Some Extremely Useful Diagnostic Codes!

2023 March Psymposium

Psychologists' Association of Alberta

Exploring Assessment in Professional Psychology

If you use the DSM-IV-TR diagnostic system, you will be familiar with some of the more common diagnoses like Major Depressive Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder. Most of these mental health conditions are classified as **F Codes**. In this article, I will review some less well-known but extremely useful diagnostic codes.

Adjustment Disorders is a category reserved for mental health problems that arise in the context of psychosocial stressors, and that do not meet the criteria for another disorder. The adjustment problem must also emerge within 3 months of the onset of the stressor and must resolve within 6 months of the stressor being removed. Types include *Adjustment disorder with anxiety (F43.22), Adjustment disorder with depressed mood (F43.21), Adjustment disorder with disturbance of conduct (F43.24), Adjustment disorder with mixed anxiety and depressed mood (F43.23), Adjustment disorder with mixed disturbance of emotions and conduct (F43.25),* or *Adjustment disorder Unspecified (F43.20).* Note that if the stressor is severe enough to be considered traumatic, then the appropriate diagnosis would be *PTSD*, *Acute Stress Disorder*, or an *Other specified trauma-related disorder (F43.89)*.

Z Codes are typically used when the condition or psychosocial problem is the main reason a person seeks support. However, these conditions can also be coded if: a) it helps to explain the need for a test or treatment, b) it plays a role in the initiation or exacerbation of a mental disorder, or c) it is a problem that should be considered in the overall management plan. There are many Z Codes, under categories of **personal or psychosocial history** (suicidal behaviour, abuse and neglect, psychological trauma, and military deployment) and **current psychosocial problems** (economic problems; educational problems; housing problems; occupational problems; problems related to the social environment; problems related to interaction with the legal system; problems related to other psychosocial, personal, or environmental circumstances; problems related to access to medical and other healthcare; and relational problems).

I will introduce some of the most common and most useful Z Codes for clinical practice. Under the **Personal Problems** umbrella, you will find: *Academic or educational problem (Z55.9), Acculturation difficulty (Z60.3), Phase of life problem (Z60.0), Problems related to unwanted pregnancy (Z64.0), Religious or spiritual problem (Z65.8), Target of (perceived) adverse discrimination or persecution (Z60.5), Uncomplicated bereavement (Z63.4), Victim of crime (Z65.4),* and *Victim of terrorism or torture (Z65.4)*.

Under the **Relational Problems** umbrella, you will find: *Child affected by parental relationship distress (Z62.898), Disruption of family by separation or divorce (Z63.5), High*

expressed emotion level within family (Z63.8), Parent-child relational problem (Z62.820), Relationship distress with spouse or intimate partner (Z63.0), Sibling relational problem (Z62.891), Social exclusion or rejection (Z60.4), Problem related to living alone (Z60.2), Discord with neighbor, lodger, or landlord (Z59.2), *Unspecified problem related to social environment (Z60.9),* and *Upbringing away from parents (Z62.29).*

Under the **Behavioural Problems** umbrella, you will find: *Adult antisocial behavior (Z72.811), Child or adolescent antisocial behavior (Z72.810), History of nonsuicidal self-Injury (Z91.52),* and *History of suicidal behavior (Z91.51)*. There is also the catch-all category of *Other problem related to psychosocial circumstances (Z65.8)*, and the curious and decidedly vague: *Unspecified problem related to unspecified psychosocial circumstances (Z65.9)*, which I have personally never had the courage to use!

R Codes and T Codes

There are also a few R codes and T Codes related to current behaviour. These include: *Current nonsuicidal self-injury (R45.88): Current suicidal behavior, Initial encounter (T14.91XA);* and *Current suicidal behavior, Subsequent encounter (T14.91XD)*. Another useful coding is *Impairing Emotional Outbursts (R45.89)*, which can be applied when the focus of clinical attention is on verbal or behavioural aggression that leads to functional impairment. This behaviour can occur alone or in conjunction with other conditions (e.g., ADHD, autism, ODD, GAD, PTSD, mood, and anxiety disorders). Of course, conditions such as *Disruptive Mood Dysregulation Disorder* (a mood disorder) and *Intermittent Explosive Disorder* (an impulse control disorder) must be ruled out.

