POLICY AND PROCEDURE

POLICY TITLE: DSAMH Utilization Management Common Criteria for All Levels of Care	**POLICY #:** DSAMH054
PREPARED BY:	**DATE ISSUED:**
RELATED POLICIES: DSAMH013 DSAMH014 DSAMH034 DSAMH035 DSAMH036 DSAMH037 DSAMH047 DSAMH048 DSAMH049	**REFERENCE:** https://dhss.delaware.gov/dsamh/eeuproci.html https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf https://www.dhss.delaware.gov/dhss/admin/policy/files/pm37.pdf
DATES REVIEWED: 12/07/2023 01/03/2024	**DATES REVISED:** 11/29/2023 12/13/2023
APPROVED BY: DocuSigned by: Joanna Champney 1B71C05196B24CA... **DATE APPROVED:** 3/21/2024 | 11:40 AM PDT	**NOTES:** ☐DSAMH Internal Policy ☐DSAMH Operated Program ☒DSAMH State Providers ☐Delaware Psychiatric Center ☒Targeted Use Policy (Defined in scope)

I. **PURPOSE:**

The purpose of this policy is to guide decisions on service needs based on medical necessity. All DSAMH guidelines are derived from generally accepted standards of behavioral health practice, guidance, and consensus statements from professional societies, as well as guidance from federal and local governmental sources. DSAMH guidelines are designed to decide the medical necessity and clinical appropriateness of services.

II. **POLICY STATEMENT**:

The Division of Substance Abuse and Mental Health uses DSAMH Common Criteria, the most recent ASAM Criteria, and other State-developed guidelines, as primary decision support tools for the DSAMH Utilization Management Program. DSAMH is committed to the philosophy of providing treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meet the individual's biopsychosocial needs. Clients may enter treatment at any level and be moved to different levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active, and takes into consideration the client's stage of readiness to change and readiness to participate in treatment.

III. **DEFINITIONS**:

"Delaware resident" means an individual who is not eligible for an out-of-state Medicaid plan and meets either of the following criteria:

1. An individual is domiciled in a permanent location or maintains a place of abode that they stay in that is a building, structure, or vehicle within the limits of the State, and spends more than 183 days in the State.
2. A person who possesses a valid Delaware-issued identification card such as driver's license or non-driver identification card.

"DSAMH Common Criteria" means a set of objective behavioral health criteria used to standardize coverage determinations, standardize eligibility for DSAMH-covered services, promote evidence-based practices, and support clients' recovery, resiliency, and wellbeing.

"Medical necessity" means health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

"PROMISE Program" means Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Home and Community-Based Services (HCBS) waiver program under DSAMH. PROMISE assesses clients for level of care needs and monitors services to ensure the client receives appropriate care from contracted providers.

"Underinsured" means a third-party payor exists, but the service is not a covered benefit under their active plan, the benefit was denied by the third-party payor, or their insurance benefits have been exhausted. The PM37 form must be used to determine underinsured eligibility and sliding scale fees (as of 12/13/23 PM37 currently only applies to IMD programs).

"Uninsured" means no third-party payer exists; the client is considered indigent.

IV. **SCOPE**: This policy applies to all DSAMH-contracted providers.

V. **PROCEDURES/RESPONSIBILITIES**:

A. DSAMH ELIGIBILITY CRITERIA: The provider must determine client eligibility by meeting the following criteria:

1. The client MUST:
   a. Be a resident of Delaware as defined AND
   b. Be one of the following:
      i. Be uninsured OR
      ii. Be underinsured OR
      iii. Receiving services under the PROMISE waiver
2. The client MUST:
   a. Have a condition or illness covered by DSAMH services AND
   b. Be 18 years old or older
3. The client MUST:
   a. Meet DSAMH common criteria AND/OR
   b. Meet ASAM Criteria OR
   c. Other tools approved by the Division

4. The client MUST NOT:
    a. be covered under a private insurance plan OR
    b. have or be eligible for an out of state Medicaid plan

