13. ABP Medically Frail and ABP Exempt

13.1. General Information

This section of the Manual is issued to address the criteria and process for determining whether a Member in the Other Adult Group COE 100 is medically frail. A medically frail Member in COE 100 may choose to continue receiving services under the ABP services package or may choose to become ABP exempt and receive services under the Medicaid State Plan benefit package.

ABP exempt means an Other Adult Group Medicaid (COE 100) recipient who has been determined as meeting the definition and criteria of medically frail (as defined in Section 13.2. of the Manual) and has chosen to receive services under the Medicaid State Plan benefit package instead of the ABP. All COE 100 members are notified of their enrollment in the ABP and of the medically frail exemption criteria/process on their HCA Medicaid eligibility notice. The eligibility notice also directs ABP recipients to the HCA/MAD website where they can find the full listing of ABP benefits and a comparison to the Medicaid State Plan. This section of the Manual explains the detailed criteria that should be used by the MCO to determine whether COE 100 members meet one of the definitions of medically frail.

13.2. Determination of Medically Frail Diagnosis

Members in COE 100 may self-identify to the MCO by telephone that they may be medically frail and may do so at any time during their eligibility for COE 100. Members in COE 100 may also be identified as potentially medically frail by the MCO through the care coordination process.

To determine whether a Member qualifies as medically frail, the MCO should reference the Medically Frail Conditions List. The Member must have a documented medical diagnosis from the list of qualifying conditions. A written statement from a licensed provider attesting to the medical condition will suffice. The entire medical record is not needed. If obtaining a written statement will cause significant delay, the MCO may confirm the diagnosis by a licensed provider over the telephone. If the diagnosis is confirmed by telephone, the MCO should document the discussion occurred and the outcome of that conversation. The MCO should determine which staff can perform this function. A nurse is not required.

There shall be no end date for a medically frail approval. Upon the Member's self-identification, or through the MCO's care coordination process, the MCO shall evaluate and confirm whether the Member qualifies as medically frail. The MCO shall confirm the Member's status and notify the Member whether they meet the criteria for ABP exempt by mail within 10 business days of the Member's self-identification. If the MCO is unable to obtain a provider's diagnosis or any requisite follow-up from

either the Member or a provider after making a good faith effort to do so within the necessary timeframe, the MCO should issue a denial letter to the Member.

The ABP Member remains enrolled in the ABP until the MCO has confirmed medically frail status and the Member has chosen to receive the ABP exempt benefit package. The MCO shall describe the benefit and cost-sharing differences between the ABP and the full Medicaid benefit package, if requested by the Member.

13.3. ABP Exempt Approval

If the Member chooses the ABP exempt benefit package, the MCO shall make the indication in Omnicaid using a Disability Type Code of ME (for an SMI, substance use disorder [SUD], or other mental disability) or PH (for a PH disability) within two business days of receiving a call from a medically frail COE 100 Member choosing the ABP Exempt benefit package; and shall mail the ABP Exempt Member an approval letter. The entry in Omnicaid should be made in the Client Detail window in the Client Subsystem and may be made at any time during the month.

If the Member does not meet medically frail criteria, the MCO shall mail the Member a denial letter. Should the Member disagree with the MCO's determination about his/her ABP Exempt status, the Member may file a reconsideration or request a fair hearing through the MCO's appeals process. If a Member does not have one of the conditions or diagnoses listed on the Medically Frail Conditions List and the Member believes that his/her condition should be considered for inclusion, a request may be sent to HCA/MAD to include the condition. The HCA/MAD Medical Director will review the request to determine whether the individual's condition should be added.

13.4. Appendices

13.4.1 ABP Benefit Chart

13.4.2 Alternative Benefit Plan-Exempt Medically Frail Conditions List

13.4.3 Chronic Substance Use Disorder (SUD) Criteria Checklist

13.4.4 Serious Mental Illness (SMI) Criteria Checklist

13.4.5 SMI-SED Criteria

13.4.1. ABP Benefit Chart

Medicaid ABP 1-8-2014

Recipient Definitions

Note there are 2 types of ABP recipients. The ABP recipient: The recipient is COE 100, but does not have a disability indicator of PH or ME. The charts below are only applicable to the ABP recipient category.

