

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration**

TECHNICAL REQUIREMENT FOR SED CHILDREN

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE; AND 2) ESTABLISHING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

General Considerations

This requirement provides a framework to be used by Prepaid Inpatient Health Plans (PIHP) for determining eligibility for Medicaid specialty mental health services for children with Serious Emotional Disturbance (SED). The criteria for Medicaid eligibility for specialty mental health services for children is based on the definition of serious emotional disturbance delineated in the Mental Health Code (Section 330.1100d) which includes the three dimensions of diagnosis, functional impairment, and duration.

A key feature of the Medicaid eligibility criteria in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for Medicaid specialty mental health services. This means that the practice of using a defined or limited set of diagnoses to determine Medicaid eligibility, for services should cease. As stated in the Mental Health Code, any diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) can be used (with the exception of developmental disorder, substance abuse disorder, or "V" codes unless these disorders occur in conjunction with another diagnosable serious emotional disorder), and should be coupled with functional impairment and duration criteria for determination of serious emotional disturbance in a child.

The Medicaid eligibility criteria delineated in this document is intended to: (1) assist PIHPs in determining severity, complexity, and duration that would indicate a need for specialty mental health services and supports for Medicaid children, and (2) bring more uniformity to these decisions for children across the system. Children meeting the criteria delineated in this document are considered to have an SED, as defined in the Mental Health Code. (Please note that the criteria contained in this document presently do not apply to MICHild beneficiaries because PIHPs are the sole provider of the mental health benefit for MICHild beneficiaries who are to be provided medically necessary mental health services by PIHPs regardless of functional impairment; however, on January 1, 2016, MICHild beneficiaries became Medicaid recipients and eligibility for services by PIHP will be determined as a child with an SED.

Selection of Services

For Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on person-centered planning (PCP) and family-centered practice. Selection of services should also be made based on medical necessity criteria, and, where applicable, the service-specific criteria, coverage policy, and decision parameters contained in the most recent version of the Medicaid Provider Manual (MPM). However, decisions regarding access/eligibility should not be based on medical necessity criteria or service-specific criteria since these decisions are a separate and subsequent process to eligibility determinations.

Special Note: For Direct Prevention Services Models (CCEP, School Success Program, Infant Mental Health, Parent Education) with a family or childcare provider regarding an individual child, the service should be noted in the child's plan of services as "medically necessary" and should be reported using the child's beneficiary identification number. PIHPs typically use "unspecified" diagnosis codes found in the International Classification of Diseases (ICD-9) for infants, young children, and individuals who receive one-time crisis intervention.

Definition of Child with SED 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Code, Section 330.1100d. In addition, extensive reviews and examinations of Child and Adolescent Functional Assessment Scale (CAFAS) data submitted by Community Mental Health Service Plans (CMHSP) for the children currently served were undertaken to establish functioning criteria consistent with the Michigan Mental Health Code definition of SED.¹ The parameters delineated below do not preclude the diagnosis of and the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current version of the DSM or ICD that results in a care-giving environment that places the child at-risk for SED.

The following is the criteria for determining when a child 7 through 17 years is considered to have an SED. All the dimensions must be considered when determining whether a child is eligible for mental health services and supports as a child with an SED. The child shall meet each of the following:

Diagnosis:

SED means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent DSM published by the American Psychiatric Association and approved by the Michigan Department of Health and Human Services (MDHHS) and that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable SED: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the DSM.

Degree of Disability/Functional Impairment:

Functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities. This is defined as:

- A total score of 50 (using the eight subscale scores on the CAFAS, or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Duration/History:

Evidence that the disorder exists or has existed during the past year for a period sufficient to meet diagnostic criteria specified in the most recent DSM.

Definition of Child with SED, 4 through 6 Years (48 months through 71 months)

For children 4 through 6 years, decisions should utilize similar dimensions to older children to determine whether a child has an SED and needs mental health services and supports. The dimensions include:

¹The recommendations for the CAFAS scores as detailed under the functioning dimension described in this document would capture about 84.2% of the children currently being served by CMHSPs.

- a diagnosable behavioral or emotional disorder,
- functional impairment/limitation of major life activities, and
- duration of condition.

