Testimony to NCVHS

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The separation of the mental health system from the physical health system has a history rife with fragmentation, poor quality and higher cost. [1-4] If having two separate systems to treat the singular construct of health was sufficient, it should have worked by now.[5] Scientific evidence just won't allow us to proceed as if the brain and behavior are separable from the body. Treating one condition at a time, whether it is a "mental health condition" or a "physical condition" without taking into account their inseparability results in poorer outcomes and higher costs, rather than achievement of what seems to be a promising "value proposition" for healthcare.

However in the face of what we know and these indisputable facts, we still have fragmentation at almost all levels in healthcare. Consider how we train our healthcare providers. Consider how we pay our providers. Consider how our providers deliver care. Consider the various ways our providers are asked to document the services they have provided.

I have been asked today to testify regarding the DSM-V and the connection to ICD-10. You may ask, why start off with a discussion about mental health and physical health integration? The answer to that is at the heart of my testimony. However, I want to begin my testimony with the caveat that I am not an expert in DSM-5 and ICD-10, I am however, a health services and health policy researcher who has practical experience on the ground and across the country with helping communities better integrate mental health within healthcare. Said differently, I am an advocate for healthcare integration and do everything I can to help our communities address fragmentation at the clinical, operational, and financial level.

So let's start by outlining some of the components of the DSM-V and ICD-10.

Currently mental health professionals have two classification systems to use for coding mental disorders: (1) the International Classification of Diseases (ICD) and (2) the Diagnostic and Statistical Manual of Mental Disorders (DSM). Almost all mental health professionals in the U.S. use the DSM-IV-TR, which was developed by the American Psychiatric Association (APA). The DSM-IV-TR provides diagnostic codes solely for mental disorders; whereas the ICD-10-CM has codes for both physical and mental disorders. Of note, in my clinical training, we were never taught about the ICD but just the DSM, and I do not think I am alone in this regard. While the ICD-10-CM has codes for mental disorders, mental health professionals in the U.S. still primarily use the DSM for diagnoses and diagnostic codes. As many of you know, no other specialty in medicine has a separate code book for its disorders – all physicians from all specialty areas use the ICD, except psychiatry.

This fifth edition of DSM has been in process for almost a decade. The previous version of *DSM, the DMS-IV,* was completed nearly 20 years ago. The new DSM-V has several updates from the DSM-IV, many of which have been highly publicized and written about.

Mental health professionals like psychologists are often licensed independently to assess and diagnose individuals who seek care for a variety of health conditions – primarily mental health. Most mental health professionals have been trained using the DSM for this purpose and apply this manual in their day to day professional lives. Because mental health diagnoses must be conveyed in terms of ICD codes, psychologists and other mental health professionals should have some familiarity with ICD or use a crosswalk from some other system (such as DSM) to ICD in order to identify the appropriate codes and be paid for their services.

The Center for Medicare and Medicaid Services (CMS) has addressed the DSM previously with regard to ICD. Specifically, CMS responded in FAQ1817 stating:

"The Introduction to the DSM-IV indicates that the DSM-IV is "fully compatible" with the ICD-9-CM. The reason for this compatibility is that each diagnosis listed in the DSM-IV is "**crosswalked**" **to** the appropriate **ICD-9-CM** code. The DSM-IV is not a HIPAA adopted code set and may not be used in HIPAA standard transactions. It is expected that clinicians may continue to base their diagnostic decisions on the DSM-IV criteria, and, if so, to crosswalk those decisions to the appropriate ICD-9-CM codes. In addition, it is still perfectly permissible for providers and others to use the DSM-IV codes, descriptors and diagnostic criteria for other purposes, including medical records, quality assessment, medical review, consultation and patient communications." And it appears that this same commentary is true with the DSM-V as it is for the DSM-IV.

But let's take a deeper look into the differences in the DSM and ICD as it relates to mental health.

For example, the DSM-V lists several symptoms of the disease and then requires that a specific number of criteria are met within a specified time frame for the diagnosis to be given. Depression is offered here as an example – on the left are the criteria for depression within the DSM. Please note the highlighted words specifying number of criteria that needs to be met as well as the duration of symptomatology.

