

CHELAN-DOUGLAS RSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	7.2
Title:	QUALITY IMPROVEMENT AND UTILIZATION	Page:	1 of 30
		Date Effective:	July 1, 2004
SUBJECT:	CLINICALLY APPROPRIATE CARE/ UTILIZATION MANAGEMENT	Date Revised:	July 1, 2004
		Authorizing Signature:	

AUTHORITY: Guiding Principle(s): Consumer Focused, Holistic/Humanitarian, Accessible, Normalizing/Non-Stigmatizing, Responsive, Effectively Managed
WAC 388-865-0280, Quality Management Process
WAC 388-865-0450, Quality Management Process
DSHS Standard Work Order, RSN/PHP Services
DSHS Title XIX Contract and Federal Waiver
42 CFR 438 Subpart D: 438.208(c)(3)(i)-(iii)
42 CFR 438.240(b)(3)
State MHD Quality Strategy Doc Sec IV, VI, X
State MHD Access to Care Standards Doc
State MHD/RSN Contract 2003-2005

SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Health Plan (CDRSN/PHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: This policy provides for mental health services that are clinically appropriate, timely, accessible and are covered mental health services under contract with the State MHD.

DEFINITIONS: "Action" means a decision by the prepaid inpatient health plan regarding one of the situations listed above in "Action" definition. The appeal process does not apply to a CMHA.

"Action" means : The denial or limited authorization of a requested service, including the type or level of service; The reduction, suspension, or termination of a previously authorized service.' The denial, in whole or in part, of payment for a service; The failure to provide services in a timely manner, as defined by the State; The failure of the CDRSN/PIHP to act within the timeframes provided in 438.408(b). (from 42 CFR 438.400)

"Administrative Hearing" means: A hearing conducted through the auspices of the state Office of Administrative hearings in accordance

with Washington Administrative Code (WAC) 388-02. The term "fair hearing" is synonymous with administrative hearing.

"Adult" means: A person who is less than 21 years of age, and is receiving services under any children's program.

"An eligible person" refers to: All Medicaid enrollees are eligible for MH benefits. To be 'authorized' for outpatient services and receive services they must meet Access to Care criteria.

"Appeal" means a request for review of an action, as "Action" is defined in this section. Appeals can only be made at the CDRSN/PIHP level only if the decision constitutes an "action".

"Arm's Length" is a phrase that can characterize the working relationship between two individuals or entities who establish protocols for working together to avoid dual relationships and/or conflict of interests. One example of the principle of 'arm's length' is that the CDRSN/PIHP cannot delegate utilization management to a direct provider of service.

"Child/Adolescent" means: A person 18 years of age or older but less than 60 years of age who is receiving services under any program other than a children's program.

"Clinical and non-clinical selected study topic" means: In general, a clinical or non-clinical issue selected for study should affect a significant portion of the enrollees (or a specified sub-portion of enrollees) and have a potentially significant impact on enrollee health, functional status or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served.

"Complaint" means: A verbal complaint about services or the lack thereof, which a consumer or potential consumer may file with a provider, the CDRSN/PIHP, or the Ombudsman services. The goal is to resolve complaints at the lowest possible level. There is no deadline for resolution of complaints. And, there is not requirement that an enrollee has to file a complaint prior to filing a grievance.

"Complaint" means: A verbal or written statement by an enrollee that expresses dissatisfaction with some aspect of services, his/her provider, or the CDRSN/PIHP.

"Consumer Enrollment" means: 1) DSHS enrolls a Medicaid recipient in a mental health prepaid health plan when the person resides in the contracted service area; (2) An enrolled Medicaid consumer who

requests or receives medically necessary nonemergency community mental health rehabilitation services requests and receives such service from the assigned mental health prepaid health plan through authorized providers only;(3) An enrolled Medicaid consumer does not need to request disenrollment from the mental health division when the recipient moves from one mental health prepaid health plan to another.

"Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"Consumer" means: A person who is now or has in the past received mental health services.

"Credentialing" means: A process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

"Delegation" refers to a formal process by which a managed care organization gives another organization the authority to perform certain functions on its behalf, such as credentialing, utilization management, and quality improvement. Although a managed care organization can delegate the authority to perform a function, it cannot delegate the responsibility for assuring the function is performed appropriately. (NCQA source) S. Norsen Q&A document April 26, 2004 states "delegation" is as follows:

"Denial" means: The decision by a CDRSN/PIHP not to authorize covered Medicaid mental health services that meet the Mental Health Division Access to Care Standards or the Medical Assistance Administration memorandum #01-03MAA, Psychiatric Hospitalization. Or the decision by a CDRSN/PIHP not to authorize covered Medicaid mental health services due to lack of medical necessity. The decision by a Community Mental Health Agency (CMHA) not to provide a covered service is not a denial and cannot be appealed. An enrollee who objects to a CMHA decision not to provide a covered service may request a grievance or a second opinion.