However, as with infants and toddlers (birth through three years), assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Impairments in functioning are revealed across life domains in the young child's regulation of emotion and behavior, social development (generalization of relationships beyond parents, capacity for peer relationships, and play, etc.), physical and cognitive development, and the emergence of a sense of self. All the dimensions must be considered when determining whether a young child is eligible for mental health services and supports as a child with an SED.

The parameters delineated below do not preclude the provision of services to an adult beneficiary of a young child who is a parent and who has a diagnosis within the current version of the DSM or ICD that results in a caregiving environment that places the child at risk for an SED.

The following is the criteria for determining when a young child beneficiary is considered to have an SED. All the dimensions must be considered when determining whether a young child is eligible for mental health services and supports.

The child shall meet each of the following:

Diagnosis:

A young child has a mental, behavioral, or emotional disturbance sufficient to meet diagnostic criteria specified in the most recent DSM and approved by MDHHS that has resulted in functional impairment as delineated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the DSM.

Degree of Disability/Functional Impairment:

Interference with, or limitation of, a young child's proficiency in performing developmentally appropriate tasks, when compared to other children of the same age, across life domain areas, and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas:

Area I:

Limited capacity for self-regulation, inability to control impulses, or modulate emotions as indicated by:

Internalized Behaviors:

- prolonged listlessness or sadness
- inability to cope with separation from primary caregiver
- shows inappropriate emotions for situation
- anxious or fearful
- cries a lot and cannot be consoled
- frequent nightmares
- makes negative self-statements that may include suicidal thoughts

Externalized Behaviors:

- frequent tantrums or aggressiveness toward others, self, and animals
- inflexibility and low frustration tolerance
- severe reaction to changes in routine
- disorganized behaviors or play
- shows inappropriate emotions for situation
- reckless behavior
- danger to self, including self-mutilation
- need for constant supervision
- impulsive or danger seeking
- sexualized behaviors inappropriate for developmental age
- developmentally inappropriate ability to comply with adult requests
- refuses to attend childcare and/or school
- deliberately damages property
- fire starting
- stealing

Area II:

Physical symptoms, as indicated by behaviors that are not the result of a medical condition, include:

- bed wetting
- sleep disorders
- eating disorders
- encopresis
- somatic complaints

Area III:

Disturbances of thought, as indicated by the following behaviors:

- inability to distinguish between real and pretend
- difficulty with transitioning from self-centered to more reality-based thinking
- communication is disordered or bizarre
- repeats thoughts, ideas, or actions over and over
- absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment

Area IV:

Difficulty with social relationships as indicated by:

- inability to engage in interactive play with peers
- inability to maintain placements in childcare or other organized groups
- frequent suspensions from school
- failure to display social values or empathy toward others
- threatens or intimidates others
- inability to engage in reciprocal communications
- directs attachment behaviors non-selectively

Area V:

Caregiving factors that reinforce the severity or intractability of the childhood disorder and the need for intervention strategies such as:

- a chaotic household/constantly changing caregiving environments
- parental expectations are inappropriate considering the developmental age of the young child
- inconsistent parenting
- subjection to others' violent or otherwise harmful behavior
- over-protection of the young child
- parent/caregiver is insensitive, angry, and/or resentful to the young child
- impairment in parental judgment or functioning (mental illness, domestic violence, substance use, etc.)
- failure to provide emotional support to a young child who has been abused or traumatized

The standardized assessment tool specifically targeting social-emotional functioning for children 4 through 6 years recommended for use in determining degree of functional impairment is the Pre-School and Early Childhood Functional Assessment Scale (PECFAS).

Duration/History:

The young age and rapid transition of young children through developmental stages makes consistent symptomatology over a long period of time unlikely.

However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

- Evidence of three continuous months of illness, or
- Three months of symptomatology/dysfunction in a six-month period, or
- Conditions that are persistent in their expression and are not likely to change without intervention, or
- A young child has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent, or caregiver, such as abuse (physical, emotional, sexual), medical trauma, and/or domestic violence.

Definition of Child with SED, Birth through 3 Years (47 months of age)

Unique criteria must be applied to define SED for the birth through three years population, given:

- the magnitude and speed of developmental changes through pregnancy, infancy, and early childhood,
- the limited capacity of the very young to symptomatically present underlying disturbances,
- the extreme dependence of infants and toddlers upon caregivers for their survival and wellbeing, and
- the vulnerability of the very young to relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of:

- the primary indicators of SED in infants and toddlers, and
- the importance of assessing the constitutional/physiological and/or caregiving/environmental factors that reinforce the severity and intractability of the infant or toddler's disorder.

