Rationale for the Adoption of ICD-10-CM Criteria for the Diagnosis of Mental Disorders

Accurate, reliable standards must be used to describe, define and measure mental health conditions as well as the effectiveness of treatments, either psychological or medicinal. The unreliability of outcome research data of the pharmaceutical industry and deceptive advertising challenges the use of medications as the first (or only) line of care for mental conditions. Similarly, the unreliability of the DSM coding system creates problems when it is used to determine choice of evidence-based psychological treatments. The results of psychotherapy treatments using effective evidenced-based treatment methods are questioned when outcomes are judged by unreliable or defective DSM-V codes. When ICD diagnostic criteria are used interchangeably with DSM criteria even greater confusion occurs. (See Addendum Comparing ICD and DSM Criteria for PTSD as an example.) Psychology must challenge false evaluations of psychological interventions and care. The ICD-10 provides psychology with a practical starting point to establish reliable diagnoses for the accurate measurement of treatment outcomes in mental health care.

The American Psychiatric Association is lobbying to have DSM-V diagnostic codes for mental conditions adopted by CMS for use in ICD-10. These DSM-IV psychiatric labels and diagnostic codes have had a negative effect on the practice of psychology just as the CMS Evaluation and Management (E&M) codes have had a negative effect on the practice psychology. CMS developed E&M codes for mental care especially for psychiatry to reduce the persistent long-term shortage of mental health specialists by providing incentive payments for psychiatry. CMS E&M codes pay a 15% or more premium over standard care by physicians but CMS does not authorize psychologists to use them. This costly experiment of preferential pay for psychiatry failed to alleviate the shortage of psychiatrists. The magnitude of this shortage still persists today after nearly a 20-year trial!

CMS could quickly remedy this shortage of mental health specialists by reimbursing licensed prescribing psychologists as mental health specialists when billing under its E&M codes. No new law is required to reimburse licensed prescribing psychologists when billing with E&M codes. This policy change would remove a major barrier to integrating psychologists’ services with primary care practices proposed under the ACA law. Presently, it is more profitable for primary care practices to hire nurse practitioners with masters degrees that are reimbursed at higher CMS rates for mental health services than the specialty care by doctoral level psychologists!

By giving psychiatry preferential pay as prescribers of psychotropic medications, CMS has had the unintended effect of diminishing therapeutic skills in psychiatry! Psychiatry fervently, but futilely, recruited graduates of American medical schools for its residency training programs. Despite this effort, psychiatry was unable to fill even half its allotted training slots necessary to meet public needs for mental health care for the future. Subsequently, psychiatry resorted to recruiting foreign trained medical personnel (whose training was hopefully equivalent to US medical school training). Psychiatry secured J-1 waivers for foreign residents through the US Health Resource Services Administration. This strategy has clearly failed! Even though HRSA authorizes Medicare funds to be used to train foreign medical graduates for supplying health services where there are medical shortages in the US, needed psychiatry positions are not filled. Even with essentially “free” graduate medical education grants provided by Medicare to psychiatric residency programs, psychiatry has still not been
able fill its assigned residency training slots!

Psychiatry’s approach to recruit foreign graduates also risks compromising quality of mental health services. Psychiatry finds that 44% of its residents have limited fluency in English and are alien to the US culture. Verbal fluency is an essential treatment skill that is necessary for effective health care. Psychiatry was once thought of as a “talking profession” for the treatment of mental conditions, but this no longer the case. Psychiatric residency focuses on learning to prescribe and manage psychotropic medications. But, lack of verbal fluency in English is a primary barrier for psychiatric residents even to treat patients with medications. Psychotherapy training in psychiatry residencies has been reduced to essentially being a “lip service.” Thus, psychiatry has abandoned an essential psychotherapeutic skill, that of treating mental conditions with psychotherapy. Instead, psychiatry and has made psychotropic medications its first line of treatment.

Using psychotropic medications as the first (and often only) line of treatment requires matching medications with specific mental diagnoses. The American Psychiatric Association has scheduled publication of its proposed fifth edition of the Diagnostic and Statistical Manual (DSM-V) for May 2013. The DSM-V attempts to attenuate the defects of the DSM-IV Manual. However, the deliberations of the committee developing DSM-V were done with secrecy despite protests of outrage from knowledgeable members of the psychiatric community. The DSM-V proposed criteria for diagnoses has resulted in greater contentiousness rather than consensus among psychiatrists.

The DSM-V committee accepted lower standards for statistical reliability for its diagnostic criteria than are used in medical care generally. It has also developed questionable diagnostic criteria for otherwise normal behavior as medical conditions to be treated by medical doctors. If DSM-V is used as a diagnostic system, it is estimated that one out of four Americans will be egregiously labeled with a psychiatric disease. Furthermore, adoption of the proprietary DSM-V codes as public policy will convert public funds into private hands to the disadvantage of psychologists, their patients and the public at large.