ABP Exempt: The recipient is COE 100 but also has a disability indicator of PH or ME, meaning either a PH or MH disability, or other condition that qualifies the recipient as medically frail.

When an ABP recipient's condition is evaluated and it is determined they meet the qualifying conditions, they may choose to become an "ABP Exempt" recipient. The benefit package of an ABP Exempt recipient changes from the standard ABP recipient to that of the "standard" Medicaid full benefit recipient. That is, the ABP benefit package ends and the ABP Exempt recipient then has access to the same benefits as a full standard Medicaid recipient.

The COE of the recipient remains 100 with a PH or ME indicator to distinguish them in the various computer systems. **Because the benefits of an ABP-Exempt recipient become the same as any other standard full benefit Medicaid recipient, we do not list their benefits in this chart.**

The term "ABP recipient" always means an ABP recipient who is **not** ABP exempt. If the recipient is exempt (and therefore eligible for the standard Medicaid full benefit services) the recipient is always referred to as an "ABP Exempt recipient".

Once the recipient becomes an ABP Exempt recipient, they are **not** subject to any of the service limits associated with ABP. They do not retain any of the additional services found only in the ABP (primarily preventive services). If the ABP Exempt recipient is enrolled in an MCO, the MCO extends the same benefits and managed care services to the ABP Exempt recipient provided to the full benefit Medicaid recipient.

An ABP Recipient has the following benefits equivalent to those of standard Medicaid Benefits: professional services and treatments, including services at FQHC's and other clinics; inpatient and outpatient hospital services; equipment and devices; laboratory and radiology; and transportation).

The coverage of the following services or providers of services under the ABP is essentially the same that for the standard Medicaid full benefit population and, therefore, would be covered by an MCO to the same extent an MCO covers and provides services to traditional full Medicaid eligible recipients. The list is intended to be used to communicate the general scope of the services. Not every provider and service

is described:

- Physician and most practitioner services and visits, including maternity service, surgeries, anesthesia, podiatry, etc., that are available for traditional full Medicaid eligible recipients;
- BH and substance abuse services, evaluations, assessments, therapies, including all the various forms of therapy such as Comprehensive Community Support Services that are available for traditional full Medicaid eligible recipients:
    - Specialized BH services for children: the MCO must ensure BH and substance abuse services provided to EPSDT recipients are available to ABP recipients ages 19 and 20;
    - Specialized BH services for adults: The specialized BH services for adults are Intensive Outpatient, Assertive Community Treatment, and Psychosocial Rehabilitation. These three services are included in the ABP;
    - Services not included in the ABP: The following services are not included in the ABP plan because they are considered more in the area of supportive waiver-type services and are not State Plan services: Family Support, Recovery Services, and Respite Services; and
    - Electroconvulsive therapy: This is a benefit under ABP, but **not** as a State Plan service for standard service.
- Cancer trials, chemotherapy, IV infusions, and reconstructive surgery services that are available for traditional full Medicaid eligible recipients;
- Dental services as available for traditional full Medicaid eligible recipients. An EPSDT recipient must have available the increased frequency schedule of oral exams every six months and orthodontia (when medically necessary) for 19 and 20 year olds per EPSDT rules;
- Diabetes treatment including diabetic shoes;
- Dialysis;
- DME, oxygen, and supplies necessary to use other equipment such as for oxygen equipment, ventilators and nebulizers, or to assist with treatment such as casts and splints that are applied by the healthcare practitioner;
- Family planning, sterilization, pregnancy termination, contraceptives;
- Hearing testing or screening as part of a routine health exam. ABP does **not** cover the hearing aids and does not typically cover audiologist's services or any services by a hearing aid dealer, except for EPSDT children, ages 19 and 20, for whom testing and hearings aids are covered;

