

Ethics, Upcoding, and the DSM-5

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The transition to DSM-5 provides an opportunity to consider ethical issues related to diagnosis. We diagnose patients for a variety of reasons, not the least of which is that health insurance companies require a diagnosis and in some states require that it is “severe enough” that treatment is *medically* necessary. In order for patients to make use of their insurance, we may be tempted to “upcode” – to provide a diagnosis more severe than warranted by their clinical presentation (Danzinger & Welfel, 2001; Kress, Hoffan, & Eriksen, 2010). Attorneys tell us that providing a diagnosis for which the patient doesn’t meet the criteria in order to bill insurance is a *legal* matter – namely, insurance fraud. Such upcoding also presents *ethical* issues, and I’ll focus on three of them.

The first issue relates to instances when diagnosing an individual is inappropriate because the problem – therefore treatment – concerns interactions between people (e.g., couples, families). There are generally no insurance-reimbursable diagnoses for relational problems unless at least one person has a disorder, in which case the diagnosis places the problem within an individual rather than on the interactions (Patterson, 1993). Family and couples therapists may find themselves tempted to upcode one member of the family in order to bill insurance.

A second ethical consideration relates to the use of diagnosis as a form of assessment as might be used for disposition or treatment planning (American Psychological Association, 2010). Standard 9.02 (Use of Assessments) encourages us to use assessment instruments that have established reliability and validity for populations tested, and, where not established, to describe the strengths and limits of test results and interpretation. DSM-5 has significant problems with reliability and validity (Gordon & Cosgrove, 2013). Thus, when using DSM-5 to diagnose as part of assessments, psychologists should tread carefully (Gordon & Cosgrove, 2013). Some propose that DSM-5 reifies as “fact” and medicalizes the psychological experience, and that we as a profession must take care to remember that those diagnoses have no inherent “truth” but are merely shorthand ways of describing one facet of psychological phenomena (Gordon & Cosgrove, 2013; Greenberg, 2013). This does not diminish our obligation to accurately apply criteria when circumstances require us to provide a DSM diagnosis.



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A third issue relates to trust and doing right by our patients (American Psychological Association, 2010). Principle A (Beneficence and Nonmaleficence) notes that we should try to benefit those in our care and to do no harm. Arguably, upcoding for insurance purposes benefits our patients, since many patients would be unlikely to receive (as much) care otherwise. This consideration weighs heavily on many practitioners. Principle B (Fidelity and Responsibility) addresses establishing trust with our patients and being aware of our professional responsibility to uphold standards of conduct. Wouldn’t upcoding foster our patients’ trust? Maybe. But upcoding creates a slippery slope, because our patients then know that we are willing to lie for them, and in doing so, we may be experienced as corruptible (Gordon & Cosgrove, 2013).

Standard 6.06 (Accuracy in Reports to Payors and Funding Sources; American Psychological Association, 2010) most clearly and directly bears on this issue. It says in providing reports (including bills with diagnostic codes) to payors, we must be accurate in reporting “. . . the fees, charges, or payments, and where applicable . . . the findings and the **diagnosis**” (emphasis added). Standard 6.01 goes even further, requiring us to *ensure* accuracy in billing and payments and to make sure we are compliant with the law.

Thus, despite possible advantages to patients if we were to upcode, our ethics code is clear that doing so is unethical. ■

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