DSM-5 Implications for Insurance and Third Party Payers

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Now that there's no GAF s
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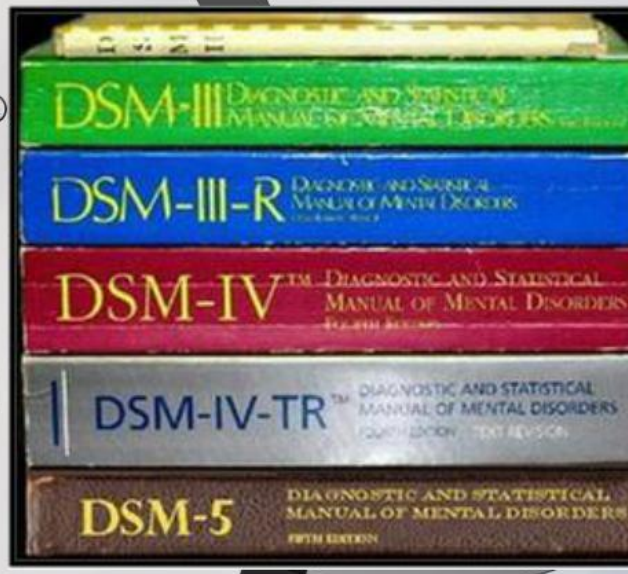
DSM-5 Paradigm Shift

- Multidimensional diagnosis
- Elimination of mind-body dualism
- Reduce NOS category-Augment specificity
- Enhance understanding of cultural and developmental influences
- Delineate between abnormal and disordered
- Modernize language
- Increase validity and reliability
- Accommodate ICD-10-CM



-5?

Multidimensional Assessment

- Similar disorders merged together with an added spectrum (e.g. Persistent Depressive Disorder, Autism Spectrum Disorder, Learning Disorder, Substance Use Disorder, Language Disorder)
- Spectrum classifications added to other disorders (e.g. ADHD)
- New hybrid multidimensional model for personality disorders in Section III

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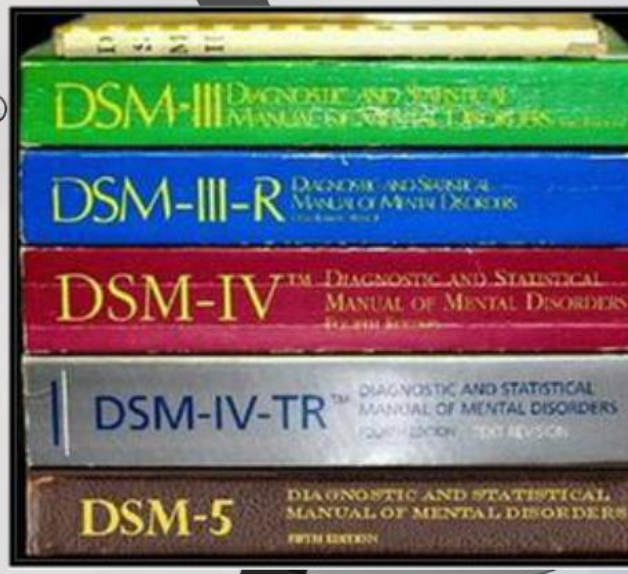

-5?

Eliminate Mind-Body Dualism

- "General Medical Condition" replaced with "Another Medical Condition"
- No multiaxial system
- Dropped specifier "With or Without Physiological Dependence" for substance use disorders
- Somatic Symptom Disorder and Pain Disorder de-emphasize "organic cause"

