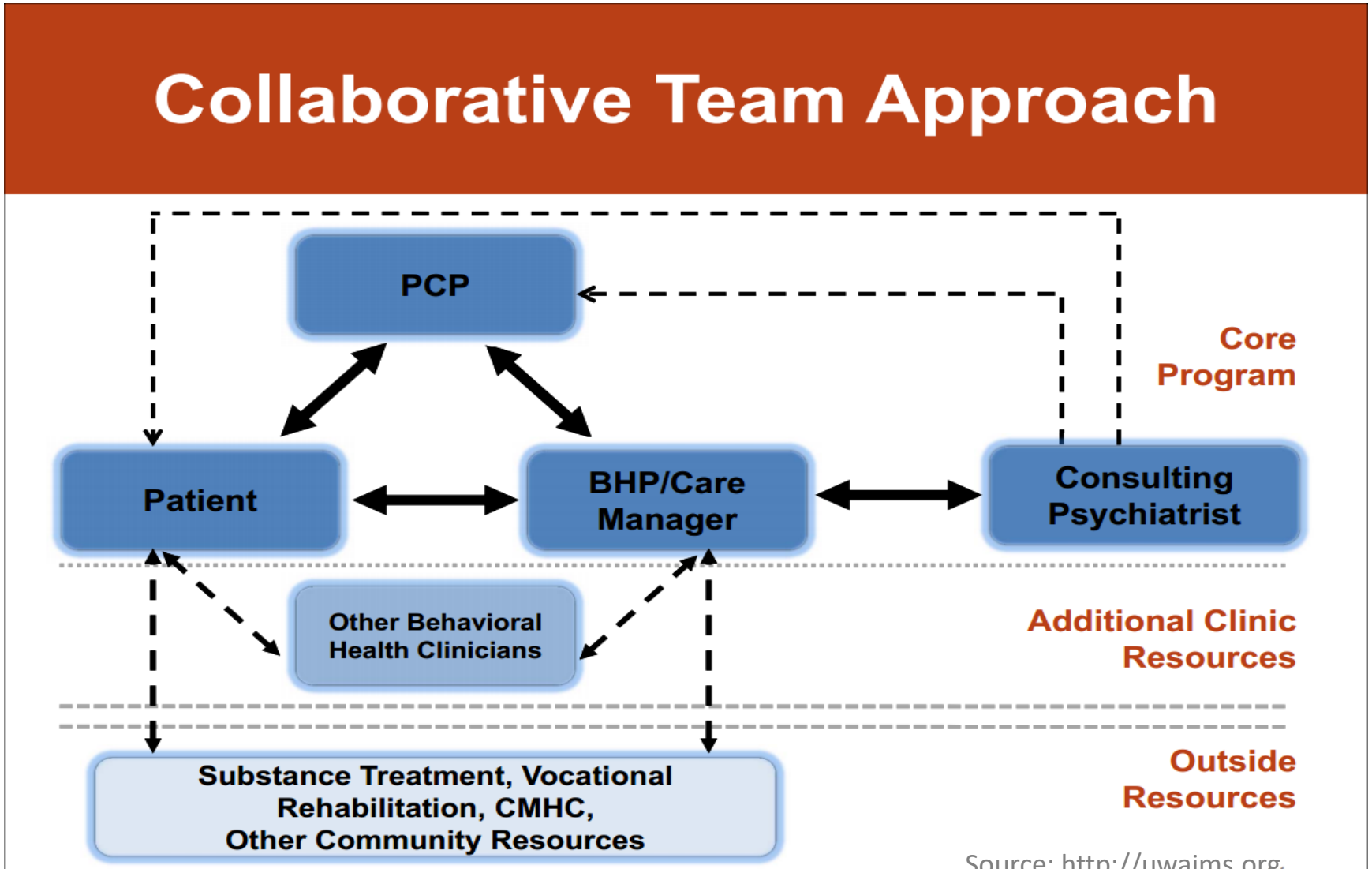
Collaborative Model

- Psychiatrist provides caseload consultation about primary care patients; works closely with primary care providers (PCPs) and other primary care-based behavioral health providers (BHP)

