

DELAWARE  
ADULT BEHAVIORAL HEALTH  
DHSS SERVICE CERTIFICATION AND  
REIMBURSEMENT MANUAL

DECEMBER 19, 2014

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## Introduction

This manual is intended to provide explanatory information for DHSS and the public regarding services and reimbursement for the Medicaid fee-for-service program including individuals in PROMISE receiving state plan services from non-physician licensed practitioners and substance use disorder (SUD) treatment services. DSAMH has adopted this same guidance for their funded programs providing behavioral health services to individuals residing in Delaware without insurance.<sup>1</sup>

## Non-Physician Licensed Behavioral Health Practitioners

**Please note:** Allowable healthcare common procedure coding systems (HCPCS) and current procedural terminology (CPT) codes for licensed chemical dependency professionals (LCDP) are contained within the substance use disorder (SUD) table rather than within the licensed behavioral health practitioner section of this manual. LCDP codes can be utilized within any setting, including skilled nursing facilities.

### 1.1. Definition

Individual, family, group outpatient psychotherapy and mental health assessment, evaluation, and testing.

### 1.2. Provider Qualifications

A licensed behavioral health practitioner (LBHP) is a **professional**, who is licensed in the State of Delaware to diagnose and treat mental illness or substance abuse acting within the scope of all applicable State laws and their professional license. A LBHP includes **professionals** licensed to practice independently:

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#### 11 LEGAL DISCLAIMER

The Delaware Adult Behavioral Health DHSS Service Certification and Reimbursement Manual ("Manual") is intended solely as an informational resource. The Delaware Department of Health and Social Services ("DHSS") makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of the Manual. The Manual, including but not limited to reimbursement rates, is subject to change without notice. The most current version of the Manual shall be the one posted online at [insert direct link here](#), and shall supersede any previous versions of the Manual. DHSS, its employees, and its agents shall not be liable for any claim, loss, injury, liability, damages, or any other legal or financial consequence related to the use of, or reliance upon, the Manual by an individual or business. The Manual is not intended to be a substitute for professional legal, financial, or business advice. The use of the Manual by an individual or business does not create an attorney-client relationship or any other professional or confidential relationship between the individual or business and DHSS. Individuals and businesses are urged to consult with an attorney, accountant, or other qualified professional if they require advice or opinions regarding the Manual, Medicaid, and/or the provision of behavioral health services in Delaware tailored to their specific needs and circumstances.

- Licensed psychologists.
- Licensed clinical social workers (LCSWs).
- Licensed professional counselors of mental health (LPCMHs).
- Licensed marriage and family therapists (LMFTs).

To provide Medicaid fee-for-service and Division of Substance Abuse Mental Health (DSAMH)-only funded services, an LBHP must have both a contract award from DSAMH and current provider enrollment with the Medicaid agency.

LBHPs may be practicing independently or be practicing within an addiction treatment or a co-occurring substance use disorder clinic licensed by the State of Delaware under State law per Delaware Administrative Code Title 16.6001. The licensure applies to all programs providing services to beneficiaries in need of programs and services for diagnosed substance use and/or mental disorders. The licensure at a minimum requires: documentation of all insurance coverage required in regulation; and a copy of the agency's Delaware business license and home state license, when applicable. The licensure also requires a description of the services to be provided by the program, including a statement of the program philosophy, goals and objectives, and a description of the methodology for each service element; and organization charts showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

**Note:** Psychiatrists are covered under the physician section of the State Plan and advanced practice nurses (APNs) and nurse practitioners (NPs) are covered under the NP section of the State Plan. However, psychiatrists and APNs/NPs often are employed by agencies that employ other licensed practitioners (OLPs). For ease of reference, psychiatrist and APN/NP codes often billed under agencies are included in this section of the provider manual. However, psychiatrists may bill any codes under the physician section of the State Plan for which he or she may be qualified. Agencies, such as clinics, may bill on behalf of the physicians, including psychiatrists employed or contracting with them. Services provided by psychiatrists are technically covered under the physician section of the Medicaid State Plan.

In general the following Medicaid management information systems (MMIS) provider types and specialties may bill these codes according to the scope of practice outlined under State law. The specific provider types and specialties that are permitted to bill each code is noted in the rate sheet.

### 1.3. Taxonomies

Please note that the physicians must bill under the physician taxonomy in Medicaid.

- 103T00000X Psychologist (must bill with HP modifier).
- 103TF0000X Psychotherapy Group (must bill claims with HP modifier for psychologist or HO for LMFT, LPCMH, or LMFT corresponding with performing provider type).
- 101Y00000X Clinical Social Worker (must bill with HO modifier).

- 101YM0800X Mental Health Counselor (must bill with HO modifier).
- 106H00000X Marriage & Family Therapist (must bill with HO modifier).
- Co-occurring Clinic: 261QM0850X Clinic/Center – Adult Mental Health (bill with either no modifier – for physician; HO – for psychologist; HO – for LMFT, LPCMH, or LMFT).

#### **1.4. Eligibility Criteria**

All Medicaid-eligible adults who meet medical necessity criteria including all Medicaid-eligible adults eligible for PROMISE. Claims will be paid through HP Enterprise Services (HP) if not eligible for managed care organization (MCO) reimbursement.

All non-Medicaid-eligible adults who are eligible to receive services through the Division of Substance Abuse and Mental Health (DSAMH). Claims will be paid through DSAMH.

To provide Medicaid fee-for-service and DSAMH-only funded services, a licensed provider must have provider qualifications verified through DSAMH by having a contract award from DSAMH and current provider enrollment with the Medicaid agency.

#### **1.5. Allowed Mode(s) of Delivery**

- Individual.
- Family.
- Group.
- Onsite.
- Off-site.
- Tele-medicine.

#### **1.6. Limitations/Exclusions**

For MCO enrollees during calendar year 2014, the provider must document that the MCO has denied payment for the claim.

1. The member, provider, or MCO may contact DSAMH to inform DSAMH when the twentieth outpatient visit for all mental health and substance use outpatient visits or when the thirtieth inpatient day for the contract year is exhausted.
2. DSAMH receives the date of service for that twentieth outpatient/thirtieth inpatient day and enters the information into the DSAMH information (REDA) screen in the MMIS to select the benefits exhausted in the MCO package indicator, which will allow the claim to be billed by HP.
3. HP will pay the provider fee-for-service Medicaid for all additional outpatient services for the contract year after that twentieth date of service.

4. On June thirtieth of each year, the benefits exhausted in the MCO package indicators are removed and the service count begins again.
5. Once the MCO issues the explanation of benefits (EOB) or the provider receives the EOB, the provider forwards the EOB to DSAMH, who ensures that it is scanned and forwarded to the provider review and fiscal units of DSAMH. The provider unit and fiscal unit verify that the EOB is the same date that the indicator was activated.

For services which the MCO will not reimburse during calendar year 2014, services which exceed the initial pass-through authorization must be approved for re-authorization prior to service delivery.

All services must be medically necessary. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. The provider is required to obtain prior authorization for all psychological testing exceeding six hours annually. All neuropsychological testing must be prior authorized.

In addition to individual provider licensure, service providers employed by addiction treatment services and co-occurring treatment services agencies must work in a program licensed by DSAMH and comply with all relevant licensing regulations.

Licensed psychologists may supervise up to seven unlicensed assistants or post-doctoral professionals in supervision for the purpose of those individuals obtaining licensure and billing for services rendered. Services by unlicensed assistants or post-doctoral professionals under supervision may not be billed under this section of the State Plan. Instead, those unlicensed professionals must qualify under the Early and Periodic Screening, Diagnosis, and Treatment program or rehabilitation sections of the State Plan or provide services under home- and community-based authorities.

Inpatient hospital visits are limited to those ordered by the beneficiary's physician. Visits to a nursing facility are allowed for LBHPs if a Preadmission Screening and Resident Review (PASRR) indicates that it is a medically necessary specialized service in accordance with PASRR requirements. Visits to intermediate care facilities for individuals with intellectual and developmental disabilities are non-covered. All LBHP services provided while a person is a resident of an Institution for Mental Disease (IMD), such as a free-standing psychiatric hospital or a psychiatric residential treatment facility are part of the institutional service and not otherwise reimbursable by Medicaid.

Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by Delaware Health and Social Services and/or its designee.

A unit of service is defined according to the CPT or HCPCS approved code set consistent with the National Correct Coding Initiative, unless otherwise specified.

Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and federal laws, regulations and policies, including the federal Acquisition Regulation, Executive Order No. 12549 and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the federal Acquisition Regulation, of a person excluded, debarred, suspended, or otherwise excluded under State and federal laws, regulations, and policies may not participate.

### 1.7. Additional Service Criteria

The services provided by OLPs in the State Plan that are listed below have an initial authorization level of benefit. Services which exceed the limitation of the initial authorization must have a medical necessity review to be approved for re-authorization beyond this initial limit:

- Admission evaluation is authorized for five evaluations per calendar year (20 units).
- Individual therapy is authorized for 32 hours per calendar year (128 units).
- Family therapy is authorized for 40 hours per calendar year (160 units).
- Group therapy is authorized for 24 hours per calendar year (96 units).
- Psychological testing is authorized for six hours per calendar year (6 units).

The codes in each category above are defined below.

Code	Description	Admission Evaluation	Individual Therapy	Family Therapy	Group Therapy	Psychological Testing
90791	Psychiatric diagnostic evaluation.	4 units				
90832	Psychotherapy, 30 minutes with patient and/or family member.		2 units			
90834	Psychotherapy, 45 minutes with patient and/or family member.		3 units			
90837	Psychotherapy, 60 minutes with patient and/or family member.		4 units			
90845	Psychoanalysis.		4 units			
90846	Family psychotherapy (without the patient present).			4 units		
90847	Family psychotherapy (conjoint psychotherapy) (with patient present).			4 units		
90849	Multiple-family group psychotherapy.				6 units	

Code	Description	Admission Evaluation	Individual Therapy	Family Therapy	Group Therapy	Psychological Testing
90853	Group psychotherapy (other than of a multiple-family group).				6 units	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach WAIS) per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.					1 unit
96102	Psychological testing (e.g., includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face.					1 unit
96103	Psychological testing (e.g., includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI) administered by a computer, with qualified health care professional interpretation and report.					1 unit
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.					1 unit
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.					1 unit
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test) administered by computer, with qualified healthcare professional interpretation and report.					1 unit

Code	Description	Admission Evaluation	Individual Therapy	Family Therapy	Group Therapy	Psychological Testing
96150	Health and behavior assessment (e.g., health focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.	1 unit				
96151	Health and behavior assessment each 15 minutes face-to-face with the patient; re-assessment.	1 unit				

Billing CPT codes with “interactive” in their description are used most frequently with adults who, due to injury or disability, have impairments in the ability to communicate verbally; these codes may also be utilized.

### 1.8. Telemedicine

Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via Health Insurance Portability & Accountability Act compliant telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service. The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee). Providers must follow all applicable federal and State security and procedure guidelines for telemedicine.

Face-to-face for OLP includes a therapist in a different room/location from the client/family, but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. If the therapist is working with a single client/family, then family or individual therapy requirements and reimbursement would apply. If the therapist is working with more than one client/family, group therapy requirements and reimbursement would apply. Therapy must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented evidence-based practices of screening and brief intervention (SBI) or promising practices approved by DSAMH. If not in the same building, then telemedicine requirements and reimbursement would apply. No prior authorization is required.

**Telemedicine services must comply with Delaware’s telemedicine requirements including, but not limited to:**

- Obtaining member’s written consent;
- Licensure and enrollment requirements;
- Written contingency planning;
- Implementation of confidentiality protocols; and
- Billing practices and requirements.

**Rate Methodologies for the CPT codes under this section of the State Plan are as follows and are listed in the rate portion of the Service Manual in this order.**

Provider Type	Percent of Physician Fee Schedule	Rate
Medicare Physician Rate for CPT Code 99354	100% of Medicare rate	\$101.84
Delaware Medicaid Physician and Psychologist	98% of Medicare rate	\$99.80
Delaware Clinical Nurse Specialist, NP, Physician’s Assistant (Medicaid Fee)	See relevant Medicaid fee schedule	
Delaware Clinical Nurse Specialist, NP, Physician’s Assistant (Non-Medicaid Fee)	100% of the Delaware Medicaid physician rate	\$99.80
Delaware LCSW, LMFT, LPCMH	75% of Delaware Medicaid physician rate	\$74.85

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay psychologists at 100% of the Medicaid physician rates. If a Medicare fee exists for a defined covered procedure code, then Delaware Medicaid will pay LCSWs, LPCMH, and LMFTs at 75% of the Medicaid physician rates.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The agency's fee schedule rate was set as of October 2, 2013, and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at [www.dmap.state.de.us/downloads/hcpcs.html](http://www.dmap.state.de.us/downloads/hcpcs.html).

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses, benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

## 1.9. Proposed Coding

**Key:**

LPCMH: Licensed Professional Counselor of Mental Health

LMFT: Licensed Marriage and Family Therapist

LCSW: Licensed Clinical Social Worker

Note: To the extent Clinical Nurse Specialists, Nurse Practitioners, and Physician’s Assistants bill under the State Plan, they should see the relevant Medicaid fee schedule, which is generally the Delaware Physician rate.

