STATE OF WASHINGTON ACCESS TO CARE STANDARDS OCTOBER 2015

Regional Support Networks/
Behavioral Health Organizations

Please visit the *new* ACS – ICD Information webpage:
https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information

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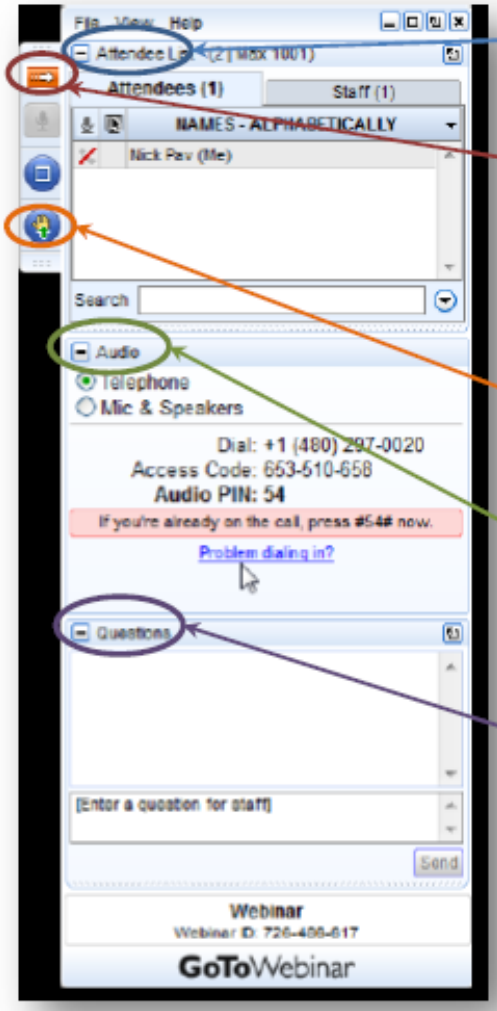
Webinar Controls



- Attendee List - Displays all the participants in-session
- Grab Tab –Allows you to open/close the Control Panel, mute/unmute your audio (if the organizer has enabled this feature) and raise your hand
- Hand – click to raise hand. Click again to lower.
- Audio pane – Displays audio format. Click Settings to select telephone devices.
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DBHR Webpage - ACS/ICD Information

- For the current ACS and other useful information please visit:
- https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information
- You may also submit ACS related questions to: icdinquiries@dshs.wa.gov

BACKGROUND

- The How and Why of Access To Care Standards

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Intention of ACS:

ACS provides:

- Initial entrance criteria

ACS does not provide:

- Sole criteria for continued stay
- Level of Care

INTRODUCTION AND SCOPE

- The statewide *Access to Care Standards (ACS)* describes the *minimum standards and criteria* for clinical eligibility for behavioral health services for the Regional Support Network (RSN) care delivery system.

BACKGROUND:

- The Division of Behavioral Health and Recovery (DBHR) Access to Care Standards (ACS) provide Regional Support Networks (RSNs) with rules to determine eligibility for authorization of mental health services within the state of Washington.

- These rules describe eligibility for services available to Medicaid enrollees throughout the Washington State public mental health system.

BACKGROUND CONT.

- These standards are the result of an emphasis that began 30 years ago to establish medical treatment policy for those dealing with a major mental illness.

- Stakeholders were invested in the development of medically necessary community-based mental health services with the intent of decreasing disability and mortality in the “chronically mentally ill” populations.

BACKGROUND CONT.

- In 2002 the President's New Freedom Commission was formed to study the mental health service delivery system within communities.

- Washington State Division of Behavioral Health and Recovery (DBHR) formed a workgroup to create Access to Care Standards eligibility and authorization criteria for services for this population. The standards were established and made available to each Regional Support Network (RSN) on 01 January 2003. These standards guide providers in determining who may be eligible for services.

BACKGROUND CONT.

- More recently, several changes occurring within a close time frame have necessitated the revision of Washington DBHR Access to Care Standards.

- The major changes are the deployment of the ***DSM-5 in 2014*** which ***eliminates*** the Global Assessment of Functioning Scale (GAF), Children's Global Assessment of Functioning Scale (CGAS) and the CMS mandate to ***implement ICD 10 coding by 01 October 2015***.

- Without the use of the GAF score, ***a way to assess level of functioning was still necessary*** to determine eligibility of services for RSN enrollees.

BACKGROUND CONT.

- To address these changes, DBHR formed the ICD 10/ACS workgroup.
- The workgroup desired a ***standardized*** way to help providers identify ***eligible diagnoses*** and determine ***functional impairment.***
- ***ACS does not*** address or endorse specific services.
- ***ACS does*** provide standardized methodology and guidance to entrance requirements.

