Delaware Department of Health and Social Services
Division of Substance Abuse and Mental Health

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Adult Behavioral Health Service Certification and Reimbursement Manual

Table of Contents

Table of Contents 2
Introduction 7
Provider Qualifications 8
Guidance for Clinicians 8
Taxonomy Codes 8
Allowed Modes of Delivery 9
Limitations and Exclusions 9
Additional Service Criteria 10
Telemedicine 11
Confidentiality, Privacy and Electronic Security 12
Contingency Planning 12
Informed Consent 13
Exception for Involuntary Detention and Commitment 13
Provider Enrollment Requirements for Telemedicine 13
Originating Site Providers 13
Distant Providers 14
General Telemedicine Requirements and Limitations 15
Prescribing Medications via Telemedicine 15
Stimulants, Narcotics and Refills 15
Billing for Covered Services 16
Service Limitations 16
Service Authorization Requirements 16
Audits of Telemedicine Services 16
Non-Covered Services 17
Addiction Services 18
Substance Use Disorder and Addiction Services 18
Service Limitations 19
Changes in Levels of Care Within the Same Program 20
Provider Qualifications for SUD and Addiction Services 20
Physicians 20
Licensed Practitioners 21

Medical Directors 21
Unlicensed Certified and Credentialed Staff 21
Qualified Health Providers 21
Certified Peer Recovery Specialists 21
Licensed Chemical Dependency Professionals 22
Behavioral Health Technicians 22
Other Unlicensed Practitioners 22
Behavioral Health Technician Credentialing 23
Requirements for Behavioral Health Technicians 23
Supervision 24
Credentialing 24
Taxonomies 24
Outpatient Services 25
Addiction Assessment and Referral 25
Staffing 26
ASAM Level 1 Outpatient Services 26
Definition and Setting 26
Support Systems 26
Staffing 27
Therapies 27
Screening/Assessment/Recovery Plan Review 28
Documentation 28
Admission Guidelines 28
Outpatient Treatment ASAM Level – OTP 30
Definition and Setting 30
Provider Qualifications 30
Support Systems 30
Staffing 31
Therapies 31
Screening/Assessment/Treatment Plan Review 32
Documentation 32
Admission Guidelines 33
Intensive Outpatient Services ASAM Level 2.1 34

Definition and Setting 34
Support Systems 34
Staffing 34
Therapies 35
Screening/Assessment/Treatment Plan Review 35
Documentation 35
Admissions Guidelines 36
Billing Guidance 37
Partial Hospitalization Services ASAM Level 2.5 38
Definition and Setting 38
Support Systems 38
Staffing 39
Therapies 39
Screening/Assessment/Treatment Plan Review 40
Documentation 40
Admissions Guidelines 40
Billing Guidance 41
Ambulatory Withdrawal Management with Extended Onsite Monitoring ASAM Level 2 43
Definition and Setting 43
Support Systems 43
Staffing 44
Therapies 45
Screening/Assessment/Treatment Plan Review 45
Documentation 46
Admission Guidelines 47
Billing Guidance 47
Residential Substance Use Disorder Services 49
Clinically Managed Low-Intensity Residential Treatment Services ASAM Level 3.1 49
Definition and Setting 49
Support Services 49
Staffing 49
Therapies 50
Screening/Assessment/Treatment Plan Review 51

Documentation 51
Admission Guidelines 51
ASAM Level 3.5 Clinically Managed High-Intensity Residential Services 54
Definition and Setting 54
Support Systems 54
Staffing 54
Therapies 55
Health education services 55
Screening/Assessment/Treatment Plan Review 56
Documentation 56
Admission Guidelines 56
Medically Monitored Intensive Inpatient Services ASAM Level 3.7 and Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7-WM 60
Definition and Setting 60
Support Systems 60
Staffing 60
Therapies 61
Documentation 62
Admission Guidelines 62
Inpatient Services ..... **Error! Bookmark not defined.**
Medically Managed Intensive Inpatient Services ASAM Level 4 ..... **Error! Bookmark not defined.**
Reimbursement for SUD and Addiction Services 64
Guidance 65
Reimbursement and Coding Summary 65
Crisis Intervention Services 66
Consumer Participation Criteria 66
Staffing and Provider Qualifications 67
Certification 68
Mobile Crisis Intervention Services 68
Mobile Crisis Intervention Activity Definition 68
Mobile Crisis Intervention Policies and Procedures 69
Mobile Crisis Intervention Personnel Manual and Personnel Files 69
Mobile Crisis Intervention State Training and Supervision 70

Ongoing Training 70
Mobile Crisis Intervention Client Rights 71
Mobile Crisis Intervention Quality Assurance 71
Mobile Crisis Intervention Hours of Operation, Staffing and Staff Schedules 71
Mobile Crisis Intervention Clinical Records 73
Mobile Crisis Intervention Amount, Duration, and Scope 74
Reimbursement for Crisis Intervention Behavioral Health Services 74
Appendix A:1 Allowable HCPCS Codes Per ASAM Level 1.0 76
Appendix A:2 : Allowable HCPCS Codes for ASAM Level 1.0 with OTP 86
Appendix C: Modifier Codes and Descriptions 124
Appendix D: Place of Service Codes and Descriptions 125
Appendix E: Individual Behavioral Health Technician Credentialing Attestation Form 127
Appendix F: Agency Annual Behavioral Health Technician Credentialing Attestation Form 128
Appendix G: DSAMH Utilization Management Common Criteria for All Levels of Care 130
Purpose 130
Policy Statement 130
Definitions 130
Scope 131
Procedures/Responsibilities 131
DSAMH Eligibility Criteria 131
Common Criteria for All Levels of Care: 132
Common Clinical Best Practice Criteria for All Levels of Care 133
Policy Lifespan 134
Resources 134

Introduction

This manual is intended to provide explanatory information for Delaware Department of Health and Social Services (DHSS) and the public regarding services and reimbursement for the treatment of substance use disorders reimbursed through the Division of Substance Abuse and Mental Health (DSAMH). This manual is applicable to any provider licensed to provide substance abuse treatment and certified to bill Medicaid by the Division of Substance Abuse and Mental Health (DSAMH).

