

# STATE OF WASHINGTON ACCESS TO CARE STANDARDS

FOR REGIONAL SUPPORT NETWORKS/BEHAVIORAL HEALTH ORGANIZATIONS

SUMMARY OF CHANGES TO ACCESS TO CARE STANDARDS

JULY 2015

## CHANGES TO THE COVERED DIAGNOSES LIST

Changes to the list of covered diagnoses were made as described below. The examples given are not all-inclusive. See the new Access to Care Standards (ACS) Covered Diagnostic Classifications list for specifics.

### THE DIAGNOSIS NO LONGER EXISTS

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 meet criteria for inclusion in the ACS.

Example: Disruptive Mood Dysregulation Disorder; a new diagnosis for children.

### CHANGE IN DIAGNOSES NAMES 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.

### REMOVAL OF A/B CATEGORIES

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.

### REMOVAL OF ADULT/CHILD CATEGORIES

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.

### UPDATE CODES FROM ICD-9 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.

## CHANGES TO THE ASSESSMENT OF FUNCTIONING TOOL

The DSM 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 was removed as a measure of functional impairment in the updated ACS.

### PREVIOUS ACS

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

### 2015 ACS

The new ACS still requires evidence of functional impairment. The new standard defines criteria for functional impairment in the following domains:

---

#### ADULTS

Persistent dysfunction in at least one of the following dysfunctions:

- 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

---

#### CHILDREN

Persistent dysfunction in at least one of the following capacities:

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

Or one of the following symptoms:

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

---

## 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.

## CHANGES TO 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. The new ACS relies upon the RSN assessment process to determine the LOC once the individual meets ACS.

## 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.

## FREQUENTLY ASKED QUESTIONS

### WHY DID THE STATE HAVE TO CHANGE 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 DSM05 utilizes the ICD-10-CM coding set. In addition, the DSM-5 removed the GAF/CGAS as a measure of functioning.

### 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

### WHAT WERE THE GOALS OF THE ACS WORKGROUP?

Some of the primary goals of the workgroup were:

- 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.

### WHAT DID THE PREVIOUS ACS REQUIRE?

The previous version of the ACS required that an individual:

- Had a qualifying diagnosis from the DSM.
- Was experiencing a deficit in level of functioning as indicated by their score on the GAF/CGAS tool.
- Met other medical necessity criteria – expected to benefit from treatment, no other treatment options available, etc.

## HOW IS THE NEW ACS DIFFERENT?

All of the requirements of the previous ACS are still in place with these updates:

- Diagnoses were updated to match DSM-5/ICD-10-CM naming conventions and new clinical criteria.
- Previously, some diagnoses considered less serious – ‘B’ diagnoses – required additional criteria in order for an individual to qualify. Those requirements were removed, allowing clinician assessment to determine severity based on standardized definitions.
- The GAF/CGAS was replaced with a more thorough descriptive approach to measuring an individual’s level of functioning.

## WHY WAS THE GAF REMOVED AND WHAT IS ITS REPLACEMENT?

The APA removed the GAF/CGAS tool in the DSM-5 due to lack of clarity and inconsistent application in clinical practice. The new Washington State ACS measure an individual’s functioning by providing clear examples and definitions of 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

---

### 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