"Dual Relationship" means: The assumption, by the professional, of more than one role in relationship to a subcontractor, which places either the CDRSN/PIHP or the sub-contractor at increased risk of harm, fraud and abuse, or exploitation. The power differential which can exist in potential dual relationship situations comes from the

potential to serve as a “change agent or influence agent” to facilitate some change in behavior or action on the part of either party to the relationship. Differences in relationship power also places the CDRSN/PIHP in a position where there is the potential to misuse power and thus cause harm to the sub-contractor.

“Dual Role Conflict” refers to the assumption by the professional of multiple role relationships with entities, which place the entity or the CDRSN/PIHP at risk of risk of harm, fraud and abuse, or exploitation.

“Emergent”: past history and/or imminent danger to self or others, prior and/or current risk of psychiatric hospitalization, sudden onset of acute psychiatric symptoms which results in serious deterioration of mental status. Enrollees are directed immediately to closest emergency room. Once in a secure environment, enrollee will be seen by QMHP within four hours.

Enrollees with “special health care needs” means: As per Judy Gosney on 3/3/04 the term “special health care needs” is applicable to all enrollees who are screened into service by the CDRSN/PIHP. S. Norsen document April 26, 2004 states: “All persons who meet the Access to Care Standard for mental health treatment meet the definition of individuals with special health care needs.”

“Grievance” means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the CDRSN/PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.)

“Inpatient Admission” refers to the authorization and admission to inpatient psychiatric unit if consumer meets eligibility and diagnostic and medical appropriateness standards. These standards include dangerousness/insufficient behavior control, symptoms and conditions requiring ongoing direction by a psychiatrist, significant interference in normal functioning, or inability to provide for basic survival needs independently or at a less restrictive level of care.

“Inpatient” means: A person who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

“Length of stay (LOS)” means: The number of days that a covered person stayed in an inpatient facility.

“Level of Care Criteria” refers to: Chelan Douglas Regional Support Network Levels of Care.

“Medical Necessity” refers to: A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunctions, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service.

“Medication Management” refers to: Enrollee is referred to this level of care if currently on psychiatric medication and symptoms are stable. Enrollee requires ongoing medication management to continue stabilization, not establish it. Ongoing therapy is not needed and not currently being utilized by enrollee.

“Older Adult” means: A person 60 years of age or older who is receiving services from the CDRSN/PIHP. (King Co. age definitions)

“Performance Improvement Project: means: A project designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

“Practice guidelines” means: Interventions or practice to be provided based on presenting problem, diagnosis, functioning or level of care. Includes likely outcomes if guidelines are followed. Practice guidelines are systematically developed statements on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions. Terms used synonymously include practice parameters, standard treatment protocols, and clinical practice guidelines.

“Practitioner” means: A term that indicates an individual clinician under contract with the CDRSN/PIHP or its agent to provide mental health services to eligible enrollees.

“Prior-authorization” means: The process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage. NOTE: In State MHD

system there is no prior-authorization, as per Steve Norsen April 26, 2004 document.

“Provider” means: A term that indicates a contracted agency that provides mental health services within the CDRSN/PIHP delivery network. The term can also be used to refer to a facility, or an individual. In a more generic context, the term “provider” refers to a physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals that provides a health care service.

“Quality Assurance” means: A focus on compliance to minimum standards (e.g., rules, regulations, contract terms) as well as reasonably expected levels of performance, quality and practice. [State Contract definition]

“Quality Improvement” means: A focus on activities to improve performance above minimum standards reasonably expected levels of performance, quality and practice. [State Contract definition]

“Quality Management” means: A system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization’s or system’s operations. [State Contract definition]

“Quality Review Team” means: An independent team per WAC 388-865 that works closely with clients and families to review provider, RSN and MHP performance.

“Reduction” means: The decision by a CDRSN/PIHP to decrease an enrollee’s previously authorized covered Medicaid mental health services. The decision by a CMHA to decrease a covered service is not a reduction.

“Routine”: request for service is not crisis-oriented, but is needed for ongoing mental health issues, which are medically and diagnostically appropriate. Counseling appointment will be scheduled within fourteen (14) working days. NOTE: Check the actual hour and day count designations in each urgency level against BBA regulations and MHD contract, the latter being more specific on the subject. BBA 438.206(c)(1) requires you make services included in the contract available 24/7 when medically necessary.