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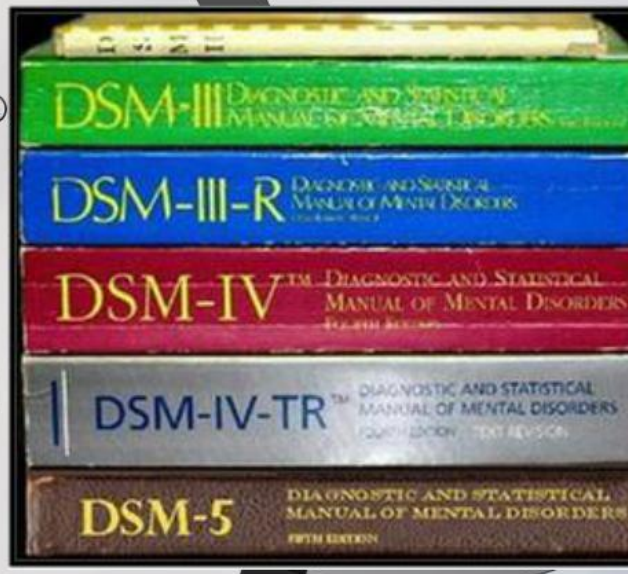

-5?

Reduce NOS Category

- NOS replaced with "Other Specified" followed by rationale or Unspecified (which is discouraged); e.g. Depressive Disorder, Other Specified, Does not meet duration criterion
- New disorders: Binge Eating Disorder, Mild Neurocognitive Disorder
- Added various sleep disorders
- Agoraphobia now a stand-alone disorder

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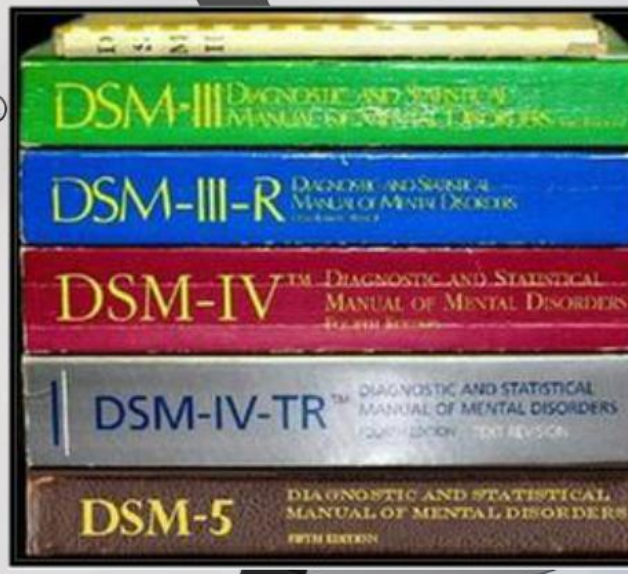

-5?

Cultural & Developmental Influences

- Revised definition of "mental disorder"
- Added possession-form manifestations to dissociative disorders
- New cultural formulation interview
- Re-ordered chapters based on life span
- Removed legal criterion from substance use disorders
- Life span examples added to ADHD criteria
- New diagnosis of Disruptive Mood Dysregulation Disorder
- Lowered PTSD diagnostic thresholds for children and adolescents; separate criteria added for children under 6
- Shubo-kyofu, Koro, and Jikoshu-kyofu as Other Specified Obsessive-Compulsive and Related Disorder

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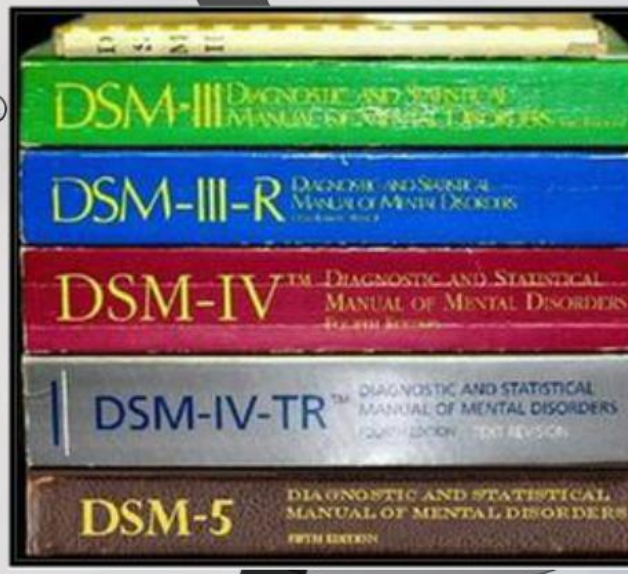