Source: http://uwaims.org

Collaborative Care

Collaborative care *optimizes* <u>all</u> behavioral health resources



SBIRT (screening, brief intervention, referral to treatment)

- **SBIRT CONSISTS OF THREE MAJOR COMPONENTS:**
- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

- http://www.integration.samhsa.gov/clinical-practice/SBIRT

Screening tools

Find one you are comfortable with, such as:

- (For substance use/SBIRT):
AUDIT, MAST, CAGE-AID, ASSIST

- For Depression: PHQ-2/9 Symptom Checklist

- For generalized anxiety: GAD-7

- For potential bipolar disorder: Mood Disorder Questionnaire

- For physical side effects of anti-psychotic medication: AIMS

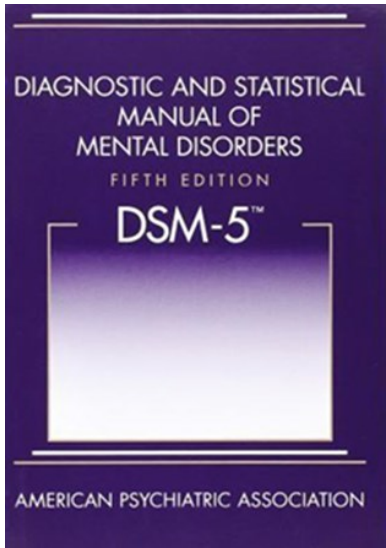
Remember

- If you remember anything else from this talk, know that screening tools are just that:

Screens and tools support your assessment. They are not the diagnostic assessment!!

Psychiatric Disorders-general rules

- Symptoms
- Duration
- Impact on functioning
- Not better explained by something else…
- Often have specifiers

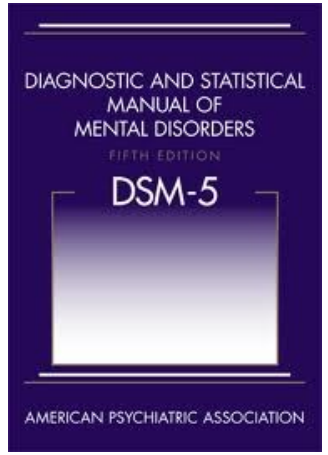


For Complex (or high risk) diagnoses

- Try to obtain previous records or testing
- (If patients refuse, that probably tells you something…)

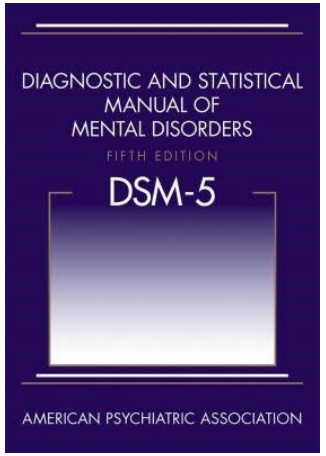
Major Categories:

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive Compulsive and Related Disorders
- Personality Disorders
- Neurocognitive Disorders
- Addictions and Related Disorders
- Trauma and Stressor Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control, and Conduct Disorders



Depressive Disorders* (not all)

- Major Depressive Disorder (Single/Recurrent episodes)
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Disruptive Mood Dysregulation Disorder
- Other (including medical conditions, bipolar depression…)



Differential Diagnosis of Major Depressive Disorder
(What else could this be?)

- Medical conditions
  (thyroid disease, anemia, sleep disorders, infections, etc…)
- Other psychiatric disorders
- Medication side effects
- Bereavement
- Psychosocial stressors/adjustment
- Other

COMORBIDITY IS THE RULE!

Example: Major Depressive Disorder—Diagnostic Criteria

Five or more of the following symptoms are present most of the day, nearly every day, during a period of at least 2 consecutive weeks:

At least 1 of these 2 symptoms

1. Depressed mood
2. Loss of interest or pleasure in all, or almost all, usual activities (anhedonia)

3. Significant weight loss when not dieting, or weight gain
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate or indecisiveness
9. Recurrent thoughts of death or suicide

DSM-5.

Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not attributable to another substance or medical condition

Severity and Course Specifiers

SEVERITY	COURSE
Mild	Single episode
Moderate	Recurrent episode
Severe	
With psychotic features	
In partial remission	
In full remission	

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Summary of DSM-5 Classification of Bipolar Disorders

Bipolar I	Bipolar II	Cyclothymic	Bipolar Disorder Other
One or more manic or mixed episodes, usually accompanied by major depressive episodes	One or more major depressive episodes accompanied by at least one hypomanic episode	At least 2 years of numerous periods of hypomanic and depressive symptoms*	Substance induced, medical, unspecified, other specified…

Look at all the Specifiers!

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features (note-early morning awakening)
- With atypical features
- With psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

Example: Summary of DSM-5 Criteria for Manic Episodes in Bipolar Disorder

- Abnormally and persistently elevated, expansive, or irritable mood fand abnormally and persistently increased goal-directed activity or energy for at least 1 week* with three of the below (four if irritable) present
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Pressured speech
- Flight of ideas or racing thoughts
- Distractibility
- Increase in goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

Social/Occupational impairment; Sxs not due to substance/medical condition

* This symptom must be present.

Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.

Bipolar Depression *

- **Clues:**

  Might*:
- be more “atypical” (think hibernation)
- have Hx of early, often abrupt onset/psychosis
- be associated with other cyclical problems (seasonal…)
- be associated with post-partum
- have family history
- have history of “overstimulation” with antidepressants.
- Migraines?

Bipolar Mixed (manic/hypomanic) State

- “Dysphoric Hypomania”
- Often misdiagnosed as agitated depression, anxiety, personality disorder
- Insomnia
- Suicidality
- Impulsivity

Different from “Rapid Cycling”
which is actually 4 or more episodes per year

Suicide

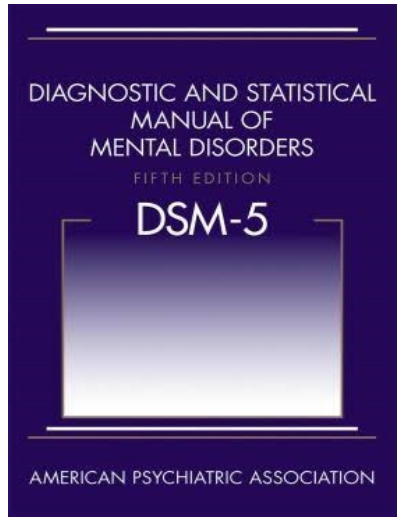
- Of all affective states, Bipolar II has the highest risk for attempts and suicide completion.

- RE: phases of illness and suicide risk,

Depressive>Mixed>Psychotic>Manic

Bowden CL. Novel Pharmacologic Interventions in the Treatment of Bipolar Disorder. *Academy for Healthcare Education CME Monograph. 2002*

DSM 5 Anxiety Disorders



Specific Phobia

Social Anxiety Disorder (Social Phobia)

Panic Disorder

Generalized Anxiety Disorder

Substance/Medication-Induced Anxiety Disorder

Agoraphobia | Separation Anxiety Disorder | Selective Mutism | Anxiety Disorder Due to Another Medical Condition | Other Specified Anxiety Disorder | Unspecified Anxiety Disorder

PTSD is now under Trauma-and Stressor-Related Disorders

OCD is now under Obsessive-Compulsive and Related Disorders

Social Anxiety Disorder (Social Phobia)

- Excessive/unreasonable fear
- Marked and persistent:
- Fear of **scrutiny** in one or more social situations.
- Concern about **embarrassing** oneself
- Exposure produces anxiety
- Above situations are avoided
- Significant social interference/distress

Can be:

- specific or generalized
- Most common-public speaking
- Women = Men
- Substance use issues

- Treatment: cognitive behavioral therapy, anti-depressants (try to avoid long term benzodiazepine use)

How is Panic Attack different from Panic Disorder?