“Screening” means: The process by which a provider evaluates persons who present for service and determines the appropriate service referral.

“Service Populations” means: See definitions for Child, Adult, and Older Adult.

“Services” refers to the following clarifications: Clinical services" means those direct age and culturally appropriate consumer services which either: (1) Assess a consumer's condition, abilities or problems; (2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

“Significant or demonstrable improvement”: means: “Significant” improvement: NCQA’s document, “Health Care Quality Improvement Studies in Managed Care Settings,” states that: “When presenting statistical results of any study, it is important to fully disclose. . .the statistical significance of the estimates produced, as well as the statistical significance of any apparent differences between units of comparison.” Building on this, CMS’s QISMC document called for specific amounts of measurable improvement to be demonstrated by the health plan. QISMC defines “demonstrable” improvement as either: *benchmarks established by CMS (for national Medicare projects) or State agencies (for statewide Medicaid QI projects) or by the health plans for individual (organizational) projects; or *a 10% reduction in adverse outcomes. Important note: As per the March 19, 2004 CMS Teleconference on “Validating Performance Improvement Projects Protocol Training”, QISMC no longer requires a specific percentage point of improvement, or reduction in adverse outcomes. This protocol does not call for a specific level of statistical achievement to be achieved but, consistent with the NCQA document, calls for disclosure and review of the statistical significance of any reported improvements in performance as one aspect of reviewing the overall success of a PIP. (“Validating Performance Improvement Projects Protocol Training”, March 19, 2004)

“Sub-contractor” means: An individual or entity performing all or part of the services under the RSN Contract 2003-2005 under a separate contract with the RSN or its sub-contractors.

“Suspension” means: The decision by a CDRSN/PIHP to decrease an enrollee’s previously authorized covered Medicaid mental health services. The decision by a CMHA to decrease a covered service is not a suspension.

“Termination” means: The decision by a CDRSN/PIHP to stop a previously authorized, covered Medicaid mental health service. The decision by a CMHA to stop a covered service is not a termination.

“Urgent”: onset of psychiatric symptoms requires attention within 24 hours to prevent serious deterioration of mental status. Not imminently dangerous to self or others, but at risk if not seen within time frame.

“Utilization management” means: A micro-level process that utilizes prospective and concurrent evaluation that affect access and level of care decisions regarding treatment. In this context, utilization review is an element of utilization management. Utilization management may include in its scope the functions of care management.

“Utilization review” means: A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

“Utilization” means: The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per 100 or 1000 persons eligible for service.

POLICY: The CDRSN/PIHP provides for mental health services to that are clinically appropriate, timely, accessible and are covered mental health services under contract with the State MHD. Services are authorized to eligible Medicaid enrollees who meet both medical necessity for care, and, the State MHD’s Access to Care Standards (ACS). Further, the CDRSN/PIHP meets the BBA requirement that states that that treatment is developed in consultation with clients and MH specialists, that they are approved quickly, and that treatment is applicable and in accordance with our quality assurance and review standards.

The CDRSN/PIHP produces and/or requires its contracted providers and practitioners to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. As a matter of policy, the treatment plan is developed by the primary treating clinician, with the enrollee’s participation, and in consultation with any other treating clinicians involved in the case, as needed. The plan of care is also reviewed against applicable State quality assurance and utilization review standards, such as the ACS. All of these requirements are documented and followed through policies and procedures within the CDRSN/PIHP and its contracted providers.

Utilization management activities start at the point of request for service, where the enrollee, family member, or advocate make a request for mental health services. The intake process within the

CDRSN/PIHP and its delivery network screens for eligibility, medical necessity, and against the Access to Care Standards. Further screening takes place if necessary for a particular case situation or specific level of care, which would cover: presenting problem, dangerousness assessment, previous treatment history, prior hospitalizations, current treatment providers and collateral contacts, and co-morbidity, such as addictions or a major medical problem. The screening process results in a determination of an automatic outpatient authorization into services, acuity and appropriate level of care placement into the CDRSN/PIHP delivery system. Authorization for inpatient services follows the guidelines in State MHD's document referred to as "Numbered Memorandum 01-03 MAA"(exhibit E of RSN contract).

The UM program monitors the delivery of mental health services provided to PBHC members. It ensures that services provided are medically necessary and appropriate. It manages benefit resources effectively and efficiently, while ensuring the provision of quality care. It identifies and resolves inefficiencies in resource utilization, such as over or under utilization. Over and under utilization of services are considered to be ineffective, and decrease the overall quality of treatment received by the member. As a matter of policy, the CDRSN/PIHP has in effect mechanisms to detect both under-utilization and over-utilization of services. The UM program measures the effect of cost containment activities on the quality of care delivered. It identifies quality of care issues and trends, and coordinates with Quality Improvement in the management of these issues. Utilization review is considered a part of utilization management.