Intellectual Functioning

The diagnosis of *Borderline intellectual functioning (R41.83)* is used when assessment of intellectual and adaptive functioning indicates that the individual struggles with below average functioning yet does not meet criteria for a *Mild intellectual developmental disorder* diagnosis. If you use this coding, you must conduct careful assessment, particularly if co-occurring mental disorders affect compliance with or ability to engage in standardized testing (e.g., severe impulsivity in ADHD). The diagnosis of *Global developmental delay (F88)* is used for children under the age of 5 when the child fails to meet expected developmental milestones in several areas of functioning, but the clinical severity level cannot be reliably assessed. Note: if this diagnosis is made, reassessment is required within a reasonable period of time.

Uncertainty in Diagnosis

A **provisional diagnosis** is one that you make when you are relatively confident the individual will soon be found to meet criteria for the diagnosis. Typically the diagnostician has some remaining data to collect or confirm, or has to wait until a time threshold has been reached.

"Diagnosis deferred," is a term that communicates you have begun your work but do not yet have sufficient evidence to reach firm diagnostic conclusions. When dealing with complex cases, this may be a wise interim step.

The last helpful diagnostic code I will leave you with is *No Diagnosis or Condition (Z03.89)*, which means that you have conducted an assessment and are giving the person a clean bill of mental health. Sometimes our work requires us to provide a stamp

of good health and functioning on a client, (e.g., for someone applying to be an air traffic controller).

Diagnoses I Suggest You Use Cautiously

Some diagnostic codes in the DSM-IV-TR are potentially problematic. I will review four of the most troubling ones.

Nonadherence to medical treatment (Z91.199), which used to be called *Noncompliance*, is a condition code with terminology that points unfavourably in the direction of the client. In reality, nonadherent behaviour reflects poor engagement in treatment, which is the responsibility of both the professional and the client. Unfortunately, this kind of coding carries judgment and invokes stigma. If a client is not following through on a treatment plan, then it is important to understand why rather than simply labelling the client as nonadherent. Before assigning a code like this, I suggest you consider conditions such as the goodness of fit between the client and therapist, or the client and therapy method. Also consider what other barriers might prevent a client from engaging in a treatment plan (e.g., time, finances, anxiety, lack of understanding or resources, lack of motivation). Of note, there is a separate coding for clients who are in conflict with service providers: *Discord with social service provider, including probation officer, case manager, or social services worker (Z64.4)*.

Malingering (Z76.5) is a coding that clearly points the finger at the client, stating that they are intentionally producing false or *"grossly exaggerated physical or psychological symptoms, motivated by external incentives."* If you plan to use this coding, you must have evidence to back up your determinations (i.e., be prepared to defend your decision in court). Note that high scores on a measure of malingering are not enough in themselves to warrant this diagnostic code.

Sex counselling (Z70.9) is the only specific focus of therapy in DSM that was assigned its own code. There is no indication why other forms of therapy (e.g., family counselling, marital counselling), or foci of therapy (e.g., career counselling, test anxiety, phobia treatment) did not receive their own unique coding. Until DSM creates codes for other important areas of functioning for which a person might seek therapy, I personally elect to not use this diagnostic code, which serves to overemphasize and target one area of human functioning. Instead, I utilize the generic *Other counseling or consultation (Z71.9)* coding.

Oppositional Defiant Disorder (F91.3). Oppositional defiant disorder is one of my pet peeves in the DSM-5-TR. Although this constellation of symptoms has been classified as a disorder, I view it more as a descriptor of behaviour. The term carries the weight of judgment and the burden of being labelled a troublemaker. Worst of all, it says nothing about what is underlying the behaviour. A better approach would be to link the behaviour to underlying challenges. E.g., Social Anxiety Disorder with oppositional features.

The DSM-5-TR and other diagnostic systems have many diagnostic options for clinicians, many of which are overlooked or sidelined. Sometimes, the best fit for a diagnostic code is one that might not often be used. I hope this article will help refresh your thinking about diagnosis and your own use of diagnostic codes.

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