			<i>Practitioner Type</i> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP
+90785	Interactive complexity (list separately in addition to the code for primary procedure). (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management (E&M) service [90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350], and group psychotherapy [90853]). (Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E&M services when no psychotherapy service is also reported).		\$14.22	\$10.66	X	X	X	X	X	X
90791	Psychiatric diagnostic evaluation.	Per evaluation	\$132.93	\$99.70	X	X	X	X	X	X
90792	Psychiatric diagnostic evaluation	Per	\$143.27	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	with medical services. (Do not report 90791 or 90792 in conjunction with 99201–99337, 99341–99350, 99366–99368, 99401–99444). (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services).	evaluation								
90832	Psychotherapy, 30 minutes with patient and/or family member.	Per evaluation	\$64.25	\$48.19	X	X	X	X	X	X
+90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure). (Use 90833 in conjunction with 99201–99255, 99304–99337, 99341–99350).	Per evaluation	\$65.71	N/A	X					X
90834	Psychotherapy, 45 minutes with patient and/or family member.	Per evaluation	\$85.18	\$63.89	X	X	X	X	X	X
+90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M services (list separately in addition to the code for primary procedure). (Use 90836 in conjunction with 99201–99255, 99304–99337, 99341–99350).	Per evaluation	\$83.14	N/A	X					X
90837	Psychotherapy, 60 minutes with patient and/or family member. (Use the appropriate prolonged services code [99354–99357] for	Per evaluation	\$127.46	\$95.60	X	X	X	X	X	X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LIMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	psychotherapy services 90 minutes or longer).									
+90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M services (list separately in addition to the code for primary procedure). (Use 90838 in conjunction with 99201–99255, 99304–99337, 99341–99350). (Use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services.)	Per evaluation	\$109.76	N/A	X					X
90839	Psychotherapy for crisis; first 60 minutes.	Per evaluation	\$133.18	\$99.88	X	X	X	X	X	X
+90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.) (Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785–90899).	Per evaluation	\$63.89	\$47.91	X	X	X	X	X	X
90845	Psychoanalysis.	Per evaluation	\$92.01	N/A	X	X				
90846	Family psychotherapy (without the patient present).	Per evaluation	\$103.35	\$77.51	X	X	X	X	X	X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
90847	Family psychotherapy (conjoint psychotherapy) (with patient present).	Per evaluation	\$106.53	\$79.90	X	X	X	X	X	X
90849	Multiple-family group psychotherapy.	Per evaluation	\$34.28	\$25.71	X	X	X	X	X	X
90853	Group psychotherapy (other than of a multiple-family group). (Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity).	Per evaluation	\$26.26	\$19.69	X	X	X	X	X	X
90870	Electroconvulsive therapy (includes necessary monitoring).	Per treatment	\$178.57	N/A	X					
90885	Psychological evaluation of records.		\$50.10	N/A	X					X
96101	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Rorschach, Wechsler Adult Intelligence Scale [WAIS]), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	Per hour	\$80.26	N/A	X	X				

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
96102	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g. MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	Per hour	\$66.79	N/A	X	X				
96103	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report.	Per test	\$27.79	N/A	X	X				
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Scoring Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	Per hour	\$98.85	N/A	X	X				
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), with qualified healthcare professional	Per hour	\$82.16	N/A	X	X				

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	interpretation and report, administered by technician, per hour of technician time, face-to-face.									
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by computer, with qualified healthcare professional interpretation and report.		\$48.20	N/A	X	X				
96150	Health and behavior assessment (e.g., health focused clinical interview, behavioral observations, psychophysiological monitoring, health oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.	15 minutes	\$21.35	N/A	X	X				
96151	Health and behavior assessment (e.g., health focused clinical interview, behavioral observations, psycho-physiological monitoring, health oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment.	Per evaluation	\$20.64	N/A	X	X				
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual.	Per evaluation	\$19.57	N/A	X	X				
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (two or more patients).	Per evaluation	\$4.59	N/A	X	X				
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).	Per evaluation	\$19.21	N/A	X	X				

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
99211 HE	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  99211 HE for MH medications (e.g., haloperidol, risperidone, fluphenazine, benztropine, and diphenhydramine).	Per visit		N/A	X					X
99201	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a problem focused history; 2) a problem focused examination; and 3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$43.43	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
99202	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) an expanded problem focused history; 2) an expanded problem focused examination; and 3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$74.55	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
99203	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a detailed history; 2) a detailed examination; and 3) medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$108.02	N/A	X					X
99204	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face	Per evaluation	\$165.63	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LIMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	with the patient and/or family.									
99205	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$206.27	N/A	X					X
99211	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.	Per evaluation	\$20.19	N/A	X					X
99212	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a problem-focused history; 2) a problem focused examination; and	Per evaluation	\$43.80	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.									
99213	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) an expanded problem focused history; 2) an expanded problem focused examination; and 3) medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$73.06	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
99214	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a detailed history; 2) a detailed examination; and 3) medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$107.75	N/A	X					X
99215	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically,	Per evaluation	\$144.20	N/A	X					X

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
	40 minutes are spent face-to-face with the patient and/or family.									
+99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient E&M service). Use 99354 in conjunction with 90837, 99201-99215, 99241-99245, 99324-99337, 99341-99350. The practitioner types in bold* can use +99354 only in conjunction with 90837.	First Hour	\$99.80	\$74.85	X	<b>X*</b>	<b>X*</b>	<b>X*</b>	<b>X*</b>	X
+99355	Each additional 30 minutes (list separately in addition to code for prolonged service). Use in conjunction with 99354. The practitioner types in bold* can use +99354 only in conjunction with 90837.	30 minutes	\$97.62	\$73.21	X	<b>X*</b>	<b>X*</b>	<b>X*</b>	<b>X*</b>	X
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., Alcohol Use Disorders Identification Test [AUDIT], Drug Abuse Screening Test [DAST]) and brief intervention (SBI) services, 15 to 30 minutes.	Per evaluation	\$35.26	N/A	X	X				

			<b>Practitioner Type</b> <i>(Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)</i>							
<b>Procedure Code</b>	<b>Description</b>	<b>Unit</b>	<b>Delaware Physician and Psychologist (Psychologist Use HP Modifier)</b>	<b>LCSW, LMFT, LPCMH (Use HO Modifier)</b>	<b>Psychiatrist</b>	<b>Psychologist</b>	<b>LMFT</b>	<b>LPCMH</b>	<b>LCSW</b>	<b>APN/NP</b>
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services, over 30 minutes.	Per evaluation	\$68.70	N/A	X	X				
Q3014	Telehealth Facility Fee note:  The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee).		\$23.76	\$23.76						

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## SUD and Addiction Services<sup>2</sup>

Addiction services include an array of individual-centered outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors.

- Outpatient addiction services include individual-centered activities consistent with the beneficiary's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with SUD. These activities are designed to help beneficiaries achieve and maintain recovery from SUDs. Outpatient SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUD; (3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and (4) medication assisted therapies (MAT) when medically necessary. Counseling should address a beneficiary's major lifestyle, attitudinal and behavioral problems that have the potential to undermine the goals of treatment. Outpatient activities are delivered on an individual, family, or group basis in a wide variety of settings including site-based facility, in the community, or in the beneficiary's place of residence. These services may be provided on site or on a mobile basis as defined by DSAMH. The setting will be determined by the goal which is identified to be achieved in the beneficiary's written treatment plan.

Outpatient activities may be indicated as an initial modality of care for a beneficiary whose severity of illness warrants this level of treatment, or when a beneficiary's progress warrants a less intensive modality of service than they are currently receiving. The intensity of the services will be driven by medical necessity. MAT should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT.

- Residential services include individual-centered residential services consistent with the beneficiary's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and behaviors. These services are designed to help beneficiaries achieve changes in their SUD behaviors. Services should address the beneficiary's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUDs; (3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and (4) MAT when medically necessary. Residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less designed to help beneficiaries achieve changes in their SUD behaviors.

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<sup>2</sup> Admission guidelines described for each level of care in this manual are consistent with *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition* (2013), and additional detail can be found there.

## **2.1 SUD and Addiction Services Limitations**

All addiction services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from an identified SUD diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license[s] and applicable State law, to promote the maximum reduction of symptoms and/or restoration of the beneficiary to his/her best age-appropriate functional level according to an individualized treatment plan. Office-based opioid treatment programs offering buprenorphine must have at least one registered controlled substances prescriber with waiver of the 1914 Harrison Act. Per federal regulations, the physician may not have a caseload exceeding 30 in the first year after receiving a waiver. In subsequent years, caseloads may not exceed 100. If prescribing buprenorphine, the prescriber must be a licensed physician with waiver to prescribe buprenorphine.

The comprehensive specialized program includes assessment, development of a treatment plan, and referral and assistance as needed for the beneficiary to gain access to other needed SUD or mental health services. Referral arrangements may include:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and be based on the beneficiary's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount, and duration of services. The treatment plan must be signed by the licensed practitioner or physician responsible for developing the plan with the beneficiary (or authorized representative) also signing to note concurrence with the treatment plan. The development of the treatment plan should address barriers and issues that have contributed to the need for SUD treatment. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the beneficiary, family, and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals consistent with all relevant State and federal privacy requirements. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services. A new assessment should be conducted when medically necessary.

Providers must maintain medical records that include a copy of the treatment plan, the name of the beneficiary, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary, are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job task oriented and must be directly related to treatment of a beneficiary's behavioral health needs. Any services or components of services,

the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered. Services cannot be provided in an IMD with more than 16 beds. Room and board is excluded from addiction services rates. Delaware residential placement under the American Society of Addiction Medicine (ASAM) criteria requires prior approval and reviews on an ongoing basis as determined necessary by the State Medicaid agency or its designee to document compliance with the placement standards.

Medicaid will not reimburse for 12-step programs run by peers. A unit of service is defined according to the HCPCS approved code set per the national correct coding initiative unless otherwise specified for licensed practitioners to utilize the CPT code set. No more than one per diem rate may be billed a day for residential SUD programs. DSAMH payment of room and board requires prior authorization from DSAMH.

Assessments and testing for individuals not in the custody of the penal system (e.g., not involuntarily residing in prison or jail overnight or detained awaiting trial) are Medicaid eligible, including any laboratory tests and urine tests. Drug court diversion treatment programs are eligible for Medicaid funding. Medicaid eligible individuals who are in the penal system and admitted to medical institutions such as SUD residential treatment programs are eligible for Medicaid funding for eligible medical institution expenditures. Laboratory procedures that the practitioner refers to an outside laboratory must be billed by the laboratory to the Medicaid MCO.

For programs offering both outpatient and residential care, the beneficiary's chart must reflect admission to the program which marks the start of the current episode and any reimbursement. If the beneficiary is in a service that is paid FFS and changes levels of care within 24 hours to a per diem funded service, it shall be considered part of the per diem service. Both FFS and per diem billing will not be permitted unless the service billed is MAT which is not included in the outpatient or per diem rate or another specific code permitted only by permission of the DSAMH fiscal officer in writing as not duplicative of current reimbursement rates. If the beneficiary is in a per diem service and changes levels of care to another per diem level of care, then only one per diem may be billed for the 24 hour period and a new episode will not be allowed (i.e., a single facility cannot bill for discrete services and multiple per diems in a single 24 hour period). For specific billing guidance on detoxification, see the ASAM 2-WM section.

## **2.2 Provider Qualifications for all SUD and Addiction Services**

Services are provided by licensed and unlicensed professional staff, who are at least 18 years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by State law and regulations and departmentally approved program guidelines and certifications.

- Addiction-credentialed physicians include:
  - Physicians certified by ASAM or the American Board of Addiction Medicine (ABAM)
  - Physicians with an Addiction Psychiatry certification bestowed by the American Board of Psychiatry and Neurology (ABPN)
  - Licensed Physicians with prescribing privileges in the state of Delaware, Board-eligible or Board certified, and knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CME credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy. Note: Prescribing clinicians who are psychiatric nurse practitioners may be utilized by a licensed agency only to the extent they are (a) operating within their scope of practice, (b) knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CEU credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy.-and (c) prescribing medications permissible under law and SAMHSA

regulations. These clinicians are not considered addiction-credentialed physicians under ASAM.

- **Licensed practitioners** under the State of Delaware regulation are licensed by Delaware and include, but are not limited to LCSWs, LPCMH, and LMFTs, NPs, APNs, medical doctors (MD and DO), and psychologists. If a medical director is required by a program, the medical director must at least have prescribing privileges under State law and may include NPs, APNs, and medical doctors (MD and DO) in addition to any other requirements specified for the particular service. Note: *State licensure of practitioners does not drive the Medicaid reimbursement (for example, RNs are licensed but are group with “unlicensed staff” due to staffing costs). The description below and the services manual, codes and rates drive reimbursement in Medicaid SUD programs*
- **Any staff who is unlicensed and providing addiction services** must be credentialed by DSAMH and/or the credentialing board. Unlicensed staff under State regulation for SUD services include certified recovery coaches, credentialed behavioral health technicians, RNs and LPNs, certified alcohol and drug counselor, internationally certified alcohol and drug counselor, certified co-occurring disorders professional, internationally certified co-occurring disorders professional diplomate, and licensed chemical dependency professional (LCDP). State regulations require supervision of recovery coaches and credentialed behavioral health technicians by a QHP meeting the supervisory standards established by DSAMH. A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMH, and LMFTs, APNs, NPs, medical doctors (MD and DO), and psychologists. The QHP provides clinical/administrative oversight and supervision of recovery coaches and credentialed behavioral health technicians staff in a manner consistent with their scope of practice.
- **Recovery coaches** must be trained and certified in the State of Delaware to provide services. Recovery coaches are at least 18 years old, and have a high school diploma or equivalent. The certification includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. Recovery coaches must self-identify as a present or former primary beneficiary of SUD services. **Note:** Recovery coaches within a licensed residential program must provide counseling consistent with an approved treatment plan. Medicaid will not reimburse for 12-step programs run by recovery coaches.
- **LCDPs** are credentialed by the Delaware Department of State, Division of Professional Regulation.
  - If the LCDP holds a current Chemical Dependency Professional license in another jurisdiction, then the professional is granted reciprocity if the license has been held for a period of time or the license is found to be similar to the Delaware certification standards.
  - If the professional is not licensed in another jurisdiction but is applying for certification in Delaware and is currently certified by the Delaware Certification Board, Inc., or other national certification board such as the NAADAC as either a NCAC or MAC, then the applicant must also have a criminal history record check and verify any current or previous licensure and/or certification. Professionals who are certified must have documentation of a Master’s degree with graduate semester courses in counseling or related education and post-Master’s experience including supervised counseling in substance abuse counseling.
- **Credentialed behavioral health technicians** are trained in ASAM techniques and credentialed, unlicensed professional staff who are at least 18 years of age with a high school or equivalent diploma.
- **All other unlicensed practitioners** who are certified by a national body must meet the requirements for credentialed behavioral health technicians in addition to any requirements for their national certification.