Programs are certified under State law per Delaware Administrative Code Title 16, Chapter 22, and are certified by DSAMH in coordination with Medicaid authority. When a program is not required to be licensed under State law, the program must be certified by DSAMH in coordination with Medicaid authority. All Substance Use Disorder treatment programs must have both licensure and certification regardless of whether they bill DSAMH or Medicaid fee for service. Mobile Crisis and Facility Based Crisis only require DSAMH Medicaid Certification verification. The program is responsible for enrolling in Delaware Medical Assistance Portal once it has the required licensure and pre-certifications through DSAMH Provider Enrollment and maintain renewals as necessary.

Service reimbursement rates in this manual apply to services rendered by DSAMH-contracted providers billing DSAMH and DSAMH-contracted providers billing fee for service (FFS) Medicaid. These rates do not apply to non-DSAMH contracted providers billing traditional Medicaid (FFS) or managed care organizations (MCO).

Providers and individual practitioners are responsible for adhering to all billing requirements. Failing to do so and submitting false claims is considered fraud and may be prosecuted by the appropriate authorities.

Note: As of September 2024, the reimbursement rates in this manual do not reflect the 2024 American Society of Addiction Medicine (ASAM) changes. A modified manual with those changes will be issued once ASAM updates are integrated into billing codes.

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 use disorder (SUD) acting within the scope of all applicable State laws and their professional license. A LBHP includes professionals licensed to practice independently:

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

To provide DSAMH-only funded services, an LBHP must have a contract award.

To provide Medicaid, an LBHP must be enrolled as a current individual provider through the Delaware Medicaid Assistance Portal for Providers (DMAP). All licensed SUD programs must enroll in DMAP. Every program should have Medicaid certification and licensure for SUD.

All License holders may be practicing independently or within an addiction treatment and co-occurring SUD clinic licensed by the State of Delaware. Credentialed only staff (CADCs) must be employed within an addiction treatment and co-occurring SUD clinic licensed by the State of Delaware. LBHPs may be practicing independently or within an addiction treatment or co-occurring SUD 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 disorders.

Credentialed-only staff, Certified Alcohol and Drug Counselors (CADCs) are qualified Behavioral Health Professionals that can perform duties under their scope of practice within a State licensed program.

Guidance for Clinicians

Psychiatrists are covered under the physician section of the State Plan. 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 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 are noted in the rate sheet.

Taxonomy Codes

Taxonomy codes are unique 10-digit codes that designate your professional classification and specialization. Providers use these codes when applying for a National Provider Identifier (NPI). Taxonomy codes are different from the two-digit place of service code set CMS uses to specify the entity where services are rendered.

These are common taxonomy codes used on LBHP professional claims:

- 103T00000X – Psychologist
- 103TF0000X – Psychotherapy Group
- 101Y00000X – Clinical Social Worker
- 101YM0800X – Mental Health Counselor
- 103TF0000X – Marriage Counselor

Allowed Modes of Delivery

- Individual
- Family
- Group
- Onsite
- Off-site
- Telemedicine

Limitations and Exclusions

All services must be medically necessary. Services exceeding the initial authorization limitation must be approved for re-authorization prior to service delivery. The provider must 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 and/or 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 working in supervision to obtain licensure and billing for services rendered. Services provided 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 Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (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 excluded from participation in federal healthcare 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.

Additional Service Criteria

The services provided by other licensed practitioners in the State Plan listed below have an initial authorization level of benefit. Services that 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 5 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)

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

Telemedicine

The Delaware Medical Assistance Program (DMAP) covers medically necessary health services furnished to eligible DMAP members as specified in the Medicaid State Plan. To help recipients receive medically necessary services, DMAP allows for telemedicine delivery for providers enrolled under Delaware Medicaid.

Telemedicine services under DMAP are subject to specifications, conditions and limitations set by the State.

Telemedicine is the use of medical or behavioral health information exchanged from one site to another via an electronic interactive telecommunications system to improve an individual's health.

Telemedicine services are provided with specialized equipment at each site including real-time streaming via the use of:

- Video camera
- Audio equipment
- Monitor

If the patient is not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection, audio only is permitted when necessary to prescribe all medications with the exception of Methadone.

Telecommunications must permit real-time encryption of the interactive audio and video exchanges with the consulting provider.

The patient (and referring provider, if present), are in one location called the originating site. The healthcare practitioner or consulting physician is in another location called the distant site.

- **Distant Site** means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via the interactive telecommunications system. All distant site consulting providers must be enrolled in DMAP or a DMAP MCO to be reimbursed for the professional services provided. Facility fees for the distant site are not covered.
- **Originating Site** means the facility in which the patient receiving Medicaid billable services is located at the time the telemedicine service is being furnished. Tele-presenters may be needed to facilitate the delivery of this service. All originating site providers must be enrolled in DMAP or in a DMAP MCO to be reimbursed for the services provided. A facility fee for the originating site is covered.

  An approved originating site may include the DMAP member's place of residence, day program, or alternate location in which the member is physically present, and telemedicine can be effectively utilized. A facility fee may not be appropriate in all settings. An example is the patient's home.

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
- Billing practices and requirements

The referring provider is the medical professional of record or medical staff person reporting to the supervising professional who has evaluated the recipient, determined the need for consultation, and arranged the services of the consulting provider (distant provider) for the purpose of diagnosis and treatment.

The referring provider is not required to be present at the originating site but may be present, as medically necessary. The referring provider will only be paid when providing a separately identifiable covered service. The referring provider's medical records must document all components of the service being billed.

The consulting or distant provider is the provider who evaluates the recipient via the telemedicine mode of delivery upon recommendation of the referring provider. Treatment is initiated as needed.

An interactive telecommunications system is required as a condition of payment. An interactive telecommunications system is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site.