Clinical excellence is a driving principal that is demonstrated at all levels of the UM program. The clinical need of the members drive the utilization management decision-making process. The effects of these decisions on clinical treatment are considered. The program is designed and intended to create a minimum of administrative complexity for the providers and program staff.

PROCEDURE: Treatment Planning: CDRSN/PIHP review of treatment planning conducted by contracted mental health providers includes a review of access time requirements, Access to Care standards, appropriate assessment, and development of treatment in collaboration with family, friends, allied providers, and others identified by the consumer. Contracted providers must ensure consumer voice is solicited, heard and incorporated into the consumer Plan of Care. For additional information see 2.1, 2.2, 2.2.1, 2.2.2, and 2.5.

Utilization Management: CDRSN/PIHP program staff, contracted provider representatives, and any physician contracted practitioners coordinate, and direct the operations of the UM program. Communication and linkage with the CDRSN/PIHP quality program is crucial in the implementation and operation of its structure.

Efficient utilization and high quality care are synonymous. Data is gathered that gives information about appropriate use of resources, compliance with treatment parameters for specific diagnoses, and timeliness of admission and care. Medical records review, data review, consumer satisfaction surveys, family surveys, Quality Review Team activities (see 7.6) are key data sources and indicators which monitor over and under utilization.

Monitoring activities that focus on utilization issues are incorporated into the Quality Management Oversight Committee work plan, which is evaluated and revised on a yearly basis. It contains a variety of projects and indicators, some of which clearly measure utilization, and others that combine utilization and quality components. (see 7.6)

The structure and process for monitoring the UM program lends itself well to a cohesive blend with the QM program process.

Delegation: In the event the CDRSN/PIHP delegates utilization management, it will not delegate to any contracted provider who delivers direct care to enrollees on behalf of the CDRSN/PIHP. See definitions above.

The regional support network would:

1. oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor; and
2. before any delegation, each RSN evaluates the perspective subcontractor's ability to perform the activities to be delegated;
3. have a written agreement that:
4. specifies the activities and report the responsibilities delegated to the subcontractor; and
5. provides for revoking delegation or imposing other sections if the subcontractors performance is inadequate.
6. monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the state, consistent with industry standards or state laws and regulations.

Take corrective action if the regional support network identifies deficiencies or areas of improvements.

Utilization review: The goal of the utilization review process is to provide the needed oversight for contracted providers so that quality services are provided in an efficient, cost effective manner. This process will ensure that payment is made only for care that is considered to be medically indicated.

Medically indicated treatment is characterized by:

- Clinically necessary and reasonable in order to treat symptoms of an illness or to diagnose a condition that is harmful to life or health.
- Ordered or approved by a physician or licensed clinician.
- Appropriate to the place and level of care in amount, duration, and frequency.
- Appropriate and in keeping with widely accepted standards of practice.
- Not primarily for convenience.
- Provided in the lowest level of care that can safely be administered without adversely affecting the member, plan of care, or liability of the provider.

Conceptually, the review program has multiple levels of activity. The member and provider rights-to-due-process have been ensured. The levels of review proposed as: NOTE: These are proposed review levels for formal review processes, if wanted or needed only. UR is not a BBA reg. Explicitly, but assumed within utilization management processes.

- Level I –CDRSN/PIHP care management staff are licensed behavioral health professionals with clinical expertise and experience in utilization and quality review processes and principles. Reviewers use approved clinical criteria.
- Level II - CDRSN/PIHP Medical Director—optional per State MHD- - is a board-certified psychiatrist and has the authority for coverage determinations regarding medical necessity, and the responsibility to notify regarding the lack of medical necessity or termination of benefits. If no Medical Director, Level II would be managed by that CDRSN/PIHP staff person responsible for clinical operations.
- Level III - CDRSN/PIHP Clinical Program Staff Committee has the responsibility to review cases requesting an appeal of the previous review decision of the medical director.
- Level IV – Provider Review Committee

The utilization review decisions are processed and documented in accordance with established standards that function to avoid disruptions in the member's treatment.

Confidentiality: The CDRSN/PIHP is committed to preserving the confidentiality of its members and providers. Written policies and

procedures are in place to ensure that member information and records remain confidential. Employees receive and sign a confidentiality agreement at the time of their hiring and annually at the time of their performance evaluation. Training includes appropriate handling, storing, and disposal of confidential information. Documents with any identifying information are shredded prior to disposal.