- Hospice services — If the hospice recipient requires NF LOC, the recipient will have to meet the requirements for receiving NF care;
- Hospital inpatient, outpatient, urgent care, emergency department, outpatient free-standing psychiatric hospitals, inpatient units in acute care hospitals for rehabilitation or psychiatric, and rehabilitation specialty hospitals:
    - Free-standing psychiatric hospitals are only covered for EPSDT children (therefore, up through age 20) for FFS recipients. However, MCOs continue to pay for inpatient free-standing psychiatric hospitals for adults; and
    - Inpatient drug rehabilitation services are not an ABP benefit. Acute inpatient services for "detox" are an ABP covered benefit.
- Immunizations, mammography, colorectal cancer screenings, pap smears, prostate-specific antigen (PSA) tests, and other age-appropriate tests that are available for traditional full Medicaid eligible recipients;
- Inhalation therapy;
- Lab including diagnostic testing, and colorectal cancer screenings, pap smears, PSA tests, and other age-appropriate tests that are available for traditional full Medicaid eligible recipients;
- Lab genetic testing to specific molecular lab tests such as breast cancer susceptibility gene (BRCA)1 and BRCA2 and similar tests used to determine appropriate treatment, not including random genetic screening;
- Medication assisted treatment (substance abuse treatment including methadone programs and suboxone);
- Ob-gyn, prenatal care, deliveries, midwives;
- Orthotics (note foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes);
- Podiatry services are available to the same extent as for traditional full Medicaid eligible recipients. (coverage is similar to Medicare);
- Prescription drug items (but not over the counter [OTC] items, except for prenatal drug items (examples include vitamins, folic acid, iron), low dose aspirin as preventative for cardiac conditions; contraception drugs and devices, and items for treating diabetes. OTC items are covered for ages 19 and 20);

- Prosthetics are available to the same extent as for traditional full Medicaid eligible recipients;
- Radiology including diagnostic imaging and radiation therapy, including mammography and other age-appropriate imagining;
- Reproductive health services are available to the same extent as for traditional full Medicaid eligible recipients;
- Telemedicine;
- Tobacco cessation counseling that are available for traditional full Medicaid eligible recipients. MCOs must cover tobacco cessation counseling beyond the Medicaid FFS coverage; and
- Transportation (emergency and non-emergency) including air and ground ambulance, taxi and handivan.

The following services are **not** covered under the standard Medicaid benefits or the ABP and are not required to be covered by the MCO for ABP members unless the MCO chooses to do so as VAS.

- Acupuncture;
- Infertility treatment;
- Naprapathy;
- Temporomandibular joint and crania mandibular joint treatment;
- Weight loss programs; and
- Any other service not covered by the standard Medicaid program unless specifically described as an added benefit for ABP in this section.

Note also the ABP does **not** include the following:

- CBs;
- NF care, except as a temporary step-down LOC from a hospital prior to being discharged to home; and
- Mi Via.

However, if an ABP recipient becomes an ABP Exempt recipient, the recipient can access CBs, NF care, and Mi Via when all the requirements to receive those services are met.

An ABP recipient has the following benefits similar to standard Medicaid recipients but with limitations. These are services which are benefits for recipients under the standard Medicaid program, but which have limitations to coverage under the ABP.