Services provided via communications equipment that does not meet this definition, or that is non-secure and non-compliant with the Health Insurance Portability and Accountability Act (HIPAA), are not covered. Secure videoconferencing via personal computers, tablets or other mobile devices may be considered to meet the requirements of telemedicine where it can be demonstrated that the use of the devices and the individual setting comply with this DMAP telemedicine policy.

Asynchronous or "store and forward" technology applications, which transfer data from one site to another using a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation, do not meet the DMAP definition of telemedicine. Information is not permitted to be stored in any format for future use.

Confidentiality, Privacy and Electronic Security

The provider must implement confidentiality protocols that comply with all HIPAA requirements and include, but are not limited to:

- All telemedicine transmissions must be performed on a dedicated secure line or must utilize an acceptable method of encryption which protects the confidentiality and integrity of the information being transmitted.
- Specifying the individuals who have access to electronic records.
- Usage of unique passwords or identifiers for each employee or other person with access to the patient records.
- Ensuring a system to prevent unauthorized access, particularly via the internet.
- Ensuring a system to routinely track and permanently record access to such electronic medical information.
- Ensuring that both the originating site and distant site are secure, private locations that protect the confidentiality of the patient and the telecommunications exchanged between the two sites.

These protocols and guidelines must be available for inspection at the telemedicine site and to DMAP upon request.

Contingency Planning

All telemedicine sites must have a written procedure detailing a contingency plan for when a failure or interoperability of the transmission or other technical difficulties render the service undeliverable.

Telemedicine delivered services are not billable to DMAP or managed care organizations (MCOs) when technical difficulties preclude the delivery of part or all of the telemedicine session.

Informed Consent

The referring, consulting, or distant provider should obtain written consent from the patient agreeing to participate in services delivered via the means of telemedicine. The patient has the right to refuse these services at any time and must be made aware of any alternatives, including any delays in service, the need to travel, or risks associated with not having services provided via telemedicine. The format used by the consulting provider to obtain written consent is left to the provider but must be maintained in the patient's records and must identify that the covered medical service was delivered by telemedicine.

Exception for Involuntary Detention and Commitment

Where a DMAP recipient is involuntarily detained or committed to a facility for care, obtaining patient consent may be impracticable. In these instances, delivery of care via telemedicine should continue to meet all other telemedicine policy requirements and all normal DMAP criteria for patient safeguards and confidentiality. Exceptions to informed consent end upon the discharge of the recipient from any facility where the patient was involuntarily detained.

Provider Enrollment Requirements for Telemedicine

All telemedicine providers, including out-of-state providers, must be enrolled with DMAP or have contractual agreements with the MCOs and have a National Provider Identifier Number (NPI) and taxonomy code. Also, providers must not currently be excluded from participating in Medicaid or Medicare by state or federal sanction. Telemedicine providers may also need to enroll with the Division of Substance Abuse and Mental Health services, as appropriate, to provide and be reimbursed for behavioral health services.

To receive payment for services delivered through telemedicine technology from DMAP, healthcare practitioners must:

- Act within their scope of practice per DSAMH licensure and certification
- Be licensed (in Delaware, or the state in which the provider is located if exempted under Delaware State law to provide telemedicine services without a Delaware license) for the service for which they bill DMAP.
- Be enrolled with DMAP/MCOs.
- Be located within the continental United States.
- Be credentialed by the Delaware Division of Medicaid & Medical Assistance (DMMA)-contracted MCOs, when needed.
- Submit a DMMA Disclosure Form.

Originating Site Providers

Originating site providers include:

- Medical Facility Sites:
    - Outpatient Hospitals
    - Inpatient Hospitals

    - Federally Qualified Health Centers
    - Rural Health Centers
    - Renal Dialysis Centers
    - Skilled Nursing Facilities
    - Outpatient Mental Health/Substance Abuse Centers/Clinics
    - Community Mental Health Centers/Clinics
    - Public Health Clinics
    - Program of All-Inclusive Care for the Elderly (PACE) Centers
    - Assisted Living Facilities
    - School-Based Wellness Centers
- Patient's Home (must comply with HIPAA, privacy, secure communications, etc., and does not warrant an originating site fee)
- Other sites as approved by the DMAP Medical Professional Sites:
    - Physicians (or Physicians Assistants under the supervision of a physician)
    - Certified Nurse Practitioners
- Others: Medical and Behavioral Health Therapists

There are no geographical limitations within Delaware regarding the location of an originating site provider.

Distant Providers

Distant providers include:

- Inpatient/Outpatient Hospitals (including Emergency Rooms/Departments)
- Physicians (or Physicians Assistants under the physician's supervision)
- Certified Nurse Practitioners
- Nurse Midwives
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors of Mental Health
- Speech/Language Therapists
- Audiologists
- Other providers as approved by DMAP

General Telemedicine Requirements and Limitations

- The recipient must be present in the Originating Site.
- The service must be medically necessary, written in the patient's recovery plan, and follow generally accepted standards of care.
- The service provided by the distant provider must be a service covered by DMAP.
- Distant providers cannot be self-referring providers.
- The recipient must be able to verbally communicate, either directly or through a representative, with the originating and distant site providers, must be able to receive services via telemedicine, and must have provided consent for the use of telemedicine. Consent is required to ensure that the recipient is a willing participant in the telemedicine delivered service and to ensure they own their recovery plan.
- Prior approval for telemedicine-delivered services is not required but the Distant Site provider must obtain prior approval for any other covered services that would normally require prior approval.
- The Distant Site provider must be located within the continental United States; Federal regulations preclude payment to providers using banking institutions located outside of the U.S.
- Claims must be completed and submitted according to DMAP billing instructions.
- The same procedure codes and rates apply as do for services delivered in person (enrolled providers will bill Usual and Customary).
- All service providers are required to develop and maintain written documentation in the form of evaluations and progress notes, the same as if originated during an in-person visit or consultation, including the mode of communication (telemedicine). Providers may opt to use electronic medical records in place of paper-based written records.
- All interactive video telecommunication must comply with HIPAA patient privacy and confidentiality regulations at the site where the patient is located, the site where the consultant is located, and in the transmission process.

