# DSM 5

PART 1
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INTRODUCTION THROUGH BI-POLAR AND RELATED DISORDERS

## Training

- General info on DSM 5 and its organization
- Where to look for the diagnoses you currently use
- Major changes made to most common diagnostic categories
- Providing more clinical information in the diagnosis – coding and narrative specifiers – how to capture?
- ICD 10: coding comparisons

## Coding Diagnoses

- Two systems:
  - The DSM 5 has the clinical information necessary for you to code diagnoses correctly. That requirement is that you code to the highest level of specificity available and accurate.
  - The ICD codes are the codes that must be used on all of your claims to payers. These codes are cross walked in your software from DSM diagnoses to the ICD diagnoses. The current ICD system is ICD 9. It is changing in March in San Francisco to ICD 10.
- Both the ICD and the DSM coding systems are intended to synch with one another. But full synchronization will not happen until 2016?
- Both are intended to provide additional clinical detail in their numbering system. The goal is much greater specificity that providers and payers can use to approve care, develop treatment plans, assess outcomes without having to delve into the actual medical record.

## Coding Diagnoses

- Because they do not fully synch providers must document additional clinical detail in the medical records that will not likely be conveyed at this time in the code for the diagnosis.
  - For example, major depression has a number of new specifiers that provide important information about probable length of treatment, treatment outcomes, and the content of planning.
- This training, therefore, is in sort of two parts.
  - The largest part will provide you with changes from DSM IV that convey important clinical information or introduce new diagnoses.
  - The second part will be concerned with how you convert your diagnoses to ICD codes for claiming purposes.

## Coding Diagnoses

- The attempts through DSM and ICD to provide greater specificity is being duplicated throughout healthcare.
  - Orthopedic docs moving to something like 35000 codes in order to inform payer about condition of patient and what is being addressed medically.
    - Not just globally but at each visit
  - Payers want to be able to pay/stratify based on risk. In order to do this they need complete diagnostic information.
  - Payers also want to see that the documentation is there to substantiate the specific diagnosis that is being used for claiming and for treatment.

## Coding Diagnoses

- Will all this happen this year?
  - NO – these coding changes and changes to the documentation that will be required will take place over a number of years as payers and providers work to determine how to use the additional clinical specificity to the benefit of the individual's being served in an efficient and effective manner.
  - What will happen in SF?
    - Planning just beginning
    - The decisions are strategic – do you see the sickest? How does a payer or funder know this? Do your treatment plans take into account clinical risk? How are you measuring this? How do plans differ based on the severity of the individual's diagnosis?
    - How does the payer know what you are treating at each visit?
  - Do I need to change all my diagnoses now?
    - No do it over time but all must be converted by September 2015.

## DSM 5: Organization of the Manual

- Section 1: history and development of DSM 5
- Section 2: criteria sets for the 19 major classifications – also included in this section are the V and Z codes (medication induced movement d/orders and other conditions that may be a focus of clinical attention)
- Section 3: assessment measures, a cultural formulation, an alternative DSM 5 model for personality d/orders, conditions for further study
- Appendices: cross walks to ICD 9 and ICD 10. Organized alpha and numerical

## The Name and Other Changes

- DSM 5 no DSM V: allows for continual updates which allows for the very rapid scientific advances being made – so expect a 5.1, 5.2, etc.
- Goal is to move away from strict categorical structure and to incorporate dimensional measures to allow the clinician to better assess severity of symptoms, illness (not just check yes or no) and to better measure outcomes.
  - Are they getting better? How is this conveyed to payer?
  - In DSM 5 there was an attempt to integrate some of these dimensional measures in order to support greater specificity in treatment decisions and evaluation of outcomes.

## The Name and Other Changes

- Dimensional measures were incorporated in some categories:
  - Intellectual developmental disorder – not simply an IQ measure but also now includes a dimensional assessment of "adaptive functioning"
  - Merging of substance abuse and dependence into one category of use with a scale of severity – mild to severe
  - Personality d/order work not accepted but described in Section 3
- Optional dimensional measures:
  - Chapter 3 of DSM – including e.g. Clinician Rated Dimensions of Psychosis Symptom Severity – look at that later
- Although incorporating dimensional measures DSM 5 still retains a primarily categorical approach.