(think “seizure vs. epilepsy” or, “one swallow does not a summer make”)

- Panic attack:

- Intense fear/discomfort

- At least 4/13 symptoms

- Short peak duration
(“within minutes”)

- Can be expected or unexpected

- Panic Disorder:

- Recurrent, unexpected panic attacks

- ≥ 1 month:

-Concern about another attack/ consequences

- Behavior change related to attacks

Example: Generalized Anxiety Disorder
Good screening tool: GAD-7

- Excessive anxiety/worry
- Restless/keyed up
- Fatigued
- Concentration problems
- Irritability
- Muscle tension
- Sleep disturbance

- Time element: more days than not, ≥ 6 months
- Women > Men
- ≥ 3/6 symptoms
- (1 in children)
- Treatment-as per panic, social anxiety
- Relaxation techniques helpful

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to sleep or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals ____ + ____ + ____ + ____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Severity:

0-4	Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

Acute or Post-traumatic Stress Disorders

- Exposure to actual/threatened death, serious injury, or sexual violence via:
  1) Directly experiencing the event
  2) Witnessing, in person, the event
  3) Learning that an event occurred to a close person
  4) Repeated/extreme exposure to aversive details (media-only if work related)

  - So, you need not have directly experienced the trauma

Either Acute or Post Traumatic Stress Disorders

- Clusters:
- **1) Intrusion symptoms**(**re-experiencing**) by recollection, dreams, “re-living” the experience, dissociative reactions (“flashbacks”), psychological/physical distress at re-exposure
- **2) Avoidance**
- **3) Negative cognitions/mood**
- **4) Arousal increase** (vigilance, startle, irritability, reckless behavior, etc…)

