Washington State Department of Social & Health Services

Transforming lives

Access to Care Standards (ACS) Frequently Asked Questions

Behavioral Health Organizations - May 2016

Please view this useful link to DSM 5 changes
http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

Please view this useful link to ICD10CM Access to Care Diagnosis List:
http://nsmha.org/datadict/codes/ICD10CM.aspx

Q1. Could you send out the references for the instruments that are measuring functional criteria for SMI and SED – and how those are scored?
And what is the reference/citation for the actual measurement instrument? Or was this something that folks made up locally? (If the latter… has it been pilot tested for reliability?)
And – does DBHR already have data collection methods or is that something that other groups will be working on?

Q2. There is no attention to the DCO-3R, and therefore to the special considerations for very young children. (The DC03-R has been cross-walked to the DSM IV and accepted for several years as a means to qualify young children). It will need to be revised to crosswalk to the DSM V.

A. To Q1 and Q2 - ACS is not a measurement instrument. It is a definition of what areas of impairment qualify for access to community mental health services in our state.
All BHO directors supported the idea of not forcing a "tool" or instrument (evidenced based or otherwise) on BHOs. There is no requirement from CMS to have a tool.
There weren't any states we could find that required the use of a tool. They use descriptions of functional impairment, like this one. BHOs are free to use a tool that helps them get to a decision about functional impairment in these areas. If a BHO wanted to use the LOCUS, for example, to help them assess functional impairment, then that is fine. The goal is to have common definitions of impairment across the state. These categories of impairment are not significant changes from the existing ACS. The only real difference is that now we don't say "as evidenced by a GAF score…" Instead, we have more specific definitions of impairment. The DCO-3R is not required for making decisions related to functional impairment for children. ACS provides criteria for this. In addition, the age defining "very young children" is not in the new ACS as the child must meet Medical Necessity regardless of age.

Q. What happened to the different classifications of schizophrenia?

A. In DSM 5, Schizophrenia is no longer sub classified as in DSM IV. The APA schizophrenia workgroup stated that there is no empirical evidence showing the subtypes of schizophrenia (paranoid type, catatonic type, undifferentiated type, etc.) had any difference in diagnosis, treatment, or prognosis. They also did not have evidence to show if one subtype is more or less severe than the other subtype. As a result, DSM 5 no longer makes any distinction for subtypes of schizophrenia. Despite ICD 10 may still has code for the DSM IV diagnoses, DSM 5 does not recognize them as valid. Thus, to make psychiatric diagnosis, please make sure you are starting with the DSM 5. Some diagnosis you may have used in the past are no longer included in the DSM 5. Just because a diagnosis exists in the ICD-10 code set does not mean it is in the DSM 5.

Q. Why is "unspecified" diagnosis included for some diagnoses but not others?

A. In the DSM 5 there are two replacements for the previously labeled "not otherwise specified" category. NOS used to be covered; DBHR determined that it did not want to remove that option. In the DSM 5 they use two terms for most categories for the "other" diagnoses:

"Other specified": This requires the clinician to document the reason why/how the criteria for the other diagnoses weren't met. Examples include F28 (other schizophrenia spectrum/psychotic d/o), F31.89 (other specific bipolar), etc.

"Unspecified": This one says "used in situations where the clinician chooses not to specify the reason…" examples of these non-covered ones include F29 (unspecified schizophrenia…) and F31.9 (other unspecified bipolar…)

Q. I have clinicians putting ICD 10 for PTSD, chronic, (F 43.12) and it is rejecting saying it does not meet access to care standards. This is confusing; so, on 9/30/15 PTSD met access to care; now on 10/1/15 it doesn't?

A. This item is not in the DSM 5 which is what the state has selected to use for diagnostic criteria. Please use the most appropriate Dx as is current in the ACS. The DX must be found in the DSM-5 and the ACS in order to be a qualifying diagnosis. Please make sure you are starting with the DSM 5. Some diagnosis you may have used in the past are no longer included in the DSM 5. Just because a diagnosis exists in the ICD-10 code set does not mean it is in the DSM 5.

Q. What was the reason for eliminating "*use* and *remission*" off the ICD 10 SUD codes?

A. The decision was based on not meeting medical necessity. "Use" may be associated with other activities like screening and brief intervention but those do not require a diagnosis. Similarly a "remission" diagnosis implies there is not current need for a treatment intervention. A remission diagnosis could end up on an assessment at the provider level in a list of client diagnosis, but if that client has another active diagnosis that requires treatment, the active diagnosis would be used for access to care and reporting.