## Organization

- Reorganization of the 19 major diagnostic classes
  - Developmental life span – begins with mental disorders usually diagnosed in infancy/early childhood
  - In all categories diagnoses most associated with children are listed first
  - Also an attempt to order according to those that are often or appear to be considered related. E.g. bipolar after schizophrenia; dissociative d/order in between trauma and somatic symptom
  - In disorders formerly thought of as "kid" or "adult" disorders – attempts to provide language and clinical examples that span life span, e.g. ADHD – talks about effects of illness at work as well as in school

## Use

- Its big – today we are talking major changes – See Handout
- Diagnosing increasingly important:
  - Meeting diagnostic criteria is becoming increasingly important with the advent of chronic health homes, outcome and risk based pricing, etc.
  - Payers understand that many psychiatric disorders have characteristic courses and expected outcomes – they will watch for these.
  - Some treatments are evidence based only for certain diagnoses or diagnostic pairs

## Definition of Mental Disorder

- ...a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or development processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual.

## Definition of Mental Disorder

- A diagnosis does not mean treatment is needed.
  - Critical to medical necessity is the severity of symptoms, the subjective distress and the functional impact and sometimes other issues like the impact of the disorder on a medical condition.
  - Some do not meet full criteria but may need treatment. E.g. Other specified or unspecified.

## Recording the Diagnosis

- Some changes that are coming will be dependent on payer requirements:
  - With many individuals having multiple diagnoses and, in some cases, receiving specific services that are evidenced based only for a specific diagnosis - it is likely that over time BH providers will have to be careful to list first the diagnosis that is the primary reason for the visit. Then list others, if addressed, after that.
  - If the disorder is due to a medical condition, it must be listed first. This is true for both ICD 9 and 10.
  - Multiple diagnoses are encouraged – e.g. no more polysubstance must list each substance separately; risk based payments based in both severity and numbers of diagnoses

## Coding the Diagnosis

- DSM 5 and ICD 9 march in lock-step ( sort of)
  - There is an ICD 9 code for each DSM 5 diagnosis –however some diagnoses may use the same code because a more specific code not available. Orgs need to figure out how to manage this issue and how it will affect any data mining – e.g. full narrative description in assessment? SEE HANDOUT
  - ICD 9 is a 3 to 5 digit number
  - ICD 10 codes are listed parenthetically next to the ICD 9 code in the training slides
  - DSM 5 used the ICD 9 code that most specifically matched the DSM diagnosis.

## Coding the Diagnosis

- Some diagnoses have a 3 digit code, but most have 4 or 5 for greater specificity
  - In DSM 5 there are certain BLANKS that must be filled in by the provider. These will seen more in the move to ICD 10. For example, with child abuse the code will change depending on whether it is an initial or follow up visit. With certain substance induced disorders the code will change depending on whether or not there is a co-occurring substance use disorder and its severity.
  - ICD 10 will require even greater specificity in some cases

## ICD 10

- Structure of code:
  - 1-3 = category
  - 4-6 = etiology, anatomic site, severity, or other clinical detail
  - 7= extension
- Greater detail
  - T74 -Adult and Child abuse, neglect and other maltreatment
  - T74.0 -Neglect or abandonment, confirmed
  - T74.11 -Adult physical abuse, confirmed
  - T74.11XA - Adult physical abuse, confirmed, initial encounter= the code

## Coding the Diagnosis

- ANATOMY OF A DIAGNOSIS
  - DIAGNOSIS –new rules on what goes first, etc.
  - SUB-TYPES: these are mutually exclusive – so instruction is to "specify whether" - e.g. delusional subtypes: jealous, persecutory, somatic, etc.
  - SPECIFIERS: there are many of these and in some cases new and important specifiers.
    - Individual may have more than one – "specify if"
    - Information is relevant to treatment course and its descriptive features
  - SEVERITY: form of specifier that is linked – still very loosely – to the level of support needed; course of the illness – "specify current severity"
  - For now – coding strategy – what is important to capture and how will you do it? We will show later how some specifiers can be added into the diagnostic information in AVATAR.

## Coding the Diagnosis

- Diagnostic uncertainty: usually not billable
  - V or Z codes which are usually not covered by themselves – there are some exceptions. There are also unspecified codes available. E.g.:
    - 300.9 – unspecified mental disorder
    - 298.9 – unspecified schizophrenia spectrum or other psychotic disorder
  - One provides more clinical information than the other but it would be expected that in the narrative documentation there would be an explanation for why – specifically –a more certain diagnosis could not be reached. See next slide.