Stress Disorders

Acute Stress Disorder

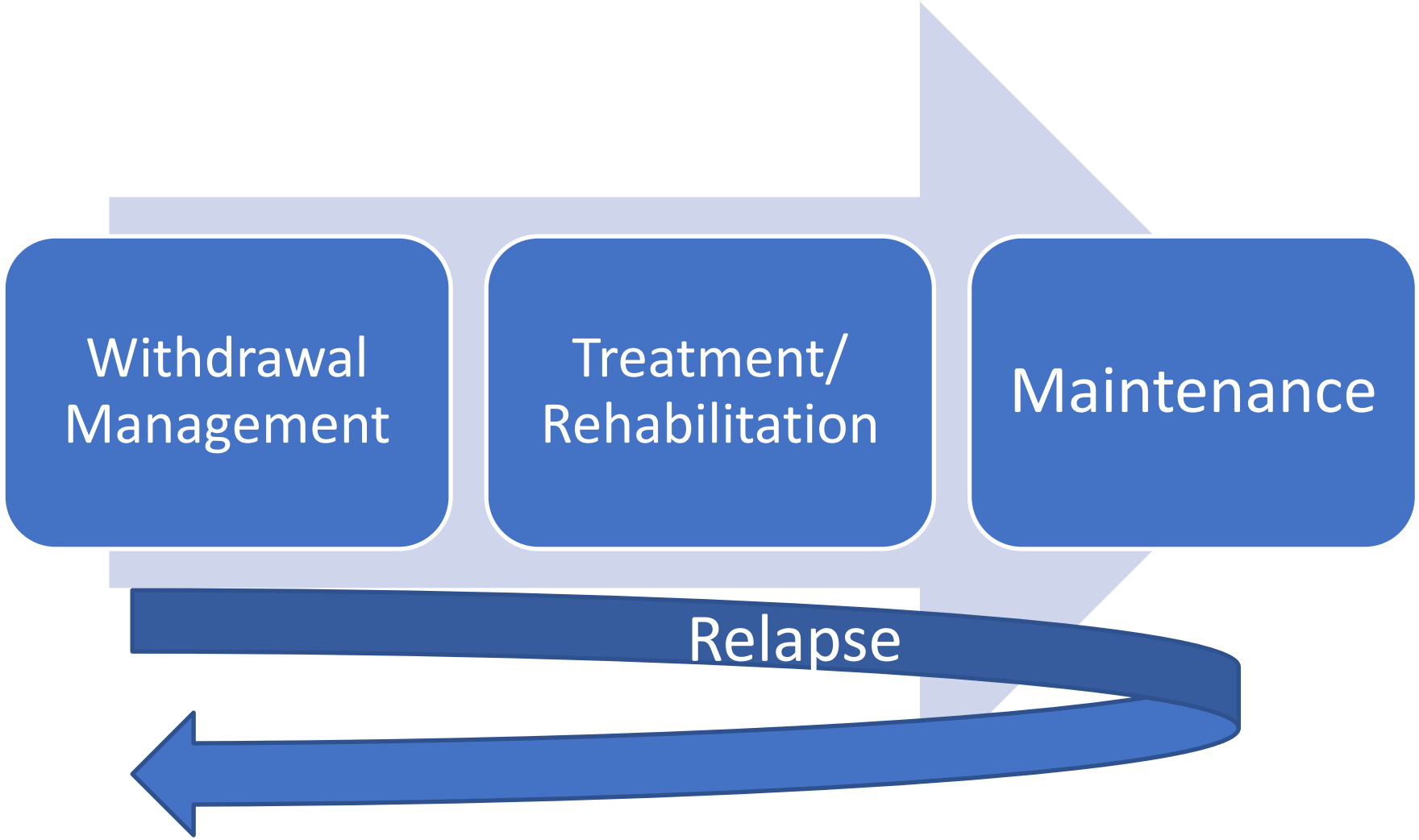
- More immediate
- Short-term

(from 3 days to 1 month)

PTSD

- Usually occurs within 3 months, and dissipates within months
- Up to 30% may be “chronic”
- Can also have “delayed expression” (6 months post)

Substance Use Disorders Continuum



General Categories

- Depressants (alcohol, benzodiazepines, barbiturates, etc…)
- Opioids (prescription pain meds, heroin, codeine, methadone, buprenorphine…)
- Stimulants (amphetamines, cocaine, methylphenidate, as well as caffeine, nicotine, etc…)
- Cannabinols
- New Psychoactive Substances (Synthetics)
- Hallucinogens
- Inhalants

Differences between DSM-IV and DSM-5 re: substance use disorders

- All: No longer “abuse vs. dependence”

- Alcohol:
- “More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking?”

- Added to DSM-5: “Wanted a drink so badly you couldn’t think of anything else…” (i.e., craving)
- Severity: Mild (2-3 symptoms)
    - Moderate (4-5 symptoms)
    - Severe (≥ 6 symptoms)

Example-Substance X

Pattern of use, number of concerns (≥2), time-frame (within a 12-month period), length of remission/maintenance

1. Larger amounts used, or for longer than intended
2. Can't cut down/control use
3. Focus/time spent on obtaining drug or recovering
4. Craving
5. Recurrent issue with fulfilling obligations/roles due to use
6. Using despite ongoing problems re: above
7. Important activities are given up/reduced (social, occupational, etc…)
8. Recurrent use despite physical hazards
9. Recurrent use despite medical/psychological impact from use
10. Tolerance
11. Withdrawal

Billing

- I am not an expert. But…

- Billing by CPT (current procedural terminology)
- E/M codes-Evaluation and Management (Hx; P/E; Decision-Making)
- Bundled, Fee for Service, Prospective Payments, etc…
- Medicare, Medicaid, FQHCs, other 3rd party payers…

Documentation

• In documenting the encounter (history, exam, decision)

one of the most helpful reminders is to consider the term,

"as evidenced by…

And, to also help the reader understand your decision-making: (i.e., there may be times where, for good reason, you were unable to do part of an examination, or made a decision that you might not have otherwise made, due to circumstances beyond your control) Don't leave the reader guessing why...

Federally Qualified Health Centers (FQHCs)

- Most bill daily prospective payment (PPS; bundled) for all CPT codes
- Behavioral health and primary care billing may vary state by state
- Behavioral health and primary care billing may be the same or different rates (i.e., BH-PPS; PC-PPS)
- Some bill PC-PPS and BH as a fee for service (Medicaid)
- Most now allow BH and PC billing on the same day (but usually not more than one BH provider…)

Medicaid and Medicare-they sound so much alike!