Q. Why were certain ICD10 codes included in the covered diagnosis list and other more specific codes for the same diagnostic area were not. One example is in the area of PTSD diagnoses:

ICD 9 has one dx for PTSD: 309.81 – Posttraumatic Stress Disorder.
ICD10 has three: F4310 – Post-traumatic stress disorder, unspecified
F4311 – Post-traumatic stress disorder, acute
F4312 – Post-traumatic stress disorder, chronic

Only one of the ICD10 dx is on the covered list: F4310 – Post-traumatic stress disorder, unspecified. Why are the other two not included?

A. DSM (IV) had PTSD, but it also had two specifiers, acute and chronic. So you could have PTSD, PTSD chronic, PTSD acute, etc.

- *The ICD 10 also has those sub categories (F43.10 (unspecified), F43.11 (acute), and F43.12 (chronic)).*
- *But…DSM 5 does not use those specifiers. The DSM authors made enough changes to the diagnosis that they felt the sub-categories weren't needed. So there is only one PTSD code now that incorporates every sub-type. When they decided to crosswalk to the ICD-10 CM they picked the "unspecified" code to be the one that matched.*

From the access to care point of view, we ask the clinician to use the DSM 5 for diagnosis, pick the correct code from the DSM (the ICD 10 codes are in the DSM) and then check and see if that is on the covered list.

Q. Co-occurring disorders within the current mental health delivery system are complicating factors, and not sufficiently addressed.

A. This will be addressed when a co-occurring benefit is available from CMS.
In the interim clinicians must still request services by applying the most relevant DX. This is sometimes referred to as the diagnosis that the organization wants to be "paid" under (Paid Diagnosis). For co-occurring consumers, the clinician still must select a DX to be in the primary position, and list the other diagnosis as a "secondary" or "tertiary".

Q. Must an MHP do a face-to-face evaluation for continued stay authorization?

A. Good practice is a face to face encounter. The person must have the appropriate credentials to confirm, update diagnostics and medical necessity. Accesses to Care Standards are not intended solely to serve as continuing stay criteria.

Q. The lack of a standard Level of Care tool, while allowing for flexibility, may contribute to inconsistent application of the Access to Care standards statewide.

A. The change to the ACS does not change the contractual requirement of the BHOs to have their own LOC determination process/system. This is not a change from previous versions of the ACS. RSN's were always required to maintain their own Level of Care system.

Q. The individual is expected to benefit from intervention. When I start thinking about the Neurocognitive Disorders that would now be eligible for services it becomes very tricky to

talk about how the patient would benefit from treatment. If you justify care, there is a whole new population that we are serving.

A. *Medical Necessity still applies. Including that the person is expected to benefit from care. It is very important to define "benefits" and "recovery". It is now commonplace to define "recovery" as maintenance. If a consumer is maintained on their medication regime and is remaining at baseline, this can (and often is) defined as recovery.*

Q. To meet the functional criteria for SMI, a person must have, as a result of a qualifying diagnosis, current dysfunction in at least one of the following 4 dimensions. This dysfunction has been present for most of the past 12 months or for most of the past 6 months with an expected continued duration of at least 6 months. This is in direct contradiction to allowing diagnoses such as Acute Stress Disorder and Adjustment Disorder. So, someone who has a long history of severe and debilitating depression must be showing symptoms for at least 6 months before accessing care.

A. Language in ACS was changed to include:
6 month minimum timeframe does not apply to all diagnosis per DSM. Examples are: acute stress disorder, adjustment disorder, and certain psychotic disorders.

Q. What about clients on an LRA who don't meet these criteria?

A. If an LRA client does not meet ACS, the LRA monitoring requirements must still be met. This service may not be allowable for Medicaid reimbursement – if they do not meet medical necessary.

Q. Mental and behavioral Disorders due to Psychoactive Substance Use are not covered.

A. This will be addressed when a co-occurring benefit is available from CMS.

Q. The criteria being used for SMI and SED need to be selected from known referenced sources to either broaden or narrow the door for access to care. For example, Federal SED cites that the condition has to persist for 1 year or longer and this document says 6 months; also, capacity is not in line with SED.

A. SED description by CMS states: "Current or anytime in the last year." As noted above, some diagnostic criteria (adjustment disorder) does not require the one year duration.

Q. The language throughout the document needs to be clearer about needs, treatment expectations, etc., in relation to *covered* diagnoses. The language is often vague and just states diagnosis, which could be misleading and suggest the BHOs can provide services for things we cannot/should not.

A. ACS addresses entrance criteria into the BHO system. ACS does not address treatment methods. It is not intended as a clinical guide. Medical necessity must be met. Clinicians are still expected to utilize best practice when treating all consumers. This includes the use of Evidence-Based Practices (EBPs) and the BHO's Practice Guidelines.