## Coding the Diagnosis

- Other specified or unspecified
  - Other specified: allows clinician to give reason why does not meet criteria in narrative –with further versions of ICD will have ability to be specific through coding in some cases.
    - In some cases specific examples of when "other specified" could or should be used are given, e.g.
      - Persistent auditory hallucinations in the absence of other features
      - Short duration cyclothymia (less than 24 months)
  - If not specified – use "unspecified diagnosis"
    - Use also when not sufficient information to make a more specific DX –payers are beginning to watch these and the length of time these stay in place now that "other specified" is available.

## Multi-Axial Will No Longer Exist

- First found in DSM III –but argued about ever since
  - Axis II –sometimes targeted for non-payment
  - Axis III – overlooked in developing plans of care (real problem with advent of aging population; chronic illness models; impact of meds on development of medical illness and vice versa)
  - Axis IV – socio-economic impact on severity and outcomes (never changes; ? Real impact on course of illness)
  - Axis V – combo of both risk and functionality in a single number (arbitrary and inaccurate)

## Multi-Axial DX Gone

- Axis IV: use the V and Z codes located in ICD 9 and 10 – located in Section 2 of DSM.
  - Benefit is now these can be coded and used for data-mining
  - Changes can be watched –e.g. homelessness
- Axis V:
  - WHODAS – multiple versions – functional assessment.
    - WHODAS is not required but interesting the spotlight it now puts on functional assessment of the individual.
    - WHODAS asks in areas not always seen in biopsychosocial assessment – later
  - Risk assessment –usually included in body of most assessments. DSM 5 does suggest and publishes one.

## Multi-Axial DX Gone

- Individual with schizophrenia, moderate cannabis use disorder, high blood pressure, COPD, homeless, severe socio-economic problems, poor education, GAP 45
  - 295.90 Schizophrenia
  - 304.30 Moderate Cannabis Use Disorder
  - I10 Hypertension
  - J44.9 COPD
  - V60.0 Homelessness
  - V60.2 Extreme poverty
  - V62.3 Academic or educational problem

## Changes in Neuro-developmental D/orders

- Revamp of former chapter "Disorders Usually First Diagnoses in Infancy, Childhood, or Adolescence"
- First chapter according to new organization of DSM
- Mental retardation term gone. Replaced by intellectual disability or intellectual developmental disorder.

## Changes in Neurodevelopmental D/orders

| | |
|---|---|
| Intellectual Disabilities | 317, 318.0, 318.1, 318.2 (F70, F71, F72, F73) |
| Communication Disorder | |
| Autism Spectrum Disorder | 315.39 (F80.9, 80.0, F80.81) |
| Attention-deficit Hyperactivity Disorder | 299.00 (F84.0)<br>314.00, 314.01 (F90.0, 90.1, 90.2) |
| Specific Learning Disorder | 315.00, 315.1, 315.2 (F81.0) |
| Motor Disorders | 315.4, 307.xx (F82), 307.3 (F98.4) |
| Other Specified Neurodevelopmental Disorder | 315.8 (F88) |
| Unspecified Neurodevelopmental Disorder | 315.9 (F89) |

## Changes in Neurodevelopmental D/orders

- Includes:
  - Intellectual disabilities
  - Communication disorders
  - Autism Spectrum disorder
  - Attention-deficit/Hyperactivity disorder
  - Specific learning disorder
  - Motor disorders
  - Other neurodevelopmental disorders
- Only some of these diagnoses can be primary depending on your license, credentials, services, and the payer you are billing.