All providers listed may provide any component of the SUD services consistent with State law and practice act with two exceptions: recovery coaches cannot perform assessments and all programs with MAT interventions must comply with federal and State laws regarding controlled substance prescriber availability.

To provide Medicaid fee-for-service and DSAMH-only funded services, a SUD provider must have provider qualifications verified through DSAMH by having a contract award from DSAMH and current provider enrollment with the Medicaid agency. SUD providers may be practicing independently only if they are a physician in an office-based opioid treatment program or a physician treating an individual with SUD in their practice. Otherwise, all practitioners must practice within an addiction treatment or a co-occurring substance use disorder clinic licensed by the State of Delaware under State law per Delaware Administrative Code Title 16.6001. The licensure applies to all programs providing services to beneficiaries in need of programs and services for diagnosed substance use and/or mental disorders. The licensure at a minimum requires: documentation of all insurance coverage required in regulation; the maximum client capacity requested; and a copy of the agency’s Delaware business license and home state license, when applicable. The licensure also requires a description of the services to be provided by the program, including a statement of the program philosophy, goals and objectives, and a description of the methodology for each service element; and organization charts of showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

### 2.3 Taxonomies

- The following programs can bill SUD codes to the extent the code is medically necessary for the client, consistent with billing guidance, and is covered under their license:
  - Co-occurring Clinic: 261QM0850X Clinic/Center – Adult Mental Health (bill with either no modifier – for physician; HO – for psychologist; HO – for LMFT, LPCMH, or LMFT; SA - Nurse).
  - Substance Use Disorder: 261QR0405X Clinic/Center - Rehabilitation, Substance Use Disorder
  
- The following programs can bill MAT codes for which they have the appropriate SAMHSA waiver. *Note: These programs are subject to audit at any given point of time to ensure the appropriate documentation is on hand.*
  - Crisis Intervention: 251S00000X Agency – Community/Behavioral Health
  - PROMISE providers (ACT, ICM, GH, etc.) - 261QM0801X Mental health Clinic/Community-Support
  - Methadone Clinic - 261QM2800X
  - FQHC 261QF0400x
  - Inpatient and outpatient hospital and individual physicians listed below with a waiver at the federal level. *Note: many of the individual physicians will not bill the substance use disorder MAT codes.*

<b><i>SUR COS Description</i></b>	<b><i>Taxonomy</i></b>	<b><i>Taxonomy Description</i></b>
Inpatient Services	273Y00000X 282N00000X 283Q00000X 283X00000X 284300000X 323P00000X	Hospital Rehabilitation Unit General Acute Care Hospital Psychiatric Hospital Rehabilitation Hospital Special Hospital Inpatient Adolescent Psychiatric Services (DSCYF)

Outpatient Services	273Y00000X 282N00000X 283Q00000X 283X00000X 284300000X	Hospital Rehabilitation Unit General Acute Care Hospital Psychiatric Hospital Special Hospital
Physician Services  Licensed Physicians with prescribing privileges in the state of Delaware, Board-eligible or Board certified, and knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CME credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy.  Note: prescribing clinicians who are psychiatric nurse practitioners may be utilized by a licensed agency only to the extent they are (a) operating within their scope of practice, (b) knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CEU credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy.-and (c) prescribing medications permissible under law and SAMHSA regulations. These clinicians are not considered addiction-credentialed physicians under ASAM.	207KA0200X 207L00000X 207N00000X 207P00000X 207Q00000X 207QA0000X 207QA0505X 207QG0300X 207R00000X 207RA00000X 207RC00000X 207RE0101X 207RG0100X 207RG0300X 207RH0003X 207RI0200X 207RN0300X 207RP1001X 207RR0500X 207RX0202X 207T00000X 207U00000X 207V00000X 207X00000X 207Y00000X 207ZP0101X 208000000X 2080A0000X 2080N0001X 208100000X 208200000X 2084N0400X 2084P0800X 2085R0202X 2085R0203X 208500000X 2086S0129X 208800000X 208C00000X 208D00000X 208G00000X 213E00000X 367500000X 367A00000X 367H00000X 208VP0000X	Allergy Anesthesiology Dermatology Emergency Physician Family Practice Family Practice, Adolescent Family Practice, Adult Family Practice, Gerontology Internal Medicine Internal Medicine, Adolescent Cardiology Endocrinology Gastroenterology Internal Medicine, Geriatric Hematology Infectious Diseases Nephrology Pulmonary Disease Rheumatology Oncology Surgery, Neurological Nuclear Medicine Obstetrics & Gynecology Surgery, Orthopedic Otolaryngology Pathology Pediatrics Pediatrics, Adolescent Neonatology Physical Medicine & Rehabilitation Surgery, Plastic Neurology Psychiatry Radiology Radiation Therapy Surgery, General Surgery, Cardiology Urology Surgery, Colon & Rectal General Practice Surgery, Thoracic Podiatry Nurse Anesthetist, Certified (Crossover) Nurse Midwife Nurse Anesthetist, Certified (CNRA) Pain Medicine

# 3

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## Specific Outpatient SUD and Addiction Services

### 3.1 Alcohol and Drug Assessment and Referral

Alcohol and drug assessment and referral programs provide ongoing assessment and referral services for individuals presenting with a current or past pattern of alcohol or other drug related disorder. The assessment is designed to gather and analyze information regarding an individual's current substance use behavior and social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, SUD treatment or referral.

The services described in this section (e.g., all ASAM Level 1 services) include referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. Referral arrangements may include:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the beneficiary's family, friends, and other community members to cultivate the beneficiary's natural support network, to the extent that the beneficiary has provided permission for such coordination.

Service providers employed by addiction treatment services and co-occurring treatment service agencies must work in a program licensed by DSAMH and comply with all relevant licensing regulations. Qualified providers shall develop, implement, and comply with policies and procedures that establish processes for referrals for an individual. Qualified providers may conduct an initial screen of an individual's presenting SUD before conducting an assessment of the individual. Qualified providers shall be licensed in accordance with State licensure laws and regulations and will comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.

### ***Staffing***

A licensed practitioner or unlicensed counselor or assessor under the supervision of a QHP may complete the assessment. However, interpretation of the information must be within the assessor's scope of practice. Consultation with the interdisciplinary team is required whenever the assessor is outside of his or her scope of practice and expertise. The QHP provides clinical/administrative oversight and supervision of non-credentialed staff at a ratio of no greater than 1:10.

### 3.2 ASAM Level 1: Outpatient Services

Outpatient Level 1 services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure standards. All outpatient SUD programs are licensed under State

law. A facility/agency license is not required for individual or group practices of licensed counselors/therapists providing these services under the auspices of their individual license(s).

These services include, but are not limited to individual, group, family counseling including psycho-education on recovery, and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but are fewer than nine contact hours per week. Delaware-ASAM criteria are used to determine appropriate medical necessity and level of care (LOC).

### ***Admission Guidelines for ASAM Level 1***

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.
2. Biomedical conditions and complications: None or very stable or receiving medical monitoring.
3. Emotional, behavioral, or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring. May have a co-occurring diagnosis.
4. Readiness to change: Participant should be open to recovery or be willing to explore his/her substance use in order to avoid a negative consequence as in mandated treatment. The individual requires monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.
5. Relapse, continued use, or continued problem potential: Participant is able to achieve abstinence, controlled use and/or addictive behaviors, and related recovery goals with minimal support or willing to explore abstinence and related goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure, and lifestyle, and attitude changes.
6. Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system.

### ***Screening/Assessment/Treatment Plan Review***

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
2. Physical examination by a qualified medical professional within 90 days prior to admission or documentation of good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
3. Individualized, interdisciplinary treatment plan per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 30 days of admission or by the fourth counseling session, whichever occurs first. This plan should be developed in collaboration with the individual.
4. Recovery plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 90 days.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

## **Staffing**

1. Level 1 outpatient settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers, and credentialed behavioral health technicians operating within their scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation but should not exceed 50 active individuals for each licensed practitioner and unlicensed counselor. For this standard, *active* is defined as being treated at least every 90 days.
3. Counseling groups should not exceed 15 individuals (assumed average of 9), psycho-educational group size is not restricted.
4. QHP supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff.
5. Peers may lead groups and meet with clients 1:1, but would bill peer support unless also meeting certification criteria to be one of the unlicensed counselors.

### **3.3 ASAM Level 1: Opioid Treatment Services: Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT)**

Opioid treatment services refers to two models of medication and concurrent psychosocial services to treat opioid addiction:

- OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Subutex and Suboxone for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer Subutex and Suboxone, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates.
- OBOT takes place in either a physician's private practice or a number of types of public sector clinics. The physician prescribes partial opioid agonist buprenorphine (which requires certification and a waiver) and/or naltrexone (an opioid antagonist). Participant fills prescription at retail outpatient pharmacy. Additional psychosocial and behavioral services are provided by referral by the OBOT, but the participant may choose which referrals to pursue.

#### **Admission Guidelines for ASAM Level 1 (Opioid Treatment Services)**

1. Acute intoxication and/or withdrawal potential: Physically addicted to opioids.
2. Biomedical conditions and complications: Meets biomedical criteria for opioid use disorder and may have concurrent biomedical illness that can be treated on outpatient basis.
3. Emotional, behavioral, or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring and/or treatment.
4. Readiness to change: Participant requires structured therapeutic and pharmacotherapy program to promote treatment progress and recovery.
5. Relapse, continued use, or continued problem potential: High risk of relapse or continued use without opioid pharmacotherapy, close outpatient monitoring and structured support.
6. Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system.

#### **Screening/Assessment/Treatment Plan Review**

1. Nursing assessment at time of admission that is reviewed by a physician to determine need

for opioid treatment services, eligibility, and appropriateness (proper patient placement) for admission and referral (applies to both OPT and OBOT).

2. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care (applies to both OPT and OBOT).
3. Physical examination (applies to OPT only; not applicable to OBOT). Per 42 CFR Part 8, a fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional (e.g., APRN or physician assistant licensed to provide physical exams under their scope of practice as defined under Delaware law) under the supervision of a program physician is completed prior to admission. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission to an OPT.
4. Individualized, interdisciplinary treatment plan within 72 hours (applies to both OPT and OBOT). The plan must be patient-centered and developed in collaboration with the patient and include an appropriate regimen of methadone or buprenorphine at a dose established by a physician or licensed supervisee. The medication regime must be reviewed and modified as the participant becomes stable and throughout treatment.
5. Treatment plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 90 days (applies to both OPT and OBOT).
6. Discharge/transfer planning begins at admission (applies to both OPT and OBOT).
7. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services (applies to both OPT and OBOT).

## **Staffing**

Level 1 (opioid treatment services) outpatient settings include an array of licensed practitioners, unlicensed counselors, RNs/LPNs, as well as certified peers and behavioral health technicians operating within their scope of practice. QHP supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff. Peers may lead groups and meet with clients 1:1, but would bill peer support unless also meeting certification criteria for unlicensed counselors.

## **OTP**

1. OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. OTPs are allowed to develop staffing models with these regulations in mind and must have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.
2. OTPs must have a designated medical director available on site or for consultation at all times the facility is open.

## **OBOT**

1. OBOT programs must have a registered controlled substances prescriber with a waiver of the 1914 Harrison Act. Per federal regulations, the physician may not have a caseload exceeding 30 in the first year after receiving a waiver. In subsequent years, caseloads may not exceed 100.

### **3.4 ASAM Level 2.1 Intensive Outpatient Treatment**

1. Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. All outpatient SUD programs are licensed under State law.
2. Services include, but are not limited to individual, group, and family counseling including psycho-education on recovery. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy. Services also include monitoring of drug use and orientation and referral to community-based support groups. Timely access to additional support systems and services, including medical, psychological, and toxicology services, are available through consultation or referral.
3. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but must be nine or more contact hours per week for adults, age 18 years and older, with a minimum of contact three days per week (not to exceed 20 hours per week). This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient, or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. Delaware-ASAM criteria are used to determine LOC.

#### ***Admission Guidelines ASAM Level 2.1***

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an intensive outpatient setting.
2. Biomedical conditions and complications: None, or sufficiently stable to permit participation in outpatient treatment.
3. Emotional, behavioral, or cognitive conditions and complications: None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability, and degree of impairment. **Note:** As noted in the ASAM admission criteria, a Level 2.1 facility may be licensed as co-occurring capable or enhanced when the facility has that added capability.
4. Readiness to change: Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another LOC have failed. Alternatively, the participant's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 program. However, the client's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest the treatment at Level 2.1 can be effective.
5. Relapse, continued use, or continued problem potential: Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan. Alternatively, there is a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification, or ambivalence toward treatment.
6. Recovery environment: Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment. Alternatively, the client lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs.

## **Screening/Assessment/Treatment Plan Review**

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a QHP. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
2. Physical examination by a qualified medical professional within a reasonable time, as determined by the client's medical condition not to exceed within 90 days prior to admission or documentation of good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
3. Individualized, interdisciplinary treatment plan per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 72 hours of admission. This plan should be developed in collaboration with the individual.
4. Treatment plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 30 days.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

## **Staffing**

1. Level 2.1 outpatient settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers, and credentialed behavioral health technicians operating within their scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment and rehabilitation but should not exceed 35 active individuals for each licensed practitioner or unlicensed counselor. For this standard, active is defined as being treated at least every 90 days.
3. Counseling groups should not exceed 15 individuals (assumed average of 9); educational group size is not restricted.
4. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.
5. QHP supervisors must be on site at least 10 hours per week during hours of operation, be available for phone consultation at all times, and supervise no more than 10 staff.
6. Addiction-credentialed physicians are part of the interdisciplinary team and must be on site at least 10 hours per week during hours of operation and be available for phone consultation at all times.