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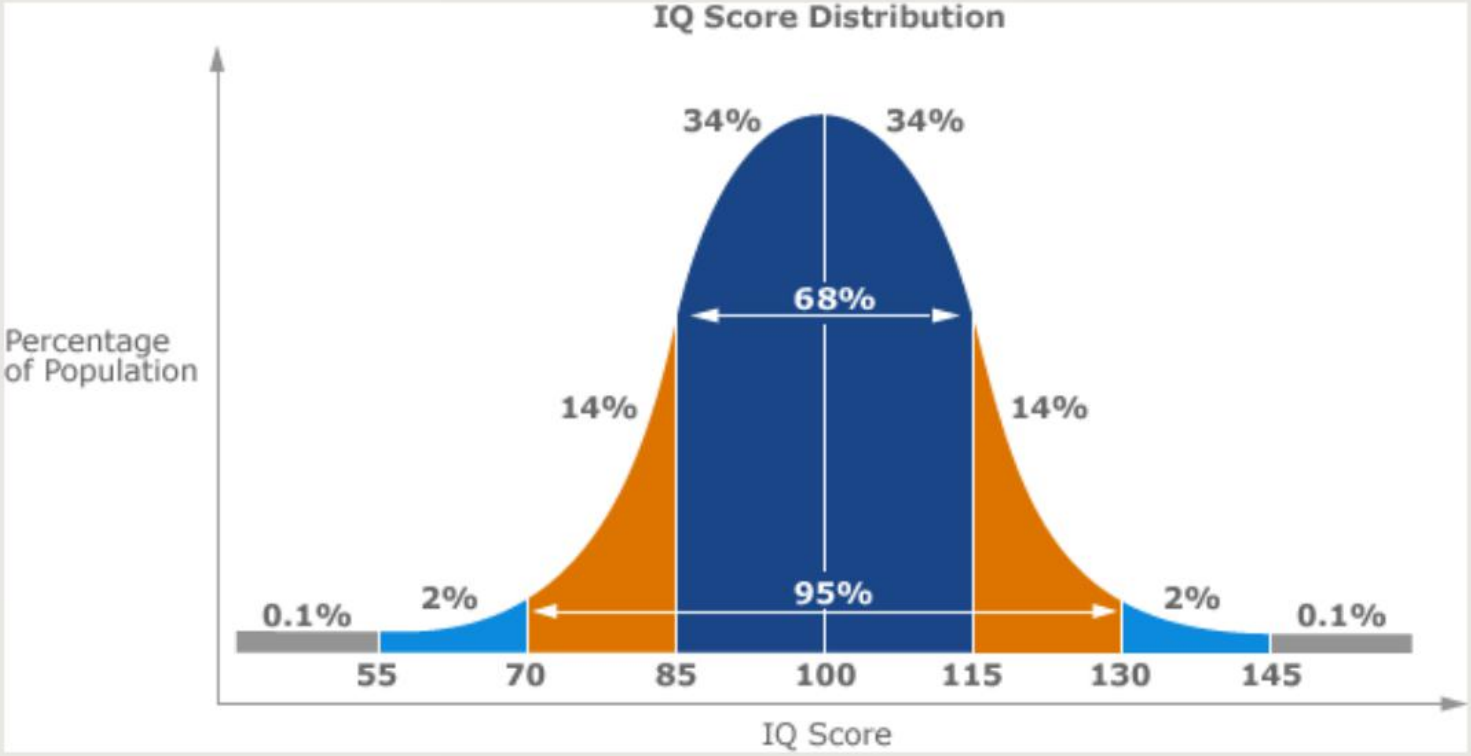
Abnormal vs. Disordered



- Revised definition of "mental disorder"
- "Paraphilias" reworded "Paraphilic Disorders"
- Intellectual Disorder severity now emphasizes adaptive functioning vs. IQ score

