Diagnosing Comorbidity

How the use of structured probes can improve clinical outcomes and enhance reimbursement
Disclosures of Conflicts

• None
Learning Objectives

By the end of this presentation, the participant will be able to:

1. Describe reasons why psychiatric comorbidity is often under-diagnosed.

2. Explain how accurate diagnosis and documentation of comorbidity promotes patient outcomes and appropriate reimbursement.

3. Use standardized probes during an intake interview to increase the chance of catching comorbid anxiety.
Vignette – Alex

A college freshman with no prior treatment history was hospitalized for suicide attempt by overdose, in the setting of increasing social isolation and falling school performance.
Vignette – Alex

A college freshman with no prior treatment history was hospitalized for suicide attempt by overdose, in the setting of increasing social isolation and falling school performance.

What diagnoses are you considering?

• Anxiety disorders  
• Bipolar disorders  
• Depressive disorders  
• Developmental disorders  
• Psychotic disorders  
• Substance disorders  
• Trauma disorders
Vignette – Alex

A college freshman with no prior treatment history was hospitalized for suicide attempt by overdose, in the setting of increasing social isolation and falling school performance.

**Hospital discharge diagnosis:**

- Major depressive disorder, single episode, severe (F32.2)
Vignette – Alex

A college freshman with no prior treatment history was hospitalized for suicide attempt by overdose, in the setting of increasing social isolation and falling school performance.

Hospital discharge diagnosis:
- Major depressive disorder, single episode, severe (F32.2)

Clinic intake diagnoses:
- Major depressive disorder, single episode, severe (F32.2)
- Social anxiety disorder (F40.1)
- Alcohol use disorder, mild, in early remission (F10.10)
- ADHD, predominately inattentive presentation (F90.0)
Psychiatric Comorbidity

Comorbidity = More than one diagnosis

Comorbidity is common in psychiatric patients.

Of all the people with 1 psychiatric diagnosis...
• At least half of them have a second diagnosis...
  • And at least half of those have a third diagnosis.
Risk of Missing Comorbidity

- Treatment ➢ wrong or missing treatment
- Relationship
- Billing
Alex: Effect on Treatment

- Clinician Bob does an intake on Alex and diagnoses MDD
- Therapist Charlie is assigned the case
- Charlie plans a behavioral activation strategy for depression
- Why won’t Alex reach out to old friends?
Alex: Effect on Treatment

- Clinician Bob does an intake on Alex and diagnoses MDD
- Therapist Charlie is assigned the case
- Charlie plans a behavioral activation strategy for depression
- Why won’t Alex reach out to old friends?
- Dr. Daniels joins the treatment team, since Alex is refractory
- Despite several antidepressant trials resulting in some improvement in mood, Alex is still failing at school
- Why can’t Alex focus on schoolwork?
Risk of Missing Comorbidity

• Treatment ➢ wrong or missing treatment
• Relationship ➢ lack of trust and adherence
• Billing
Study: patients care about comorbidity

### Table 3. Desire for treatment for current DSM-IV comorbid anxiety disorders in SCID patients with principal diagnosis of major depressive disorder. (N=300)

<table>
<thead>
<tr>
<th>Anxiety disorders</th>
<th>Frequency of the disorder</th>
<th>Desire for treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>37</td>
<td>21</td>
</tr>
<tr>
<td>Social phobia</td>
<td>98</td>
<td>72</td>
</tr>
<tr>
<td>Obsessive–compulsive disorder</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>172</td>
<td>149</td>
</tr>
</tbody>
</table>

DSM = Diagnostic and Statistical Manual of Mental Disorders; SCID = Structured Clinical Interview for DSM-IV.
Study: Effect on Adherence

• Researchers compared the effect of disagreement between:
  • Diagnosis made by routine clinical care at a CMHC and
  • Diagnosis determined by a structured interview (the kind done for research trials)

• Having the “wrong” diagnosis recorded in the chart (as compared to the research diagnosis) was associated with greater rates of cancellations, no shows, and drop outs.
Risk of Missing Comorbidity

• Treatment ➢ wrong or missing treatment

• Relationship ➢ lack of trust and adherence

• Billing ➢ less credit for complexity
Brief discussion of CPT codes

• Prescribers document symptoms, signs, and decision-making to justify billing for the visit.

• Most med management visits will be coded at “99213” or “99214”, depending on complexity.
Brief discussion of CPT codes

• Prescribers document symptoms, signs, and decision-making to justify billing for the visit.
• Most med management visits will be coded at “99213” or “99214”, depending on complexity.
• The higher the complexity, the higher the reimbursement (99214), to compensate for the increased work to safely treat the patient.
• Therefore, prescribers are under pressure to fully document complexity.
## Evaluation and Management Services Guide

### Coding by Key Components

<table>
<thead>
<tr>
<th>History</th>
<th>Modifying Factors; Associated signs and symptoms</th>
<th>Family medical; Social</th>
<th>Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>HPI</td>
<td>PFSH</td>
<td>ROS</td>
</tr>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>(1-3 elements or 1-2 chronic conditions)</td>
<td>N/A</td>
<td>Problem pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Yes</td>
<td>(4 elements or 3 chronic conditions)</td>
<td>Expanded</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1 element)</td>
<td>(2-9 systems)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete</td>
<td>(10-14 systems)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2 elements (est) or 3 elements (new/initial))</td>
<td></td>
</tr>
</tbody>
</table>