## **3.5 ASAM Level 2.5 Partial Hospitalization Program (PHP)**

PHP or day treatment generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical, and laboratory services. Intensive services at this LOC provide comprehensive bio-psychosocial assessments and individualized treatment, and allow for a valid assessment of dependency. This LOC also provides for frequent monitoring/management of the client's medical and emotional concerns in order to avoid hospitalization. These conditions will lead to generalization of what was learned in treatment in the client's natural environment. **Note:** The only distinction between intensive outpatient program (IOP) and PHP programs are the service intensity required by the client.

These services include, but are not limited to individual, group, family counseling, and

psycho-education on recovery, as well as monitoring of drug use, medication management, medical, and psychiatric examinations, CI coverage, and orientation to community-based support groups. Partial hospitalization services should include evidence-informed practices, such as CBT, motivational interviewing, and multidimensional family therapy.

These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of 20 contact hours per week for adults, age 21 years and older, at a minimum of three days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. Delaware-ASAM criteria are used to determine LOC.

### ***Admission Guidelines ASAM Level 2.5***

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in a partial hospital setting.
2. Biomedical conditions and complications: None, or not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management.
3. Emotional, behavioral, or cognitive conditions and complications: None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability, and degree of impairment.
4. Readiness to change: Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another LOC have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program. Alternatively, the client's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the client's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest the treatment at Level 2.5 can be effective.
5. Relapse, continued use, or continued problem potential: Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan and active participation in a Level 1 or Level 2.1 program. Alternatively, there is a high likelihood of relapse or continued use or continued problems without near-daily support and monitoring, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment.
6. Recovery environment: Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in a partial hospitalization program. Alternatively, family members and/or significant others who live with the client are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The client requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is not active opposition to, or sabotaging of, his or her recovery efforts.

### ***Screening/Assessment/Treatment Plan Review***

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours of admission which substantiates appropriate patient placement.

Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.

2. Physical examination by a qualified medical professional within a reasonable time, as determined by the client's medical condition not to exceed within 90 days prior to admission or documentation of good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
3. Individualized, interdisciplinary treatment plan per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 72 hours of admission. This plan should be developed in collaboration with the individual.
4. Treatment plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 30 days.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### **Staffing**

1. Level 2.5 outpatient settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and credentialed behavioral health technicians operating within their scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment and rehabilitation but should not exceed 35 active individuals for each clinical practitioner. For this standard, active is defined as being treated at least every 90 days.
3. Counseling groups should not exceed 15 individuals (assumed average of 9); educational group size is not restricted.
4. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer.
5. Supervisors must be on site at least 10 hours per week during hours of operation, be available for phone consultation at all times, and supervise no more than 10 staff.
6. Addiction-credentialed physicians are part of the interdisciplinary team and must be on site at least 10 hours per week during hours of operation and be available for phone consultation at all times.

### **3.6 ASAM Level 2-WM Ambulatory Withdrawal Management with Extended Onsite Monitoring**

Level 2-WM is an organized outpatient service, which may be delivered in an office setting, health care, or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, withdrawal management, and referral services. Appointments for services are regularly scheduled. These services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Withdrawal management is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in the less supervised setting is relatively safe. Counseling services may be available through the withdrawal management program or may be accessed through affiliation with entities providing outpatient services. Medication-assisted therapies (MAT) utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT.

Additionally, this LOC can include up to 23 hours of continuous observation, monitoring, and

support in a supervised environment for an individual to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate LOC to continue the recovery process. These 23-hour programs are referred to as Level 2-WM (23 hour) in this manual. Because these programs operate 24/7 and the client must be discharged within 23 hours of admission, program expectations differ from other ambulatory withdrawal management with extended onsite monitoring programs (i.e., Level 2-WM (23 hour) has different requirements than Level 2-WM). For individuals in need of greater than 23 hours, Level 3.2-WM, Clinically Managed Residential Withdrawal Management or Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management should be used depending on the severity of the individual's withdrawal syndrome.

If the individual is admitted to detoxification and remains for less than 4 hours, the provider would solely bill Level 2-WM codes. The service would not be considered Level 2-WM (23 hour) and the provider would use H0014 and H0014 TD codes for services rendered. Level 2-WM indicates up to "several hours of monitoring, medication, and treatment".

Delaware will consider detoxification services less than 4 hours to be Level 2-WM and activities performed "upon admission" to a Level 2-WM setting are required to be consistent with the SPA Services Manual and should be completed within this 4 hour timeframe. This would include:

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
4. If the individual is discharged to the typical IOP LOC for induction/detox (Level 2-WM) within 4 hours, the H0014 codes would be billed for the assessment and discharge planning activities noted above.

The IOP (Level 2-WM) program would then proceed with assessment/treatment planning/billing process/etc. per the SPA Services Manual when the member begins services in the IOP. If the member remains at the Level 2-WM (23 hour) setting MORE THAN 4 HOURS BUT LESS THAN 24 HOURS, the per diem rate is used (H0012) instead of the H0014 codes. The Level 2-WM (23 hour) program would ensure that all required assessment/treatment planning/billing process/etc. occurs per the SPA Services Manual.

If the individual remains in the facility greater than 24 hours, then it is a residential detox bed and the H0014 and H0012 codes would not be billed at all. Instead, the residential per diem would be billed. It would be expected that the individual would meet medical necessity for this level of care and is anticipated to remain in the residential detoxification setting for longer than 36 hours even if the individual does not remain that long.

1. The residential detox program would begin billing the per diem rate upon admission to the facility. No outpatient H0014 or H0012 codes would be permitted.
2. The facility may not bill using the H0014 or H0012 codes within 24 hours of admission to a residential detoxification level of care.
3. The residential detox would begin billing its per diem upon admission; it cannot begin billing the per diem on the same day the H0012 codes were billed (i.e., only 1 per diem in a 24-hour period).

## **Admission Guidelines**

### **Level 2-WM**

Participant is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The participant is assessed as being at moderate risk of severe withdrawal syndrome outside the program setting; is free of severe physical and psychiatric complications; and would safely respond to several hours of monitoring, medication, and treatment.

### **Level 2-WM (23 hour)**

Participant is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent, but the severity of the withdrawal is unknown and the participant would benefit from extended observation and monitoring by clinical and medical staff in order to determine the most appropriate LOC (e.g., the presence of co-occurring physical and/or psychiatric conditions or combinations of classes of substances that increase risk of severe withdrawal and physical symptoms).

## **Screening/Assessment/Treatment Plan Review**

### **Level 2-WM**

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. A medical care plan within 24 hours of admission based on the findings of a physical examination (completed prior to admission or on site by psychiatric medical staff or nursing staff), including a brief screening to identify motivation for treatment, relapse potential, and recovery environment at discharge. The medical plan shall be reviewed by a physician and shall be filed in the individual's record and updated as needed.
4. Initial treatment plan within 24 hours of admission and comprehensive treatment plan within seven days of admission.
5. Updates to treatment plan every seven days.
6. Methadone and buprenorphine/naloxone must be available for use with opiate withdrawal as preferred medications. Opioid withdrawal with medications must follow DSAMH protocols.
7. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
  - a. The individual's physical condition, including vital signs.
  - b. The individual's mood and behavior.
  - c. Statements about the individual's condition and needs.
  - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
  - e. Additional notes shall be documented, as needed.
10. Physician orders *are* required for medical and psychiatric management.

### ***Level 2-WM (23 hour)***

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. Initial treatment plan at admission.
4. Methadone and buprenorphine/naloxone must be available for use with opiate withdrawal as preferred medications. Opioid withdrawal with medications must follow DSAMH protocols.
5. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
6. If the individual steps down to Level 2-WM, then all screening/assessment/treatment plan review for that ASAM level must be completed consistent with that LOC.
7. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.
8. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
  - a. The individual's physical condition, including vital signs.
  - b. The individual's mood and behavior.
  - c. Statements about the individual's condition and needs.
  - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
  - e. Additional notes shall be documented, as needed.
9. Physician orders *are* required for medical and psychiatric management.

### ***Staffing***

1. Level 2-WM and Level 2-WM (23 hour) facilities shall have qualified professional medical, nursing, counseling, and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
2. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

### ***Level 2-WM***

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
2. A designated prescriber available on site or for consultation at least 10 hours per week; a physician's assistant (PA), NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.
3. At least one nurse (NP, RN, or licensed practical nurse [LPN]) available on site at least 10 hours per week but at no time serve more than 15 beneficiaries.
4. Licensed practitioners or unlicensed counselors with direct supervision on site; one clinician per 12 individuals.
5. One full-time certified peer.

### ***Level 2-WM (23 hour) Staffing***

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law. Programs unable to comply with this requirement for an addiction-credentialed physician may obtain, at the discretion of DSAMH, a time-limited waiver following the submission of a plan to ameliorate this deficiency.
2. A designated prescriber with on call availability 24/7 for consultation and in order to

discharge participant to higher LOC if necessary. A PA, NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.

3. At least one nurse (NP, RN, or LPN) per 12 individuals on site at all times.
4. One certified peer per 12 individuals on site during days and evenings.
5. One behavioral health technician per 12 individuals on site at all times.

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## Specific Residential SUD and Addiction Services

All programs are licensed under State law per Delaware Administrative Code Title 16.6001. The licensure applies to all programs providing services to beneficiaries in need of programs and services for diagnosed substance use and/or mental disorders. The licensure at a minimum requires: documentation of all insurance coverage required in regulation; the maximum client capacity requested; and a copy of the agency's Delaware business license and home state license, when applicable. The licensure also requires a description of the services to be provided by the program, including a statement of the program philosophy, goals and objectives, and a description of the methodology for each service element; and organization charts of showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

### 4.1 ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment

Residential programs offer at least 10 hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least five hours a week of individual, group, family therapy, medication management, and psycho-education. All facilities are licensed by DSAMH.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. Services provided may include individual, group and family therapy, medication management, and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses, or group homes where treatment services are not provided (e.g., halfway house). Delaware-ASAM criteria are used to determine LOC.

#### ***Admission Guidelines***

1. Acute intoxication and/or withdrawal potential: None, or minimal/stable withdrawal risk and can be safely managed in a Level 3.1 setting.
2. Biomedical conditions and complications: None or stable. If present, the participant must be receiving medical monitoring.
3. Emotional, behavioral, or cognitive conditions and complications: None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery and must be concurrently addressed through appropriate psychiatric services.
4. Readiness to change: Participant should be open to recovery but in need of a structured, therapeutic environment to promote treatment progress and recovery due to impaired ability to make behavior changes without the support of a structured environment.
5. Relapse, continued use, or continued problem potential: Participant understands the risk of relapse but lacks relapse prevention skills or requires a structured environment to continue to apply recovery and coping skills.
6. Recovery environment. Participant is able to cope, for limited periods of time, outside of the 24-hour structure but the participant's environment jeopardizes recovery.

### **Screening/Assessment/Treatment Plan Review**

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Comprehensive bio-psychosocial assessment consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.
3. Physical examination performed within a reasonable time, as determined by the client's medical condition. **Note:** This is referred to community providers not involved with direct services in ASAM 3.1.
4. Individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual within 72 hours of admission.
5. The treatment/treatment plan is reviewed in collaboration with the individual every 60 days and documented accordingly.
6. Discharge/transfer planning begins at admission.
7. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### **Staffing**

1. Level 3.1 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
2. Although they do not provide direct services, an addiction-credentialed physician is part of the interdisciplinary team either through employment or contractual arrangement. The physician, available at least two and one-half hours per week, reviews admission decisions and confirms medical necessity of services.
3. One licensed practitioner or unlicensed counselor with direct supervision per 16 residents is on site during the day. A licensed practitioner/unlicensed counselor is on call 24/7 when not on site.
4. One recovery coach per 16 residents is on site during days and evenings while residents are awake.
5. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation but should not exceed 35 active individuals for each licensed practitioner and unlicensed counselor. For this standard, active is defined as being treated at least every 90 days.
6. House manager (1 FTE per shift) awake and on site at night to supervise activities of the facility. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

## **4.2 ASAM Level 3.2-WM Clinically Managed Residential Withdrawal Management**

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. The program emphasis is on peer and support, not medical and nursing care. All facilities are licensed by DSAMH.

Withdrawal management is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less intensive, non-medical alternative to inpatient withdrawal management. Delaware-ASAM criteria are used to determine LOC.

### ***Admission Guidelines***

Participant has been assessed as not requiring medication, but does require 24-hour monitoring to complete withdrawal and continue treatment and/or self-help recovery. Withdrawal signs and symptoms are not severe and do not require the full resources of an acute care general hospital or a medically supported program. Participant does require 24-hour monitoring because the participant's recovery environment cannot support withdrawal and recovery, or a recent history of withdrawal management at a lower LOC was unsuccessful due to environmental factors and/or lack of skill, including the continued use of substances.

### ***Screening/Assessment/Treatment Plan Review***

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission, including an addiction-focused history and addiction severity index (ASI), about the individual to provide a clear understanding of the individual's present status. If self-administered withdrawal management medications are to be used, a physical examination by a physician, physician assistant, or nurse practitioner should be made at time of admission. Assessment of addiction-focused history and ASI to be reviewed with a physician during the admission process.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. Full physical exam within 24 hours.
5. Initial individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 24 hours which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.
6. A comprehensive treatment plan within three days if participant is still in the service and additional updates to the treatment plan as indicated.
7. Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
  - a. The individual's physical condition, including vital signs.
  - b. The individual's mood and behavior.
  - c. Statements about the individual's condition and needs.
  - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
  - e. Additional notes shall be documented, as needed.
10. Physician orders are required for medical and psychiatric management.