Furthermore, the rapid development of infants and toddlers, results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess the infant or toddler in the appropriate developmental context.

The access eligibility criteria delineated below do not preclude the provision of services to an adult beneficiary who is a parent of an infant or toddler and who has a diagnosis within the current version of the DSM or ICD that results in a caregiving environment that places the infant or toddler at high risk for an SED.

The following is the criteria for determining when an infant or toddler beneficiary is considered to have an SED or is at high risk for an SED and qualifies for mental health services and supports. All the dimensions must be considered when determining eligibility.

The child shall meet each of the following:

Diagnosis:

An infant or toddler has a mental, behavioral, or emotional disturbance sufficient to meet the diagnostic criteria specified in the most recent DSM consistent with the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition* (see attached crosswalk) that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable SED: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment:

Interference with, or limitation of, an infant or toddler's proficiency in performing developmentally appropriate skills as demonstrated by at least one indicator drawn from two of the following three functional impairment areas:

Area I:

General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems. Indicators are:

- uncontrollable crying or screaming
- sleeping and eating disturbances
- disturbance (over or under expression) of affect, such as pleasure, displeasure, joy, anger, fear, curiosity, and apathy toward environment and caregiver
- toddler has difficulty with impulsivity and/or sustaining attention
- developmentally inappropriate aggressiveness toward others and/or toward self
- reckless behavior(s)
- regression because of a trauma
- sexualized behaviors inappropriate for developmental age

Area II:

Behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibit the infant or toddler's daily adaptation and relationships. Behavioral indicators are:

- a restricted range of exploration and assertiveness
- severe reaction to changes in routines
- tendency to be frightened and clinging in new situations
- lack of interest in interacting with objects, activities in their environment, or relating to others and infant or toddler appears to have one of the following reactions to sensory stimulation:
 - hyper-sensitivity
 - hypo-sensitive/under-responsive
 - sensory stimulating-seeking/impulsive

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler, parent/caregiver, and environmental characteristics. Indicators in the infant or toddler are:

- does not meet developmental milestones (i.e., delayed motor, cognitive, social/emotional, speech, and language) due to lack of critical nurturing
- has severe difficulty in relating and communicating
- disorganized behaviors or play
- directs attachment behaviors non-selectively
- resists and avoids the caregiver(s) which may include childcare providers
- developmentally inappropriate ability to comply with adult requests, disturbed intensity of emotional expressiveness (anger, blandness, or apathetic) in the presence of a parent/caregiver who often interferes with the infant or toddler's goals and desires, dominates the infant or toddler through over-control, does not reciprocate to the infant or toddler's gestures, and/or whose anger, depression, or anxiety results in inconsistent parenting. The parent/caregiver may be unable to provide critical nurturing and/or be unresponsive to the infant or toddler's needs due to diagnosed or undiagnosed peri-natal depression or other mental illness, etc.

The standardized assessment tool specifically targeting social-emotional functioning for infants and is the Devereaux Early Childhood Assessment (Infant, Toddler or Clinical Version).

Duration/History:

The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

- (1) The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal development (inconsistent parenting or caregiving, chaotic environment, etc.), or
- (2) The infant or toddler has been observed to exhibit the functional impairments for more days than not for a minimum of two weeks (see Areas I-III above), or
- (3) The infant or toddler has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent, or caregiver, such as abuse (physical, emotional, sexual), medical trauma, and/or domestic violence.

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC:0-3R and DSM-5

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Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 years range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial, and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC: 0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC: 0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to DSM-5 billable diagnosis. Two caveats: **Do not start with Axis I; Evaluate all axes.** Choose the diagnosis/diagnoses that characterize the focus of treatment.

Overview of Assessment Framework:

Part 1:

Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregiver's capacities, and challenging the child's adaptive capacities? Have these stressors undermined the caregiver's capacity to be protective? The presenting problems may indicate stresses or cumulative risk (Axis IV). Is the presentation of symptoms related to stress or risk a focus of treatment?