Consumer information gathered to facilitate utilization reviews and claims administration is available only for the purpose of review, and is maintained in a confidential manner. All minutes, reports, medical records, and other data are kept in a manner ensuring strict confidentiality. Medical records that are requested are only those which will provide information relevant to complete reviews.

Program evaluation: The UM program performance is formally reviewed on an annual basis. The evaluation is in written format, and is presented to a Committee comprised of contracted providers and others as determined by the CDRSN/PIHP. The report is then reviewed and forwarded to the Quality Committee for approval and oversight.

SEE ALSO: Chapter 2.1, Medical Necessity--Level One and Level Two Criteria
Chapter 2.7, Service Level Determination and Authorization
Chapter 7.2, Provider Quality Assurance/Improvement Plan
Glossary of Terms and Acronyms

Access to Care Standards – 11/25/03

Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the most restrictive authorization criteria that can be applied. RSNs may choose to expand the criteria based on savings generated from Medicaid capitation payments. The standards should not be applied as continuing stay criteria.

- An individual must meet all of the following before being considered for a level of care assignment:**
- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
 - * The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness.
 - * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
 - * The individual is expected to benefit from the intervention.
 - * The individual’s unmet need can not be more appropriately met by any other formal or informal system or support.

* = *Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment OR long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care OR may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability OR requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care OR may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment <u>Must be the result of a mental illness.</u>	<ul style="list-style-type: none"> * Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND- * <u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u> <p>Domains include:</p> <ul style="list-style-type: none"> * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs 	<ul style="list-style-type: none"> * Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND- * <u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u> <p>Domains include:</p> <ul style="list-style-type: none"> * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)

Access to Care Standards – 11/25/03

Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the most restrictive authorization criteria that can be applied. RSNs may choose to expand the criteria based on savings generated from Medicaid capitation payments. The standards should not be applied as continuing stay criteria.

- An individual must meet all of the following before being considered for a level of care assignment:**
- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
 - * The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness.
 - * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
 - * The individual is expected to benefit from the intervention.
 - * The individual’s unmet need can not be more appropriately met by any other formal or informal system or support.

* = *Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:</p> <ul style="list-style-type: none"> * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment:</u></p> <ul style="list-style-type: none"> * Individual Treatment * Medication Monitoring * Peer Support <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 11/25/03

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the most restrictive authorization criteria that can be applied. RSNs may choose to expand the criteria based on savings generated from Medicaid capitation payments. The standards should not be applied as continuing stay criteria.

- An individual must meet all of the following before being considered for a level of care assignment:**
- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
 - * The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness.
 - * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
 - * The individual is expected to benefit from the intervention.
 - * The individual’s unmet need would not be more appropriately met by any other formal or informal system or support.

* = ***Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment OR long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care OR may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability OR requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care OR may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment Must be the result of an emotional disorder or a mental illness.	<ul style="list-style-type: none"> * Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND- * <u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 60 or below.</u> (Children under 6 are exempted from CGAS.) Domains include: Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors <ul style="list-style-type: none"> * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs 	<ul style="list-style-type: none"> * Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND- * <u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 50 or below.</u> (Children under 6 are exempted from CGAS.) Domains include: Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors <ul style="list-style-type: none"> * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children’s mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children’s mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)

Access to Care Standards – 11/25/03

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the most restrictive authorization criteria that can be applied. RSNs may choose to expand the criteria based on savings generated from Medicaid capitation payments. The standards should not be applied as continuing stay criteria.

<p>An individual must meet all of the following before being considered for a level of care assignment:</p> <ul style="list-style-type: none"> * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders. * The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness. * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. * The individual is expected to benefit from the intervention. * The individual’s unmet need would not be more appropriately met by any other formal or informal system or support.

* = ***Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: <ul style="list-style-type: none"> * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports * The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment: <ul style="list-style-type: none"> * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
11-25-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: The following covered diagnoses must be considered for eligibility. RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (Indicate the General Medical Condition not listed above) Without Behavioral Disturbance	B
294.11	Dementia Due to... (Indicate the General Medical Condition not listed above) With Behavioral Disturbance	B
---.---	Substance-Induced Persisting Dementia (refer to Substance-related Disorders for substance specific codes)	B
---.---	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to <i>(Indicate the General Medical Condition)</i> With Delusions	A
293.82	Psychotic Disorder Due to <i>(Indicate the General Medical Condition)</i> With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS DEPRESSIVE DISORDERS	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
ANXIETY DISORDERS		
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
SOMATOFORM DISORDERS		
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
FACTITIOUS DISORDERS		
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
DISSOCIATIVE DISORDERS		
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
SEXUAL AND GENDER IDENTITY DISORDERS		
EATING DISORDERS		
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
ADJUSTMENT DISORDERS		

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
PERSONALITY DISORDERS		
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a “B” diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

- * High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
- * Two or more hospital admissions due to a mental health diagnosis during the previous two years
- * Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- * Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
11-25-03

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: The following covered diagnoses must be considered for coverage. RSNs may choose to expand this list based on savings generated from Medicaid capitation payments.