## **Staffing**

An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers, and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The team also includes unlicensed counselors, as well as certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
2. A psychiatrist, psychiatric NP, or APRN is on site at least five hours/week per 16 residents to assess the individual within 24 hours of admission (or earlier, if medically necessary), and available to provide onsite monitoring of care and further evaluation on a daily basis.
3. Primary care/physical health physician (or physician extender) on site at least five hours/week for each 16 residents.
4. One nurse (RN or LPN) per 16 residents is on site at all times with an RN supervisor or NP on call.
5. One licensed practitioner or unlicensed counselor with direct supervision is on site during days and evenings per 16 residents.
6. One recovery coach per 16 residents is on site during days and evenings.
7. One behavioral health technician is on site and awake at all times per 16 residents.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

### **4.3 ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential Treatment**

Residential programs offer 24-hour treatment staff with at least 30 hours per week of a combination of clinical and recovery-focused services specifically focused on individuals where the effects of the substance use or a co-occurring disorder has resulted in cognitive impairment. At least 10 of the 30 hours is to include individual, group, and/or family counseling. The level of impairment is so great that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Similarly, the patient's cognitive limitations make it unlikely that he or she could benefit from other levels of residential care.

The functional limitations seen in individuals who are appropriately placed at Level 3.3 are primarily cognitive and can be either temporary or permanent. They may result in problems in interpersonal relationships, emotional coping skills, or comprehension. For example, temporary limitations may be seen in the individual who suffers from an organic brain syndrome as a result of his or her substance use and who requires treatment that is slower paced, more concrete, and more repetitive until his or her cognitive impairment subsides. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. All facilities are licensed by DSAMH.

Level 3.3 programs provide a structured recovery environment in combination with high intensity, population-specific clinical services to support recovery. Delaware-ASAM criteria are used to determine LOC.

### **Admission Guidelines**

1. Acute intoxication and/or withdrawal potential: None, or minimal risk of withdrawal or

- withdrawal needs can be managed at this level.
2. Biomedical conditions and complications: None or stable. If present, the participant must be receiving medical monitoring.
  3. Emotional, behavioral, or cognitive conditions and complications: Moderate to high severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the individual's cognitive deficits.
  4. Readiness to change: Because of intensity and chronicity of addictive disorder participant has little awareness of need for change or of the relationship between addiction and impaired level of functioning. Participant requires structured and repeated intervention within a 24-hour milieu to consider and/or make behavior changes or engage in and stay in recovery and treatment.
  5. Relapse, continued use, or continued problem potential: Participant has little awareness of relapse triggers and is in imminent danger of relapse or continued substance use. Participant requires relapse prevention activities that are delivered at a slower pace, more concretely and more repetitively within a 24-hour structured environment.
  6. Recovery environment: Environment interferes with recovery and is characterized by moderately high risk of victimization and or abuse or the participant is unable to cope outside of a 24-hour structure, but recovery is achievable within a 24-hour structure.

### ***Screening/Assessment/Treatment Plan Review***

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment within 24 hours of admission that is reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 48 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed within a reasonable time, as determined by the client's medical condition.
5. Individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed within 72 hours and in collaboration with the individual.
6. The treatment/treatment plan is reviewed in collaboration with the individual every 30 days and documented accordingly.
7. Discharge/transfer planning begins at admission.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### ***Staffing***

1. Level 3.3 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and

allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. An RN on site per 16 residents during the day shift.
4. A psychiatrist or psychiatric NP is on site at least five hours/week for every 16 residents.
5. A primary care/physical health physician (or physician extender) is on site at least two and one half hours/week for every 16 residents.
6. One licensed practitioner or unlicensed counselor with direct supervision per 16 residents is on site during days and evenings and on call 24/7 when not on site.
7. One behavioral health technician and/or recovery coach per 16 residents is on site and awake at all times.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

#### **4.4 ASAM Level 3.5 Clinically Managed High Intensity Residential Treatment**

Residential programs offer 24-hour treatment staff with at least 30 hours per week of a combination of clinical and recovery-focused services specifically focused on individuals who have significant social and psychological problems. At least 10 of the 30 hours are to include individual, group, and/or family counseling. All facilities are licensed by DSAMH.

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Delaware-ASAM criteria are used to determine LOC.

#### ***Admission Guidelines***

1. Acute intoxication and/or withdrawal potential: None, or withdrawal symptoms can be safely managed at this level.
2. Biomedical conditions and complications: None or stable and participant can self-administer any prescribed medication, or, if condition is severe enough to distract from treatment and recovery participant can receive medical monitoring within the program or through another provider.
3. Emotional, behavioral, or cognitive conditions and complications: Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder enhanced setting is required for seriously and persistently mentally ill patients.
4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences. If there is high severity in this dimension but not in other dimensions, the individual; therefore, needs ASAM Level 1 placement with inclusion of motivational enhancement therapy (MET). MET is a therapeutic intervention and a component part of the program.
5. Relapse, continued use, or continued problem potential: Participant is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued use, with limited ability to initiate or sustain ongoing recovery and sobriety in a less structured environment.
6. Recovery environment: Participant lives in an environment with moderately high risk or abuse or is a culture highly invested in substance use. Participant lacks skills to cope with

challenges to recovery outside of a highly structured 24-hour setting.

### **Screening/Assessment/Treatment Plan Review**

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment within 24 hours of admission that is reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 48 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed within a reasonable time, as determined by the client's medical condition.
5. Individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed within 72 hours and in collaboration with the individual.
6. The treatment/treatment plan is reviewed in collaboration with the individual every 30 days and documented accordingly.
7. Discharge/transfer planning begins at admission.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### **Staffing**

1. Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. An RN on site per 16 residents during the day shift.
4. A psychiatrist or psychiatric NP is on site at least five hours/week for every 16 residents.
5. A primary care/physical health physician (or physician extender) is on site at least two and one-half hours/week for every 16 residents.
6. One licensed practitioner or unlicensed counselor with direct supervision per 16 residents is on site during days and evenings and on call 24/7 when not on site.
7. One behavioral health technician and/or recovery coach per 16 residents is on site and awake at all times.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

## **4.5 ASAM Level 3.7 Medically Monitored Intensive Inpatient Treatment**

This co-occurring disorder treatment facility provides 30 hours of structured treatment activities per week including, but not limited to psychiatric and substance use assessments, diagnosis treatment, and rehabilitation services. At least 10 of the 30 hours is to include individual, group, and/or family counseling target population for this LOC are participants with high risk of withdrawal symptoms, moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require a 24-hour treatment LOC. Whereas individuals whose most severe problems are in readiness to change, relapse potential, and living environment are best served in clinically managed residential programs or PHP with supportive housing. All facilities are licensed by DSAMH. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour medically monitored treatment setting.

This level of service also provides a planned regimen of 24-hour professionally directed evaluation, observation, and medical monitoring of addiction and mental health treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. Appropriate for patients whose sub-acute biomedical and emotional, behavior, or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, co-occurring disorder treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health. Delaware-ASAM criteria are used to determine LOC.

### ***Admission Guidelines***

Individuals in this LOC may have co-occurring addiction and mental health disorders that need to be stabilized and meet the eligibility criteria for placement in a co-occurring disorder-capable program or difficulties with mood, behavior, or cognition related to a substance use, mental disorder, emotional behavioral, or cognitive symptoms that are troublesome, but may not meet the Diagnostic and Statistical Manual of Mental Disorders criteria for a mental disorder.

1. Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program.
2. Biomedical conditions and complications: Moderate to severe conditions which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital.
3. Emotional, behavioral, or cognitive conditions and complications: Moderate to severe conditions and complications (such as diagnosable co-morbid mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others. Psychiatric symptoms are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.
4. Readiness to change: Participant unable to acknowledge the relationship between the addictive disorder and mental health and/or medical issues, or participant is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured medically monitored setting (but not medically managed).
5. Relapse, continued use, or continued problem potential: Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support.

6. Recovery environment: Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive LOC.

### ***Screening/Assessment/Treatment Plan Review***

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed by a physician within 24 hours of admission, or a review and update by the facility physician of the record of a prior physical exam no more than seven days old.
5. Individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 72 hours which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.
6. The treatment/treatment plan is reviewed and updated in collaboration with the individual every 30 days and documented accordingly.
7. Discharge/transfer planning begins at admission.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### ***Staffing***

1. Level 3.7 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. A psychiatrist or psychiatric NP is on site at least 10 hours/week for every 16 residents.
4. A primary care/physical health physician (or physician extender) is on site at least five hours/week for every 16 residents.
5. One RN on day shift per 16 residents to oversee and monitor participant progress and medication administration. One LPN at all times per 16 residents.
6. One licensed or certified clinician or counselor with direct supervision on site during days and evenings for every 16 residents.
7. One behavioral health technician and/or recovery coach on site and awake at all times for every 16 residents.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or

certified peer.

#### **4.6 ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management**

Medically monitored inpatient withdrawal management within a residential setting is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically-supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DSAMH and have federal Center for Substance Abuse Treatment OTP certification and Drug Enforcement Agency approval.

##### ***Admission Guidelines***

Provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour residential care. It sometimes is provided as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Intakes are accepted 24 hours per day. Delaware-ASAM criteria are used to determine LOC.

##### ***Screening/Assessments/Treatment Plan Review***

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission, including an addiction-focused history and ASI, about the individual to provide a clear understanding of the individual's present status. If self-administered withdrawal management medications are to be used, a physical examination by a physician, physician assistant, or NP should be made at time of admission. Assessment of addiction-focused history and ASI to be reviewed with a physician during the admission process.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. Full physical exam within 24 hours.
5. Initial individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 24 hours which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.
6. A comprehensive treatment plan within three days if participant is still in the service and additional updates to the treatment plan as indicated.
7. Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
  - a. The individual's physical condition, including vital signs.
  - b. The individual's mood and behavior.
  - c. Statements about the individual's condition and needs.

- d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
- e. Additional notes shall be documented, as needed.

10. Physician orders are required for medical and psychiatric management.

### **Staffing**

An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers, and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems. The interdisciplinary team also includes an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
2. A psychiatrist, psychiatric NP, or APRN is on site at least 15 hours/week per 16 residents to assess the individual within 24 hours of admission (or earlier, if medically necessary), and available to provide onsite monitoring of care and further evaluation on a daily basis.
3. Primary care/physical health physician (or physician extender) on site at least 15 hours/week for 16 residents.
4. One nurse (RN or LPN) per 16 residents is on site at all times with an RN supervisor or NP on call.
5. One licensed practitioner or unlicensed counselor with direct supervision is on site during days and evenings per 16 residents.
6. One recovery coach per 16 residents is on site during days and evenings.
7. One behavioral health technician is on site and awake at all times per 16 residents.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.
9. All residential programs are licensed under State law.

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## Reimbursement for SUD and Addiction Services

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay psychologists at 100% of the Medicaid physician rates as outlined under 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Delaware will pay LCSWs, LPCMH, LMFTs at 75% of the Medicaid physician rates as outlined under 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register [of Regulations]. The agency's fee schedule rate was set as of October 2, 2013, and is effective for services provided on or after that date. All rates are published on the DMAP website at [www.dmap.state.de.us/downloads/hcpcs.html](http://www.dmap.state.de.us/downloads/hcpcs.html).

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses, benefits, employer taxes (e.g., FICA, unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

**Note:** For ASAM Level 2-WM, the clinicians will bill the appropriate CPT codes in conjunction with IOP codes. For ASAM Level 2-WM (23 hour), there is an inclusive HCPCS code based on these staffing requirements. For licensed practitioners eligible under the OLP section of the State Plan (e.g., psychologists, LCSWs, LPCMHs, and LMFTs), they may bill eligible outpatient SUD services under codes found in this section of the manual, as well as codes found in the non-Physician LBHP section of the State Plan manual. All practitioners within licensed residential

SUD programs regardless of licensure must be consistent with the residential codes found in this SUD section of the State Plan manual.

## 5.1 Addiction Services Reimbursement and Coding Summary

**Note:** For ASAM Level 2-WM, the clinicians will bill the appropriate CPT codes in conjunction with IOP codes (other non-physician (e.g., psychotherapy) and physician codes (e.g., evaluation and management codes) used in non-residential outpatient settings are listed above in the OLP table). For ASAM Level 2-WM (23 hour), there is an all-inclusive program code. All residential codes for services provided at or above levels ASAM 3 are considered all inclusive.

**Modifiers:**

**HF** – Substance abuse program

**HE** – Mental health program

**HW** – Funded by the state mental health agency

**HI** – Integrated mental health and intellectual/developmental disabilities program

**HG** – Opioid addiction treatment program

**HQ** – Group setting

**HR** – Family/couple with client present

**HS** – Family/couple without client present

**TG** – Complex/high tech LOC

Note: To the extent Clinical Nurse Specialists, Nurse Practitioners, and Physician’s Assistants bill under the State Plan, they should see the relevant Medicaid fee schedule, which is generally the Delaware Physician rate.