Part 2:

What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III)? Is the child struggling with daily tasks due to health or developmental problems? NOTE: that developmental disorder diagnoses are included on DC: 0-3R Axis III – diagnoses used by developmental specialists (e.g., speech/language, OT, PT, special education).

Part 3:

Does the child demonstrate age-level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of his/her daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4:

What is the role/contribution of relational dynamics: are there patterns of rigidity in parent/child interactions, tension, or conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies and possibly impact the child's developmental trajectory or the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5:

Are the child's difficulties pervasive, occurring across settings and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC: 0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular child. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In the absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative, or chronic stress, consider the context for enduring and significant adjustment challenges. A child’s behavioral difficulties may be an indication of the child’s struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC: 0-3R formulation (reviewing each axis for salient assessment findings)	Select DSM crosswalk diagnosis for billing purposes	
DC: 0-3R	DSM-5 Code	DSM-5
Psychosocial Risk/Stressors	NOTE: Axis IV Checklist in DC: 0-3R does not focus exclusively on risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many checklist items are more specific stress factors in family life. Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk – Distinguish history from chronic and current stressors.	309.9	Adjustment Disorder, unspecified (Trauma- and Stressor-Related Disorder, unspecified) <ul style="list-style-type: none"> New Dx criteria E: <i>Once the stressors or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.</i>
300 Adjustment Disorder	309.xx 309.0 309.24 309.28 309.9 309.3 309.4	Adjustment Disorder, (specify) with Depressed Mood with Anxiety with Anxiety and Depressed Mood Adjustment Disorder, unspecified RESERVED – this code is reserved for Axis I, 240 Mixed Disorder of Emotional Expressiveness RESERVED – this code is reserved for Axis II, Relationship Disorder
If traumatic events meet DC: 0-3R Axis I criteria and the child’s symptom presentation is pervasive across situations and relationships, evaluate:		From DSM-5 Trauma- and Stressor-Related Disorders
100 Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder

Part 2

The presence of specific physical health (constitutional), developmental, or learning challenges undermines the child’s functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of co-occurring medical conditions that may also undermine the child’s capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3R Developmental and/or health/medical disorders are recorded on Axis III	DSM-5 Code	DSM-5
For primary diagnosis, crosswalk to:	309.9	Adjustment Disorder, unspecified
	315.9	Neurodevelopmental Disorder, unspecified
For secondary diagnosis (if needed)	307.9	Crosswalk to DSM-5 Axis I and record as secondary diagnosis
	315.39	Communication Disorder, unspecified
	315.9	Social (Pragmatic) Communication Disorder
	315.4	Neurodevelopmental Disorder, unspecified
	315.8	Developmental Coordination Disorder
	319	Global Developmental Delay (under age 5)
		Intellectual Disability, unspecified
Codes are not needed for health/medical conditions. Provide descriptive information about health/medical issues. Distinguish history, chronic conditions, and current issues.		
Identify names of specific current and chronic medical diagnoses, e.g. asthma, obesity, ear infections, prematurity, genetic syndromes (Fragile X, Prader Willis, etc.), and sleep apnea.		

Part 3

Consider the child’s capacity to participate in meaningful everyday family routines and interactions. Does the child demonstrate functional limitations in capacities to integrate emotional, cognitive, and communicative competencies to meet emotionally meaningful goals, to “problem solve” effectively, and to express wants, needs, likes, and dislikes? Does the child use age-level developmental skills in daily life routines with each of the important people in the child’s daily life?

<p>AXIS V – Functional Social-Emotional Capacities</p>	<p>Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow the child to be in the lead compared to structured contexts in which the child is expected to follow another’s ideas or respond to directions. Challenges presented in the child’s functional competencies may involve many factors. If the child’s functional competencies are not at age-level, then the child does not have age-level expected capacities for “problem-solving” responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment</p>	
<p>DC: 0-3R</p>	<p>DSM-5 Code</p>	<p>DSM-5</p>
<p>IF not at age-level in any one or more of the capacities:</p>	<p>309.9</p>	<p>Adjustment Disorder, unspecified (Trauma- and Stressor-Related Disorder, unspecified)</p>
	<p>315.9</p>	<p>Neurodevelopmental Disorder, unspecified</p>
<p>Treatment planning requires assessment to identify contribution of the factors undermining the child’s functional competency. The child’s functional challenges may be context-specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional issues.</p> <p>In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, and relationship problems.</p> <p>For treatment planning, specify the developmental processes that are not at age-level and identify factors that are involved in, or affected by, functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV and III above and Axis II below.</p>		

Part 4

What are the patterns of flexibility, tension, and conflict in the interactions of the child with each of the important people in the child’s daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life? If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child’s difficulties with developmental progress, functioning in daily routines, and adjustment?