Prescribing Medications via Telemedicine

Stimulants, Narcotics and Refills

Hard copy prescriptions can be written and sent via delivery service to the referring site for the consumer to pick up a couple of days after the appointment; however, this lag can be overcome by carefully planning appointments to coincide with the refill cycle. The consulting provider writing the prescription should be available to manage emergencies or any prescription gaps between appointments. The originating site must be able to connect with the consulting provider outside of "telemedicine transmission hours."

For access to care between telemedicine visits, including emergency and urgent care, patients should contact the referring provider or specialist, as appropriate.

Any of the following models may be used to provide for prescribing medications through telemedicine:

- **Model 1:** The distant provider consults with the referring physician (if present during the telemedicine session or by other means) about appropriate medications. The referring provider then executes the prescription locally for the patient
- **Model 2:** The consulting physician works with a medical professional at the originating site to provide frontline care, including writing prescriptions. This method is common at mental health centers. The

medical professional must be available on site to write the prescription exactly as described by the consulting physician.

- **Model 3:** The consulting physician directly prescribes and sends/calls-in the initial prescription or refill to the patient's pharmacy.

Billing for Covered Services

The Distant Provider or Consulting Provider (site without the patient) will bill the appropriate CPT code reflecting the service provided using the "GT" modifier to indicate a telemedicine service was performed. Typically, the distant provider will bill codes for consultations, office or outpatient visits, psychotherapy, medication management, psychiatric interview or examination, substance abuse screening and brief interventions, neurobehavioral examination, end stage renal disease services, medical nutrition therapy, etc. The GT modifier will not affect payment in any way.

The Originating Site Provider (site with the patient present) will bill a facility code of either:

- CPT code Q3014 when the originating site is a physician's office or similar setting.
- CPT code Q3014 along with Revenue Center codes 078 (telemedicine) and/or 0789 (other telemedicine services) when the originating site is located in a hospital or other similar facility setting.

These coding values indicate that the service was provided via telemedicine. Providers should continue to bill their appropriate Usual & Customary charge for the service provided.

Please refer to the DMAP website at http://www.dmap.state.de.us/home/index.html for updates on DMAP policy and current fee reimbursement.

Service Limitations

Up to three different consulting providers may be reimbursed for separately identifiable telemedicine services provided to a recipient per date of service. Only one facility fee is allowed per date, per patient. There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable covered service. Medical records must document that all components of the service being billed were provided to the recipient.

Service Authorization Requirements

Telemedicine is not a medical service and does not require prior authorization. Where a covered medical service does require prior authorization, the distant provider must submit the PA request and must be approved prior to the delivery of the medical service via the means of telemedicine.

Audits of Telemedicine Services

Services billed that indicate telemedicine as the mode of service delivery but are not substantiated by the claim form or written medical records are subject to disallowances in an audit.

Non-Covered Services

Providers will **not** be reimbursed for:

- Costs to establish an originating site or to purchase telemedicine equipment use or upgrade of telemedicine technology
- Transmission charges
- Charges of an attendant who instructs a patient on the use of the equipment
- Charges of an attendant who supervises/monitors a patient during the telehealth encounter
- Chart reviews
- Telephone calls since they do not involve direct, in-person patient contact.
- Internet services for online medical evaluations since they do not involve direct, in-person patient contact
- Electronic mail messages or facsimile transmissions between a healthcare practitioner and a patient or an individual consultation between two healthcare practitioners

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.

Addiction Services

Addiction services[1] include an array of person-centered outpatient and residential services consistent with the patient's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder or gambling disorder symptoms and behaviors. Hereinafter, throughout this manual, whenever substance use or substance use disorder (SUD) is referenced, gambling disorder (an addiction disorder recognized under the most current version of the DSM), may be used as an eligible condition for purposes of certification and reimbursement for services.

Substance Use Disorder and Addiction Services

Addiction services are provided as part of a comprehensive specialized program available to all clients covered by Medicaid and DSAMH with significant functional impairments resulting from an identified SUD diagnosis. Services must be medically necessary and must be recommended by a licensed practitioner or physician, acting within the scope of their professional licensure and applicable State law, to promote the maximum reduction of symptoms and/or restoration of the patient to their best age-appropriate functional level according to an individualized recovery plan.

The comprehensive specialized program includes assessment, development of a recovery plan, and referral and assistance as needed for the patient 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 patient's family, friends, and other community members to cultivate the patient's natural support network, to the extent that the patient has provided permission for such coordination.

The activities included in the service must be intended to achieve identified recovery plan goals or objectives. The recovery plan should be developed with the active participation of the patient and reflect their goals and desires for services. Family, members of the support network, and collateral providers should participate as appropriate.

The recovery plan should identify the services intended to reduce the identified condition and the anticipated outcomes of the patient. The recovery plan must specify the frequency, amount, and duration of services. The recovery plan must be signed by the licensed practitioner or physician responsible for developing the plan with the patient and any other persons included in the development of the recovery plan.

[1] 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.

The recovery plan should address barriers to engagement in services and strategies to reduce those barriers. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The recovery plan review should involve the patient, family, supports and collateral providers, and include a reevaluation of the plan to determine whether services have contributed to meeting the stated goals consistent with all relevant State and federal privacy requirements. Recovery plans should be reviewed and updated as the patient's progress or recovery status changes and reflect the strengths, needs, abilities, and preferences of the patient.

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

Service Limitations

Work Sites

Services provided at a work site must not be job task oriented and must be directly related to treatment of a patient'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 patient receiving covered services (including housekeeping, shopping, childcare, and laundry services) are non-covered.

Institutes for Mental Disease

Services cannot be provided in an Institution for Mental Disease (IMD) with more than 16 beds. Room and board are 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. Please see Policy 54 in Appendix G.