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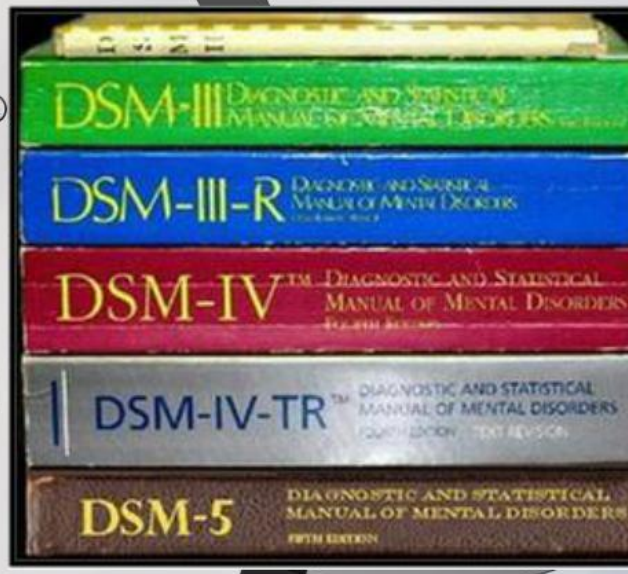

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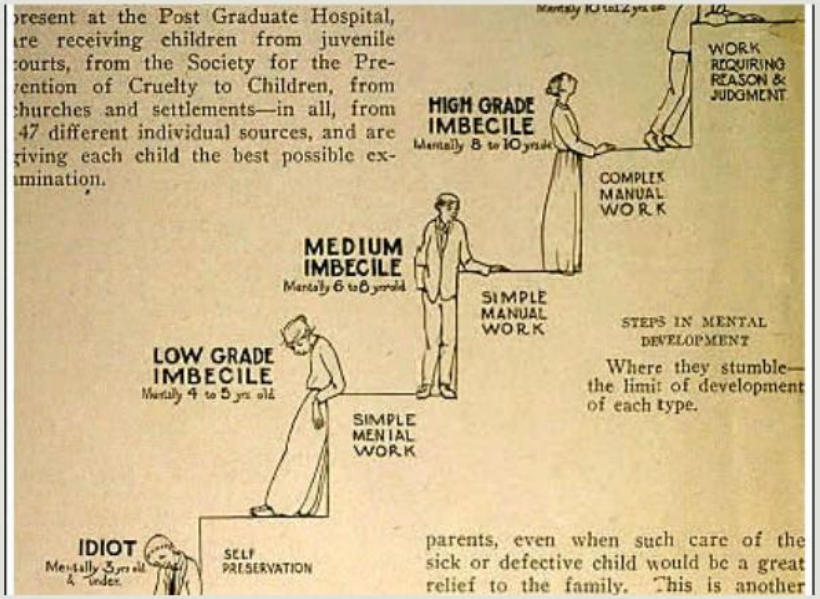
Oh, My...We've Come a Long Way!



Fun Fact: The Three Stooges were actually brilliant diagnosticians suggesting actual DSM-I diagnostic labels to each other. Who knew?

Modernize/Sanitize Language

- "Mental Retardation" now "Intellectual Disability (Intellectual Developmental Disorder)"
- "Hypochondriasis" now "Illness Anxiety Disorder"
- "Stuttering" now "Childhood-Onset Fluency Disorder"
- Roman numerals in DSM title now Arabic numerals (DSM-5 instead of DSM-V)
- Somatoform Disorders now "Somatic Symptom Disorders"
- "Pathological Gambling" now "Gambling Disorder"
- "Gender Identity Disorder" now "Gender Dysphoria"
- "Phonological Disorder" now "Speech Sound Disorder"

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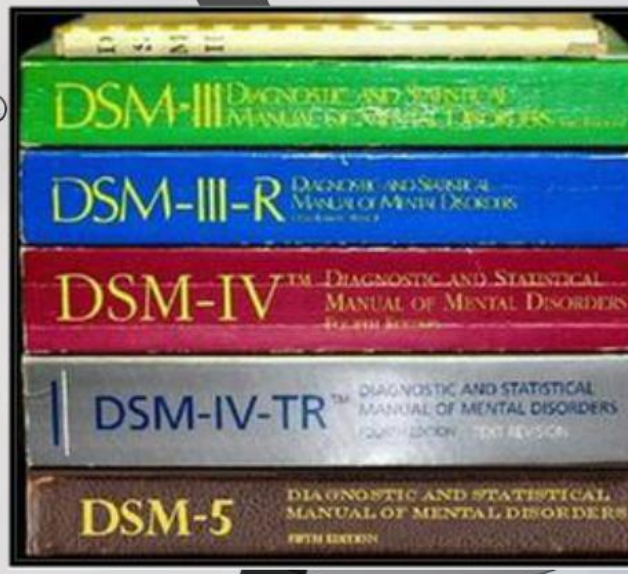

-5?