Service	**Limitations for ABP Recipients (COE 100) for Ages 21 and above**	**For Ages 19 and 20** Limitations do not apply to ABP recipients (COE 100) who are Ages 19 or 20 because of EPSDT rules. Recipients Under Age 19 Are Not
Bariatric surgery	Limited to 1 per lifetime. Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.	Covered under EPSDT if medically necessary (perhaps unlikely) without the lifetime limit. Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.
Cardiac rehabilitation	Limited to 36 hours per cardiac event.	Covered under EPSDT if medically necessary without the limit on hours.
Chiropractic	Not covered.	Covered under EPSDT if medically necessary (this very rarely happens).
Drug items that do not require a prescription (OTC)	Not covered except for items related to prenatal care; low dose aspirin for preventing cardiac events; treatment of diabetes, items used for contraception (foams, devices, etc.). Coverage of diabetic test strips, and similar items are described under medical supplies, below. An MCO may choose to cover any OTC product when the OTC product is less expensive than the therapeutically equivalent drug that would require a prescription (a “legend” drug).	Covered using the same provisions as for recipient under EPSDT in the standard Medicaid program.
Glasses and contact lens	Not covered except for aphasia (following removal of the lens.) Eye exams and treatment related to eye diseases and testing for eye diseases are a benefit, but that the refraction component of the exam (a separate code) is not a benefit.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program.
Hearing aids	Not covered. Hearing screening is covered, but only when part of a routine health exam. Typically; additional separate payment is not made for this part of the exam. Hearing testing by an audiologist or a hearing aid dealer is not a benefit.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program.
HH services	Limited to 100 visits annually – a visit cannot exceed 4 hours. An MCO has the option of providing these services through private duty nursing and nursing registry personnel	Covered under EPSDT without the limitation on the dollar amount or length of visits.

Service	Limitations for ABP Recipients (COE 100) for Ages 21 and above	For Ages 19 and 20 Limitations do not apply to ABP recipients (COE 100) who are Ages 19 or 20 because of EPSDT rules. Recipients Under Age 19 Are Not
Medical foods for errors of inborn metabolism, or as a substitute for other food for weight gain, weight loss, or specialized diets, for use at home by a recipient.	Not covered.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.
Disposable medical supplies such as diapers, under pads, gauzes, gloves, dressings, colostomy supplies, for use at home by a recipient.	Not covered. Except for diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.). However, supplies necessary to utilize oxygen or DME such as administer oxygen, use nebulizer, clean tracheas for ventilator use, or assist in treatments such as casts or splints are covered. Medical supplies used on an inpatient basis, applied as part of a treatment in a practitioner's office, outpatient hospital, residential facilities, as a HH service, etc. are covered though often these items are not paid separately in addition to the payment for the overall service. When separate payment is allowed in these settings, the items are considered covered.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.
Pulmonary rehabilitation	Limited to 36 hours per year.	Covered under EPSDT without the limitation on the number of visits.
Rehabilitation and Habilitation • PT • OT • SLP	Rehabilitative services for short-term physical, occupational, and speech therapies are covered. Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment. Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, dependent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the Member's physical condition within the extension period. Other than the above onetime extension, therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered.	Covered under EPSDT without the limitation on duration.

Service	Limitations for ABP Recipients (COE 100) for Ages 21 and above	For Ages 19 and 20 Limitations do not apply to ABP recipients (COE 100) who are Ages 19 or 20 because of EPSDT rules. Recipients Under Age 19 Are Not
Extended care hospitals (LTC hospitals)	Extended care hospitals are not covered. Sometimes these are referred to as LTC hospitals (certified as acute care hospitals but focus on care for more than 25 days). NF LTC stays are not covered by ABP except as a temporary step-down LOC following discharge from a hospital prior to being discharged to home.	Covered under EPSDT without the limitations.
Sleep studies	Not covered.	Covered under EPSDT.
Transplants	Limited to 2 per lifetime.	Covered under EPSDT without the dollar amount limitation.

ABP benefits that may exceed the standard Medicaid Coverage are listed below. The following services must be provided to ABP recipients, even though these services **may not** be covered for standard Medicaid eligible recipients, but may already be required to be provided through an MCO to a Member.

Service	Notes
Preventive care, annual physicals, etc.	Under preventive care, a large range of services are covered as part of or in addition to the preventative care exam. See extended comments on the preventive services at the end of this document.
Autism spectrum disorder	There are no age or dollar limits for Applied Behavioral Analysis (ABA) benefits.
Disease management	
Electroconvulsive therapy	
Educational materials and counseling for a healthy lifestyle	
Nutritional counseling	
Skilled nursing	Skilled nursing is generally provided only through a HH agency under the Medicaid FFS program. However, an MCO can also provide skilled nursing through private duty nursing.