Q. I am "very concerned that Autistic Spectrum and Intellectual Disability diagnoses weren't on the list. It's great the Neurocognitive Disorders will be covered, but then it makes it all the more nonsensical to not cover the ASD and ID dx. These are folks that really should have specialty care at a CMHC available when needed (i.e. when the other functional/symptom criteria are met).

A. Theses dx are covered under HCA/DDA services not part of the BHO benefit package. If there is a co-occurring (MH) dx, the MH would be treated if ACS are met.

Q. The lack of non-uniform level of care system across the state may be problematic. Clients can and do travel across the state. Discussing client care or obtaining collateral information may be difficult if we do not have a common language to use to discuss client status, etc.

A. Access to Care Standards (ACS) are not Levels Of Care (LOC). This is not a change from previous versions of the ACS. RSN's (now BHOs) were always required to maintain their own Level of Care system.

Q. I think I understand the reasons for excluding "pervasive and specific developmental disorders" from the covered diagnosis list, the population with these diagnoses (particularly autism spectrum conditions) may not receive treatment that they could benefit from. Their function is often significantly impaired and publicly-funded primary care may not have the resources or skills to address these symptoms that mental health staff have. (For the sake of comparison, someone with an autism spectrum disorder, which is not on the list, may have significantly worse function than someone with unspecified anxiety disorder, which is on the list.)

A. Theses dx are covered under HCA/DDA services not part of the RSN benefit package. If there is a co-occurring (MH) dx, the MH would be treated if ACS are met.

Q. Which of the reasons you gave for including/excluding diagnosis were used for excluding catatonia and unspecified in the schizophrenia category and avoidant/restrictive food intake disorder and binge eating disorder in the eating disorders category?

A. Schizophrenia diagnoses are not differentiated in the DSM 5. Eating disorders were not expanded from the previous ACS related to provision of these services by the BHO system.

Q. What is the purpose of having additional duration of dysfunction (6 months, 1 year) above and beyond the duration of the symptoms already identified for diagnosis in DSM?

A. 6 month minimum time frame does not apply to all diagnosis per DSM as noted in the functional criteria on page 4 of the ACS.

Q. We have identified a number of dx that have not been identified as either included or excluded?

A. Outside of the list of diagnostic classifications not covered on page 25. Those codes not listed elsewhere in the document are not covered. Please make sure you are starting with the DSM 5. Some diagnosis you may have used in the past are no longer included in the DSM 5. Just because a diagnosis exists in the ICD-10 code set does not mean it is in the DSM 5.

Q. If someone has not only the new dementia diagnosis but also has depression and the depression does not meet the new access to care standards, then do we say we can serve them because of the depression?

A. No - If it does not meet ACS. This is addressed in the multiple diagnosis section of the ACS: "Individuals who have both a covered and non-covered diagnosis may be eligible for service based on the covered diagnosis. BHOs provide services that address the covered diagnosis and coordination of care for non-covered diagnosis."

Q. In regard to functional criteria, will autism diagnosis in children be covered?

A. No. It is not an ACS dx. The state has a different funding and treatment process for autism spectrum disorders that does not include BHOs.

Q. How are we to use this standardized Level of Care? What form are we supposed to use?

A. Each BHO is required to have a LOC system. Please contact them.

Q. Are we waiting to hear from our BHOs about what we are using for levels of care then? And we are also waiting to hear from our BHOs continuing stay criteria will be?

A. Each BHO is required to have a LOC system. Please contact your BHO.

Q. What is the rationale for excluding autism spectrum disorders from services?

A. We did not expand eligible diagnosis for the BHO system. The state has a different funding and treatment process for autism spectrum disorders that does not include BHOs.

Q. What was the reason for not including other eating disorder diagnoses for children such as Avoidant/Restrictive Food Intake Disorder?

A. Eating disorders were not expanded from the previous ACS related to provision of these services by the RSN system

Q. Do you anticipate adding more descriptors to some of the guidelines for "impairment?" for instance, the term dysfunction could be broadly interpreted (see example re: person with BPD - moderate problems at work but not considered dysfunctional?

A. No. Not at this time.

Q. Removal of "in remission," including "sustained remission," and "early remission"

Medication Assisted Treatment (MAT) includes people who have been in remission for several months to years. Therefore, I recommend keeping the in remission codes since this should be a billable code and acceptable for re-authorization.

A. *The client must meet ACS dx through ASAM criteria. This is not an ACS issue rather, a clinical issue. Maintenance/Aftercare is not a covered service.*

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