BACKGROUND CONT.

Who was involved in the ACS Workgroup?

- Psychiatrists and licensed mental health professionals
- Consumer representatives
- Geriatric mental health specialists
- Child mental health specialists
- RSN and Provider clinical staff
- RSN and Provider Coding/IT staff
- State and community hospital providers

BACKGROUND CONT.

What were the goals of the ACS workgroup?

- ***Ensure*** that those experiencing mental health symptoms that result in a significant impairment of daily functioning are able to ***access mental health treatment.***
- ***Maintain*** the ***integrity*** of the RSN ***community mental health system*** and ***make clear the distinction*** between the ***two types*** of coverage available to Medicaid enrollees in our state; the RSN managed care system and the Apple Health mental health benefit managed by other carriers.
- Review the updated clinical criteria of DSM diagnoses to ***ensure that the correct diagnoses were included in the ACS.***
- ***Update the coding*** system from ICD-9 to ICD-10-CM.

October 2015
CODING AND SYSTEM CHANGES

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Why did the state revise the ACS?

- The Center for Medicare and Medicaid Services (CMS) required states to move to the ICD-10-CM coding system by 01 October 2014. Since then, implementation has been delayed to 01 October 2015.
- The state's current ACS relies upon the DSM-IV/ICD-9 diagnoses and the long standing DSM Global Assessment of Functioning (GAF)/Children's Global Assessment Scale (CGAS).
- The 2013 update to the manual (DSM-5) had significant clinical changes that would affect access to care in our state when adopted.
- The DSM-5 utilizes the ICD-10-CM coding set. In addition, the DSM-5 removed the multiaxial diagnostic assessment including GAF/CGAS as a measure of functioning.

Eliminated Diagnoses

- In the ***DSM-5***, some diagnoses were ***re-conceptualized*** so that symptoms formerly applied to one diagnosis are now ***grouped*** with other disorders. As a result, some ***diagnoses were deleted*** from the new manual.

- ***Example:*** Bipolar Disorder, Most Recent Episode Mixed. 'Mixed' as an episode type as removed from the DSM-5, resulting in the elimination of this diagnosis. Now, any mixed symptoms are coded under an existing depressive or manic episode.

Addition of New Diagnoses

- The *DSM-5* introduced diagnoses that were not in previous versions.
- The workgroup determined that some of these *met criteria* for inclusion in the ACS.
- *Example:* Disruptive Mood Dysregulation Disorder; a new diagnosis for children.

Change in diagnosis name and new clinical constructs

- *Example 1:* The DSM-5 changed the way Schizophrenia is diagnosed and named.

- *Example 2:* Dementia is no longer a diagnosis in the DSM-5. Instead, the new diagnosis category and clinical criteria are described under neurocognitive disorders.

- *Example 3:* Reactive Attachment Disorder. Some of the criteria for this disorder was removed and placed into a new diagnostic category; Disinhibited Social Engagement Disorder.

Update Codes to ICD 10-CM

- Regardless of the clinical changes to the DSM, all *diagnoses use different codes* in the *DSM-5*.

- The approved diagnoses list in the *ACS* now *reflects* the diagnostic groupings used by the *ICD-10-CM*.

CATEGORICAL REVISON

Removal of:

- A/B Categories
- Adult/Child Categories

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A/B Category Removal – Why?

- Previously some ‘B’ diagnoses required *additional criteria* in order to qualify for access to care.

- The differentiation between ‘A’ and ‘B’ was removed, placing greater emphasis on the assessment of *functional impairment* as the *indicator* of how severely the mental illness affects the individual.

Adult/Child Category Removal – Why?

- In the previous ACS, there were two lists of diagnoses; one for adults and another for children.
- This distinction was removed.
- Diagnosis limitations for children or adults are already ***determined*** by ***age requirements*** in DSM criteria.

THE ASSESSMENT OF FUNCTIONING TOOL

- Removal of the Global Assessment of Functioning (GAF) and Children's Global Assessment of Functioning Scale (CGAS)
- Functional Assessment

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GAF/CGAS Removal – Why?

- The ***DSM -5 no longer supports*** the Global Assessment of Functioning ***(GAF)***/Children's Global Assessment Scale ***(CGAS)*** or the ***multi-axial diagnostic*** approach.

- As a result, the ***GAF/CGAS was removed*** as a measure of functional impairment in the updated ACS.

GAF/CGAS Removal – Why? Cont.

- ***Previously***, the ACS stated that an individual must have an impairment in one of the following areas as indicated by a specific ***GAF/CGAS score:***
  - Health and self-care
  - Cultural factors
  - Home & family life, safety, and stability
  - Work, school, daycare, pre-school, or other daily activities
  - Ability to use community resources to fulfill needs

The revised ACS still requires evidence of functional impairment.