Peer-run 12-step Programs

12-step programs run by peers are not reimbursable by DSAMH or Medicaid.

Residential SUD

No more than one per diem rate may be billed a day for residential SUD programs. 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.

Justice System

Assessments and testing for patients not in 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 patients 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 Medicaid MCO enrollees) and to Medicaid (for Medicaid FFS enrollees).

Changes in Levels of Care Within the Same Program

For programs offering both outpatient and residential care, the patient's chart must reflect admission to the program that marks the start of the current episode and any reimbursement. If the patient is in a service that is paid fee for service (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 medication assisted treatment (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 patient 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 3.7-WM section.

Provider Qualifications for 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.

Physicians

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 for addiction treatment

Intent: Prescribing clinicians who are psychiatric nurse practitioners may be utilized by a licensed and/or certified 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 for addiction treatment; and,
c. Prescribing medications permissible under law and SAMHSA regulations.

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

Licensed Practitioners

Licensed practitioners under State of Delaware regulations include (but are not limited to) LCSWs, LPCMHs, LMFTs, NPs, APNs, medical doctors (MDs and DOs), and psychologists. Effective 7/1/2016, Licensed Chemical Dependency Professionals (LCDPs) are also included in this section.

Medical Directors

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 (MDs and DOs) in addition to any other requirements specified for the specific service.

Intent: State licensure of practitioners does not drive the Medicaid reimbursement (for example, RNs are licensed but are grouped with "unlicensed staff" due to staffing costs). The description below and the services manual, codes and rates drive reimbursement in Medicaid certified programs.

Unlicensed Certified and Credentialed Staff

Any staff who is unlicensed and providing addiction services must be credentialed by DSAMH and/or the credentialing board.

Certified and Credentialed staff under State regulation for SUD services include:

- Credentialed behavioral health technicians
- RNs and LPNs
- Certified alcohol and drug counselors
- Internationally certified alcohol and drug counselors
- Certified co-occurring disorders professionals
- Internationally certified co-occurring disorders professionals
- Internationally certified co- occurring disorders professional diplomates
- Licensed chemical dependency professionals (LCDPs)

Credentialed behavioral health technicians are considered credentialed, though providers must develop their onboarding procedure to achieve this.

Qualified Health Providers

QHPs include the following professionals, registered with their respective Delaware board: LCSWs, LPCMH, LCDPs, CADCs, and LMFTs, APNs, NPs, medical doctors (MD and DO), and psychologists. Effective 7/1/2016, LCDPs and CADCs are included in the definition of a QHP.

The QHP provides clinical/administrative oversight and supervision of recovery coaches and credentialed behavioral health technicians staff consistent with their scope of practice.

Certified Peer Recovery Specialists

A CPRS must be trained and certified in the State of Delaware to provide services. A CRPS must be 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. A CPRS must self-identify as a present or former primary patient of SUD services.

Intent: A CPRS within a licensed and/or certified residential program must provide counseling consistent with an approved recovery plan. Medicaid will **not** reimburse for 12-step programs run by recovery coaches.

Licensed Chemical Dependency Professionals

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 National Association for Alcoholism and Drug Abuse Counselors (NAADAC) as either a National Certified Addiction Counselor (NCAC) or Master Addiction Counselor (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 SUD counseling.

Behavioral Health Technicians

Behavioral health technicians are unlicensed professional staff at least 18 years old with a high school or equivalent diploma trained and credentialed in ASAM techniques.

Other Unlicensed Practitioners

All other unlicensed practitioners certified by a national body must meet the requirements for credentialed behavioral health technicians and any requirements for their national certification. DSAMH recommends that gambling programs hire Gambling Counselors who are accredited by a national credentialing organization such as the National Gambling Counselor Certification Board (NCGC) or the American Academy of Health Care Providers in the Addictive Disorders (CAS).

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.
- All programs with MAT interventions must comply with federal and State laws regarding controlled substance prescriber availability.

To provide both Medicaid FFS 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 practice independently only if they are a physician in an office-based opioid treatment program or a physician treating a patient with SUD in their practice. Otherwise, all practitioners must practice within an addiction treatment clinic or co-occurring SUD clinic licensed and/or certified 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 patient capacity requested
- 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
- A description of the methodology for each service element
- Organizational charts showing incumbent names, positions, degrees, and credentials (e.g., license, certification), all vacant positions, and illustrating direct and indirect reporting and supervisory relationships.

Behavioral Health Technician Credentialing

The Credentialed Behavioral Health Technician is recognized as a member of the multidisciplinary team in outpatient and residential SUD treatment settings.

Behavioral health technicians working with patients within outpatient or inpatient SUD programs are responsible for the following:

- Education
- Informal counseling focused on goal setting and skill development for coping and managing symptoms
- Informal counseling to address lifestyle, attitudinal and behavioral problems
- Social support
- Referral and assistance with accessing resources
- Assistance with clinical recovery plan development

Requirements for Behavioral Health Technicians

DSAMH has established the following criteria to be designated a behavioral health technician. Individuals must:

- Be at least 18 years of age
- Have a high school diploma or equivalent
- Pass criminal, abuse/neglect and professional background checks
- Complete the following trainings within 30 days of hire and annually thereafter:
    - Cardiopulmonary resuscitation (CPR)
    - Basic first aid
    - Reporting suspected abuse or neglect
    - Patient rights and protections
    - Cultural competency
    - Confidentiality
    - Basic principles of recovery-oriented services and trauma-informed care (including gambling disorders for BHTs in addiction programs providing addiction services for gambling disorders)
    - ASAM criteria, including guiding principles, and levels of care
    - Co-occurring conditions and goals for integrated care
    - Person-centered recovery plan development
    - Medical records and documentation

Supervision

Behavioral health technicians must receive clinical and administrative supervision and oversight by a qualified healthcare professional (QHP). Behavioral health technicians should have access to both individual and group supervision.

Credentialing

All credentialed behavioral health technicians must practice within an SUD treatment or co-occurring SUD clinic licensed and/or certified by the State of Delaware under State law per Delaware Administrative Code Title 16.6001.