Preventive care services, typical of what is found in a commercial insurance plan, are covered for ABP recipients. Typically, this includes annual exams with all the components appropriate for the age, condition, and history of the recipient as recommended by various physician specialty associations and academies.

Additionally, for recipients who are aged 19 and 20, all of the screening and preventive services available to this age group under the EPSDT provisions are benefits for both ABP recipients and ABP Exempt recipients.

The requirements related to ABP include assuring the ABP population's preventive care benefits include the recommendations of the United States Preventive Services Task Force (USPSTF). These recommendations are found at the following website:

https://www.uspreventiveservicestaskforce.org/

ABP coverage of preventive services is not intended to be to only those services on the list. Other preventive services that are generally found in a commercial insurance plan would be covered. The list is not intended to describe or replace the preventive screening and services available to EPSDT recipients. The following list includes items that may need special attention or comment, but we have removed items from the list that are routinely performed in hospitals at the time of birth (e.g., phenylketonuria screening), and services for children for which the EPSDT screenings and service components are already more comprehensive. When the website above is updated with new recommendations, those additions and charges are considered to be part of the requirement.

Service	USPSTF Recommendations	Application to Medicaid
Abdominal aortic aneurysm screening: men	One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have never smoked.	Technically a new requirement, but Medicaid would not currently deny a claim for this service.
Alcohol misuse: screening and counseling	Clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	Technically a new requirement, but practitioners would already be performing this function during exams. The counseling component does not have to include any providers not currently covered by the Medicaid program.
Anemia screening: pregnant women	Routine screening for iron deficiency anemia in asymptomatic pregnant women.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Aspirin to prevent cardiovascular disease: men	The use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.

Service	USPSTF Recommendations	Application to Medicaid
Aspirin to prevent cardiovascular disease: women	The use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	Covered – already in managed care coverage requirements or as a standard. Medicaid recipient State Plan service.
Bacteriuria screening: pregnant women	Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Blood pressure screening in adults	Screening for high blood pressure in adults age 18 years and older.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
BRCA screening, counseling about	Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Breast cancer preventive medication	Clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Breast cancer screening	Screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Breastfeeding counseling	Interventions during pregnancy and after birth to promote and support breastfeeding.	At this time, based on comparison with commercial plans MAD interprets this as instruction or counseling that would occur during the routine prenatal care and postpartum care; and possibly assessed for any issues or lack of success by the pediatrician treating the newborn.
Cervical cancer screening	Screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus testing every 5 years.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Chlamydial infection screening: non-pregnant women	Screening for chlamydial infection in all sexually active non-pregnant young women age 24 years and younger and for older non-pregnant women who are at increased risk.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Chlamydial infection screening: pregnant women	Screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: men 35 and older	Screening men age 35 years and older for lipid disorders.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.

Service	USPSTF Recommendations	Application to Medicaid
Cholesterol abnormalities screening: men younger than 35	Screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: women 45 and older	Screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: women younger than 45	Screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Colorectal cancer screening	Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Depression screening: adults	Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	Covered – already in managed care coverage requirements. The "depression care supports" component does not have to include any provider types not currently covered by the Medicaid program.
Diabetes screening	Screening for Type 2 Diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Falls prevention in older adults: exercise or PT	Exercise or PT to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	At this time and based on comparison with commercial plans, MAD interprets this as detection of the issue during routine annual preventive care exams, and referring as necessary. The referrals might be to community programs, home use of TV and DVD programs, etc. We do not believe the requirement is to pay for the exercise class or PT.
Falls prevention in older adults: vitamin D	Vitamin D supplementation to prevent falls in community- dwelling adults age 65 years and older who are at increased risk for falls.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Folic acid supplementation	All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.