## Changes in Neurodevelopmental D/orders - Intellectual

- Intellectual disability (Intellectual developmental disorder – ICD 11 term)
  - Despite name change and greater recognition of its multi-domain impact, still considered to be a mental disorder
  - No longer a reliance on IQ as sole determinant of diagnosis or severity – recognizes that the "impairment in general mental abilities" has an impact on adaptive functioning.
  - Criteria same: (A)deficits in intellectual functioning, (B)adaptive functioning as well as (C) onset during developmental period
    - Criteria B met via analysis of adaptive functioning in TABLE I
    - Criteria B met when at least one domain requires support in order for individual to perform adequately in school and/or work and/or home. Must be directly related to Criterion A

## Changes in Neurodevelopmental D/orders - Intellectual

- Specifiers for severity of adaptive functioning organized by TABLE 1 domain chart.
  - Conceptual : intellectual functioning
  - Social: social and communicative behavior
  - Practical: personal needs (including legal and health decisions, raising a family), independent employment, recreational
  - As move up scale level of supports needed, intensity, and length of time supports needed increases
  - So requires standardized psyc testing but adaptive functioning is ascendant in diagnosing.
  - Specify severity (not sub-type): Mild (317), Moderate (318.0), Severe (318.1), Profound (318.2) - no change in name but change in how determined – Note: severity specifiers have different codes.

## Changes in Neurodevelopmental D/orders - Intellectual

- 315.8: Global Developmental Delay: child under age 5 when clinical severity cannot be reasonably assessed. Requires periodic reassessment. Billable?
- 319: Unspecified IDD – must be over 5; should only be used in exceptional circumstances; usually there is a disability or reason why standardized testing cannot be used – e.g. blindness

## Changes in Neurodevelopmental D/orders - Communication

- Communication Disorders: deficits in language, speech and communication- not usually primary
  - Language d/o: combines DSM expressive and mixed receptive-expressive language d/o
  - Speech/sound d/o former DSM IV phonological disorder
  - Child-onset fluency d/o former stuttering
  - Social (pragmatic) communication d/o – New for persistent difficulties in both verbal and non-verbal communication
    - Note: this cannot be diagnosed if child also exhibits the restricted, repetitive behaviors, interests, and activities associated with autism spectrum d/o (see next slide)
    - Maybe some individuals currently diagnosed with PDD?

## Changes in Neurodevelopmental D/orders - Communication

- Social (pragmatic) communication d/o
  - Criterion A: persistent difficulties in the social use of verbal and non-verbal communication. Must be manifested by every one of 4 difficulties listed: using communication for social purposes; impairment in ability to change communication to match context; difficulty following rules for conversation or storytelling; difficulties in understanding what is not explicitly stated
  - Criterion B: deficits result in functional limitations – including social, academic, and occupational performance
  - Criterion C: onset is in early development but may not be fully manifested at that time until demands exceed abilities
  - Criterion D: not attributable to another diagnosis
- Rare in children younger than 4 because of need to assess language to diagnose
  - Some milder forms may not be apparent until early adolescence when demands more complex.

## Changes in Neurodevelopmental D/orders - Autism

- Combines:
  - autistic disorder,
  - Asperger's disorder,
  - pervasive developmental disorder,
  - childhood disintegrative disorder,
  - Rett's disorder.

## Changes in Neurodevelopmental D/orders - Autism

- Autism Spectrum Disorder – consensus that formerly separate d/orders are actually a single condition with different levels of severity of symptoms in:
  - Social communication and interactions ( Criterion A)
  - Restricted, repetitive behaviors, interests, and activities (RBBs) (Criterion B)
  - Must have symptoms in both core areas – Criterion A and B
    - Diagnose Social Communication Disorder if RBBs not present
      - Caution that complete developmental history needed as RBBs may have been present in past

## Changes in Neurodevelopmental D/orders - Autism

- Specify level: DSM chart (pg 52) for each of Criterion A & B to determine severity – see handout
  - Level 3: requires very substantial support
  - Level 2: requires substantial support
  - Level 1: requires support

## Changes in Neurodevelopmental D/orders - Autism

- Criterion C and D and E:
  - C: early onset which may have been masked by supports
  - D: symptoms cause significant impairment in social, occupational, other functioning
  - E: not better explained by another diagnosis

## Changes in Neurodevelopmental D/orders - Autism

- Specify if: w/wo intellectual impairment, language impairment; association with known genetic, environment, or medical factor; association with another neurobehavioral d/order; with catatonia
  - Note for medical, environmental or genetic factors – may require another code and may need to be coded first
  - Catatonia requires a separate code as well
- Record by:
  - If medical/genetic/environmental/neurobehavioral: Autism Spectrum D/order associated with.....
  - Severity specified by level of support needed in each of the two domains in Table 2;
  - Then record if w/w/out intellectual impairment
  - Then language impairment – with description e.g. no intelligible speech
  - Catatonia should be recorded separately: Catatonia associated with Autism Spectrum D/order