Licensure requires submission of organizational charts showing staff names, positions, degrees and credentials (e.g., license, certification) and illustrating direct and indirect reporting and supervisory relationships.

Licensed and/or certified SUD programs must maintain training documentation in each patient's personnel record within 30 days of hire and annually submit (and maintain current) documentation attesting that all employed behavioral health technicians meet the established credentialing criteria using the attached form. DSAMH reserves the right to request copies of supporting documentation. Providers must Attest to orientation and training at time of renewal of licensure or certification and submit to Policy and Compliance during the Audit engagement process.

Co-occurring clinics and SUD agencies must have agency provider qualifications (including procedures for employee training and education verification) verified through DSAMH by having a contract award from DSAMH and current provider enrollment with the Medicaid agency. As part of the clinic and agency licensure and contract monitoring, DSAMH will also verify that agencies have followed procedures for employee training and education verification.

NOTE: Most SUD agencies have a certain degree of co-occurring capacity ranging from screening to co-occurring treatment services. For this manual, co-occurring clinics are clinics that specialize in co-occurring services and meet the intensity of services as defined in ASAM Level 2.5 Partial Hospital Programs.

Please refer to Appendix E for the Individual Behavioral Health Technician Credentialing Attestation Form.

Taxonomies

DSAMH Licensed and Certified SUD programs can bill SUD codes to the extent the code is medically necessary for the patient, consistent with billing guidance, and is covered under their license:

- SUD: 261QR0405X Clinic/Center – Rehabilitation, SUD, Co-Occurring Program

Outpatient Services

Addiction Assessment and Referral

Addiction assessment and referral programs provide ongoing assessment and referral services for patients presenting with a current or past pattern of substance use or gambling-related disorders. The assessment is designed to gather and analyze information regarding a patient's current substance use and problem gambling behavior and social, medical and treatment history. The assessment provides sufficient information for problem identification and, if appropriate, treatment or referral.

The services described in this section (e.g., all ASAM Level 1 services) include referral and assistance as needed for the patient 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 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 patient's family, friends, and other community members to cultivate the patient's natural support network, to the extent that the patient 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 and/or certified 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 a patient. Qualified providers may conduct an initial screening of a patient presenting with SUD before assessing the patient.

Qualified providers shall be licensed in accordance with State licensure laws and regulations and will comply with licensing standards regarding assessment practices. Once a patient receives an assessment, a staff member shall provide the patient with a recommendation for further assessment or treatment and an explanation of that recommendation.

All programs are licensed under State law per Delaware Administrative Code Title 16, Chapter 22, and certified by DSAMH in coordination with Medicaid authority. When a program is not required to be licensed under State law, the program must be certified by DSAMH in coordination with Medicaid authority. The licensure or certification applies to all programs providing services to beneficiaries in need of programs and services for diagnosed substance use disorders.

The licensure or certification at a minimum requires:

- Documentation of all insurance coverage required in regulation
- Maximum patient capacity requested
- A copy of the agency's Delaware business license and home state license, when applicable

The licensure or certification also requires a description of the services to be provided by the program, including:

- A statement of the program philosophy, goals and objectives
- A description of the methodology for each service element
- Organizational charts showing incumbent names, positions, degrees and credentials (e.g., license, certification), all vacant positions, and illustrating direct and indirect reporting and supervisory relationships

Staffing

A licensed practitioner or certified and credentialed assessor 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 their scope of practice and expertise.

The QHP provides clinical/administrative oversight and supervision of certified Recovery Coaches and Credentialed Behavioral Health Technicians at a ratio of no greater than 1:10.

ASAM Level 1 Outpatient Services

Definition and Setting

Outpatient Level 1 services are professionally directed screening, evaluation, treatment and ongoing recovery and disease management services. Services are provided in regularly scheduled sessions, fewer than 9 hours per week, for adults in any appropriate community setting that meets State licensure standards.

All outpatient SUD treatment programs are licensed and certified under State law (Title 16, Chapter 22). 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).

The services follow a defined set of policies and procedures or clinical protocols and are designed to help the person achieve changes in their alcohol, tobacco and/or other substance use or addictive behaviors. Treatment must address major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or impair the patient's ability to cope with major life tasks without the addictive use of alcohol, tobacco, and/or other substances and/or addictive behaviors, such as gambling.

These services include individual and group counseling, family therapy, educational groups, occupation and recreational therapy, psychotherapy, addiction pharmacotherapy, or other therapies. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. Delaware ASAM criteria are used to determine appropriate medical necessity and level of care (LOC).

Support Systems

- Medical, psychiatric, psychological, laboratory and toxicology services available on-site or through consultation or referral.
- Medical and psychiatric consultation available within 24 hours by phone or, if in person, within a timeframe appropriate to the severity and urgency of the consultation requested.
- Direct affiliation with (or close coordination through referral to) more intensive levels of care and medication management.
- Emergency services available by telephone 24/7.

Staffing

- Level 1 outpatient settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, certified peer recovery specialists and credentialed behavioral health technicians operating within their scope of practice.
- Caseload size is based on needs of patients actively engaged in services to ensure effective, individualized treatment and recovery services.
- Counseling groups should not exceed 15 patients (assumed average of 9). Psycho-educational group size is not restricted.
- QHP supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff.
- A certified peer recovery specialist may lead groups and meet with patients 1:1 but would bill peer support unless also meeting certification criteria to be one of the unlicensed counselors.
- Medication management requires an independently licensed practitioner with authority to prescribe in Delaware.

Therapies

Therapies are skilled treatment services that may include:

- Individual and group counseling
- Motivational enhancement
- Family therapy
- Educational group
- Psychotherapy
- Addiction pharmacotherapy

For people with mental health conditions, the issues of psychotropic medication, mental health treatment and their relationship to substance use and addictive disorders are addressed.