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
+90785	HF		Interactive complexity (list separately in addition to the code for primary procedure). <i>(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an E&amp;M service [90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350], and group psychotherapy [90853].)</i> <i>(Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E&amp;M services when no psychotherapy service is also reported.)</i> <i>Licensed practitioners only.</i>			\$14.22	\$10.66
90832	HF		Psychotherapy, 30 minutes with patient and/or family member. <i>Licensed practitioners only for substance abuse program.</i>	Per session		\$64.25	\$48.19
90834	HF		Psychotherapy, 45 minutes with patient and/or family member. <i>Licensed practitioners only for substance abuse program.</i>	Per session		\$85.18	\$63.89
90837	HF		Psychotherapy, 60 minutes with patient and/or family member.	Per session		\$127.46	\$95.60

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
			<i>Licensed practitioners only for substance abuse program.</i>				
90839	HF		Psychotherapy for crisis; first 60 minutes. <i>Licensed practitioners only for substance abuse program must be part of certified crisis program.</i>	60 minutes		\$133.18	\$99.88
90840			Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.) <i>Licensed practitioners only for substance abuse program must be part of certified crisis program.</i>	30 minutes follow-on		\$63.89	\$47.91
90846	HF		Family psychotherapy (without the patient present). <i>Licensed practitioners only for substance abuse program.</i>	Per session		\$103.35	\$77.51
90847	HF		Family psychotherapy (conjoint psychotherapy) (with patient present). <i>Licensed practitioners only for substance abuse program.</i>	Per session		\$106.53	\$79.90
90849	HF		Multiple-family group psychotherapy.			\$34.28	\$25.71
90853	HF		Group psychotherapy (other than of a multiple-family group).	Per session		\$26.26	\$19.69
H0001			Alcohol and/or drug assessment.	One session (One visit)	\$77.30		
H0004	HF		Behavioral health counseling and therapy (ASAM Level 1). <b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.	One session (15 minutes)	\$19.33		
H0005			Alcohol and/or drug services, group counseling by a clinician (ASAM Level 1). <b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.	One session (45 minutes)	\$9.66		
H0010			Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient) (Level 3.2-WM).	Per diem (medical portion)	\$290.70		
H0010	HW		Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient) (Level 3.2-WM). <b>Room and board note:</b> MMIS will not process — not Medicaid.	Per diem (room and board portion)	\$58.10		
H0011			Alcohol and/or drug services;	Per	\$354.67		

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
			acute detoxification (residential addiction program inpatient) (Level 3.7-WM).	diem (medical portion)			
H0011	HW		Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (Level 3.7-WM).  <b>Room and board note:</b> MMIS will not process — not Medicaid.	Per diem (room and board portion)	\$65.84		
H0012			Alcohol and/or drug abuse service; subacute detoxification (residential addiction program outpatient) (Level 2-WM 23-hour).	Per diem	\$267.26		
H0014	TD		Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Registered Nurse	Per 60 minutes	\$104.45		
H0014			Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Unlicensed Practitioner	Per 60 minutes	\$77.30		
H0015			Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education. Level 2.1 at least 9 contact hours per week but not in excess of 19 hours per week; a minimum of contact 3 days per week. <b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.	Per hour	\$77.30 per hour		
H0015	HQ		Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education. Level 2.1 at least 9 contact hours per week but not in excess of 19 hours per week; a minimum of contact 3 days per week. <b>Note:</b> Utilize HR and HS modifiers as needed for	Per hour	\$12.88 per hour		

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
			family/couple therapy.				
H0015	TG		Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.	Per hour	\$77.30 per hour		
			Level 2.5 a minimum of 20 contact hours per week; a minimum of contact 3 days per week.				
			<b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.				
H0015	HQ	TG	Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.	Per hour	\$12.88 per hour		
H0020			Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program). (Limited to one per day.)	Per Service		\$4.00	
H0038	HF		Self-help/peer services, substance abuse program.	Per 15 minute	\$14.75		
H0048	HF		Alcohol and/or other drug testing: collection and handling only, specimens other than blood.	Per service	YTD		
			Collection and handling of specimens (UAs) for alcohol/drug analysis. To ensure the integrity of the specimen a chain of custody from the point of collection throughout the analysis process is necessary. Service frequency is limited based on medical necessity.				
H2034			Alcohol and/or drug abuse halfway house services, per diem (Level 3.1).	Per diem	\$150.53		
				(medical portion)			
H2034	HW		Alcohol and/or drug abuse halfway house services, per	Per diem	\$41.14		

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
			diem (Level 3.1).				
			<b>Room and Board Note:</b> MMIS will not process — not Medicaid.	(room and board)			
H2036	HI		Alcohol and/or drug treatment program, per diem (Level 3.3 – cognitive impairment).	Per diem (medical portion)	\$189.44		
H2036			Alcohol and/or drug treatment program, per diem (Level 3.5 – no cognitive impairment).	Per diem (medical portion)	\$189.44 (Medicaid 16 and under beds) \$114.05 (Non-Medicaid 47 beds)		
H2036	TG		Alcohol and/or drug treatment program, per diem (Level 3.7).	Per diem (medical portion)	\$291.65		
H2036	HW		Alcohol and/or drug treatment program, per diem.	Per diem (room and board)	\$45.84		
J0571			Buprenorphine, oral, 1 mg	Per dose	Actual cost per dose		
J0572			Buprenorphine/naloxone, oral, less than or equal to 3 mg	Per dose	Actual cost per dose		
J0573			Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	Per dose	Actual cost per dose		
J0574			Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	Per dose	Actual cost per dose		
J0575			Buprenorphine/naloxone, oral, greater than 10 mg	Per dose	Actual cost per dose		
J2315			Injection, naltrexone, depot form, 1 mg	Per unit	\$2.75 per unit		
T1502	HF		Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit. This code may only be used for the following medication assisted therapies: buprenorphine (SUBUTEX <sup>®</sup> ), buprenorphine and naloxone (SUBOXONE <sup>®</sup> ), by an alcohol and drug provider type. Frequency max 7 administrations per week (1 unit–1 administration).  No modifier = oral.	Per service		\$4.00	

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2014 Physician	2014 Delaware
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)
99211	HE		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  99211 HE for injection of MH medications, including long-acting and acute forms of anti-psychotic medications and medications used to treat acute side effects of antipsychotic medications (e.g., haloperidol, risperidone, benztropine)	Per visit		\$20.19	
99211	HF		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  For Vivitrol up to 1 time per month	Per visit		\$20.19	

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## Crisis Intervention

Crisis intervention (CI) services are provided to a beneficiary who is experiencing a behavior health crisis, designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution, and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual behavioral health crisis. CI is a face-to-face intervention and can occur in a variety of locations including, but not limited to an emergency room or clinic setting, in addition to other community locations where the beneficiary lives, works, attends school, and/or socializes.

Specific activities include:

- An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level.
- Short-term CI including crisis resolution and de-briefing with the identified Medicaid beneficiary.
- Follow up with the individual, and as necessary, with the beneficiary's caretaker and/or family member(s) including follow up for the beneficiary who is in crisis and assessed in an emergency room prior to a referral to the CI team.
- Consultation with a physician or with other qualified providers to assist with the beneficiary's specific crisis.

Qualified staff shall assess, refer, and link all Medicaid beneficiaries in crisis. This shall include, but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of beneficiaries; and arranging for linkage, transfer, transport, or admission as necessary for Medicaid beneficiaries at the conclusion of the CI service. CI specialists shall provide CI counseling, on and off-site; monitoring of beneficiaries; assessment under the supervision of a certified assessor; and referral and linkage, if indicated. CI specialists, who are nurses, may also provide medication monitoring and nursing assessments. Psychiatrists in each crisis program perform psychiatric assessments, E&M as needed; prescription and monitoring of medication; as well as supervision and consultation with CI program staff. Certified peers may be utilized under clinical supervision for the activities of crisis resolution and de-briefing with the identified Medicaid beneficiary and follow up.

### 6.1 Consumer Participation Criteria

These rehabilitative services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid beneficiaries. CI services must be medically necessary. The medical necessity for these rehabilitative services must be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable State law to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. Licensed practitioners of the healing arts include, but are not limited to: LBHPs, APNs, NPs, and physicians. All beneficiaries who are

identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible.

A beneficiary in crisis may be represented by a family member or other collateral contact who has knowledge of the beneficiary's capabilities and functioning. Beneficiaries in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care. The assessment of risk, mental status, and medical stability must be completed by a credentialed mental health screener, LBHP, APN, NP, or physician with experience regarding this specialized mental health service, practicing within the scope of their professional license or certification. The crisis plan developed from this assessment and all services delivered during a crisis must be by qualified staff provided under a certified program. Crisis services cannot be denied based upon substance use. The beneficiary's chart must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within 24 hours of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed.

The CI services should follow any established crisis plan already developed for the beneficiary, if it is known to the team, as part of an individualized treatment plan to the extent possible. The CI activities must be intended to achieve identified care plan goals or objectives.

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

## **6.2 Taxonomies**

- Crisis Intervention: 251S00000X Agency – Community/Behavioral Health.

## **6.3 Provider Qualifications under the Medicaid State Plan Authority**

Individual practitioners may be licensed as:

- Psychiatrists, board certified emergency physicians, or a physician in another area of specialty. Board certified emergency physicians must also complete a required informational training. Physicians in other areas of specialty must attend four hours of training and be credentialed by DSAMH.
- RN.
- APN operating in collaboration with a Delaware licensed physician.
- Licensed Behavioral Health Practitioner including:
  - Licensed psychologist.
  - LCSW.
  - LPCMH.
  - LMFT.
- Licensed PA supervised by a licensed physician.

Individual practitioners may be certified as:

- A credentialed mental health screener who is not licensed must meet all State requirements, including having two years of clinical and/or crisis experience; at least a bachelors or master's degree in a mental health related field; and completing 40 hours of crisis services in an employed position under direct supervision of a psychiatrist or credentialed mental health screener following completion of the mental health screener training and satisfactory score on the mental health screener credentialing examination.
- A certified peer on a CI team who is an individual who has self-identified as a beneficiary of mental health and/or SUD services, is at least 21 years of age, and meets the qualifications

set by the State, including specialized peer specialist training, certification and registration. A certified peer must have, at minimum, a high school education or GED, (preferably with some college background). Delaware state-approved standardized peer specialist training includes academic information as well as practical knowledge and creative activities. The training shall be focused on the principles and concepts of peer support and how it differs from clinical support. The training will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. Each crisis program including certified peers staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law.

- A CI specialist who is an unlicensed mental health professional with a bachelors or master's degree in a mental health-related field. The CI specialist must receive training and regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP, APN, NP, or physician with experience regarding this specialized mental health service.

#### **6.4 Certification – Note: this section is draft and subject to finalization by DHSS**

Programs shall be certified by DSAMH as a crisis program providing:

- Mobile CI services and/or
- Facility-based CI services.

To provide Medicaid fee-for-service and DSAMH-only funded services, a Crisis provider must be certified and have provider qualifications verified through DSAMH by having a contract award from DSAMH and current provider enrollment with the Medicaid agency.

#### *Mobile Crisis Intervention Services*

Mobile CI services means a face-to-face intervention that can occur in a variety of locations including, but not limited to, an emergency room or office-based where the beneficiary happens to be, in addition to other community locations where the beneficiary lives, works, attends school, and/or socializes. Services are available 24 hours a day experiencing a mental health crisis.

Each crisis program is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable State law. A licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable State law (e.g., LBHP, physician, NP, or APN) is available for consultation and able to recommend treatment 24 hours a day, 7 days a week to the CI program.

To provide Medicaid fee-for-service and DSAMH-only funded services, a crisis program must have both a contract award from DSAMH and current provider enrollment with the Medicaid agency. Crisis programs must contract with Medicaid MCOs to receive Medicaid managed care reimbursement. Crisis providers under this particular authority and reimbursement structure may not practice independently and must practice within a program certified by DSAMH as having met the CI certification standards contained within this Manual.

Title 16, Chapter 51 of the Delaware Code states that only psychiatrists and professionals credentialed by the Delaware Department of Health & Social Services (DHSS) as a Mental Health Screener (MH Screener) have the authority to detain or abrogate a detainment of a person involuntarily for a psychiatric evaluation. No person shall hold themselves out to the public as credentialed mental health screener unless the persons are credentialed in accordance with Title 16, Chapter 51 of the Delaware Code. DSAMH is the DHSS Division responsible for implementing and enforcing this law.

## **6.5 Mobile Crisis Intervention Policies and Procedures** **Note: this section is draft and subject to finalization by DHSS**

Mobile CI programs must have a policy and procedure manual consistent with the requirements in these standards to address operations and services. The program's policies and procedures shall include:

1. A statement of program philosophy and goals;
2. Geographical area to be served;
3. Types of services offered;
4. Intake, assessment, and referrals;
5. Completion and utilization of all forms used by the program;
6. Making mandated reports of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904, 3910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6) (including non-retaliation policies when personnel report abuse and neglect.);
7. Responding to medical emergencies;
8. Engagement of police, other emergency response personnel and other professionals as necessary;
9. Confidentiality that complies with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164; and
10. Clients' rights.

## **6.6 Mobile Crisis Intervention Personnel Manual and Personnel Files** **Note: this section is draft and subject to finalization**

Each program shall develop and maintain a personnel manual that includes:

1. Staff rules of conduct consistent with due process including:
  - a. Examples of conduct that constitute grounds for disciplinary action;
  - b. Examples of unacceptable performance that constitute grounds for disciplinary action.
2. Policies and procedures on mental health, and alcohol and drug abuse problems of staff (including staff member assistance policies and procedures).
3. Safety and health of staff, including:
  - a. Rules about any required medical examinations and rules about communicable diseases that could affect the health or safety of the program's clients or staff.

Each program shall maintain a separate personnel file for each staff member in a manner that ensures the privacy of program staff. The personnel file shall include at a minimum:

1. The name and telephone number of a person the agency can contact in an emergency;
2. The current job title and job description signed by the staff member;
3. An application for employment signed by the staff member or a resume;
4. A copy of the staff member's license or certification;
5. The results of reference investigations and verification of experience, training and education, including:
  - a. Primary source verification of the staff member's educational degree certificate(s), based on job description;
  - b. Primary source verification of the staff member's license(s), and/or certification(s), as applicable, based on job description;
  - c. A statement signed by the staff member acknowledging that s/he understands the requirements of 42 USC §290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
  - d. Records documenting all required staff member health clearances, including any medical test results required.

## **6.7 Mobile Crisis Intervention State Training and Supervision** **Note:** **this section is draft and subject to finalization by DHSS**

Each program shall have an orientation curriculum to ensure all staff is familiar with the program policies and procedures, and have a working knowledge of at least the following:

1. Personnel policies and procedures, regarding the health and safety of staff;
2. Program policies and procedures regarding the reporting of cases of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904, 910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6), including non-retaliation policies when personnel report abuse and neglect;
3. Program policies and procedures regarding client's rights;
4. Program policies and procedure regarding the training of all staff regarding culturally competent practices;
5. Program policies and procedures regarding the obligation to report violations of law and applicable codes of ethics to the appropriate certification and/or licensure boards; and
6. All staff, trainees and volunteers shall receive training within the first year of employment about:
  - a. Hepatitis;
  - b. HIV/AIDS;
  - c. Tuberculosis;
  - d. Other sexually transmitted diseases; and
  - e. Infection control

Each program shall have an on-going training curriculum:

1. Certified peers and CI specialists must receive training and regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP, APN, NP, or physician with experience regarding this specialized mental health service.
2. Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually.
3. Training shall be provided on a continuing basis and shall include, but not be limited to, orientation to the screening system, provisions contained within the screening law, explanation of mental illness, CI skills, systems interaction and transportation.