## Changes in Neurodevelopmental D/orders - ADHD

- Added to this chapter to reflect ADHD relationship to brain development
- Similar to DSM IV –same 18 symptoms and same divide into categories of: inattention and impulsivity/ hyperactivity (A1 and A2)
  - 6 needed for children in one domain
  - 5 needed for adults and adolescents 17 years +
  - There is a mixed type specifier
- New examples added to assist with diagnosing across age ranges – e.g problems not just at school but also at work
- Criterion C: Cross-situational requirement strengthened to "several" symptoms in two or more settings – e.g. home, school, work, friends, etc

## Changes in Neurodevelopmental D/orders - ADHD

- Criterion B: Onset criterion changed:
  - Before: symptoms causing impairment before age 7
  - NOW: several present prior to age 12
- Use specifiers that map to original sub-types (different code in some cases) – now used to describe the current presentation rather than a sub-type
  - Combined: both A1 &A2 met for prior 6 mos (314.01)
  - Predominately inattentive: A1 but not A2 prior 6 mos (314.00)
  - Predominately hyperactive/impulsive: A2 but not A1 prior 6 mos (314.01)
- Specify also if: in partial remission = met criteria before, fewer than full met now; BUT still impairment in functioning
- Specify severity – mild, moderate, severe – related to both numbers of symptoms but also severity even if only minimum needed – must show relationship to problems in social/occupational functioning.
- Co-morbid diagnosis with Autism SD allowed

## Changes in Neurodevelopmental D/orders - ADHD

- One more time - NO NOS, now instead:
  - Other specified: do not meet criteria at this time; used when clinician wants to communicate reason why doesn't meet e.g. Other specified, with insufficient inattention symptoms
  - Unspecified: does not meet criteria but specific reason not specified or where there is insufficient information to make a more specific diagnosis
  - These conventions hold true throughout the DSM 5
  - Note there must be an accompanying clinically significant distress or impact on functioning to diagnose at all – this must be in the documentation to support either "other" or "un"

## Changes in Neurodevelopmental D/orders – Specific Learning D/O

- Can be diagnosed as secondary, not primary illness
- Combines DSM IV's reading, mathematics, disorder of written expression, and learning d/order NOS
  - Reflected concern that 4 separate distinct dx not justified
  - Specifier subtypes for reading (315.00), written expression (315.2) and math (315.1) – separately coded
  - Recognition that often not just one
  - Specify current severity: mild, moderate, severe – this reflects impairment overall
- Each must be coded separately
  - Also listed under each are sub-skills that are impaired. These must be documented also
- E.g. Learning disorder, severe, with impairment in reading –then list specific subskills impaired
  - "with impairment in reading and impairment in the sub-skills of word reading accuracy and reading rate."

## Changes in Neurodevelopmental D/orders – Motor Disorders

- Motor Disorders include:
  - Developmental coordination disorder
  - Stereotypic movement disorder
  - Tourette's disorder
  - Persistent motor or vocal tic disorder
  - Provisional tic disorder
  - Other and unspecified tic disorders
- Tic criteria are standardized across all of these disorders: " sudden, rapid, recurrent, non-rhythmic motor movement or vocalization"
  - May "wax and wane in frequency, but have persisted for more than a year"
- Stereotypic movement disorder: (Attempted in DSM 5 to more clearly distinguish between it and body focused repetitive behavior d/orders in OCD which include obsessions and repetitiveness driven by obsessions, SMD is driven but purposeless. See differential discussion).
  - Specify with or w/o self-injurious behavior
  - Specify if associated with known medical, environmental or genetic d/order –may need to be coded first
  - Specify severity

## Changes in Neurodevelopmental D/orders – Other

- Conduct disorder moved to a new chapter "Disruptive, Impulse-Control, and Conduct Disorders"
- Elimination orders have own chapter
- Feeding disorders, e.g. pica moved to combined chapter with other eating disorders
- Separation anxiety disorder and selective mutism now in Anxiety Disorder chapter
- Reactive Attachment Disorder moved to Trauma and Stressor Related Disorders