No GAF – No CGAS – Now What?

- In the 2015 ACS there now is ***no longer a requirement to use the GAF/CGAS*** measurement instrument. ***Instead, the new ACS*** requires use of ***standardized/common definitions*** of what areas of impairment qualify for access to community mental health services in our state.

No GAF – No CGAS – Now What?

- RSNs are *free to use an additional tool* that helps them get to a decision about functional impairment in these areas.
- The *GOAL* is to have *common definitions of impairment across the state.*
- These categories of impairment are *not a significant change* 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.*

No GAF – No CGAS – Now What?

- Additionally, there is no requirement from CMS to have an *"one for all - all for one"* tool.
- Also, the workgroup could *not find any state* that *required the use of a "specific" tool* like the GAF.
- They use *descriptions of functional impairment,* as is now in the redesigned 2015 ACS.

Functional Assessment – 2015 ACS

- The guidelines for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) have become essential elements in the "managed care" model of providing services with Medicaid funds.
- ***For complete detail descriptions and instruction regarding how to apply the functional impairment, please refer to the new 2015 ACS.***

Functional Assessment - 2015 ACS

The new standard defines criteria for functional impairment in the following domains:

ADULTS

Persistent dysfunction in at least one of the following domains:

- Inability to live in an independent or family setting without supervision
- Risk of serious harm to self or others
- Dysfunction in role performance
- Risk of deterioration

Functional Assessment - 2015 ACS

CHILDREN

Persistent dysfunction in at least one of the following domains:

- Self-care
- Community
- Social relationships
- Family
- School/work

Or symptoms in one of the following areas:

- Psychosis
- Danger to self, others, or property as a result of emotional disturbance
- Trauma

Functional Assessment - 2015 ACS

MEDICAL NECESSITY

Both the child and adult ACS still require that medical necessity be met in order for an individual to qualify for services. Medical necessity includes:

- The individual has a mental illness as determined by a Mental Health Professional (MHP).
- The impairments and corresponding needs are the result of a mental illness.
- The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning result from the presence of a mental illness.
- The individual is expected to benefit from the intervention.
- The individual's unmet needs cannot be more appropriately met by any other formal or informal system or support.

IMPLEMENTATION

- CLINICAL EXAMPLE(S)
- PRACTICAL APPLICATION

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Clinical Case Example #1

- **Persistent Depressive Disorder**

(formerly Dysthymic Disorder, a "B" diagnosis for adults)

- Individual meets diagnostic criteria for Persistent Depressive Disorder, an updated version of Dysthymic Disorder in the DSM 5
- Long term depression, with recent isolation, regular thoughts of suicide (no attempts), and risk of termination at work due to excessive use of sick days.
- Based on the above, individual would have a GAF of 41-50
- Previous ACS: Would not meet ACS due to lack of additional "B" criteria.
- **New ACS:** Meets ACS diagnostic and level of functioning criteria SMI category 3, dysfunction in role performance and category 2, risk of serious harm to self.

Clinical Case Example #2

- **Child: Adjustment Disorder with Depressed Mood (former "B" diagnosis for children)**
- Meets criteria for Adjustment Disorder with Depressed Mood
- Has depressed mood, serious impairment in functioning at school, some isolation and expresses some thoughts of suicide (no attempts).
- Based on the above, child would have a C-GAS of 51-60
- Current needs include individual and family therapy.
- Previous ACS: Would not meet ACS due to lack of additional "B" criteria.
- **New ACS:** Meets ACS diagnostic and level of functioning criteria SED category 3, dysfunction in role performance and symptom 2, risk of serious harm to self.
- Note: If the child's functioning was not as impaired or their needs could be met by another system, they would not meet criteria.

Clinical Case Example #3

- **Obsessive Compulsive Disorder (former "B" diagnosis for adults)**
- Meets criteria for OCD, including severe obsessional rituals
- Due to OCD, has serious impairment in social and work functioning. Unable to work.
- Based on the above, client would have a GAF of 41-50
- Is expected to benefit from treatment and there are no less restrictive options for treatment in the community.
- Previous ACS: Would not meet ACS due to lack of additional "B" criteria.
- **New ACS:** Meets criteria due to qualifying diagnosis and functional impairment in SMI category 3, dysfunction in role performance.
- Note: If the individual's functioning was not as impaired or their needs could be met by another system, they would not meet criteria.