## **6.8 Mobile Crisis Intervention Client Rights**

**Note: this section is draft and subject to finalization by DHSS**

1. All programs shall ensure that clients' rights are fully protected as enumerated in Del.C. §2220 and include the following:
  - a. To be free from retaliation for exercising any enumerated right.
  - b. To be free from abuse, mistreatment and neglect, as proscribed by Title 16, Chapters 9 and 11 of the Delaware Code;
  - c. To be free from unjustifiable force, as defined by 11 Del. C. § 468;
  - d. To be free from seclusion, physical restraint, drugs or other interventions administered primarily for purposes of staff convenience; provided, however, that restraint or seclusion may be administered pursuant to and documented contemporaneously by the written order of an authorized, licensed mental health professional to the extent necessary to prevent physical harm to self or others. Consistent with Title 16, Chapter 51 of the Delaware Code, Administration of restraint shall include the following safeguards:
    - i. Authorizing orders shall specify the form, duration, and conditions of restraint based on a deliberative determination that the restraint is the least restrictive alternative intervention to prevent physical harm to the patient or others;

- ii. The client shall receive a medical examination within an hour of initiation of restraint by a physician, or, if a physician is not available, a nurse;
  - iii. During the course of restraint the client shall be closely monitored to assess well-being and facilitate prompt discontinuation of restraint when no longer necessary to prevent physical harm to the patient or others;
  - iv. Subsequent to administration of restraint, an interactive clinical assessment shall be undertaken, which includes the client, and, at the request of the client, a representative of the protection and advocacy agency, to review catalysts resulting in the necessity of the restraint and appropriateness of revision to the treatment plan.
- e. To be assured that any incident of abuse; neglect or mistreatment will be reported;
  - f. To file a grievance or complaint with the program in accordance with its policy and procedures. Procedures for receiving, investigating, hearing, considering, responding to and documenting grievances shall:
  - g. Include a procedure for receipt of grievances from clients or persons acting on their behalf;
  - h. Provide for the investigation of the facts supporting or disproving the grievance;
  - i. Identify the staff responsible for receipt and investigation of grievances;
  - j. Be posted in a public place;
  - k. Participate, and/or have others of his/her choice participate, in an informed way in the grievance process;
  - l. To be informed that participation in treatment is voluntary, except as provided in 16 Del.C. §§2211, 2212, 2213 and 2215;
  - m. To refuse service, except as provided in 16 Del.C. §§2211, 2212, 2213
  - n. To communicate with legal counsel;
  - o. To confidentiality of all records, correspondence and information relating to assessment, diagnosis and treatment in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
  - p. To review his/her own records in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164. Client request for review and a summary of the review if granted shall be documented in the client's record.

## 6.9 Mobile Crisis Intervention Quality Assurance

**Note: this section is draft and subject to finalization by DHSS**

All CI programs shall:

1. Have a written quality assurance plan that provides for the periodic review of clinical services to include the provision of culturally competent services including:
  - a. Professional services;
  - b. Administrative services; and
  - c. Infection Control.
2. Develop and implement performance indicators and assess outcome measures.
3. Provide a mechanism to collect opinions from service recipients, personnel and other stakeholders (e.g., law enforcement, hospitals) regarding the quality of service provided.
4. Conduct a needs assessment at a minimum of every five (5) years to inform staffing patterns and types of services to be provided.

## 6.10 Mobile Crisis Intervention Hours of Operation, Staffing and Staff Schedules

**Note: this section is draft and subject to finalization by DHSS**

1. CI programs shall operate seven (7) days per week, twenty-four (24) hours per day and maintain twenty-four (24) hour per day CI capability, which for mobile teams shall include provision of de-escalation and screening services in any location in the geographic area, under the following circumstances:
  - a. Whenever there is indication that there may be a reasonable likelihood of dangerousness to self, others or property due to mental illness;
  - b. Whenever the individual is unable or unwilling to come to the crisis program or when transporting the individual may put him or her or others at further risk; and
  - c. Whenever the consumer's history, behavior or location presents safety concerns that cannot be resolved through consultation by the crisis program with the police, transportation by the police to an appropriate facility for further evaluation is coordinated.
  - d. Mobile CI Programs must be capable of receiving crisis calls from a centralized hotline or referral source at all times directly by a certified screener, CI specialist or other clinical personnel under the supervision of the screener or CI specialist and shall receive calls that have been forwarded from other sources during off hours
2. Develop policies and procedures for transporting consumers in crisis, in accordance with all applicable Federal and State laws. This plan shall include transportation to an appropriate treatment facility (for example, facility-based crisis program, psychiatric facility, psychiatric unit of a general hospital, special psychiatric hospital once identified).
3. Each crisis program shall be supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law. A licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law (e.g., an LBHP, physician, NP or APN) shall be available for consultation and able to recommend treatment twenty-four (24) hours per day, seven days a week to the CI program.
4. Mobile CI programs shall have adequate qualified staff to respond within 1 hour of referral.

## 6.11 Mobile Crisis Intervention Activity Definition

**Note: this section is draft and subject to finalization by DHSS**

CI programs provide CI services to a beneficiary who is experiencing a behavioral health crisis. CI services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution, and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. CI programs also provide consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating knowledge about and access to mental health crisis services. All services delivered during a crisis must be provided by qualified staff under a certified program.

All activities must occur within the context of a potential or actual behavioral health crisis. The CI services should follow any established crisis plan already developed for the beneficiary, if it is known to the team, as part of an individualized treatment plan to the extent possible. The CI activities must be intended to achieve identified care plan goals or objectives. CI programs shall provide the four activity components outlined above and explained here in more depth:

1. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. The Assessment by qualified staff, includes:
  - i. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. This includes contact with the client, family members, or

- other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. This may include an evaluation of any person found within the service area of the center to determine the need for community-based services, PROMISE program eligibility or inpatient or involuntary psychiatric care and treatment. Assessment of the crisis situation and identification of stabilization, diversion and support services needed and/or screening for commitment.
- ii. The assessment of risk, mental status, and medical stability must be completed by a credentialed mental health screener, LBHP, APN, NP, or physician with experience regarding this specialized mental health service, practicing within the scope of their professional license or certification.
  - iii. Mobile CI programs shall respond within 1 hour of referral to initiate the assessment.
2. Short-term CI including crisis resolution and de-briefing with the identified Medicaid beneficiary. Short-term CI, including:
    - i. Crisis resolution and de-briefing with the beneficiary;
    - ii. Provision of emergency and consensual treatment to the person receiving the assessment;
    - iii. Crisis/early intervention counseling; and
    - iv. Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis.
    - v. For mobile CI programs, development of a crisis plan if one is not already in place.
  3. Follow up with the individual, and as necessary, with the beneficiary's caretaker and/or family member(s), including follow up for the beneficiary who is in crisis and assessed in an emergency room prior to a referral to the CI team, to determine the need for any further services or referral to any services. Arranging for linkage, transfer, transport, or admission as necessary for beneficiaries at the conclusion of the CI service including referral to psychiatric and other community services, when appropriate.
    - i. This includes referral via personal contact to the most appropriate, least restrictive treatment setting indicated, linkage and follow-up in order to maintain contact with all consumers until they are engaged in another service licensed by the appropriate authority, where applicable, or are no longer in crisis;
    - ii. Initiation of involuntary commitment proceedings, where appropriate consistent with state law.
  4. Consultation with a physician or with other qualified providers to assist with the beneficiary's specific crisis.

## 6.12 Mobile Crisis Intervention Clinical Records

**Note: this section is draft and subject to finalization by DHSS**

Programs shall maintain a record for each client that is accurate, legible and signed by the staff member who provided the service.

Mobile CI programs shall:

1. Maintain a standardized client record-keeping system, with client records that are uniform in format and content and includes (to the extent applicable and possible):
  - a) Date and time of assessment;
  - b) Beneficiary name, address, telephone number, gender, date of birth and unique identifier number (e.g., Medicaid number);
  - c) The client's significant medical history documenting:
    - i) Current medical conditions;
    - ii) Any medications the client is currently taking; and
    - iii) Allergies.
  - d) The name and telephone number of the person to contact in an emergency;

- e) Assessment;
  - f) Treatment/Crisis Plan (if not already developed);
  - g) Progress notes;
  - h) Discharge plan; and
  - i) Discharge summary.
2. Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff.
  3. Update each record within twenty-four (24) hours of delivery of a service.

### **6.13 Mobile Crisis Intervention Amount, Duration, and Scope**

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

CI services by their nature are crisis services and are not subject to prior approval. CI services are authorized for no more than 23 hours per episode. Activities beyond the 23 hour period must be prior authorized by the State or its designee. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within 24 hours of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed.

Providers receiving referrals to visit individuals at home following a visit to an emergency rooms will bill only the follow-up HCPCS codes. Providers visiting individuals discharged from a site-based program within 24 hours is considered reimbursement within in the original 23 hour charge. If a site-based program bills using the 15-minute unit, the program's reimbursement may not exceed the site-based per diem rate in a 24 hour period (e.g., five 15-minute units are roughly equal to one per diem).

Service components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary are not eligible for Medicaid reimbursement.

### **6.14 Reimbursement for Crisis Intervention Behavioral Health Services**

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay psychologists at 100% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Delaware will pay LCSWs, LPCMH, LMFTs at 75% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of October 2, 2013, and is effective for services provided on or after that date. All rates are published on the DMAP website at [www.dmap.state.de.us/downloads/hcpcs.html](http://www.dmap.state.de.us/downloads/hcpcs.html).

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses, benefits, employer taxes (e.g., FICA, unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

## 6.16 Mobile Crisis Intervention Coding

HCPCS Code	Modifier		Provider Qualification	Tx Context	Description	Units	Rate Per	
	(1)	(2)					¼ hour	Diem
H2011				Ind.	CI service, per 15 minutes, (mobile crisis team).	15 min.	\$146.99	

### *Facility-based Crisis Intervention Services*

Facility-based CI services means services are available 24 hours a day to assist people experiencing a mental health crisis and services are provided in an established location that is staffed with a multi-disciplinary team of physicians, nurses, LBHPs, certified peers and certified CI specialists. Facility-based programs offer walk-in services and provide CI services for up to 23 hours for an individual.

Each crisis program is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable State law. A licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable State law (e.g., LBHP, physician, NP, or APN) is available for consultation and able to recommend treatment 24 hours a day, 7 days a week to the CI program.

To provide Medicaid fee-for-service and DSAMH-only funded services, a crisis program must have both a contract award from DSAMH and current provider enrollment with the Medicaid agency. Crisis programs must contract with Medicaid MCOs to receive Medicaid managed care reimbursement. Crisis providers under this particular authority and reimbursement structure may not practice independently and must practice within a program certified by DSAMH as having met the CI certification standards contained within this Manual.

Title 16, Chapter 51 of the Delaware Code states that only psychiatrists and professionals credentialed by the Delaware Department of Health & Social Services (DHSS) as a Mental Health Screener (MH Screener) have the authority to detain or abrogate a detention of a person involuntarily for a psychiatric evaluation. No person shall hold themselves out to the public as credentialed mental health screener unless the persons are credentialed in accordance with Title 16, Chapter 51 of the Delaware Code. DSAMH is the DHSS Division responsible for implementing and enforcing this law.

## **6.17 Facility-Based Crisis Intervention Policies and Procedures**

**Note: this section is draft and subject to finalization by DHSS**

CI programs must have a policy and procedure manual consistent with the requirements in these standards to address operations and services. The program's policies and procedures shall include:

1. A statement of program philosophy and goals;
2. Geographical area to be served;
3. Types of services offered;
4. Intake, assessment, and referrals;
5. Completion and utilization of all forms used by the program;
6. Making mandated reports of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904, 3910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6) (including non-retaliation policies when personnel report abuse and neglect.);
7. Responding to medical emergencies;
8. Engagement of police, other emergency response personnel and other professionals as necessary;
9. Confidentiality that complies with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164; and
10. Clients' rights.
11. Admission and discharge processes;
12. Policies and procedures consistent with 42 CFR §2.12(c)(5) and HIPAA 45 CFR parts 160 and 164 when discharging a client involved in the commission of a crime on the premises of the program or against its staff, including designation of the person who shall make a report to the appropriate law enforcement program;
13. Policies and procedures consistent with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164 when a client leaves against medical or staff advice and the client may be dangerous to self or others;
14. Communicating with law enforcement personnel when a client commits or threatens to commit a crime on program premises or against program personnel, in compliance with 42 CFR §2.12(c)(5) and HIPAA 45 CFR parts 160 and 164;
15. Mandated reporting of infectious or contagious diseases, in compliance with state law and 42 CFR Part 2 and HIPAA 45 CFR Parts 160 and 164;
16. Medication policies and procedures, in compliance with the Delaware State Boards of Medical Practice, Nursing, and Pharmacy;
17. Policies and procedures, as applicable, for the collection of urine specimens; and
18. Reporting any violations of law or codes of ethics to the appropriate certification and/or licensure boards.

## **6.18 Facility-Based Crisis Intervention Personnel Manual and Personnel Files**

**Note: this section is draft and subject to finalization by DHSS**

Each program shall develop and maintain a personnel manual that includes:

1. Staff rules of conduct consistent with due process including:
  - a. Examples of conduct that constitute grounds for disciplinary action;
  - b. Examples of unacceptable performance that constitute grounds for disciplinary action.

2. Policies and procedures on mental health, and alcohol and drug abuse problems of staff (including staff member assistance policies and procedures).
3. Safety and health of staff, including:
  - a. Rules about any required medical examinations and rules about communicable diseases that could affect the health or safety of the program's clients or staff.

Each program shall maintain a separate personnel file for each staff member in a manner that ensures the privacy of program staff. The personnel file shall include at a minimum:

1. The name and telephone number of a person the agency can contact in an emergency;
2. The current job title and job description signed by the staff member;
3. An application for employment signed by the staff member or a resume;
4. A copy of the staff member's license or certification;
5. The results of reference investigations and verification of experience, training and education, including:
  - a. Primary source verification of the staff member's educational degree certificate(s), based on job description;
  - b. Primary source verification of the staff member's license(s), and/or certification(s), as applicable, based on job description;
  - c. A statement signed by the staff member acknowledging that s/he understands the requirements of 42 USC §290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
  - d. Records documenting all required staff member health clearances, including any medical test results required.