DC: 0-3R Axis II Relationship Classification	<p>If a specific relationship is characterized by patterns of difficult interactions between the child and the adult, (lack of flexibility, tension, and unresolvable conflict) then the child’s behavioral problems may reflect the presence of ongoing challenges to the child’s adjustment. Undermining of Axis V functional competencies may be specific to a relationship.</p> <p>Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.</p>	
	DSM-5 Code	DSM-5
<p>900 Relationship Disorder If PIR-GAS of 40 or below, Dx of relationship disorder</p>	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, chronic
<p>If PIR-GAS of 41-80 – Features of Disorder Difficulties may not yet be ingrained. Interventions may be focused on addressing risks of deterioration in the child’s adaptive functioning or development.</p>	309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, chronic
		NOTE: Specific Relationship Disorder may co-occur with other diagnoses.

Part 5

Is (some part of) the child’s problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

In addition to difficulties identified above, is there a DC: 0-3R Axis I diagnosis?	DSM-5 Codes	DSM-5
DC: 0-3R Clinical Disorders		
100 Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder
200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	309.0	Adjustment Disorder with Depressed Mood
	309.9	Adjustment Disorder, unspecified (Trauma- and Stressor-Related Disorder, unspecified)
220 Anxiety Disorders		
221 Separation Anxiety	309.21	Separation Anxiety Disorder
222 Specific Phobia	300.01	Panic Disorder
223 Social Anxiety Disorder	300.23	Social Anxiety Disorder (Social Phobia)
224 Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
225 Anxiety Disorder, NOS	300.00	Anxiety Disorder, unspecified
230 Depression of Infancy and Early Childhood		
231 Type I Major Depression	296.99	Disruptive Mood Dysregulation Disorder
	296.20	Major Depressive Disorder, Single Episode, unspecified
232 Type II Depressive Disorder, NOS	311	Depressive Disorder, unspecified
240 Mixed Disorder of Emotional Expressiveness		
	309.3	Adjustment Disorder with Disturbance of Conduct

300 Adjustment Disorder	309.xx 309.0 309.24 309.28 309.9 309.3 309.4	Adjustment Disorder, (specify) with Depressed Mood with Anxiety with Anxiety and Depressed Mood Adjustment Disorder, unspecified RESERVED – this code is reserved for 240 Mixed Disorder of Emotional Expressiveness-above RESERVED – this code is reserved for Axis II, Relationship Disorder
400 Regulation Disorders of Sensory Processing 410 Hypersensitive 411 Type A – Fearful/Cautious 412 Type B – Negative/Defiant 420 Hyposensitive/Under Responsive 430 Sensory Stimulation-Seeking/Impulsive	 315.9	Same DSM-5 code for all subtypes Neurodevelopmental Disorder, unspecified
500 Sleep Behavior Disorder NOTE: <i>IF primary diagnosis, the Sleep Disorder is not a symptom related to, or secondary to, other problems.</i>		NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis. Sleep Disorder can be secondary diagnosis.
510 Sleep Onset Disorder 520 Night-Waking Disorder	309.9	Adjustment Disorder, unspecified
For secondary diagnosis (if needed)	780.52	Insomnia Disorder
	780.59	Sleep-Wake Disorder, unspecified
600 Feeding Behavior Disorder Note: <i>IF primary diagnosis, the Feeding Disorder is not a symptom related to, or secondary to, other problems.</i> 601 Feeding Disorder of State Regulation 602 Feeding Disorder of Caregiver-Infant Reciprocity (this Dx is specific to feeding interactions so is less pervasive than a relationship disorder) 603 Infantile Anorexia 604 Sensory Food Aversions 605 Feeding Disorder Associated with Concurrent Medical Conditions 606 Feeding Disorder Associated with Insults to Gastrointestinal Tract	 307.59	(Same DSM-5 Code for all DC: 0-3R subtypes) Feeding or Eating Disorder, unspecified