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS		
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE		
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS		
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to (Indicate the General Medical Condition) With Delusions	A
293.82	Psychotic Disorder Due to (Indicate the General Medical Condition) With Hallucinations	A
298.9	Psychotic Disorder NOS	A
MOOD DISORDERS		
DEPRESSIVE DISORDERS		
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
BIPOLAR DISORDERS		
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
ANXIETY DISORDERS		
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a “B” diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- * High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
- * At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver’s ability to adequately address the child’s needs.
- * Two or more hospital admissions due to a mental health diagnosis during the previous two years
- * Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- * Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- * Child is under six years of age and there is a severe emotional abnormality in the child’s overall functioning as indicated by one of the following:

1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers)

Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child’s functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn’t respond to comfort from caregivers).

**CHELAN
DOUGLAS
RSN/PHP**

**Levels of Care
and
Definition of Service**

CHELAN-DOUGLAS RSN/PHP LEVELS OF CARE AND DEFINITIONS OF SERVICE

REFERRAL/OUTREACH SERVICES

CRITERIA:

- Person resides in Chelan-Douglas RSN/PHP and/or Wenatchee Community Service Office area.
- Person requests assistance, service and/or information.
- Acuity score 7 or below.

CONSIDERATIONS:

- Many established family and natural supports.
- History of many coping skills.
- History of adjustment at home, school/job and in community.
- Person and family feels confident in most life domains.
- Person is seeking information.
- Person can be served by community support services or natural supports.

INTENSITY OF SERVICE:

- Self-help groups, peer-support groups, family education and support, to be determined and obtained by persons requesting information and referral.
- Consultation.

LENGTH OF STAY/SERVICE:

- No present need requiring medically necessary services provided by the Chelan-Douglas Regional Support Network/PHP Provider Network at this time as jointly determined by consumer and interviewer.
- One time service to be open and closed on the same day of service.

TYPE OF SERVICE:

- Referral to natural support system and community resources.
- Community outreach services.

AUTHORIZATION:

- Approved by Chelan-Douglas RSN/PHP Provider Network Clinical Supervisors and reviewed by appropriate Mental Health Specialist (geriatric, ethnic minority, child, disability).

CHELAN-DOUGLAS RSN/PHP LEVELS OF CARE AND DEFINITIONS OF SERVICE

UNIVERSAL SERVICES

CRITERIA:

- Person resides in Chelan-Douglas RSN/PHP and/or Wenatchee Community Service Office area.
- Person requests assistance, service and/or information.
- Requested service is determined to be medically necessary by:
 - Primary Care Physician, psychiatrist; or
 - EPSDT;
 - and DSM IV Diagnosis as identified in MHD Access to Care.
- Acuity Score usually 5 to 10.
- Strength of functioning scores usually less than 37.

CONSIDERATIONS:

- Established family and natural supports.
- History of coping skills with previous issues.
- History of successful adjustment at home, school/job and in community.
- Person & family feel confident in most life domains.
- Minimal need or interest for involvement and coordination of multiple systems.
- Temporary situation stress with recent onset of challenges in independent, vocational, family or community functioning.

INTENSITY OF SERVICE:

- Low intensity, brief intervention mental health services.

LENGTH OF STAY/SERVICE:

- 180 Days or less.

TYPE OF SERVICE:

- These services are brief in duration, intensity and have limited linkage with other systems.
- Coordination of currently existing mental health interventions.
- Assistance with effective use of established family and natural supports.
- Adults: Individual, family and/or group support services including case management (i.e. consultation and coordination with Allied Service Providers) which is of limited duration on an as-needed basis. Plan of Care is developed to identify service needs such as medication management, case management support, brief interventions, consultation, etc.
- Children/Adolescents: Family focused support is the preferred method of service. With specific authorization from CDRSN Care Management, other traditional counseling services may be used on a case by case basis. Plan of Care is developed enlisting categorical services such as medication management, case management, brief interventions, consultation, etc.
- Psychiatric and medical services to ensure consumer access to prescribed medications when necessary.