Service	USPSTF Recommendations	Application to Medicaid
Healthy diet counseling	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related- chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	Coverage of this benefit exceeds the coverage currently found in Medicaid rules. It may include covering additional providers when there is a referral. May be performed by a physician, dietician, or other qualifying practitioner
Hepatitis B screening: pregnant women	Screening for Hepatitis B virus infection in pregnant women at their first prenatal visit.	Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.
Hepatitis C virus infection screening: adults	Screening for Hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
HIV screening: non-pregnant adolescents and adults	Clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
HIV screening: pregnant women	Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
Intimate partner violence screening: women of childbearing age	Clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
Obesity screening and counseling: adults	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	Covered – already in managed care coverage requirements. May be performed by a physician, dietician, or other qualifying practitioner
Osteoporosis screening: women	Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Rh incompatibility screening: 24–28 weeks' gestation	Repeated Rh (D) antibody testing for all unsensitized Rh (D)- negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
STI counseling	High-intensity behavioral counseling to prevent STIs in all sexually active adolescents and for adults at increased risk for STIs.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.

Service	USPSTF Recommendations	Application to Medicaid
Skin cancer behavioral counseling	Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	Broader requirement than currently exists as a standard Medicaid recipient service.
Tobacco use counseling and interventions: non-pregnant adults	Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	Broader requirement than currently exists as a standard Medicaid recipient service.
Tobacco use counseling: pregnant women	Clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service.
Syphilis screening: non-pregnant persons	Clinicians screen persons at increased risk for syphilis infection.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service.
Syphilis screening: pregnant women	Clinicians screen all pregnant women for syphilis infection.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service.

13.4.2. Alternative Benefit Plan-Exempt Medically Frail Conditions List

Alternative Benefit Plan-Exempt Medically Frail Conditions List

Effective January 1, 2014; Revised August 15, 2014

In order for a COE 100 (Other Adult Group) Medicaid recipient to be exempt from the Alternative Benefit Plan (ABP), he/she must have a documented medical diagnosis of one of the conditions or services listed below.

- Acquired Immune Deficiency Syndrome (AIDS)
- ALS (Lou Gehrig's Disease)
- Angina Pectoris
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascites
- Blindness
- Cancer (current diagnosis/treatment, within five years)
- Cardiomyopathy
- Chronic Substance Use Disorder – refer to the Substance Use Disorder (SUD) Criteria effective August 2015 (or subsequent replacement version)
- Cirrhosis of the liver
- Compromised immune system
- Coronary insufficiency
- Coronary occlusion
- Crohn's disease
- Cystic Fibrosis
- Dermatomayositis
- Diabetes (Insulin Dependent)
- Disability: A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more ADLs – refer to the NF LOC Supplement effective January 1, 2014 (or subsequent replacement version)
- Friedreich's Disease
- Hemophilia

- Hepatitis C (Active)
- HIV+
- Hodgkin's Disease
- Huntington's Chorea
- Hydrocephalus
- Intermittent Claudication
- Juvenile Diabetes
- Kidney failure
- Lead poisoning with cerebral involvement
- Leukemia
- Lupus Erythematosus Disseminate
- Malignant tumor (If treated/occurred within previous five years)
- Metastatic cancer
- Motor or sensory aphasia
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Open heart surgery
- Organ transplant
- Paraplegia or Quadriplegia
- Parkinson's Disease
- Peripheral Arteriosclerosis (If treated within previous three years)
- Polyarthritis (Periarteritis Nodosa)
- Polycystic kidney
- Posterolateral Sclerosis
- Renal failure
- Serious Mental Illness – refer to the Serious Mental Illness (SMI) Criteria Checklist effective July 27, 2010 (or subsequent replacement version)
- Sickle Cell Anemia

- Silicosis
- Splenic Anemia (True Banti's Syndrome)
- Still's Disease
- Stroke (CVA)
- Syringomyelia
- Tabes Dorsalis (Locomotor Ataxia)
- Terminal illness requiring hospice care
- Thalassemia (Cooley's or Mediterranean Anemia)
- Topectomy and Lobotomy
- Wilson's Disease

13.4.3. Chronic SUD Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder Other Hallucinogen Use
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder – Phencyclidine Use Disorder –
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders

Sources: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document, and Desk Reference to the Diagnostic Criteria from DSM-5. HCA (formerly HSD) March 2016.