Increase Validity and Reliability

- Eliminated GAF score (suggested WHODAS)
- 6 month duration extended to entire life span for phobias to minimize diagnosis of transient fears
- Increased minimum # of symptoms for a substance use disorder to 2
- Eliminated childhood disorders chapter
- Extended Separation Anxiety Disorder to adults
- Added spectrum and specifier options to cut down on over-diagnosis (e.g. "with anxious distress")
- Implemented new findings in neuroscience (e.g. split bipolar and depressive disorders into separate chapters, absorbed Gambling Disorder into addictive disorders chapter)
- New "other specified' option
- Adjustment Disorders, PTSD, Acute Stress Disorder organized under "Trauma and Stress-Related Disorders" chapter
- Cross situational requirement added to ADHD
- Schizophrenia subtypes removed
- Antisocial P.D. linked to Conduct Disorder; Schizotypal Personality Disorder listed in Schzophrenia Spectrum Disorders chapter
- 2 subtypes of Reactive Attachment Disorder split into reaction Attachment Disorder and Disinhibited Social Engagement Disorder
- Eliminated bereavement exclusion for Major Depressive Disorder

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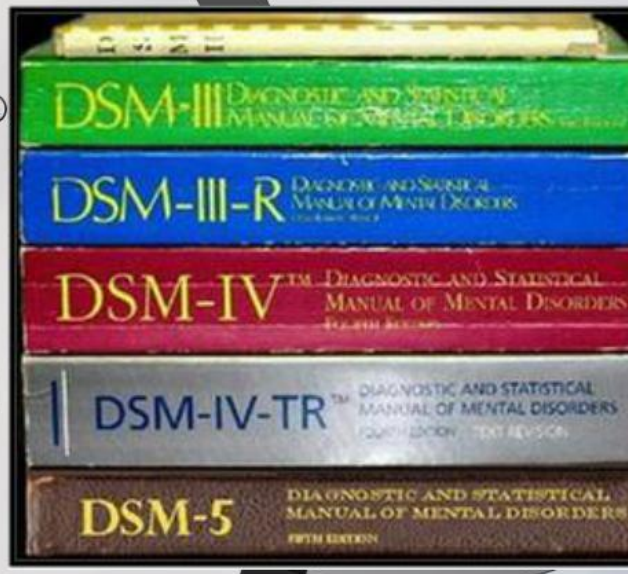
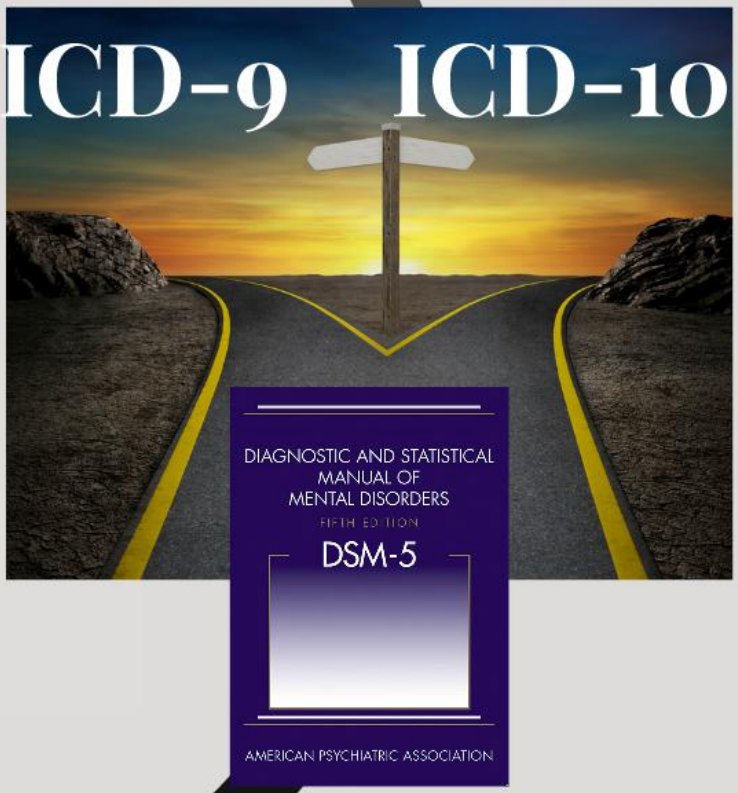


