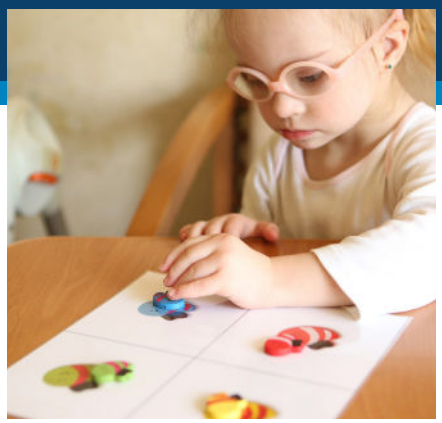
ZERO TO THREE
Early connections last a lifetime

DC:0–5 Crosswalk: A Briefing Paper



Infants, young children, and parents can have serious mental health problems that affect development. Undiagnosed or untreated mental health disorders can affect multiple domains of development and can have serious consequences for early learning, social competence, and lifelong health. While infant and early childhood mental health (IECMH) problems can be effectively identified and treated, systemic reimbursement issues impede the ability to pay for IECMH services through Medicaid and other mechanisms. Limitations may arise because services to infants and young children (birth through 5 years old), which often take the whole family into account and treat the child through their caregivers, do not fit cleanly into the individual treatment categories for older children and adults. Even though many of the diagnostic codes used for adult and adolescent service provision are inappropriate for use in young children, most insurers—including Medicaid and other third party payers—do not recognize disorders from an infant diagnostic classification system such as *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–5)[1] and the previous version, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised Edition* (DC:0–3R)[2]. Please see the box on page 3 for definitions of these and other key terms.

Because many IECMH providers use DC:0–5 for clinical assessment of infants and young children and for treatment planning, they are forced to do a conversion between DC:0–5 diagnoses and diagnostic codes appropriate for older individuals in order to receive compensation for their services. Crosswalks have been developed to aid providers in this conversion. Providers should be able to assess, diagnose, and bill directly for IECMH services for very young children. In a recent survey of state mental health directors, state Medicaid directors, and members of state infant mental health associations conducted by ZERO TO THREE, respondents reported numerous benefits to using a developmentally appropriate diagnostic classification system such as DC:0–5. These included increased ability to accurately diagnose mental health disorders in infants and young children, enhanced ability to treat these disorders, and increased recognition of behavioral and developmental challenges in very young children. Please see Figure 1 for more information. Crosswalks are a stopgap solution to the real policy issue: many insurers do not recognize early childhood-specific diagnoses from DC:0–5, making reimbursement for IECMH services an ongoing challenge.

This briefing paper will address what a crosswalk is, provide an example of a crosswalk for several disorders in DC:0–5, discuss why a crosswalk is important, and provide policy recommendations for implementing a crosswalk and for moving toward recognition of early childhood-specific diagnoses.

What Is a Crosswalk?

A crosswalk provides a means of connecting developmentally appropriate early childhood disorders with codes more recognized or accepted for eligibility purposes (medical and/or service necessity) such as the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), or with billing codes (e.g., the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision;* ICD-10). In many states, the crosswalk has been an important tool for IECMH providers to bill for treatment services under existing adult, adolescent, and child codes while also facilitating the use of developmentally appropriate diagnoses and treatments for infants and young children. States including California, Florida, Maine, and Minnesota have used such crosswalks for many years.

ZERO TO THREE has developed a crosswalk between DC:0–5, DSM-5, and ICD-10. This crosswalk is intended to be used as a guide; states may need to adapt this crosswalk to align with their state service delivery guidelines. Table 1 is an example of a crosswalk for several disorders in DC:0–5.

Table 1: Crosswalk From DC:0–5 to DSM-5 and ICD-10

DC:0–5	DSM-5	ICD-10	
Disorder Name	Disorder Name	Disorder Name	Code
Neurodevelopmental Disorders			
Early Atypical ASD	Other Specified Neurodevelopmental Disorder	Pervasive Developmental Disorder, Unspecified	F84.9
Overactivity Disorder of Toddlerhood	ADHD, predominantly hyperactive-impulsive presentation	Disturbance of Activity and Attention	F90.1
Anxiety Disorders			
Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder of Childhood	F93.2
Trauma, Stress, and Deprivation Disorders			
Complicated Grief Disorder	Other Specified Trauma- and Stressor-Related Disorder (Persistent Complex Bereavement Disorder)	Other Reactions to Severe Stress	F43.8

Why Is a Crosswalk Important?

Although DC:0–5 is an incredibly useful diagnostic classification system for mental health disorders in infants and young children, most states do not recognize these disorders for medical necessity or service eligibility, or for billing purposes. IECMH providers in those states may need to create a

Policy Recommendations in Brief

State mental health agencies and state Medicaid agencies should:

- recognize the disorders from DC:0–5 in children from birth to 5 years old as eligible behavioral health conditions and permit reimbursement accordingly.