<p>700 Disorders of Relating and Communicating (Referred to as PDD in the DSM classification.)</p>	<p>299.00</p>	<p>NOTE: A mental health diagnosis for the child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autistic Disorder can be secondary diagnosis within mental health.</p>
<p>DC: 0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.</p>		<p>DC: 0-3R age distinctions do not apply in crosswalk.</p>
<p>710 Multisystem Developmental Disorder (MSDD)</p>	<p>299.80</p>	<p>Pervasive Developmental Disorder, NOS – can be primary Dx</p>
	<p>300.00</p>	<p>Anxiety Disorder, unspecified</p>
	<p>315.9</p>	<p>Neurodevelopmental Disorder, unspecified</p>
<p>For secondary diagnosis (if needed) This may be important for advocacy work with other service providers or agencies.</p>	<p>299.00</p>	<p>Autistic Disorder Can be secondary diagnosis, but not primary diagnosis. Specify severity: Level 3 – Requiring very substantial support Level 2 – Requiring substantial support Level 1 – Requiring support</p>
<p>800 Other Disorders Not relevant to Medicaid billing crosswalk</p>		<p>This code would be used to include diagnostic codes from the ICD, DSM, or other classifications into a DC: 0-3R formulation; in that context, the DC: 0-3R would serve as the primary system for diagnostic classification & no crosswalk would be needed.</p>
<p>If a DC: 0-3R Axis I Diagnosis has not been identified, first, reconsider assessment areas above</p>	<p>This crosswalk includes directions for all DC: 0-3R axes to ICD-9 Axis I Codes. See Above.</p>	
<p>If no DC: 0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities:</p>		
	<p>315.9</p>	<p>Neurodevelopmental Disorder, unspecified</p>
	<p>309.9</p>	<p>Adjustment Disorder, unspecified</p>
	<p>309.9</p>	<p>Trauma- and Stressor-Related Disorder, unspecified</p>

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC: 0-3R and ICD-10 CM

October 2015

Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 years range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial, and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC: 0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC: 0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to ICD-10 billable diagnosis. Two caveats: **Do not start with Axis I; Evaluate all axes.** Choose the diagnosis/diagnoses that characterize the focus of treatment.

Overview of assessment framework:

Part 1:

Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregiver's capacities, and challenging the child's adaptive capacities? Have these stressors weakened the caregiver's capacity to be protective? The presenting problems may indicate risk or cumulative stress (Axis IV). Is the presentation of risk a focus of treatment?

Part 2:

What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III)? Is the child struggling with daily tasks due to health or developmental problems? NOTE: that developmental disorder diagnoses are included on DV: 0-3R Axis III – diagnoses used by developmental specialists, e.g., speech/language, OT, PT, special education).

Part 3:

Does the child demonstrate age-level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of the child's daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4:

What is the role/contribution of relational dynamics: are there patterns of rigidity in parent/child interactions, tension, or conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies and possibly impact the child's developmental trajectory or the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5:

Are the child's difficulties pervasive, occurring across settings, and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC: 0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular child. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative, or chronic stress, consider the context for enduring and significant adjustment challenges. A child’s behavioral difficulties may be an indication of the child’s struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC: 0-3R formulation (reviewing each axis for salient assessment findings)	Select ICD-10 crosswalk diagnosis for billing purposes	
DC: 0-3R	ICD-10 Code	ICD-10
Psychosocial Risk/Stressors	NOTE: Axis IV Checklist in DC: 0-3R does not focus exclusively on risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many checklist items are “daily hassles.” Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk – Distinguish history from chronic and current stressors.	F43.9	Reaction to Severe Stress, unspecified.
300 Adjustment Disorder	F43.20 F43.21 F43.22 F43.23 F43.24 F43.25	Adjustment Disorder, unspecified with Depressed Mood with Anxiety with Mixed Anxiety and Depressed Mood RESERVED – this code is reserved for Axis I, 240 Mixed Disorder of Emotional Disturbance RESERVED – this code is reserved for Axis II, Relationship Disorder- See Axis II Relationship Disorder
If stress/risk events meet DC: 0-3R Axis I criteria, and the child’s symptom presentation is pervasive across situations and relationships, evaluate:		
100 Post Traumatic Stress Disorder	F43.10 F43.11 F43.12	Post Traumatic Stress Disorder, unspecified Acute Chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive Attachment Disorder of Childhood (inhibited form)
	F94.2	Reactive Attachment Disorder of Childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur

Part 2

The presence of specific physical health (constitutional), developmental, or learning challenges undermines a child’s functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of (co-occurring) medical conditions that may also undermine a child’s capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC: 0-3R Developmental and/or health/medical disorders are recorded on Axis III	ICD-10 Code	ICD-10
For primary diagnosis, crosswalk to:	F43.20	Adjustment Disorder, unspecified
	F93.9	Childhood Emotional Disorder, unspecified
For secondary diagnosis (if needed)	F80.1 F80.2 F80.9 F81.9 F82 F79	For secondary diagnosis: Expressive Language Disorder Mixed Expressive-Receptive Language Disorder Development Disorder of Speech and Language, unspecified Developmental Disorder of Scholastic Skills, unspecified Specific Developmental Disorder of Motor Function Intellectual Disabilities, unspecified
ICD-10 codes are not needed for physical health/medical conditions. Provide descriptive information about health/medical issues. Distinguish history, chronic conditions, and current issues.		
Identify names of specific current and chronic medical diagnoses, e.g. asthma, obesity, ear infections, prematurity, genetic syndromes (Fragile X, Prader Willis, etc.), and sleep apnea		

Part 3

Consider the child’s capacity to participate in meaningful everyday family routines and interactions. Does the child demonstrate functional limitations in capacities to integrate emotional, cognitive, and communicative competencies to meet emotionally meaningful goals, to “problem solve” effectively, and to express wants, needs, likes, and dislikes? Does the child use age-level developmental skills in daily life routines with each of the important people in the child’s daily life?

<p>AXIS V – Functional Social-Emotional Capacities</p>	<p>Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow the child to be in the lead compared to structured contexts in which the child is expected to follow another’s ideas or respond to directions. Challenges presented in the child’s functional competencies may involve many factors. If the child’s functional competencies are not at age-level, then the child does not have age-level expected capacities for “problem-solving” responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment.</p>	
<p>DC: 0-3R</p>	<p>ICD-10 Code</p>	<p>ICD-10</p>
<p>IF not at age-level in any one or more of the capacities:</p>	<p>F94.9</p>	<p>Childhood Disorder of Social Functioning</p>
	<p>F99</p>	<p>Not Otherwise Specified</p>
<p>Treatment planning requires assessment to identify the contributing factors undermining the child’s functional competency. Standardized testing may be indicated. The child’s functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional/physical health issues.</p>		
<p>In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, and relationship problems.</p>		
<p>For treatment planning, specify the developmental processes that are not at age-level and identify factors that are involved in, or affected by, functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV and III above and Axis II below.</p>		

Part 4

What are the patterns of flexibility, tension, and conflict in the interactions of the child with each of the important people in the child’s daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life? If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child’s difficulties with developmental progress, functioning in daily routines, and adjustment?

<p>DC: 0-3R Axis II Relationship Classification</p>	<p>If a specific relationship is characterized by patterns of difficult interactions between the child and the adult, (lack of flexibility, tension, and unresolvable conflict) then the child’s behavioral problems may reflect the presence of ongoing challenges to the child’s adjustment. Undermining of Axis V functional competencies may be specific to a relationship. Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.</p>	
<p>DC: 0-3R</p>	<p>ICD-10 Code</p>	<p>ICD-10</p>
<p>900 Relationship Disorder If PIR-GAS of 40 or below, Dx of relationship disorder</p>	<p>F43.25</p>	<p>Adjustment Disorder with Mixed Disturbance of Emotions and Conduct</p>
<p>If PIR-GAS of 41-80 – Features of Disorder Difficulties may not yet be ingrained. Interventions may be focused on addressing risks of deterioration in the child’s adaptive functioning or development.</p>	<p>F43.25</p>	<p>Adjustment Disorder with Mixed Disturbance of Emotions and Conduct</p>
<p>NOTE: Specific Relationship Disorder may co-occur with other diagnoses.</p>		

Part 5

Is (some part of) the child’s problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