-5?

The Great Myth of DSM Codes

- There is no such thing as a DSM code!!!
- DSM-5 offers both ICD-9-CM and ICD-10-CM codes for each disorder
- e.g. Generalized Anxiety Disorder 300.02 (F41.1)



#MentalHealthMatters

3 Ways the Affordable Care Act is Increasing Access to Mental Health and Substance Use Disorder Services

ONE

The **Affordable Care Act** will expand **mental health** and **substance use disorder benefits** and parity* protections for **62 million Americans**—that's one of the largest expansions in behavioral health coverage in a generation.

TWO

Most health plans must now cover **preventive services** like **depression screening** for adults and **behavioral assessments** for children at **no cost**.

THREE

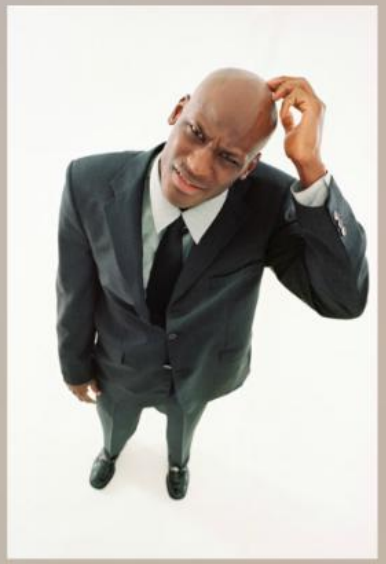
Starting in 2014, plans won't be able to deny you coverage or charge you more due to **pre-existing health conditions**, including mental illnesses.

**Parity means coverage for behavioral health services must be generally comparable to coverage for medical and surgical care.*

Thanks to the healthcare law and federal parity protections, **recovery is within reach** for more Americans. Visit healthcare.gov to learn how to sign up for coverage through a health insurance marketplace.

Learn more at **HealthCare.gov**

DSM-5 and Insurance FAQs



Question 1:

Now that there is no multiaxial diagnostic system, will insurance companies start paying for personality disorders and V-codes?

Answer: I Seriously Doubt It!

- V-codes aren't disorders; they are stressors and circumstances that may be a focus of clinical attention. Remember, insurance is for pathology, not circumstances.
- Most insurance companies reason that because personality disorders aren't very treatable, they shouldn't be covered. The mere fact that there is no delineation between Axis I and Axis II doesn't really address their reasoning. (Of course, they're pretty much wrong, but oh, well) http://www.apa.org/monitor/mar04/axis.aspx

Question 2:

When should I start using DSM-5?

Answer: As Soon As You're Ready, and You Should Get Ready Now!

DSM-5 is soooooo 2013 already.
Get with the times, man!

(DSM-5 was released 5/19/13)

Centers for Medicaid & Medicare Services (CMS) Says...

- It doesn't really matter; what matters is that you use the current ICD codes (I'm paraphrasing) https://questions.cms.gov/faq.php?id=5005&faqId=1817 . Until 10/1/15, HIPPA-regulated providers are required to use ICD-9.
- On 10/1/15, we must shift to ICD-10 (DSM-5 includes ICD-10 codes, but DSM-IV does not) http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-07-31.html

But...What About Your Contracts?