If state mental health departments and Medicaid offices will not recognize disorders from DC:0–5, IECMH leaders and agency officials should:

- develop or adopt a crosswalk from DC:0–5 to ICD-10 and DSM-5 to facilitate Medicaid reimbursement for infant and early childhood mental health (IECMH) services.

State policymakers, advocacy organizations, and state infant mental health associations should:

- advocate for language in state Medicaid/other third party health plans and behavioral health plans to support the use of developmentally sensitive, evidence-informed criteria such as DC:0–5 and crosswalks between DC:0–5 and ICD-10 or DSM-5 codes if needed for billing purposes.

Policymakers and IECMH leaders should:

- provide information to Medicaid staff and other mental health leaders to improve knowledge of IECMH, and DC:0–5.

Part C Interagency Coordinating Councils, state Part C agencies, and state Part C Program Coordinators should:

- ensure that applicable DC:0–5 diagnoses are included in state Part C Early Intervention eligibility criteria.

Key Terms

Crosswalk: A crosswalk provides a means of connecting diagnostic codes between different classification systems to facilitate billing. In many states, the crosswalk has been an important tool for infant and early childhood mental health providers to bill for treatment services under existing adult, adolescent, and child codes while making appropriate diagnostic assessments of young children.

DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood **(DC:0–5):** DC:0–5 was published in December 2016. It revised and updated DC:0–3R by expanding the age range to 5 years old (from 3 years old), extending criteria to younger ages, and including disorders relevant for young children even if also found in DSM-5.

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised **(DC:0–3R):** DC:0–3R was published in 2005 by ZERO TO THREE and strengthened DC:0–3 by incorporating empirical research and clinical practice. It supported the clinician in diagnosing and treating mental health problems in the earliest years.

Diagnostic and Statistical Manual of Mental Disorders **(DSM):** DSM, published by the American Psychiatric Association, provides guidance to mental health professionals on diagnosing and treating mental health disorders in children and adults. It is used by third-party payers to make decisions about reimbursement. The codes in DSM are designed to match the codes in the International Classification of Diseases and Related Health Problems (ICD), which is the most widely used classification system in the world. The DSM is now in its fifth edition (DSM-5).

International Classification of Diseases and Related Health Problems **(ICD):** ICD is the standard diagnostic tool for epidemiology, health management, and clinical purposes. It is used to monitor the incidence and prevalence of disease and is the official system for assigning codes to diagnoses and procedures that are used for reimbursement decision making. ICD is now in its tenth edition (ICD-10).

crosswalk between DC:0–5 and adult, adolescent, and child diagnostic codes for billing purposes. Third-party payers have not adopted the DC:0–5 and require ICD or DSM codes that correspond to a diagnosis; therefore, a crosswalk serves a crucial function in making it possible for providers to bill and receive payment for their services.

Implementation of DC:0–5 serves multiple purposes—professional development, standardization of practice, billing, and awareness building. A DC:0–5 crosswalk is one strategy to use an appropriate early childhood DC:0–5 diagnostic classification while maintaining acceptable eligibility and billing codes within the billing system as it is currently designed.

Recommendations for Policymakers

Ideally states should have a system that recognizes infant and early childhood-specific mental health diagnoses from DC:0–5. However, until policy catches up with practice, we provide several policy recommendations to ensure that mental health disorders in young children are accurately diagnosed.

State mental health agencies and state Medicaid agencies should:

- **recognize the disorders from DC:0–5 in children from birth to 5 years old as eligible behavioral health conditions and permit reimbursement accordingly.** State health care authorities should recognize IECMH disorders, including Relationship Specific Disorder of Infancy/Early Childhood, as medically and service-eligible disorders and allow billing for behavioral health treatments for these disorders.

If state mental health departments and Medicaid offices will not recognize disorders from DC:0–5, IECMH leaders and agency officials should:

- **develop or adopt a crosswalk from DC:0–5 to ICD-10 and DSM-5 to facilitate Medicaid reimbursement for IECMH services.** While it would be best to have state health care authorities recognize DC:0–5, if the billing system cannot accommodate it, state policies should crosswalk DC:0–5 and adult, adolescent, and child diagnostic codes (i.e., DSM-5 and ICD-10) to enable billing and reimbursement.