Clinical Case Example #4

- **Child: Acute Stress Disorder**
- Meets criteria for Acute Stress Disorder immediately after experiencing abuse (1 month qualifier).
- Severe functional impairment at school and home due to symptoms.
- Would have a C-GAS score of 41-50
- Previous ACS: Qualifies due to diagnostic and C-GAS criteria.
- **New ACS:** Meets diagnostic and SED functional impairment criteria for categories 4, functioning in the family, and 5, functioning at school as well as symptom 3, trauma symptoms. Despite the one-month qualifier for this diagnosis, dysfunction is expected to last at least six months.

Clinical Case Example #5

- **Borderline Personality Disorder (formerly a "B" diagnosis for adults)**
- Meets criteria for Borderline Personality Disorder.
- Two hospitalizations in the last two years, but none in the last six months. Has moderate impairment at work, including conflict with coworkers. Has few friends.
- Based on the above, individual would have a GAF of 51-60
- Previous ACS: Does meet ACS due to "B" criteria. (2 hospitalizations in last two years) and qualifying diagnosis.
- **New ACS:** Has a qualifying diagnosis, but due to lack of current functional impairment, would not meet criteria for SMI.
- Note: If the individual's functioning was more impaired, they would qualify.

Clinical Case Example #6

- **Major Neurocognitive Disorder**
- **(Alzheimer's Dementia, formerly a "B" diagnosis for adults).**
- Meets criteria for Major Neurocognitive Disorder

- Recent move to memory care center, frequent crisis team contacts due to some behavioral issues (striking out at staff). No psychiatric hospitalizations. Requires 24 hour care and at times experiences psychotic symptoms. Is prescribed psychotropic medications by consulting psychiatrist at the facility.

- Based on the above, individual has a GAF score of 21-30

- Assessor does not believe individual will benefit from mental health treatment at CMHC.

- Previous ACS: Would not meet ACS due to lack of additional "B" criteria and is not expected to benefit from additional treatment at CMHC.

- **New ACS:** Does not meet criteria because individual is not expected to benefit from treatment, as above.

- Note: If individual was expected to benefit from additional treatment, they could meet criteria.

OTHER CHANGES

- LEVEL OF CARE AND INTENSITY OF SERVICE DETERMINATION
- TRANSITION/DISCHARGE PLANNING

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Level of Care (LOC) and Intensity of Service Determination

- The previous ACS described two levels of care – Level 1 (brief) and Level 2 (community support).
- At the same time, the RSN was required to develop additional levels for care and an assessment process to determine the type of intensity services provided to individual. e.g. LOCUS/CALOCUS.
- The ***revised*** ACS ***relies upon the RSN assessment*** process to determine the LOC once the ***individual meets ACS.***
- *ACS does not address treatment methods. It is not intended as a clinical guide. Medical necessity must be met.*

Level of Care (LOC) and Intensity of Service Determination Cont.

- Authorizing entities ***must develop appropriate Levels of Care (LOC)*** to assist Service Providers with assigning authorized individuals appropriate service packages, with the appropriate service intensity.
- Assignment into an appropriate Level of Care (LOC) ***is based on the individual's need(s) and specific SMI (adult) or SED (children) criteria.***
- The individual's need(s) Level of Care, and specific SMI/SED ***criteria must be reflected on the individualized and mutually-developed treatment/service plan.***
- ***The Individualized Treatment/Service Plan*** (ITP/ISP) must demonstrate that the selected intervention(s) are reasonably necessary to ***improve, stabilize, or prevent deterioration of functioning*** resulting from the presence of a mental illness.

Transition /Discharge Planning

A new section addressing continuing stay criteria and discharge transition planning was added to the ACS.

- ***RSNs are still required to develop their own continuing stay criteria.*** The ***ACS*** now ***require*** providers to ***develop discharge criteria*** for individuals ***at the point of entry into services.***

Transition/Discharge Planning Cont.

- Consumers who require services beyond the initial authorization period ***must continue to meet medical necessity criteria.*** Authorizing ***entities must establish continuing stay criteria, to include a Level of Care (LOC)*** system that allows for ***movement along a continuum of care inclusive of discharge.***

- Authorizing entities must ensure that Network Providers have ***a system in place for establishing discharge criteria*** at the time of initial admission. ***Discharge criteria must be reviewed with the consumer at regular intervals throughout the episode of care.***

Covered Diagnostic Classifications

Please see 2015 ACS for complete detailed list of covered Diagnostic Classifications

https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information#overlay-context=bhsia

DSM - 5

- Please visit the DBHR ICD10/DSM5 ACS webpage
- See Summary of Changes Document

Exclusion Categories

- *Exclusion categories are complete. There are specific codes that are referenced at the end of the document. Dx classifications e.g. sleep wake disorder.*

Thank you for your participation~

- QUESTIONS?