Medicaid (Title XIX)

- A “means-tested” health/insurance program to help the indigent obtain medical care

  (qualify based on assets/income)

- Jointly financed by state and federal governments

- Administered by individual states

Medicare (Title XVIII)

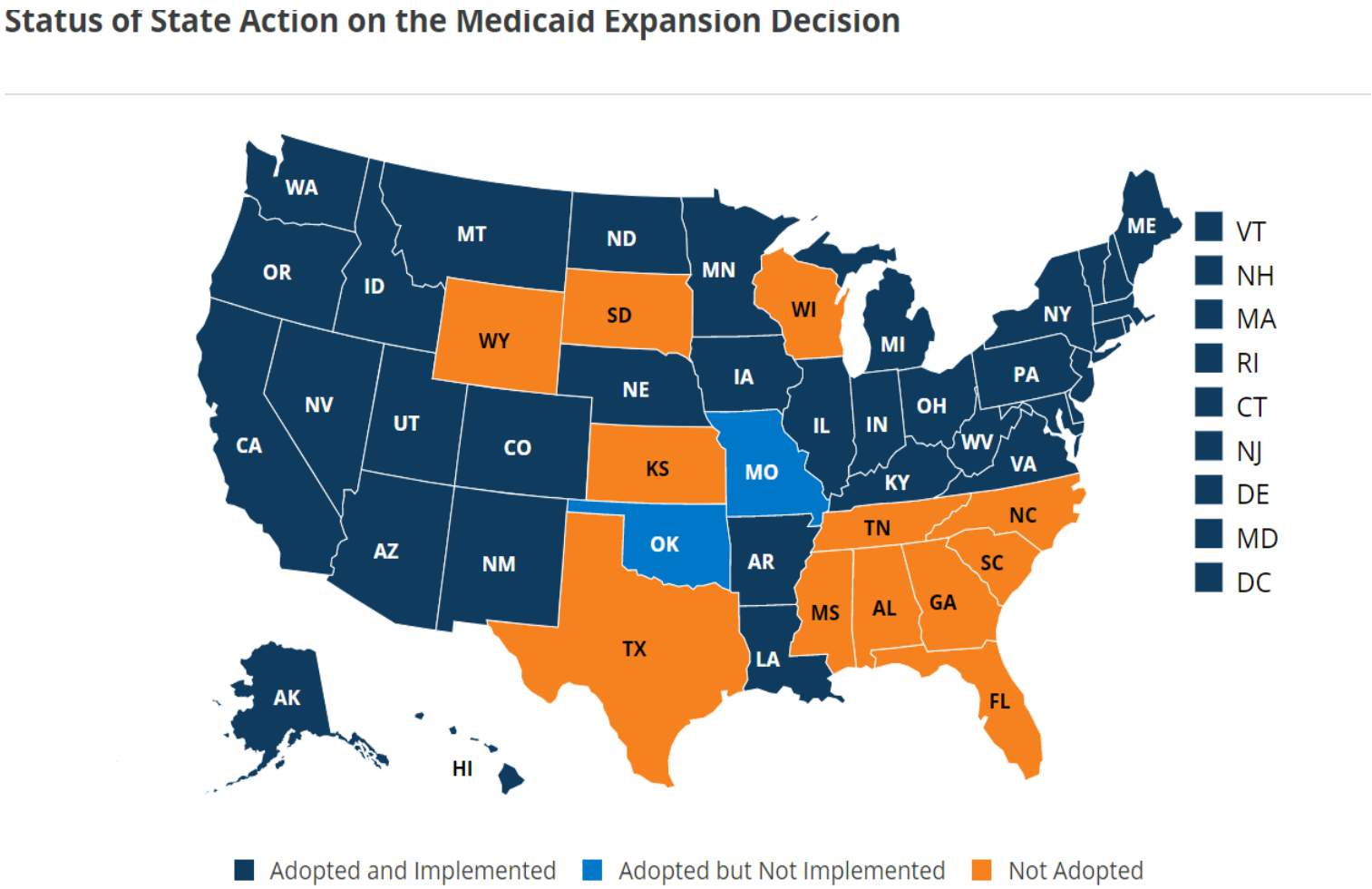
- An “Entitlement” health insurance program (entitled, by tax contributions)
- 65+
- Disabled
- End-stage renal disease