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder 301.22 (F21)
- Delusional Disorder 297.1 (F22)
- Brief Psychotic Disorder 298.8 (F23)
- Schizophreniform Disorder 295.40 (F20.81)
- Schizophrenia 295.90 (F20.9)
- Schizoaffective Disorder (bipolar or depressive type) 295.70 (F25.0, F25.1)
- Substance/Medication-Induced Psychotic Disorder – see substance-specific codes – included here but not discussed
- Psychotic Disorder Due to Another Medical Condition (with delusions or with hallucinations) 293.81, 293.82 (F06.2, F06.0)

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Catatonia Associated with Another Mental Disorder 293.89 (F06.1)
- Catatonic Disorder Due to Another Medical Condition 293.89 (F06.1)
- Unspecified Catatonia 293.89 (F06.1)
- Other Schizophrenia Spectrum and Other Psychotic Disorder (other specified or unspecified) 298.8 (F28)

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Generally arranged along a continuum of less to more severe
- Two notable changes:
  - New assessment measure for symptoms of psychosis – acknowledgement that symptoms are heterogeneous but that severity can be predictor of cognitive or neurobiological deficits. See handout –symptoms measure include: hallucination, delusions, disorganized speech, abnormal psychomotor behavior as well as depression and mania and cognitive impacts
    - Scoring scale given. No composite scoring. Suggest noting movement along scale.
    - Not required but suggested for certain diagnoses specify severity using this Clinician Rated Assessment.
  - New specifiers that can be used only after a one year duration of the disorder – limited to delusion, schizophrenia, and schizoaffective

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- For Delusional, Schizophrenia, and Schizoaffective:
  - Specifiers only after 1 year duration of disorder:
    - First episode, currently in acute episode
    - First episode, currently in partial remission
    - First episode, currently in full remission
    - Multiple episodes, currently in acute episode
    - Multiple episodes, currently in partial remission
    - Multiple episodes, currently in full remission
    - Continuous: can include some brief subthreshold periods
    - Unspecified
  - For catatonia specifier you must use an additional code.

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Generally arranged along a continuum of less to more severe
- Schizotypal Personality Disorder listed here but discussed in personality disorders
- Delusional disorder changes:
  - Non-bizarre removed as adjective in Criterion A – now a specifier
  - Somatic subtype edited to ensure those with a delusion regarding a physical defect are diagnosed with body dysmorphic disorder now in OCD chapter. Also see differentials for OCD and Body Dysmorphic – New criterion that symptoms cannot be better explained by another…
  - No longer separates delusional and shared delusional
    - If shared beliefs but does not meet criteria for delusional d/order then "other specified" used
  - Specifiers for type: e.g. grandiose, jealous, with bizarre content

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Shared psychotic disorder gone –rarely used and usually other diagnoses available
- Schizophrenia:
  - Special treatment for bizarre delusions and special types of hallucinations gone ( DSM IV allowed for just one symptom if delusions "bizarre" or hallucinations included "running commentary/more than one voice"
    - Instead need two of symptoms in Criterion A and
      - Criterion A: delusions, hallucinations, disorganized speech, grossly disorg or catatonic behavior, negative symptoms
    - Individual must now have at least one of three core positive symptoms: delusions, hallucinations, and disorganized speech
  - Sub-types eliminated: determination that clinical utility and predictive validity poor – no distinct responses to treatment or course of illness. Instead dimensional approach to rating severity of core symptoms –See Clinician-Rated Dimensions of Psychosis Symptom Severity in Section III. 1-5 scale

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Schizo-affective disorder changes:
  - Major change is that duration of major mood episode (manic or depressive) concurrent with Criterion A of schizophrenia
    - DSM IV: present for a "substantial portion of the total duration of the active and residual periods of the illness"
    - DSM 5: present for a " **majority** of the total duration of the active and residual portions of the illness"
      - If no then schizophrenia, not schizoaffective

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Catatonia (Specifier) –used with another mental disorder
- Catatonic Disorder Due to another Medical Condition
- In both include name of other disorder in narrative – e.g. Catatonia Due to Major Depression
- Both contexts require 3 catatonic symptoms out of the 12 listed
  - Much less complicated than DSM IV
- Criteria described and diagnosed with specifier and separate code, Catatonia:
  - With another mental disorder – it's a specifier for another diagnosis – code first mental disorder, then code for catatonia
  - Due to another medical condition ( code first medical then catatonic disorder) – separate diagnosis concurrent with another medical condition
  - Unspecified – code first note 781.99 other symptoms involving nervous and musculoskeletal systems - does not meet full criteria