Screening/Assessment/Recovery Plan Review

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. This assessment should include:

- Comprehensive bio-psychosocial assessment that substantiates appropriate patient placement completed within 14 days of admission.
    - Includes a comprehensive substance use and addictive disorders history obtained as part of the initial assessment and reviewed by a physician, per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards).
    - Reviewed and signed by a qualified professional.
    - This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate location of care and a comprehensive bio-psychosocial assessment to inform the recovery plan and on-going care.
- Documentation of a physical examination by a qualified medical professional completed within 90 days prior to admission or of a good faith effort to refer the patient for a physical and/or efforts made to obtain documentation of the previously conducted physical examination.
- Individualized interdisciplinary recovery 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.
    - Developed in collaboration with the patient, the recovery plan reflects their goals, and articulates short-term, measurable recovery goals, preferences and activities designed to meet those goals.
    - The recovery plan should be reviewed/updated in collaboration with the patient as needed based on changes in functioning, or at a minimum of every 90 days.
- Discharge/transfer planning that begins at admission.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admission Guidelines

Dimension 1: Acute Intoxication and/or withdrawal. No signs or symptoms of withdrawal, or the patient's withdrawal can be safely managed in an outpatient setting.

Dimension 2. Biomedical conditions and complications: If any, are sufficiently stable to permit participation in outpatient treatment.

Dimension 3. Emotional, behavioral or cognitive conditions and complications: The person has no symptoms of a co-occurring mental disorder or any symptoms are mild, stable, fully related to a substance use or other addictive disorder and do not interfere with the person's ability to focus on addiction treatment issues, or the person's psychiatric symptoms are mild, mostly stable, and primarily related to either a substance use or other addictive disorder or to a co-occurring cognitive, emotional or behavioral condition.

Mental health monitoring is needed to maintain stable mood, cognition, and behavior; and the person's mental status does not preclude their ability to understand the information presented and participate in recovery planning and the treatment process and the person is assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another.

Dimension 4. Readiness to change: The person expressed willingness to participate in recovery planning and to attend all scheduled activities mutually agreed upon in the recovery plan; and the person acknowledges that they have a substance-related or other addictive disorder and/or mental health condition and wants help to change; or the person is ambivalent about a substance-related or other addictive disorder and/or mental health condition.

They require monitoring and motivating strategies but not a structured milieu program; or the person may not recognize they have a substance-related or other addictive disorder and/or mental health condition but is ambivalent about change. They are invested in avoiding negative consequences and need monitoring and motivating strategies to engage in treatment and progress through stages of change, or the person may not recognize they have a substance-related or other addictive disorder and/or mental health condition.

Dimension 5. Relapse, continued use or continued problem potential: Participant can achieve or maintain abstinence, controlled use, and/or addictive behaviors, and related recovery goals or the person is able to achieve awareness of a substance use or other addictive disorder and related motivational enhancement goals, only with support and scheduled therapeutic contact. This includes ambivalence about preoccupation of alcohol use, other drug use, gambling, cravings, peer pressure, and lifestyle or attitude changes.

Dimension 6. Recovery environment: The patient's psychosocial environment is sufficiently supportive that outpatient treatment is feasible, or the patient does not have an adequate primary or social support system but has demonstrated motivation and willingness to obtain such a support system or the patient's family, guardian, or significant others are supportive but require professional interventions to improve the patient's chance of treatment success and recovery.

Outpatient Treatment ASAM Level 1.0 OTP

Definition and Setting

OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone, buprenorphine, or extended-release naltrexone) and offer, but do not require, 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, buprenorphine, or extended-release naltrexone but receives medication dispensed at the OTP pursuant to a physician's order.

Provider Qualifications

OTPs must conform to the Federal opioid treatment standards set forth under 42 C.F.R. 8.12 and achieve and maintain accreditation with a SAMHSA-approved national accrediting body.

C.F.R. Part 8. 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 considering 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.

OTPs must have a designated medical director available on site or for consultation at all times when the facility is open.

Support Systems

- Medical, psychiatric, psychological, laboratory, and toxicology services available on-site or through consultation or referral.
    - Medical and psychiatric consultation available within 24 hours by phone or, if in person, within a timeframe appropriate to the severity and urgency of the consultation requested.
- Direct affiliation with (or close coordination through referral to) more intensive levels of care and medication management.
- Emergency services are available by telephone 24/7.

Staffing

Level 1 (opioid treatment services) outpatient settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, RNs/LPNs, as well as certified peer recovery specialists 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. Certified peer recovery specialists may lead groups and meet with patients 1:1 but would bill peer support unless also meeting certification criteria for unlicensed counselors.

Level 1 outpatient settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, certified peer recovery specialists and credentialed behavioral health technicians operating within their scope of practice.

OTPs must have a medical director, who is a physician, and meets the following criteria:

- Completed an accredited residency program and meet one of the following:
    - Obtained addiction credentialing in addiction medicine or in addiction psychiatry; or
    - Completed at least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
- Holds board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.

Caseload size is based on the needs of patients actively engaged in services to ensure effective, individualized treatment, and recovery.

- Counseling groups should not exceed 15 patients (assumed average of 9), psycho-educational group size is not restricted.
- QHP supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff.
- Certified peer recovery specialists may lead groups and meet with patients 1:1 but would bill peer support unless also meeting certification criteria to be one of the unlicensed counselors.

Medication management requires an independently licensed practitioner with authority to prescribe in Delaware.

Therapies

Skilled treatment services that include, but medication cannot be made dependent upon:

- Individual and group counseling
- Motivational enhancement
- Family therapy
- Educational group
- Psychotherapy
- Addiction pharmacotherapy

For persons with mental health conditions, the issues of psychotropic medication, mental health treatment and their relationship to substance use and addictive disorders are addressed.