## 6.19 Facility-Based Crisis Intervention State Training and Supervision

**Note: this section is draft and subject to finalization by DHSS**

Each program shall have an orientation curriculum to ensure all staff is familiar with the program policies and procedures, and have a working knowledge of at least the following:

1. Personnel policies and procedures, regarding the health and safety of staff;
2. Program policies and procedures regarding the reporting of cases of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904, 910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6), including non-retaliation policies when personnel report abuse and neglect;
3. Program policies and procedures regarding client's rights;
4. Program policies and procedure regarding the training of all staff regarding culturally competent practices;
5. Program policies and procedures regarding the obligation to report violations of law and applicable codes of ethics to the appropriate certification and/or licensure boards; and
6. All staff, trainees and volunteers shall receive training within the first year of employment about:
  - a. Hepatitis;
  - b. HIV/AIDS;
  - c. Tuberculosis;
  - d. Other sexually transmitted diseases; and
  - e. Infection control
7. Instruction and training in the elements of the fire plan.

Each program shall have an on-going training curriculum:

1. Certified peers and CI specialists must receive training and regularly scheduled clinical supervision from a person meeting the qualifications of a LBHP, APN, NP, or physician with experience regarding this specialized mental health service.

2. Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually.
3. Training shall be provided on a continuing basis and shall include, but not be limited to, orientation to the screening system, provisions contained within the screening law, explanation of mental illness, CI skills, systems interaction and transportation.

## 6.20 Facility-Based Crisis Intervention Client Rights

**Note: this section is draft and subject to finalization by DHSS**

1. All programs shall ensure that clients' rights are fully protected as enumerated in Del.C. §2220 and include the following:
  - a. To be free from retaliation for exercising any enumerated right.
  - b. To be free from abuse, mistreatment and neglect, as proscribed by Title 16, Chapters 9 and 11 of the Delaware Code;
  - c. To be free from unjustifiable force, as defined by 11 Del. C. § 468;
  - d. To be free from seclusion, physical restraint, drugs or other interventions administered primarily for purposes of staff convenience; provided, however, that restraint or seclusion may be administered pursuant to and documented contemporaneously by the written order of an authorized, licensed mental health professional to the extent necessary to prevent physical harm to self or others. Consistent with Title 16, Chapter 51 of the Delaware Code, Administration of restraint shall include the following safeguards:
    - i. Authorizing orders shall specify the form, duration, and conditions of restraint based on a deliberative determination that the restraint is the least restrictive alternative intervention to prevent physical harm to the patient or others;
    - ii. The client shall receive a medical examination within an hour of initiation of restraint by a physician, or, if a physician is not available, a nurse;
    - iii. During the course of restraint the client shall be closely monitored to assess well-being and facilitate prompt discontinuation of restraint when no longer necessary to prevent physical harm to the patient or others;
    - iv. Subsequent to administration of restraint, an interactive clinical assessment shall be undertaken, which includes the client, and, at the request of the client, a representative of the protection and advocacy agency, to review catalysts resulting in the necessity of the restraint and appropriateness of revision to the treatment plan.
  - e. To be assured that any incident of abuse; neglect or mistreatment will be reported;
  - f. To file a grievance or complaint with the program in accordance with its policy and procedures. Procedures for receiving, investigating, hearing, considering, responding to and documenting grievances shall:
  - g. Include a procedure for receipt of grievances from clients or persons acting on their behalf;
  - h. Provide for the investigation of the facts supporting or disproving the grievance;
  - i. Identify the staff responsible for receipt and investigation of grievances;
  - j. Be posted in a public place;
  - k. Participate, and/or have others of his/her choice participate, in an informed way in the grievance process;
  - l. To be informed that participation in treatment is voluntary, except as provided in 16 Del.C. §§2211, 2212, 2213 and 2215;
  - m. To refuse service, except as provided in 16 Del.C. §§2211, 2212, 2213
  - n. To communicate with legal counsel;

- o. To confidentiality of all records, correspondence and information relating to assessment, diagnosis and treatment in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
- p. To review his/her own records in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164. Client request for review and a summary of the review if granted shall be documented in the client's record.
- q. Not deny any person equal access to its facilities or services on the basis of race, color, religion, ancestry, sexual orientation, gender expression, national origin, or disability.
- r. Not deny any person equal access to its facilities or services on the basis of age or gender.
- s. Ensure that the program complies with the federal Americans with Disabilities Act, 28 U.S.C. §§12101 et seq. and 28 Code of Federal Regulations, Part 36 (July 1991) and 16 Del.C. §2220.

## **6.21 Facility-Based Crisis Intervention Quality Assurance**

**Note: this section is draft and subject to finalization by DHSS**

All CI programs shall:

1. Have a written quality assurance plan that provides for the periodic review of clinical services to include the provision of culturally competent services including:
  - a. Professional services;
  - b. Administrative services;
  - c. Infection Control; and
  - d. Environment of Care.
2. Develop and implement performance indicators and assess outcome measures.
3. Provide a mechanism to collect opinions from service recipients, personnel and other stakeholders (e.g., law enforcement, hospitals) regarding the quality of service provided.
4. Conduct a needs assessment at a minimum of every five (5) years to inform staffing patterns and types of services to be provided.

## **6.22 Facility-Based Crisis Intervention Hours of Operation, Staffing and Staff Schedules**

**Note: this section is draft and subject to finalization by DHSS**

1. CI programs shall operate seven (7) days per week, twenty-four (24) hours per day and maintain twenty-four (24) hour per day CI capability.
2. Develop a plan for transporting consumers, in accordance with all applicable Federal and State laws. This plan shall include transportation between crisis programs and transportation from these services to an appropriate treatment facility (for example, psychiatric facility, psychiatric unit of a general hospital, special psychiatric hospital once identified).
3. Facility-based programs must provide capacity to receive individuals in crisis with 24-hour capability, for the purpose of assessment, intensive supervision, medication monitoring and crisis stabilization.
4. Each crisis program shall be supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law. A licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law (e.g., an LBHP, physician, NP or APN) shall be available for consultation and able to recommend treatment twenty-four (24) hours per day, seven days a week to the CI program.
5. Facility-based programs shall be staffed at all times with:
  - a. Psychiatrist/NP;
  - b. Nurses;
  - c. LBHPs;

- d. Certified peers;
- e. Credentialed mental health screeners;
- f. CI specialists; and
- g. Constables (as needed for security).

## 6.23 Facility-Based Crisis Intervention Crisis Intervention Activity Definition

**Note: this section is draft and subject to finalization by DHSS**

CI programs provide CI services to a beneficiary who is experiencing a behavioral health crisis. CI services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution, and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. CI programs also provide consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating knowledge about and access to mental health crisis services. All services delivered during a crisis must be provided by qualified staff under a certified program.

All activities must occur within the context of a potential or actual behavioral health crisis. The CI services should follow any established crisis plan already developed for the beneficiary, if it is known to the team, as part of an individualized treatment plan to the extent possible. The CI activities must be intended to achieve identified care plan goals or objectives. CI programs shall provide the four activity components outlined above and explained here in more depth:

1. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. The Assessment by qualified staff, includes:
  - i. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. This includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. This may include an evaluation of any person found within the service area of the center to determine the need for community-based services, PROMISE program eligibility or inpatient or involuntary psychiatric care and treatment. Assessment of the crisis situation and identification of stabilization, diversion and support services needed and/or screening for commitment.
  - ii. The assessment of risk, mental status, and medical stability must be completed by a credentialed mental health screener, LBHP, APN, NP, or physician with experience regarding this specialized mental health service, practicing within the scope of their professional license or certification.
  - iii. Facility-based CI programs shall initiate the assessment within 1 hour of admission and complete that assessment within 4 hours of admission. The evaluation shall be completed sooner if necessary to provide inpatient or involuntary psychiatric care and treatment.
2. Short-term CI including crisis resolution and de-briefing with the identified Medicaid beneficiary. Short-term CI, including:
  - i. Crisis resolution and de-briefing with the beneficiary;
  - ii. Provision of emergency and consensual treatment to the person receiving the assessment;
  - iii. Crisis/early intervention counseling; and

- iv. Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis.
  - v. Medication monitoring, which shall include medication for the purpose of crisis stabilization. Medication shall be administered in accordance with state law and shall not be given to consumers in non-emergency situations without their consent. There shall be no administration of prescription or non-prescription medications until qualified medical personnel have examined the client, or qualified medical personnel have been consulted.
  - vi. Development of a treatment/crisis plan based on the assessment if one is not already in place.
  - vii. Development of a discharge plan based on individual needs and a crisis plan, if one is not already in place.
3. Follow up with the individual, and as necessary, with the beneficiary's caretaker and/or family member(s) to determine the need for any further services or referral to any services. Arranging for linkage, transfer, transport, or admission as necessary for beneficiaries at the conclusion of the CI service including referral to psychiatric and other community services, when appropriate.
    - i. This includes referral via personal contact to the most appropriate, least restrictive treatment setting indicated, linkage and follow-up in order to maintain contact with all consumers until they are engaged in another service licensed by the appropriate authority, where applicable, or are no longer in crisis;
    - ii. Initiation of involuntary commitment proceedings, where appropriate consistent with state law.
  4. Consultation with a physician or with other qualified providers to assist with the beneficiary's specific crisis.

## 6.24 Facility-Based Crisis Intervention Clinical Records

**Note: this section is draft and subject to finalization by DHSS**

Programs shall maintain a record for each client that is accurate, legible and signed by the staff member who provided the service.

Facility-Based CI programs shall:

1. Maintain a standardized client record-keeping system, with client records that are uniform in format and content and includes (to the extent applicable and possible):
  - a) Date and time of admission;
  - b) Beneficiary name, address, telephone number, gender, and date of birth;
  - c) The client's significant medical history documenting:
    - i) Current medical conditions;
    - ii) Any medications the client is currently taking; and
    - iii) Allergies.
  - d) The name and telephone number of the person to contact in an emergency;
  - e) Appropriate Consent to Release Information forms;
  - f) Acknowledging receipt of the notice of clients' rights;
  - g) Acknowledging his/her understanding of the agency's agreement with the confidentiality requirements;
  - h) Copies of any laboratory reports and drug tests ordered by the program;
  - i) Informed consent regarding prescribed pharmacotherapy obtained from the client prior to delivery of the medication prescription;
  - j) Assessment;
  - k) Treatment/Crisis Plan (if not already developed);
  - l) Progress notes;
  - m) Discharge plan; and

- n) Discharge summary.
- 2. Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff.
- 3. Update each record within twenty-four (24) hours of delivery of a service.

## **6.25 Facility-Based Crisis Intervention Facility Standards**

**Note: this section is draft and subject to finalization by DHSS**

Facility-based programs shall:

1. Provide privacy for communications between clients and staff members;
2. Provide waiting areas and meeting spaces that are welcoming to diverse populations and cultures;
3. Include rest rooms for clients, visitors and staff;
4. Maintain up-to-date documentation verifying that they have a certificate of occupancy and meet applicable federal, state and local building, zoning, fire, and safety and accessibility requirements;
5. Maintain facilities in neat and clean condition, and eliminate any hazardous conditions that endanger the health or safety of clients, visitors or staff;
6. Not permit tobacco use in program facilities;
7. Display up to date certificates or approval/inspection by Fire Department authorities whenever this is required/available in the specific community where the program is located;
8. Establish a plan of action in the event of emergencies or disasters, based on the program's capability and limitations. The plan shall include provisions:
  - a) For responding to severe weather, loss of power or water or other natural disasters;
  - b) For evacuation plans with specific primary and alternative evacuation routes;
  - c) For posting evacuation routes in areas visible to staff, clients and visitors;
  - d) For responding to accidents that result in injury or death;
  - e) Governing how available resources will be used to continue client care;
  - f) Governing how the program will effectively activate community resources to prevent or minimize the consequences of a disaster;
  - g) Concerning staff preparedness and the designation of roles and functions;
  - h) Concerning criteria for the cessation of nonessential services and client transfer determinations; and
  - i) Governing how it will protect the safety of clients and staff and the security of its records.

## **6.26 Facility-Based Crisis Intervention Amount, Duration, and Scope**

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

CI services by their nature are crisis services and are not subject to prior approval. CI services are authorized for no more than 23 hours per episode. Activities beyond the 23 hour period must be prior authorized by the State or its designee. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within 24 hours of a previous episode, it shall be considered part of the previous episode and a new episode will not be allowed.

Providers receiving referrals to visit individuals at home following a visit to an emergency rooms will bill only the follow-up HCPCS codes. Providers visiting individuals discharged from a site-based program within 24 hours is considered reimbursement within in the original 23 hour charge. If a site-based program bills using the 15-minute unit, the program's reimbursement may not exceed the site-based per diem rate in a 24 hour period (e.g., five 15-minute units are roughly equal to one per diem).

Service components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary are not eligible for Medicaid reimbursement.

## **6.27 Reimbursement for Crisis Intervention Behavioral Health Services**

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay psychologists at 100% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5. If a Medicare fee exists for a defined covered procedure code, then Delaware will pay LCSWs, LPCMH, LMFTs at 75% of the Medicaid physician rates as outlined under Attachment 4.19-B, item 5.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of October 2, 2013, and is effective for services provided on or after that date. All rates are published on the DMAP website at [www.dmap.state.de.us/downloads/hcpcs.html](http://www.dmap.state.de.us/downloads/hcpcs.html).

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses, benefits, employer taxes (e.g., FICA, unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

## 6.28 Facility-Based Crisis Intervention Coding

HCPCS Code	Modifier		Provider Qualification	Tx Context	Description	Units	Rate Per	
	(1)	(2)					¼ hour	Diem
S9485				Ind.	CI mental health services, per diem.	Per Diem		\$766.52