B. COMMON CRITERIA FOR ALL LEVELS OF CARE:
1. The provider holds a contract for the level of care for which they are billing DSAMH AND
2. The client is eligible for DSAMH benefits AND
3. The service(s) are within the scope of the provider's professional training and licensure and/or certification AND
4. The client's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care;
    a. Assessment and/or treatment of the factors leading to admission require the intensity of services provided in the proposed level of care;
    b. The client's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
5. Co-occurring behavioral health and medical conditions can be safely managed AND
6. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active," service must be as follows:
    a. Supervised and evaluated by the appropriately credentialed provider based on the level of care;
    b. Provided under an individualized treatment plan that is focused on addressing the factors leading to admission, and makes use of clinical best practices;
    c. Reasonably expected to improve the client's presenting problems within a reasonable period of time AND
7. The factors leading to admission have been identified and are integrated into the treatment and discharge plans AND
8. Clinical best practices are being provided with sufficient intensity to address the client's treatment needs AND
9. The client's family and other natural resources are engaged to participate in the client's treatment as clinically indicated AND
10. Common discharge criteria include but are not limited to:
    a. The factors which led to admission have been addressed to the extent that the client can be safely transitioned to a less intensive level of care or no longer requires care.
    b. The factors which led to admission cannot be addressed and the client must be transitioned to a more intensive level of care.
    c. Treatment is primarily for the purpose of providing a social, custodial, recreational, or respite care.
    d. The client requires medical/surgical treatment that cannot be provided in the current level of care.
    e. The client is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

C. COMMON CLINICAL BEST PRACTICE CRITERIA FOR ALL LEVELS OF CARE:

1. The initial evaluation:
    a. Gathers information about the presenting issues from the client's perspective, and includes the client's understanding of the factors that lead to requesting the services in a trauma-informed and person-centered manner;
    b. Focuses on the client's specific needs;
    c. Identifies the client's goals and expectations;
    d. Is completed in a timeframe commensurate with the client's needs or otherwise in accordance with clinical best practices, DSAMH standards, Medicaid regulations, and/or contract requirements.
2. Services meet the following conditions:
    a. Consistent with generally accepted standards of clinical practice;
    b. Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
    c. Consistent with generally accepted best practices;
    d. Clinically appropriate for the client's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks AND
3. There is a reasonable expectation that the service(s) will improve the client's presenting problems within a reasonable period of time.
4. The provider collects information from the client and other sources and completes an initial evaluation pursuant to Title 16 6001 8.1.2.1.7.
5. The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
6. The provider and, whenever possible, the client, use the finding of the initial evaluation and diagnosis to develop a treatment plan pursuant to Title 16 6001 8.1.2.1.8.
7. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.
8. As needed, the treatment plan also includes interventions that enhance the client's motivation, promote informed decisions, and support the client's recovery, resiliency, and wellbeing. Examples include, but are not limited to, psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
9. The provider informs the client of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The client gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
10. Treatment focuses on addressing the factors precipitating admission to the point that the client's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or client no longer requires care.
11. The treatment plan and level of care are reassessed when the client's condition improves, worsens, or does not respond to treatment. The treatment plan may be reassessed when specifically requested by the client.
    a. When the client's condition has improved, the provider determines if the treatment plan should be altered, or if treatment at the current level of care is no longer required.

b. When the client's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the client's condition should be treated in another level of care.

10. Discharge planning begins at admission with the goal of stable community reintegration. This includes addressing social determinants of health that may not be directly related to behavioral health needs pursuant to DSAMH013 Discharge from Services.

VI. **POLICY LIFESPAN**: This policy will be reviewed annually.

VII. **RESOURCES**:

A. https://dhss.delaware.gov/dsamh/eeuproci.html
B. https://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Substance%20Abuse%20and%20Mental%20Health/6001.shtml
C. https://dhss.delaware.gov/dhss/dsamh/files/ReimbursementManual.pdf