13.4.4. SMI Criteria Checklist/SED Criteria Checklist



Serious Mental Illness (SMI) determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

☐ 1. **Age:** Must be an adult 18 years of age or older.

☐ 2. **Diagnoses:** Have one of the diagnoses as defined under the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system BH services.

☐ 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

☐ 4. **Duration:**

□ The disability must be expected to persist for six months or longer.

Person must meet SMI criteria and at least one of the following in A or B:

☐ A. Symptom Severity and Other Risk Factors

☐ Significant current danger to self or others or presence of active symptoms of a SMI.

☐ Three or more emergency room visits or at least one psychiatric hospitalization within the last year.

☐ Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions, emotional/behavior/cognitive conditions.

□ Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

☐ B. Co- Occurring Disorders

☐ Substance Use Disorder (SUD) diagnosis and any mental illness that affects functionality.

☐ SMI or SUD and potentially life-threatening- chronic medical condition (e.g., diabetes, HIV/AIDS, hepatitis).

☐ SMI or SUD and Developmental Disability.



Severe Emotional Disturbance (SED) determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

☐ A. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ B. The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the

simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. [*Dear State Director letter,* July 11, 2013, from CMS, SAMHSA, ACF.] In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

- ☐ Abandoned or neglected;
- ☐ Sexually abused;
- ☐ Sexually exploited;
- ☐ Physically abused;
- ☐ Emotionally abused; or
- ☐ Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an ex parte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

☐ 3. **Functional Impairment:**

The child/adolescent must have a Functional Impairment in two of the listed capacities:

☐ *Functioning in self-care:*

Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*

Inability to maintain safety without assistance; a consistent lack of age- appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*

Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified

by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, in- ability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well- being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self- sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*

Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*

The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Mood and anxiety symptoms*

The disturbance is excessive and causes clinically significant distress and which substantially interferes with or limits the child's role or functioning in family, school, or community activities

☐ *Trauma symptoms:*

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience
a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

13.4.5. SMI-SED Criteria

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – persistent (chronic) motor or vocal tic
Neurodevelopmental Disorders	307.23	F95.2	Tourette's Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention Deficit/Hyperactivity Disorder (ADHD): Predominantly
Neurodevelopmental Disorders	314.01	F90.1	ADHD: Predominantly
Neurodevelopmental Disorders	314.01	F90.2	ADHD: Combined
Neurodevelopmental Disorders	314.01	F90.8	ADHD: Other Specified
Neurodevelopmental Disorders	314.01	F90.0	ADHD: Unidentified
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify.
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	296.20	F32.9	Unspecified
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder due to another medical condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder due to another medical condition
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions
Trauma and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma and Stressor Related Disorders	309.89	F43.8	Other specified trauma and stressor-related
Trauma and Stressor Related Disorders	309.9	F43.9	Unspecified trauma and stressor-related
Trauma and Stressor Related Disorders	313.89	F94.1	Trauma and stressor-related Disorder
Trauma and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom) Disorder. Specify: With attacks of seizures; or with special sensory
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom)
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom)

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa – Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa – Binge-eating/Purging
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct	312.33	F63.1	Pyromania
Disruptive, Impulse Control and Conduct	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct	312.89	F91.8	Other Specified Disruptive Impulse
Disruptive, Impulse Control and Conduct	312.9	F91.9	Unspecified Disruptive, Impulse Control
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available]	301.83	F60.3	Borderline Personality Disorder
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder – Other Hallucinogen Use
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder – Phencyclidine Use Disorder –
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders – moderate, severe

Sources: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document, and Desk Reference to the Diagnostic Criteria from DSM-5.