State policymakers, advocacy organizations, and state infant mental health associations should:

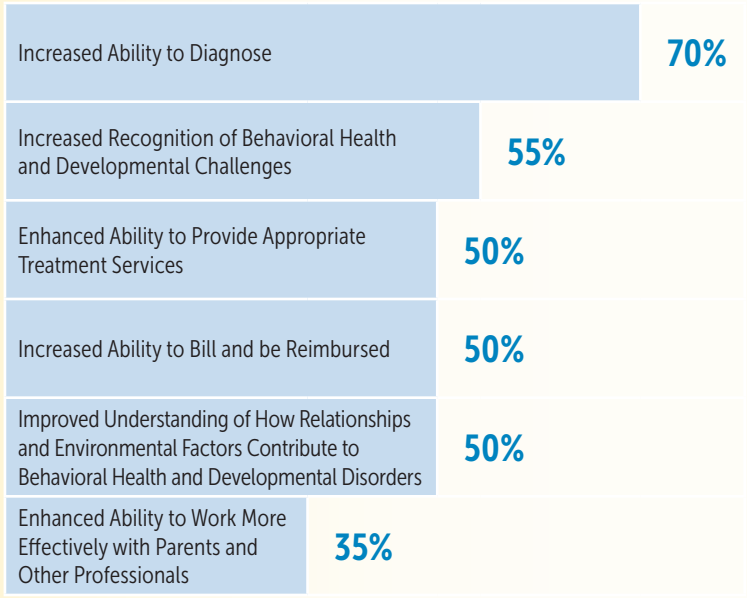
- **advocate for language in state Medicaid/other third-party health plans and behavioral health plans to support the use of developmentally sensitive, evidence-informed criteria such as DC:0–5 and crosswalks between DC:0–5 and ICD-10 or DSM-5 codes if needed for billing purposes.** Insurers are doing a disservice to

infants, young children, and families by not requiring a developmentally appropriate diagnostic tool, DC:0–5, along with the crosswalk to facilitate billing. State policymakers, advocacy organizations, and state infant mental health organizations should ensure that Medicaid and other public and commercial health and behavioral health insurance plans include language to allow for diagnosis and treatment services under DC:0–5 disorders, or via a crosswalk between these disorders and adult, adolescent, and child mental health disorder codes in DSM-5 and ICD-10.

Policymakers and IECMH leaders should:

- **provide information to Medicaid staff and other mental health leaders to improve knowledge of infant and early childhood mental health, and DC:0–5.** Medicaid staff and other mental health leaders may not be familiar with IECMH and DC:0–5 as the most appropriate system for diagnosis, treatment, clinical communication, and research purposes for children from birth through 5 years old. Policymakers and IECMH leaders should provide them with information on IECMH and DC:0-5 (including trainings such as DC:0–5 Training, DC:0–5 Seminars and Overview Trainings, and DC:0–5 Faculty Training Resource).

Figure 1: Perceived Benefits to Using a Crosswalk



Perceived Benefits to Using a Crosswalk

ZERO TO THREE surveyed state mental health directors, state Medicaid directors, and members of state infant mental health associations about their use of crosswalks. Data collection took place over 5 months (November 2014 to March 2015) via a survey emailed to individuals and agencies. In all, 74 participants provided responses, representing a total of 33 states.

Access to a crosswalk allows providers to fully adopt DC:0–5 and integrate it into their practice, as it allows payment for services and makes usage feasible. Of the respondents who reported using the previous version, DC:0–3R, with a crosswalk, many perceived benefits were identified, including the following:

- **Increased ability to diagnose:** Seventy percent reported increased ability to diagnose relationship and other behavioral health disorders in infants and young children.
- **Enhanced ability to provide appropriate treatment services:** Fifty percent indicated an enhanced ability to provide appropriate treatment services to young children.
- **Increased ability to bill and be reimbursed:** Fifty percent reported an increased ability to bill and be reimbursed for services provided to young children and their families.
- **Increased recognition of behavioral health and developmental challenges:** Fifty-five percent reported an increased recognition of behavioral health and developmental challenges in young children.
- **Improved understanding of how relationships and environmental factors contribute to behavioral health and developmental disorders:** Fifty percent indicated an improved understanding of how relationships and environmental factors contribute to behavioral health and developmental disorders.
- **Enhanced ability to work more effectively with parents and other professionals:** Thirty-five percent reported an enhanced ability to work more effectively with parents and other professionals to develop effective treatment plans.

Part C Interagency Coordinating Councils, state Part C agencies, and state Part C Program Coordinators should:

- **ensure that applicable DC:0–5 diagnoses are included in state Part C Early Intervention eligibility criteria.** Part C eligibility criteria vary from state to state; regulations allow each state to create its own definition. Part C Interagency Coordinating Councils, state Part C agencies, and state Part C Program Coordinators should ensure that DC:0–5 diagnoses applicable to Part C are included in state Part C Early Intervention eligibility criteria.

For more information, and to see other briefing papers in the series, please visit www.zerotothree.org and www.zerotothree.org/DC05

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/policy-and-advocacy/social-and-emotional-health

Endnotes

1 ZERO TO THREE. (2016). *DC:0–5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (DC:0–5). Washington, DC: Author.

2 ZERO TO THREE. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (Rev. ed.). Washington, DC: Author.