DC: 0-3R	ICD-10 Code	ICD-10
In addition to difficulties identified above, is there a DC: 0-3R Axis I diagnosis?		
DC: 0-3R Clinical Disorders		
100 Post Traumatic Stress Disorder	F43.10 F43.11 F43.12	Post Traumatic Stress Disorder, unspecified Acute Chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive Attachment Disorder of Childhood (inhibited form)
	F94.2	Reactive Attachment Disorder of Childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur
200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	F43.20 F43.9	Adjustment Disorder, unspecified Reaction to Severe Stress, unspecified
220 Anxiety Disorders		
221 Separation Anxiety	F93.0	Separation Anxiety Disorder of Childhood
222 Specific Phobia	F40.9	Phobic Anxiety Disorder, unspecified
223 Social Anxiety Disorder	F40.10	Social Phobia, unspecified
224 Generalized Anxiety Disorder	F41.1	Generalized Anxiety Disorder
225 Anxiety Disorder, NOS	F41.9	Anxiety Disorder, unspecified
230 Depression of Infancy and Early Childhood		

DC: 0-3R	ICD-10 Code	ICD-10
231 Type I Major Depression	F32.9	Major Depressive Disorder, Single Episode, unspecified
	F33.9	Major Depressive Disorder, Recurrent, unspecified
232 Type II Depressive Disorder, NOS	F34.9	Persistent Mood (Affective) Disorder, unspecified
240 Mixed disorder of emotional expressiveness	F43.24	Adjustment Disorder with Disturbance of Conduct
300 Adjustment Disorder		See Axis IV Above
400 Regulation Disorders of Sensory Processing	F41.9	Anxiety Disorder, unspecified
410 Hypersensitive		
411 Type A – Fearful/Cautious		
412 Type B – Negative/Defiant		
420 Hyposensitive/Under-Responsive		
430 Sensory Stimulations-Seeking/Impulsive		
500 Sleep Behavior Disorder	F43.20	Adjustment Disorder, unspecified
NOTE: <i>The sleep difficulties are not symptoms related to, or secondary to, other problems.</i>		
NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis.		
For secondary diagnosis: (if needed)		Sleep Disorder can be Secondary Diagnosis.
510 Sleep Onset Disorder	G47.50	Parasomnia, unspecified
520 Night Waking Disorder	G47.9	Sleep Disorder, unspecified
	F51.4	Sleep Terrors (Night Terrors)
600 Feeding Behavior Disorder	F98.2	(Same ICD-10 Code for all DC:0-3R subtypes) Other Feeding Disorders of Infancy and Early Childhood
NOTE: <i>IF primary diagnosis, the feeding difficulties are not a symptom related to, or secondary to, other problems.</i>		
601 Feeding Disorder of State Regulation		
602 Feeding Disorder of Caregiver-Infant Reciprocity (this Dx is specific to feeding interactions so is less pervasive than a relationship disorder)		

DC: 0-3R	ICD-10 Code	ICD-10
603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder Associated with Concurrent Medical Conditions		
606 Feeding Disorder Associated with Insults to Gastrointestinal Tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the ICD-10 classification.)	F84.0	NOTE: A mental health diagnosis for the child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autistic Disorder may be secondary diagnosis within mental health.
DC: 0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC: 0-3R age distinctions do not apply in crosswalk.
710 Multisystem Developmental Disorder (MSDD)	F84.9 F41.9	Pervasive Developmental Disorder, unspecified NOTE: Can be primary diagnosis Anxiety Disorder, unspecified
For secondary diagnosis (if needed) This may be important for advocacy work with other service providers, agencies.	F84.0	Autistic Disorder NOTE: Can be secondary diagnosis, but not primary diagnosis.
800 Other Disorders	Not relevant to Medicaid billing crosswalk	This code would be used to include diagnostic codes from the ICD, DSM, or other classifications into a DC: 0-3R formulation; in that context, the DC: 0-3R would serve as the primary system for diagnostic classification and no crosswalk would be needed.
If a DC:0-3R Axis I Diagnosis has not been identified, first, re-consider assessment areas above		This crosswalk includes directions for all DC: 0-3R axes to ICD-9 Axis I Codes. See Above.
If no DC: 0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities:		
	F99	Mental Disorder, unspecified
	F93.9	Childhood Emotional Disorder, unspecified
	F94.9	Childhood Disorder of Social Functioning, unspecified

