SAN MATEO COUNTY
MENTAL HEALTH SERVICES DIVISION

DATE: January 12, 2006

MENTAL HEALTH POLICY NO.: 06-01

SUBJECT: Diagnosis of Mental Health Disorders

AUTHORITY: 45 CFR (HIPAA Privacy Regulations); Department of Mental Health Contract with County; CCR, Title 9, Division I, 1830.205; MH Policy 93-10 Scope of Practice; SMCMH Documentation Manual

SUPERSEDES: MH Policy 95-01, DSM-IV

ATTACHMENTS:

A. DSM-IV to ICD-9 Cross Walk for Diagnoses Requiring Clinician Decision

B. Notice of Revised Diagnosis

C. Medical Necessity Criteria for Specialty Mental Health Services

DEFINITIONS

DC: 0-3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

DSM-IVTR Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision

ICD-9 International Classification of Diseases, 9th Edition

PURPOSE

- To provide a point of reference for requirements and practices related to the diagnosis of mental health disorders.
- To establish new policy and procedure based on changes in federal law.

POLICY

1. ICD-9 Codes

   Federal HIPAA Law now requires the use of ICD-9 codes when submitting claims for federally funded services (Medicare and Medi-Cal). The intent of this requirement is to assure consistent identification and coding of medical conditions by all health care providers and across all states. The ICD-9 is a medical model structure that does not always reflect current psychiatric principles and practices.

   In order to promote the best interests of the client and to further the goals of recovery, effective January 1, 2006, diagnosing clinicians will code services in the following manner.

   a. Use DSM IV-TR descriptions of conditions on Axis I and Axis II on the assessment, physician's initial note (PIN) and any other similar documents.
   b. Write the DSM-IVTR diagnostic code on the assessment, physician's initial note (PIN) and any other similar documents.
   c. In most cases, the ICD-9 code will be identical to the DSM-IVTR code. Write the ICD-9 code on the assessment, physician's initial note (PIN) and any other similar documents.
   d. In some cases, clinical decisions must be made to select the most appropriate ICD-9 code. The "Quick Reference for DSM-IVTR/ICD-9 Coding Exceptions" (Attachment A) will indicate where basic diagnostic code decisions or decisions about modifiers (usually $5^{th}$ digits) need to be made.
   e. Axis III – Only physicians may diagnose medical conditions using ICD-9 codes. Other staff will continue to record medical conditions as reported by the client/parent/guardian or known to the clinician by other verified means.
   f. There are no changes in coding practices for Axis IV and Axis V (GAF).
   g. Claims to federal and state funding services will be submitted using ICD-9 codes.

2. Deferred Diagnoses/Rule-Out Diagnoses

   A primary diagnosis may be deferred for a maximum of 2 months after case opening. A primary, provisional or rule-out diagnosis must be confirmed or changed within 2 months of case opening. NOTE: Diagnoses may be amended, added, or deleted at any time during the course of treatment using the procedure outlined in item #3 in this policy.

3. Changing Diagnoses

   Many processes, both clinical and financial, require that the correct diagnoses are available in the computer (for example, claims are edited for allowed diagnoses before submitting to payers). In order to assure accuracy of diagnoses in the information system, the following procedure for recording diagnostic reformulations between usual assessment periods is now required. NOTE: Diagnostic reformulations that occur during the annual assessment period may be noted on the (yellow) annual assessment form; no additional form is required.

a. The Notice of Revised Diagnosis form (Attachment B) is required when making changes on Axis I and/or Axis II at times outside of usual scheduled assessment periods.
b. Clinician shall complete diagnostic information (as described in 1, above) on the Notice of Revised Diagnosis form and indicate whether a diagnosis is deleted, added or changed.
c. Clinician shall submit the Notice of Revised Diagnosis form to administrative support staff for data entry and filing; support staff shall file the Notice of Revised Diagnosis form in the medical record in the assessment section.
d. Clinician shall write a progress note outlining his/her rationale for the diagnostic change.

4. Medical Necessity Criteria for Specialty Mental Health Services

To be eligible for Medi-Cal or Medicare reimbursement for Outpatient Specialty Mental Health Services, clients must meet diagnostic, impairment and intervention related criteria. Attachment C identifies DSM- IVTR diagnoses that are eligible (included) or ineligible (excluded) for reimbursement.

a. A client may receive services for one or more included diagnosis when an excluded diagnosis is also present.
b. An included diagnosis must be the primary focus of the intervention being provided. Interventions targeted at excluded diagnoses are permissible provided they are connected to appropriate goals in the Client Plan and the rationale for their inclusion in the treatment plan is consistent with the diagnostic formulation.
c. It may be appropriate to serve an individual who does not meet medical necessity criteria. If a staff member believes there are extenuating circumstances that would warrant such an exception, the staff member must consult with his/her supervisor. Administrative staff must be notified that the clinical staff has reviewed and approved diagnoses for clients not meeting medical necessity.

5. Primary and Secondary Diagnosis

All assessment documents ask clinicians to define diagnoses as primary or secondary. Consistent with DSM-IVTR's definition of the principal diagnosis as "the reason for the visit," the primary diagnosis will be assigned to that included mental health condition that has brought the individual to seek services in our system. Although excluded diagnoses may be an additional focus of treatment, they must be listed as secondary to the primary mental health condition.

6. Who May Provide a Diagnosis?

DMH has delegated decisions concerning scope of practice to the local Mental Health Director. The most complete description of allowed staff functions may be found in MH

Policy 93-10, Practice Standards (Scope of Practice), and in the Documentation Manual. **Only staff in categories with diagnosis as an allowed function may provide a diagnosis**. Per DMH guidance, a diagnosis developed by a staff member who is not allowed to do so by scope of practice is not made acceptable by countersignature of an eligible staff member.

NOTE: Trainees may provide diagnoses under conditions that assure that all of their work is closely supervised and co-signed by their supervisor.

7. Pre-To Three Procedure

Background: Since 2001, the Pre-to-Three Team has been allowed to diagnose infants and young children using the DC: 0-3 Diagnostic Classification for Mental Health and Developmental Disorders of Infancy and Early Childhood. Staff identify a DC: 0-3 diagnosis and write this on the infant assessment form (unless a DSM-IVTR diagnosis is more accurate). Clinical staff also write a DSM-IVTR diagnosis for clerical staff input. Where no equivalent DSM-IVTR diagnosis is available, a deferred diagnosis is accepted, with no expectation that this diagnosis, unless reformulated, would be changed.

Procedure:

a. Pre-to-Three staff may continue to develop diagnoses based on DC: 0-3, except that:
   1) Where a DSM-IVTR diagnosis best describes the presenting difficulty, that descriptor and code should be entered on the assessment, reassessment or diagnosis change form, followed by the ICD-9 code.
   2) When an ICD-9 diagnosis best describes the presenting difficulty, staff will write (only) that descriptor and code on the assessment, reassessment or diagnosis change form.
b. For DC: 0-3 diagnosis, staff will first enter this on the assessment, reassessment or diagnosis change form, followed by the DSM-IVTR diagnosis and the ICD-9 code (as described in Bullet 1, this policy).
c. Where the only appropriate diagnosis is that found in DC: 0-3, then codes for deferred diagnoses may be written in the DSM-IVTR and the ICD-9 column.

Approved: _____

Gale Bataille, Director
Mental Health Services Division

Reviewed: _____

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