AUTHORIZATION:

- Approved by Chelan-Douglas RSN/PHP Provider Network Clinical Supervisors and reviewed by appropriate Mental Health Specialist (geriatric, ethnic minority, child, disability).
- Authorized by Chelan-Douglas RSN/PHP Care Management at intake.
- CDRSN/PHP Care Management must authorize beyond six months.

CHELAN-DOUGLAS RSN/PHP LEVELS OF CARE AND DEFINITIONS OF SERVICE

TARGETED SERVICES

CRITERIA:

- Person resides in Chelan-Douglas RSN/PHP and/or Wenatchee Community Service Office area.
- Person requests assistance, service and/or information.
- Requested service is determined to be medically necessary by:
 - Primary Care Physician, psychiatrist; or
 - EPSDT;
 - and DSM IV Diagnosis as identified in MHD Access to Care.
- Acuity Score usually between 11 and 14.
- Strength of functioning scores usually less than 37.

CONSIDERATIONS:

- Family and natural system in need of multiple social supports.
- Coping skills overstressed by current concern in either home, school/work or community.
- Person and family feel confident in several life domains.
- Moderate need or interest for involvement and coordination of multiple systems.
- Situation is reoccurring and requires intervention to resolve.
- May have temporary out-of-home living environment (i.e., crisis respite, CRC, foster care, etc.).

INTENSITY OF SERVICE:

- Community Support/Rehabilitation Services and collaborative case management.
- 24/7 Stabilization and crisis intervention services as needed.

LENGTH OF STAY/SERVICE:

- 180 Days.

TYPE OF SERVICE:

- Designed for children, families and adults whose needs cannot be effectively addressed with services provided through universal services.
- These services are moderate to high in duration, intensity, linkage and flexible in time and location of service.
- Services are provided in community locations, focused on the strengthening of family supports and designed to increase consumer independence and quality of life.
- Coordination of currently existing mental health interventions combined with specifically developed tailored interventions to meet the unique and specific unmet needs of the individual and family.
- Development of a Plan of Care which focuses on:
 - Needs & tailored response to need
 - Involvement by Allied Providers and Community Supports in resolving current concern
 - Incorporating family strengths in specified solutions
- Adults: Individual, family & group support services including case management which consists of intensive service coordination with community resources to develop a tailored plan of care vital to rehabilitation or recovery, . The Plan of Care may include all services available under Universal Services as well tailored interventions provided in a place and time of the consumer's choosing and convenience.
- Children: Family focused intervention is the preferred method of treatment and support to develop a tailored plan of care vital to rehabilitation and recovery. The Plan of Care may include all services available under Universal Services but shall include tailored intervention provided in the community and at times most convenient to the consumer and family.

AUTHORIZATION:

- Approved by Chelan-Douglas RSN/PHP Provider Network Clinical Supervisors and reviewed by appropriate Mental Health Specialist (geriatric, ethnic minority, child, disability).
- Authorized by Chelan-Douglas RSN/PHP Care Management at intake.
- CDRSN/PHP Care Management must authorize beyond six months.

CHELAN-DOUGLAS RSN/PHP LEVELS OF CARE AND DEFINITIONS OF SERVICE

INTENSIVE INDIVIDUALIZED CARE

CRITERIA:

- Person resides in Chelan-Douglas RSN/PHP and/or Wenatchee Community Service Office area.
- Person requests assistance, service and/or information.
- Requested service is determined to be medically necessary by:
 - Primary Care Physician, psychiatrist; or
 - EPSDT;
 - and DSM IV Diagnosis as identified in MHD Access to Care.
- Acuity Score between 15 and 18.
- Strength of functioning scores usually 37 to 48.

CONSIDERATIONS:

- Universal or Targeted Services have been unable or is unlikely to meet consumer need.
- Person and family have experienced significant difficulty in building effective family or natural supports
- Extraordinary supports are deemed to be medically necessary in home/school/work or community settings.
- High need and intensity for involvement and coordination of multiple systems.

INTENSITY OF SERVICE:

- Highest intensity for outpatient, longer-term Individualized and Tailored Care.
- 24/7 Mental health care services provided.

LENGTH OF STAY/SERVICE:

- 180 Days.

TYPE OF SERVICE:

Specifically developed and created interventions to meet the unique and specific unmet needs of the individual and family.