It may come as a surprise to psychologists still using the DSM codes to bill for their services that payers convert these codes to ICD-10-CM that is the official version of ICD in current use in the US and is mandated for third party billing by HIPAA for all electronic billing and reimbursement.

The signatories, below, petition the American Psychological Association Practice Organization (APAPO) to adopt the International Statistical Classification of Disease and Related Health Problems of the World Health Organization as the standard for practice of psychologists diagnosing and treating mental disorders. We urge the immediate adoption of ICD-10 by APAPO.
Potential diagnostic confusion when there is no uniform standard and both the International Classification of Disease (ICD 10) and the Diagnostic and Statistical Manual IV are used interchangeably by practitioners.

Reclassification of military personnel with PTSD at Madigan Army Medical Center in Seattle last year has resulted in Congressional Hearings in both the House and the Senate. The reclassification caused a reduction in benefits of veterans of Iraq and Afghanistan. The psychiatric staff was reassigned and the Army has begun reviewing the records of all veterans with PTSD. This has raised questions about the use of DSM coding system of mental disorders.

Post Traumatic Stress Disorder is a diagnosis listed in the International Classification of Disease of the World Health Organization and in the Diagnostic and Statistical Manual of the American Psychiatric Association. There are differences in the criteria to diagnose PTSD between the ICD and DSM that result in diagnostic confusion in practice that may significantly effect benefits for Veterans and has resulted in major differences in estimates of the prevalence of PTSD in epidemiological studies. The Center for PTSD Studies of the Veterans Health Affairs posted on GOOGLE the following comparison of PTSD criteria of the ICD and DSM systems that are important for practitioners.

**Comparison of the ICD-10 PTSD Diagnosis With the DSM-IV Criteria**

Both sets of diagnostic criteria for PTSD include a history of exposure to a traumatic event and symptoms from each of three symptom clusters. The symptom clusters include intrusive recollections, avoidant symptoms, and hyper-arousal symptoms. Both also include a criterion concerning duration of symptoms. The ICD-10 does not specify a functioning criterion, as does DSM-IV-TR (Criterion F). The ICD-10 criteria are outlined below, with differences from DSM-IV-TR noted.

**Criterion A: Stressor**: Exposure to a stressor. Unlike DSM there is no subjective stressor criterion (A2).

**Criterion B: Re-experiencing** Persistent remembering of the stressor in one (as is true in the DSM-IV-TR) of: Intrusive flashbacks Vivid memories or recurring dreams Experiencing distress when reminded of the stressor

**Criterion C: Avoidance**

Requires only one symptom of actual or preferred avoidance. DSM-IV-TR requires three symptoms from this cluster, and includes both numbing and avoidance symptoms whereas the ICD-10 does not.

**Criterion D: Hyper-arousal**. Either D1, or two of D2. DSM-IV-TR requires two symptoms from this entire hyper-arousal cluster.

D1: Inability to recall
D2: Two or more of:
Sleep problems
Irritability
Concentration problems
Hypervigilance
Exaggerated startle response
**Criterion E**

Onset of symptoms within 6 months of the stressor. This differs from DSM-IV-TR which specifies symptom duration of greater than one month.

The DSM system has been taught in the graduate training of psychologists. The Center for Medicare and Medicaid is shifting to the ICD-10 CM to conform to healthcare reform of the ACA. The VHA criteria currently in effect are recommended for use by psychological practitioners for the following reasons.

Criterion A2 of the DSM requiring a subjective experience of anxiety or fear at the time of the trauma has been problematic. The ICD recognizes soldiers have been trained to focus on their duties rather than on their personal safety and to ignore subject experiences in the height of battle. Similar training to complete the mission despite personal risk occurs with firefighters and police as well. Victims of accidents and catastrophes only recognize the extent of the danger they had experienced. Criterion D Hyper-arousal Criterion D1 of the ICD recognizes that the person may not be able to recall the trauma or event triggering the PTSD. This is not specified in the DSM code. If hyper-arousal signs are listed as criteria both the ICD and DSM require two symptoms of hyper-arousal. DSM lists numbing as a symptom of PTSD but the ICD does not.

**Criterion C: Avoidance:** ICD requires one symptom one symptom of avoidance while the DSM requires 3 symptoms.

**Criterion E.** The ICD requires the onset of PTSD to occur within 6 months of the traumatic event. The DSM does not specify this time period. Rather DSM requires that the symptoms of PTSD last for a period of 1 month.

**References**
3. VA National Center for PTSD