- Part A- Hospital Insurance
- Part B- Supplemental Medical

  (doc, ER, visits, outpatient surgery, labs, dialysis, etc…)
- Part C- Medicare Advantage
- Part D- Prescription Drug coverage

Medicaid Expansion

- 138% of federal poverty level
- Previously was primarily for pregnant women, children/families in need
- New eligible group (essentially, poor single men)
- Federal Matching is at 90%



NATIONAL ASSOCIATION OF Community Health Centers

State Policy Report #34

Health Center Reimbursement for Behavioral Health Services in Medicaid

November 2010

Summary of Findings

Substance Abuse Services

- 65% (26 of 40) of states pay health centers for substance abuse services directly through Medicaid.
- 33% (13 of 39) of states carve out substance abuse services to another entity; whether Health Centers are included in the managed care network varied state by state.
- 66% (27 of 41) of states paid for substance abuse visits on the same day as a medical visit.
- 53% (20 of 38) paid for substance abuse group visits.
- 54% (19 of 35) paid a PPS rate for substance abuse services. States paying for services at a non-PPS rate varied in the methodologies used and how those other rates are determined.
- 28% (10 of 36) of states have approved Screening Brief Intervention and Referral to Treatment (SBIRT) codes for use; of those 80% have activated the codes in their Medicaid system so that health centers can actually bill for and receive payment.

Mental Health Services

- For mental health services, 81% (39 of 48) of states pay health centers directly through Medicaid.
- 51% (23 of 45) carve out mental health services to other entities like Managed Care Organizations, though health centers are not always included in such networks.
- 70% (32 of 46) of states pay for mental health visits on the same day as medical visits.
- 51% (23 of 45) pay for mental health group visits.
- 64% (30 of 47) of states pay PPS rates for mental health services. States paying for services at a non-PPS rate varied in the methodologies used and how those other rates are determined.

Medicare Billing during national emergency

(Expansion of Telehealth via 1135 Waiver)

- Providers:
- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Certified nurse anesthetists
- Clinical psychologists
- Clinical social workers
- Registered dietitians, and nutrition professionals
- See G codes re: PT, OT, SLPT

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Summary of Medicare Telemedicine Services

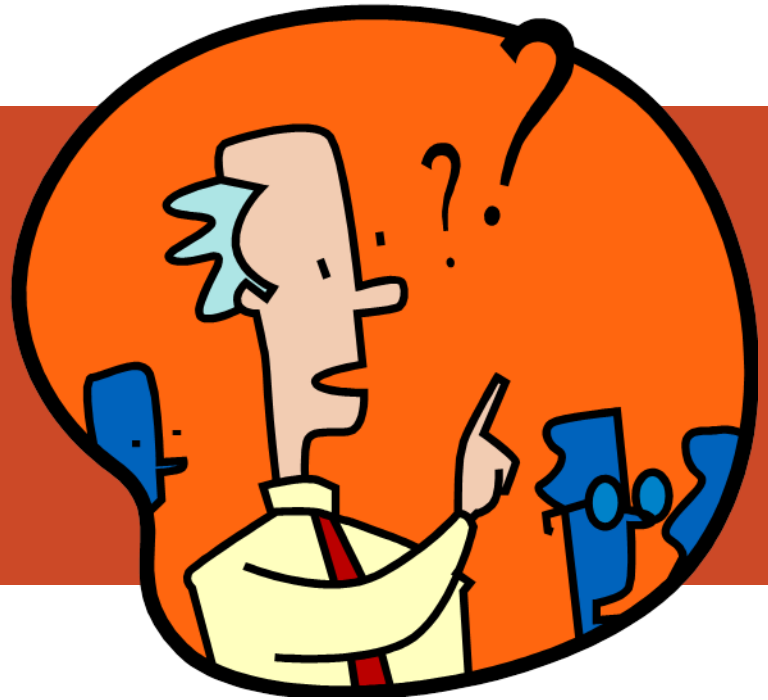
TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Keys

- Check with similar programs that have “figured it out.”

- Focus on the locus of control
  - (some places you can make changes, re-negotiate, etc…)
  - Other places you have to lobby for change, particularly legislatively

Questions, thoughts?



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