On the right, you can see how ICD-10 addresses depression. If one looks deeper into the ICD-10 you will see beyond these initial criteria and see a narrative format that describes more about the symptoms and the disease. In short, if one spends time comparing the two, the DSM applies specific criteria and time periods to the diagnosis while the ICD offers up more general criteria.

The DSM-V has a full listing of ICD-9/10 codes in it, both numerical and alphabetical, in its appendix. Meaning, any mental health provider using the DSM as a diagnostic manual can have access to the appropriate ICD 9/10 codes. This is important as there has often been confusion in the mental health field about the crosswalk and what was required for ICD from the DSM.

Interestingly enough, mental health providers are not required to use the DSM as HIPAA initially endorsed the ICD-9-CM as its "formal code set" for mental disorders. As you all well know, the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 to tackle the need for a consistent framework for electronic transactions. On August 17, 2000, HIPAA adopted specific code sets for diagnosis and procedures to be used in all transactions. The HIPAA official code book for diagnosing

mental disorders is the ICD-9-CM. All mental health care providers and health insurance companies must use these codes for all data collection and billing purposes.

According to an expert in the field, Dr. Dayle Jones from University of Central Florida: "When HIPAA first announced that the ICD-9-CM was its official code book for mental disorders, mental health professionals questioned whether they could continue using the DSM-IV." She stated that "Counselors can use the DSM-IV for diagnosis because the diagnostic codes appearing in the DSM-IV are derived from the ICD-9-CM. Thus, the DSM-IV codes automatically meet coding and reporting requirements under HIPAA."

It is important to note that there are other differences between the DSM-V and ICD-10. For example, the DSM was produced by a single national professional association for psychiatrists (the American Psychiatric Association) while the ICD was produced by a global health agency with a public health mission to help countries reduce the disease burden including mental disorders; the DSM generates revenue for the American Psychiatric Association while the ICD is free through the internet; the DSM was developed primarily by psychiatrists with the ICD's development being multidisciplinary; and, the DSM as a manual is approved by the American Psychiatric Association while the ICD is approved by the World Health Assembly.

As mentioned, health insurance companies must follow HIPAA, and since ICD is the HIPAA-compliant code set, this begs the question: what role does the DSM play in healthcare?

The answer to the question appears to primarily fall on the clinical relevance of diagnostic manuals for mental health. Since most of the ½ million mental health providers have received training on the DSM, this manual continues to have a profound influence on the provision of clinical services as well as the perception of its need in the mental health community. As stated previously, it does not appear to ever have been formally stated that the DSM has to be used by mental health providers (unless an agency determines it, state law dictates it, or a professional societies ethical guidelines include it).

Where does this leave us?

If one of the needs for US healthcare is to better defragment, we must understand what continues to make us disintegrated. Since the majority of U.S. mental health professionals – whether psychologists, counselors, social workers, or other others – have been trained predominately using only the DSM for diagnosis, are we inadvertently creating a workforce that perpetuates fragmented care? Rather than help unite our healthcare workforce writ large with a common system for diagnosis and classification, we continue to have a separate piece of that pie for mental health. Since most mental health providers have little knowledge about the ICD or the fact that the DSM diagnostic codes, which are required for billing and recording purposes, come from the ICD, it seems there is a substantial disconnect between some of our training programs and the reality of healthcare.

And while there is still much to be learned from the new DSM-V and the impact it will have on mental health and in healthcare, the fact that ICD 9/10 codes are included within the DSM-V help mental health providers with a connection to the ICD.

In preparation for this testimony I talked to several mental health trainees, including my own, and asked them about the DSM. One person I spoke to mentioned that their hospital did not require them to use the DSM at all, while another reported not using the DSM either but also admitting to not being educated enough on the ICD to speak competently about it. Regardless of the level of trainee, there appeared to be confusion or outright misunderstanding in the mental health field around the DSM and ICD. During my research for this testimony I was continually amazed at the confusion that exists in the field around the role of DSM for mental health providers. There are countless forums and frequently asked question sections on website solely aimed to help educate providers around the DSM-V and ICD-10.

Within the context of DSM-V's arrival and ICD-10's proliferation, there appears to be yet another opportunity to address fragmentation in healthcare and how our coding and classification systems, payment structures, administrative entities, and training programs offer us a chance to better integrate whole person healthcare.

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