## Changes in Schizophrenia Spectrum and Other Psychotic Disorders

- Catatonia
  - Unspecified – code first note 781.99 other symptoms involving nervous and musculoskeletal systems, then 293.89 unspecified catatonia when:
    - Catatonic like symptoms that cause clinical distress but underlying
      - Medical disorder unknown
      - Mental health disorder unknown
    - Full criteria for catatonia not met
    - Not enough information

## Changes to Bipolar and Related Disorders

Bipolar I Disorder 296.40-296.46 (F31 series), 296.50-56 (F31 series)

Bipolar II Disorder 296.89 (F31.81)

Cyclothymic Disorder 301.13 (F34.0)

Substance/Medication-Induced Bipolar and Related Disorder – see substance abuse section – listed but not discussed here

Bipolar Disorder Due to Another Medical Condition 293.83 (F06.33, F06.34)

Other Bipolar and Related Disorder 296.89 (F31.89)

Unspecified Bipolar and Related Disorder 296.80 (F31.9)

## Changes to Bipolar and Related Disorders

- Mood disorders divided into bipolar and related disorders and depressive disorders with each in its own chapter
  - Biopolar disorders now own category of conditions
- Bipolar I and II: many of same as DSM IV
  - Bipolar I= criteria met for at least one manic episode (may be preceded or followed by hypomanic or depressive episode )
  - Bipolar II = current or past hypomanic and major depressive episode (both) /no mania
- Concern re: earlier identification of Bipolar I and II so Criterion A in addition to emphasis on mood:
  - New emphasis on changes in activity and energy and not just mood – "abnormally and persistently increased goal directed activity or psychomotor agitation" (Manic and hypomanic)
- Criteria for Bipolar I, most recent episode mixed have been dropped and now a specifier of "with mixed features" can be applied to episodes of mania or hypomania when depressive features present or alternatively for episodes of depression when features of mania/hypomania present

## Changes to Bipolar and Related Disorders

- Recording Bi-Polar I
  - Bi-polar I disorder, type of current or most recent episode, severity/psychotic/remission specifiers, other specifiers
    - There are separate codes for all but the last "other specifiers"
    - Severity applied only if currently meet criteria for a mood episode
    - If psychotic features, this is coded rather than a code for severity
- Recording Bi-Polar II
  - One code only so that type of most recent episode, severity/psychotic/remission specifiers not available in code BUT should be in narrative:
    - Bi-polar II disorder, current episode _____, severity/psychotic/remission specifiers, other specifiers
    - Severity specified only if criteria for mood episode met now

## Changes to Bipolar and Related Disorders

- The other specifiers for Bipolar/related disorders:
  - Anxious distress specifier (pg 149) : DSM notes that anxiety has been reported as a "prominent" finding in many mental health settings with bipolar and major depression. As such it is associated with higher suicide risk, non or longer response to Rx. Important to identify.
    - Anxious distress specifier: 2 out of 5 listed symptoms during majority of days of current episode.
      - Symptoms:
        - Feeling keyed up or tense
        - Feeling unusually restless
        - Difficulty concentrating because of worry
        - Fear that something awful might happen
        - Feeling of might lose control
      - Specify in addition severity: mild, moderate, moderate-severe, severe. E.g. severe – 4 of 5 symptoms with motor agitation

## Changes to Bipolar and Related Disorders

- Other specifiers:
  - Mixed features –replaces sub-type – and can be applied to either bi-polar I or II
  - Bipolar I/II:
    - With rapid cycling
    - With melancholic features
    - With aytpical features
    - With psychotic features: specify whether mood congruent or mood incongruent
    - With catatonia (use additional catatonia code),
    - Peripartum onset
    - Seasonal pattern
  - Specific and detailed advice on distinction between a major depressive episode and grief

## Changes to Bipolar and Related Disorders

- Other specified bipolar and related disorder - criteria are given for specific conditions where this diagnosis might be used:
  - Short duration hypomanic episodes and major depressive episodes
  - Hypomanic episodes with insufficient symptoms and major depressive episode
  - Hypomanic episode without prior major depressive episode
  - Short duration cyclothymia