- Aetna: DSM: "Diagnoses submitted on claims must be current and consistent with the most recent DSM criteria" (Source: Aetna Behavioral Health Provider Manual, p. 6 http://www.aetna.com/healthcare-professionals/documents-forms/BH-Health-Provider-Manual.pdf published 2013)
- Blue Cross/New Directions Behavioral Health: Under "Guidelines for Treatment Record Documentation" on p. 46, "Diagnosis: The treatment record documents a DSM·V or ICD-9 diagnosis or clinical impression within the first three visits." https://www.ndbh.com/docs/providers-behavioral-health-plan-providers/provider-and-facility-manual.pdf?Status=Master

And Just to Confuse You...

- Humana/LifeSynch: The most recent provider manual on LifeSynch's website is from 2011, and it requires DSM-IV diagnoses (http://www.lifesynch.com/library/documents/resources/provider/provider_manual.pdf).
- Managed Health Network (MHN): Contract indicates "the diagnosis must be contained in the most recent edition of the DSM."
- Mental Health Associates (MHNet/Coventry): MHNet's Medical Necessity Criteria manual for 2014 specifically requires DSM-5
- Value Options online authorization process forces the clinician to enter a DSM-5 diagnosis
- Vocational Rehabilitation: Counselor Policy Manual specifies that the most current edition of the DSM should be used, yet it references a multiaxial diagnostic system

But, Aaron...What About the Forms???

"...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." http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/Insurance-Implications-of-DSM-5.pdf

Without the
stem, What
Diagnosis
ike?

Question 3:

Now that there's no GAF score, how will clinicians demonstrate level of functioning to insurance companies?

