

Access to Care Standards (ACS) Webinar Questions

16 July 2015

Please view this useful link to DSM 5 changes

<http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>

Q. Why is bipolar I disorder, current or most recent episode manic, partial and full remission omitted from the list especially since hypomanic, partial and full remission are included Also, it appears that bipolar i disorder, most recent episode hypomanic, partial and full remission appear to be miscoded.

A. Please see ACS revision dated: Sept.11, 2015. This has been added.

Q. Are you going to send out the handouts?

A. A recording of the webinar and a printable version of the presentation (slide deck) has been posted to ACS webpage.

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 RSN 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 3 of the ACS.

Q. We do not have these examples you are referring to in this webinar.

A. Please see webpage.

Q. With the removal of the multi-axial how will medical issues be recognized which were previously documented with Axis 3?

A. This is dependent upon your individual data system(s).

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 14. Those codes not listed elsewhere in the document are not covered.

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.

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

A. No. It is not an ACS dx.

Q. I also think it is interesting that you refer to these categories as SMI for adults and SED for children, when according to DSM 5 they do not wish for us to refer to individuals as having an illness or disease, but should be referred to as having a disorder. Based upon this it, should be SMD (serious mental disorder) and SED (serious emotional disturbance)

A. These terms are mirrored as stated in WAC.

Q. Is there a sample of how the conceptualization should be presented or structured?

A. Refer to the ACS and or training webinar presentation for guidance.

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

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

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

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

Q. Will adjustments be made to ACS when SUD is included with the implementation of BHOs? Since we will be serving persons even with mild SUD, would functional impairments be determined using different criteria?

A. SUD dx will be added – more to come soon.

Q. Will this presentation be sent or be able to be downloaded to us?

A. Yes it is available on the webpage.

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Q. Can the slides be emailed out?

A. Please download them from the ACS webpage.

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

A. We did not expand eligible diagnosis for the RSN system.

Q. Are we going have to change all currently diagnosed clients over to new criteria and diagnosis?

A. Starting October 1 2015 everyone will need to use the new ICD 10 codes.

Q. Why were 'unspecified' diagnosis included form some diagnoses but not others?

A. Not all unspecified diagnosis were included in the ACS revision as we did not want to expand the RSN system.

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. When should be begin transitioning diagnosis then, if you are not going to accept ICD9 codes after September 30th. Will you accept them prior? Or will it be an abrupt change?

A. ICD 10 codes are required 10/01/2015.

Access to Care Standards (ACS) Inbox FAQs

September, October 2015

Q. We have been waiting for follow up communications from the ICD-10 webinar regarding additional SUD codes needed for nicotine dependence and a deferred diagnosis. We use these codes daily. We are required to assess for nicotine dependence and though it is never the primary diagnosis, we are required to include it in our recovery plans and diagnosis information. Also, we assess people for SUD services and some people do not require follow up services. I have 3 assessments waiting for approval for a new ICD code, that we currently cannot bill because no diagnosis was assigned. When can we expect an update?

A. Please see guidance and FAQs from webinar on the DBHR website listing current SUD diagnosis list.

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.

Q. Philosophy of addiction treatment has shifted from recommending treatment for acute episodes, to treating addiction as a chronic condition that needs ongoing care at various levels of intensity. Based on this philosophy, how will the Recovery Benefit be covered (i.e. follow-ups, check-ins, aftercare)? This is another case where “in remission” is needed.

A. See answer above.

Q. Removal of “use” for all substances, i.e. “Cannabis use, unspecified, uncomplicated” It’s my understand that ASAM .5 Early Intervention services won’t be covered in the BHO. .5 Early Intervention is where we would see a “use” or “misuse” classification. If we are responsible to provide care when intervention is indicated, then shouldn’t we provide .5 and keep these codes?

A. .5 could be covered via other funding sources.

A. .5 will not meet ACS dx criteria.

Q. Inhalant Use Disorders

This is not on the “Covered Diagnostic Classifications” list. Shouldn’t this be included? Inhalants can be a primary substance for treatment admission and is included in DSM 5.

A. These are included in the October diagnostic list and will be included in the new ACS effective April 2016.

Q. Cannabis Dependence

This is not on the “Covered Diagnostic Classifications” list. Only Cannabis Abuse, uncomplicated is listed. Shouldn’t this be included along with the DSM equivalent Cannabis Use Disorder Moderate and Cannabis Use Disorder Severe?

A. See above.

Q. ICD-10 codes are more specific than ICDP-9 codes. How many specifiers are necessary?

A. Code to the code. Use whatever you can to tell the diagnosis story.

Q. Billing substance abuse vs. dependence

How will we communicate to providers how to bill abuse vs. dependence? Though DSM V provides a clear symptom count for substance use disorder, some guidance might be helpful to providers.

SUD mild	2-3 sx	Substance Abuse
SUD moderate	4-5 sx	Substance Dependence
SUD severe	6+ sx	Substance Dependence
?		Substance Misuse is not covered in ICD-10.

However, if we provide services under the BHO for this classification how will this translate? SUD mild 1 sx?

A. This is included in the DSM 5 and is included in the WAC. The ACS cannot provide this guidance.

Q. WAC 388-877B-0350 requires a minimum of 72 hours of treatment within a maximum of 12 weeks. Since treatment should be individualized and based on the client’s presenting need, will this WAC be revised?

A. This is not an ACS question. Please contact Denis Malmer at DBHR.

Q. I am trying to locate the updated suboxone policy for providers that includes any prior authorization or limits for urine drug screen requirements used for Substance Disorders for the adult population.

A. This is not an ACS question. However, since Suboxone is an HCA benefit, paid for by HCA, please contact the HCA to see if there are any restrictions about UAs for Suboxone. You may also consult the HCA Provider Billing Instructions.

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.*

Q. Regional Support Networks (RSNs) throughout the state utilize the PA (Prior Authorization) module within the ProviderOne system for community psychiatric inpatient authorizations. Beginning October 1, 2015, are we able enter ICD 10 codes in the "Diagnosis Code" field within this screen?

A. *Yes, just leave out the decimal.*