### Medical Decision Making Element

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of significant complications, morbidity, and/or mortality

**Determined by**
- Problem points chart
- Data points chart
- Table of risk

### Problem Points

**Category of Problems/Major New Symptoms**
- Self-limiting or minor (stable, improved, or worsening) *(max=2)*
- Established problem (to examining physician); stable or improved
- Established problem (to examining physician); worsening
- New problem (to examining physician); no additional workup or diagnostic procedures ordered *(max=1)*
- New problem (to examining physician); additional workup planned*

*Additional workup does not include referring patient to another physician for future care

**Points per problem**
- 1
- 1
- 2
- 3
- 4
Why Not Diagnose Comorbidity?

• Parsimony ➢ cover everything with one diagnosis

• Hierarchy

• Focus

• Incentives
Why Not Diagnose Comorbidity?

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Why Not Diagnose Comorbidity?

• Parsimony ➢ cover everything with one diagnosis

• Hierarchy ➢ one diagnosis trumps the others

• Focus ➢ describe the chief complaint only

• Incentives ➢ too busy and no reward for it
SCID: Structured Clinical Interview for DSM Disorders

• Modeled on clinical diagnostic interview
  • Starts social history, then HPI, ROS, PPH, PMH...
  • Script with both open-ended and focused questions

• Questions are **standardized** to minimize variability
  • Interview adheres to the order and wording of questions
  • Trained judgment is used to clarify and interpret responses

• Takes about 90 minutes and requires extensive training
  • Gold standard in diagnosis for research trials
SCID compared to usual diagnosis

• Researchers went to a rural community MH clinic and also to an urban academic MH clinic
• The researchers did a SCID on each new patient at the clinic (N = 164)
• Otherwise, the patients had the clinic’s usual intake procedure, with a diagnostic interview by a clinician, sometimes with a psychiatrist’s input. The clinician didn’t know the SCID results.
• How did SCID diagnosis and chart diagnosis compare?
SCID compared to usual diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>SCID Only</th>
<th>Clinical Only</th>
<th>Both SCID and Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>II</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>45</td>
<td>15</td>
<td>39</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>10</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Depression not otherwise specified</td>
<td>2</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>25</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social phobia</td>
<td>22</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>22</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>22</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>18</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety disorder not otherwise specified</td>
<td>11</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>5</td>
<td>58</td>
<td>6</td>
</tr>
</tbody>
</table>
SCID compared to usual diagnosis

• According to the SCID,
  • a majority of patients in a mental health clinic met criteria for a depressive disorder,
  • a majority met criteria for an anxiety disorder, and
  • about one-third of patients had both depressive and anxiety disorders.

• If the SCID is more valid than the clinical interview, then we are missing a lot of anxious co-morbidity!
The effect of adding SCID to intake

MIDAS Project in Rhode Island

• An outpatient practice in RI got a grant to do a SCID (Structured Clinical Interview for DSM) at every intake.
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Comp Psych. 1999; 40(3):182-191
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• They compared the last 500 patients before the change (“clinical” group) to the first 500 patients to get the SCID on intake (“SCID” group).

The average patient in the clinical group had 1.4 diagnoses vs. 2.3 diagnoses in SCID group.
Summary, so far

• Comorbidity is common – the majority of our patients have more than 1 diagnosis

• Depression is a very common chief complaint, and comorbid anxiety is common in those patients – and they want it treated

• Clinicians who use a standardized approach to the intake are more likely to make a comorbid diagnosis than clinicians who have a non-standardized approach
So how do we do better?

• Pie-in-the-sky option: everyone gets a SCID
  • Too expensive
  • Too time-consuming

• An alternative: easier structured tools
  • MINI (Mini International Neuropsychiatric Interview)
  • CIDI (Composite International Diagnostic Interview)
  • PDSQ (Psychiatric Diagnostic Screening Questionnaire)
But what can I do *tomorrow*?

- Add standardization to your routine interview to help pick up comorbidity
The Simplest Tool: A Checklist

• A page with brief reminders of what you want to cover

• Take notes on the checklist, then copy-paste into your documentation

• Powerful tool for ensuring that every patient gets asked the same questions

Psych ROS
- Depression/SI/NSSI
- Anxiety/panic
- Irritability/agression/HI
- Mania
- Psychosis
- OCD
- Body/eating
- ADHD/learning
- Trauma/abuse
- Substance use
  - Alcohol
  - Tobacco
  - Marijuana
  - Other illicit/Rx
Next Level: Screening Probes

1. Do you get very anxious about speaking to people you don’t know well? (social)
2. Do you often feel nervous when in public or crowded places? (agoraphobia)
3. Do you ever feel an anxiety attack, like a sudden surge of panic or fear? (panic)
4. Is there anything specific that you’re very afraid of, like heights, needles, or dogs? (phobia)
5. ...
Resource for Screening Questions

• The Psychiatric Interview
  by Daniel Carlat
Conclusion

• Clinicians who use a standardized approach to the intake are more likely to make a comorbid diagnosis than clinicians who have a non-standardized approach

• Correctly making and documenting comorbid diagnoses improves patient outcomes and makes appropriate billing easier

• Checklists and screening questions are simple tools that can standardize your interview and increase the chance you’ll catch comorbidity
Thank you!

www.CareTransitionsNetwork.org
CareTransitions@TheNationalCouncil.org

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