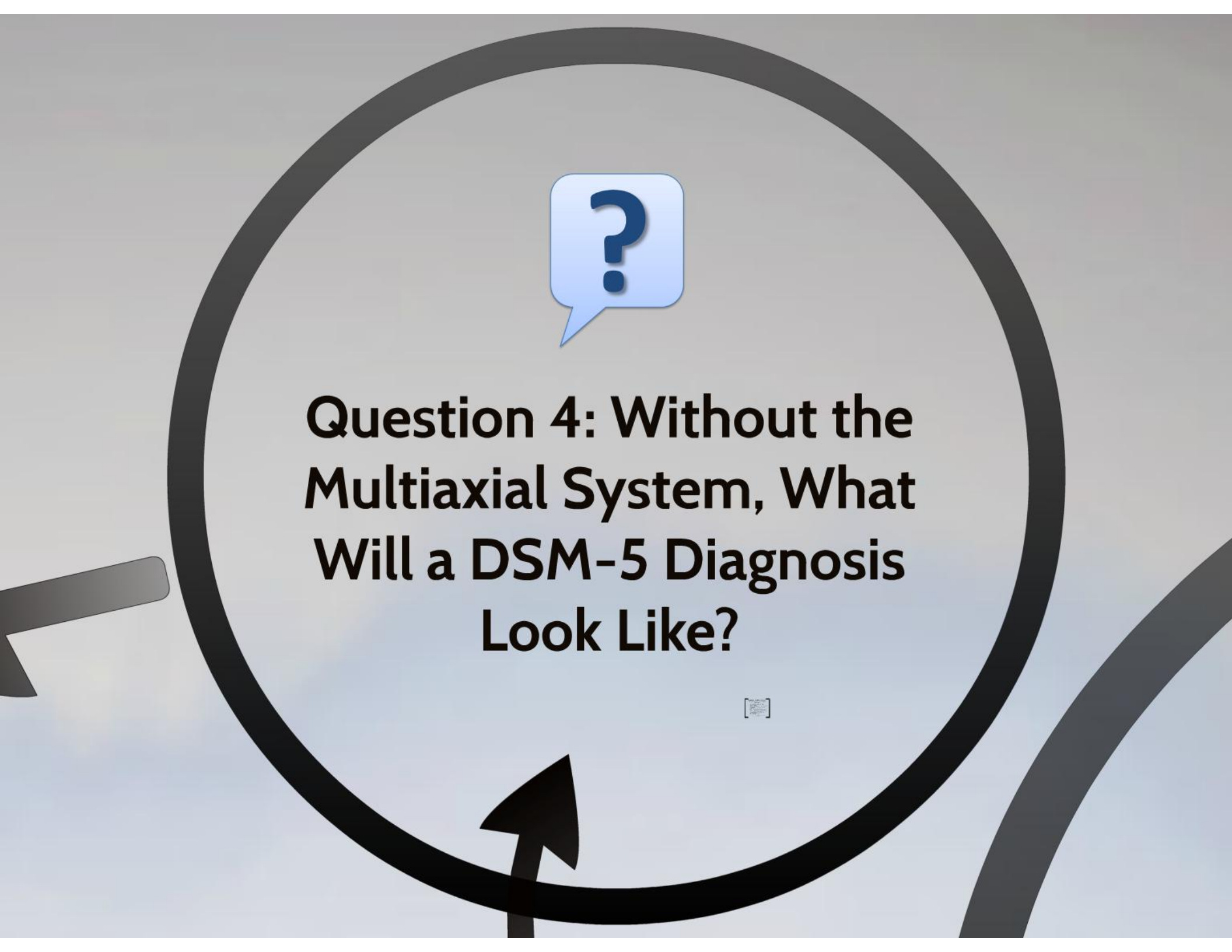
hift

Answer: Lots of Ways!

- World Health Organization Disability Assessment Scale (WHODAS)
- Tests (e.g. SCL-90-R, BDI-II)
- Severity specifiers
- Clinical documentation
- ASAM Treatment Criteria (for SUDs)

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

"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 method 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 being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes."
Source: http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1685444


Question 4: Without the Multiaxial System, What Will a DSM-5 Diagnosis Look Like?

List Disorders, Conditions, Stressors by Order of Clinical Importance and Focus of Intervention

- V62.21 Problem Related to Current Military Deployment Status
- 301.89 Other Specified Personality Disorder, Mixed personality features--dependent and avoidant symptoms
- 327.26 Comorbid Sleep-Related Hypoventilation
- 300.4 Persistent Depressive Disorder (Dysthymia), With anxious distress, In partial remission, Early onset, With pure dysthymic syndrome, Moderate
- V62.89 Victim of Crime
- 278.00 Overweight or Obesity

Source: King, J.H. (2013, August). Understanding and using the DSM5. Counseling Today, 56(2).

Question 6:

Now that there's no multiaxial diagnostic system, will counselors actually be paid for counseling focused on a non-mental medical disorder (e.g. Diabetes, Obesity)?

Answer: Nope. Practice within your scope as a mental health professional. You wouldn't get paid for treating Axis III with the DSM-IV, why would you get paid for treating those conditions now? That being said, the patient may have a diagnosable mental disorder that is related to the other medical condition, which you certainly could treat.

Remember: Insurance Companies Like Stats, Tests, and Measurements!

- ASAM Treatment Criteria (Substance Abuse)
- Symptoms Checklist 90-Revised
- Beck Depression Inventory, Beck Anxiety Inventory
- DSM-5 Cross Cutting Symptom Measures and WHODAS 2.0 (http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures)

DSM-5 Resources

- APA: www.dsm5.org
- My DSM-5 Resource Page (visit www.anorton.com, click on "Resources," then "Counselor Resources," then "DSM-5 Resource Page")
- There's an app for that! (http://www.appi.org/Pages/DSM5Mobile.aspx)

Q&A With the Presenter

www.anorton.com

Aaron Norton is a Licensed Mental Health Counselor, Certified Addictions Professional, and Certified Rehabilitation Counselor at Integrity Counseling, Inc., a group private practice in Largo, FL, where he specializes in mental health and substance abuse evaluation, cognitive behavioral therapies for anxiety and depressive disorders, Motivational Interviewing for addictive disorders, and clinical supervision as a Qualified Supervisor. He is the President of the Suncoast Mental Health Counselors Association and an Adjunct Instructor for the Dept. of Rehabilitation & Mental Health Counseling at the University of South Florida's College of Behavioral & Community Sciences. He is an experienced writer, trainer, presenter, and consultant.

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