- Designed for children, families and adults, whose needs cannot be effectively addressed through, Universal or Targeted services.
- These services are very high in intensity, linkage and flexibility.
- Services are developed within the structured practice patterns, approach and philosophy of Individualized and Tailored Care and are delivered using the concepts of Wraparound.
- An individualized Plan of Care shall focus on strengths addressing the unique unmet needs of an individual and family by creating interventions in at least three life domains.
- The Plan of Care will guide the activities of all involved family members, community supports, and service providers. A trained neutral facilitator, not involved in the provision of direct care services, will facilitate the Wraparound Team and produce the Plan of Care.
- Services in the Plan of Care may include:
 - Existing Mental Health services from Universal and Targeted Care levels.
 - Planned respite
 - Crisis respite and community stabilization
 - Created, individualized and tailored interventions as described in the Plan of Care which are developed in a facilitated team process
- The Plan of Care will be implemented through use of interventions which will be funded through PHP services and include created interventions funded through Mental Health Exceptional Care Funds or other community or family funding sources.
 - (This means that if a service is a covered service within Universal and Targeted Services then the existing Provider Network will be the sole provider of this service either through direct provision or subcontract by the provider. Services which are not covered within the existing network can be funded from a variety of sources including community and collaborative sources and may include the CDRSN/PHP Exceptional Care Funds subject to CDRSN Care Management Approval.)

AUTHORIZATION:

- Level of care recommendation submitted by Chelan-Douglas RSN/PHP Provider Network Clinical Supervisors and reviewed by an appropriate Mental Health Specialist (geriatric, ethnic minority, child disability). Consumers authorized at this level will be concurrently receiving services at either Universal or Targeted Levels.
- Authorized by Chelan-Douglas RSN/PHP Care Management at intake.
- CDRSN/PHP Care Management must authorize beyond six months.
- Chelan-Douglas RSN/PHP Care Managers may provide oversight by actively participating and hands-on observation on Individualized and Tailored Care Teams.

CHELAN-DOUGLAS RSN/PHP LEVELS OF CARE AND DEFINITIONS OF SERVICE

INPATIENT PSYCHIATRIC HOSPITAL SERVICES

CRITERIA:

- Person resides in Chelan-Douglas RSN/PHP and/or Wenatchee Community Service Office area, or are within the first six months of transfer to another RSN, or is in Chelan or Douglas County and experiencing a mental health crisis.
- Person is covered regardless of ability to pay.
- Person requests and/or consents to inpatient psychiatric hospitalization or meets ITA criteria.
- Requested service is determined to be medically necessary by:
 - Primary Care Physician; or
 - EPSDT;
 - and DSM IV
- Require inpatient psychiatric hospitalization to stabilize their level of functioning in order to return to home or less restrictive living environment.
- Person must meet the criteria of RCW 71.05 or 71.34.
- Person must meet the definition of Medical Necessity WAC 388-865-0150; Medical Necessity.
- Must be medically stable.
- Acuity Score usually between 19 and 20.
- Strength of functioning scores usually 49 to 60.

CONSIDERATIONS:

- All other less restrictive outpatient alternatives have been ruled out. (i.e., Natural supports, in-home crisis respite, out-of-home crisis respite, 24-hour 1:1 stabilization, etc.)
- Current LRA revoked.

INTENSITY OF SERVICE:

- 24/7 Acute psychiatric inpatient care.

LENGTH OF STAY/SERVICE:

- Determined by on-call CDRSN/PHP Care Manager, with LOS as determined by PAS per authorization.
- The CDRSN/PHP Care Manager will provide authorization for extension of length of stay.
- When ITA is implemented or if LRA is revoked, LOS as determined by a court order.

TYPE OF SERVICE:

- Inpatient psychiatric hospitalization at one of the following hospitals:
 - Sacred Heart Medical Center
 - Lourdes Counseling Center
 - Lake Chelan Community Hospital
 - Eastern State Hospital
 - CLIP (Tamarack, Child Study and Treatment Center, Pearl Street, McGraw, and Martin Center).
- Alternative psychiatric hospital placements to be approved by on-call CDRSN/PHP Care Manager.
- CDRSN/PHP providers will maintain therapeutic contact with service recipients during hospitalizations at a minimum of daily for children (under 18 years of age), weekly for children in CLIP hospitals, twice each week for adults in community hospitals, and weekly for adults in state hospitals.
- Discharge planning that includes addressing hospital recommendations, residential and placement issues, transitional services, a risk management plan, strength-based family centered planning family centered strengths based treatment planning, and family teams.

AUTHORIZATION:

- Approved by CDRSN Care Management in conjunction with Primary Care Physician, ARNP, or Physician's Assistant and reviewed by an appropriate Mental Health Specialist (geriatric, ethnic minority, child, disability).