Screening/Assessment/Treatment Plan Review

Elements of the screening, assessment and treatment plan review include:

- Screening examination by qualified practitioner to ensure the person meets the criteria for admission and there are no contraindications to treatment with MOUD.
    - Medication should begin at this time if there are no contraindications.
    - If the exam/labs are completed by an outside practitioner, it must be completed less than 7 days prior to the OTP admission.
- Full history and physical, including laboratory tests within 14 calendar days of admission.
    - The physical can be completed in-person or via audio/visual telehealth for methadone or audio/visual or audio-only telehealth for buprenorphine and extended-release naltrexone.
    - OTPs can accept a physical examination completed by a non-OTP practitioner if the examination is verified by a licensed OTP practitioner.
    - Laboratory testing must be completed within 30 days prior to admission.
- For patients new to the program, a comprehensive bio-psychosocial assessment must be completed within 14 calendar days of admission to substantiate appropriate patient placement per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). This assessment:
    - Must be reviewed and signed by a qualified professional.
    - Typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate location of care and a comprehensive bio-psychosocial assessment to inform the recovery plan and ongoing care.
- Individualized, interdisciplinary recovery plan within 21 days.
    - The plan must be person-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 patient becomes stable and throughout treatment.
    - The plan should articulate short-term, measurable recovery goals, preferences and activities designed to meet those goals.
- Recovery plan reviewed/updated in collaboration with the patient as needed based on changes in functioning, or at a minimum of every 90 days.
- Physical exams should occur no less than once per year.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admission Guidelines

Dimension 1: Acute Intoxication and/or withdrawal: Physical dependence on an opioid and, if in withdrawal, the patient's withdrawal can be safely managed in an outpatient setting.

Dimension 2. Biomedical conditions and complications: If any, are sufficiently stable to permit participation in outpatient treatment.

Dimension 3. Emotional, behavioral or cognitive conditions and complications: The patient has no symptoms of a co-occurring mental disorder or any symptoms are mild, stable, fully related to a substance use or other addictive disorder and do not interfere with the person's ability to focus on addiction treatment issues, or the person's psychiatric symptoms are mild, mostly stable, and primarily related to either a substance use or other addictive disorder or to a co-occurring cognitive, emotional or behavioral condition.

Mental health monitoring is needed to maintain stable mood, cognition, and behavior; and the person's mental status does not preclude their ability to understand the information presented and participate in recovery planning and the treatment process and the person is assessed as not posing a risk of harm to self or others and is not vulnerable to victimization by another.

Dimension 4. Readiness to change: The patient expressed willingness to participate in recovery planning and to attend all scheduled activities mutually agreed upon in the recovery plan; and the person acknowledges that they have a substance-related or their addictive disorder and/or mental health condition and wants help to change; or the patient is ambivalent about a substance-related or other addictive disorder and/or mental health condition.

They require monitoring and motivating strategies but not a structured milieu program; or the person may not recognize they have a substance-related or other addictive disorder and/or mental health condition but is ambivalent about change. They are invested in avoiding negative consequences and need monitoring and motivating strategies to engage in treatment and progress through stages of change, or the person may not recognize they have a substance-related or other addictive disorder and/or mental health condition.

Dimension 5. Relapse continued use or continued problem potential: The patient can achieve or maintain abstinence, controlled use, and/or addictive behaviors, and related recovery goals or they can achieve awareness of a substance use or other addictive disorder and related motivational enhancement goals only with support and scheduled therapeutic contact. This includes ambivalence about preoccupation of alcohol use, other drug use, gambling, cravings, peer pressure, and lifestyle or attitude changes.

Dimension 6. Recovery environment: The patient's psychosocial environment is sufficiently supportive that outpatient treatment is feasible, or the patient does not have an adequate primary or social support system but has demonstrated motivation and willingness to obtain such a support system or the person's family, guardian, or significant others are supportive but require professional interventions to improve the person's chance of treatment success and recovery.

Intensive Outpatient Services ASAM Level 2.1

Definition and Setting

Intensive outpatient programs provide 9 to 19 hours of structured programming per week consisting primarily of counseling and education about addiction-related and mental health disorders.

Services include individual, group and family counseling including psychoeducation 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 medication management, monitoring of addictive behaviors, 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 and are tightly coordinated.

Intent: If the program is only providing outpatient therapy, then it should focus on providing just those ASAM 1.0 services solely to patients needing that level of care. However, if the program is appropriately staffed, then the program could provide IOP to patients needing a higher level of care and outpatient services to patients needing a lower level of care. If a physician is on-site providing direct care for the IOP level of care, the agency would bill for the physician's direct services using the appropriate physician CPT codes.

Support Systems

- Medical, psychiatric, psychological, laboratory, and toxicology services available on-site or through consultation or referral. Medical and psychiatric consultation is available within 24 hours by phone or within 72 hours in person.
- Direct affiliation with (or close coordination through referral to more and less intensive levels of care and supportive housing services.
- Emergency services are available by telephone 24 hours per day, 7 days per week.

Staffing

Level 2.1 outpatient settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, certified peer recovery specialists and credentialed behavioral health technicians operating within their scope of practice.

Level 2.1 programs must have a medical director who is a physician and meets the following criteria:

- Completed an accredited residency program and meets one of the following:
    - Obtained addiction credentialing in addiction medicine or in addiction psychiatry; or,
    - At least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
- Board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.

Caseload size is based on the needs of patients actively engaged in services to ensure effective individualized treatment and recovery. For this standard, active is defined as being treated at least every 90 days.

Counseling groups should not exceed 15 patients (assumed average of 9); educational group size is not restricted.

- One FTE during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer recovery specialist.
- QHP supervisors must be on site at least 10 hours per week during hours of operation, always be available for phone consultation, and supervise no more than 10 staff.
- 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 always be available for phone consultation.

Therapies

- A minimum of 9 hours per week of skilled treatment services. Services may include patient and group counseling, medication management, family therapy, educational groups and other therapies. Services are provided in amounts, frequencies and intensities appropriate to the treatment plan's objectives.
- Family therapy involving family members, guardians or significant others in the assessment, treatment and continuing care of the patient.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient's developmental stage and comprehension level.
- Motivational interviewing, enhancement and engagement strategies that are used in preference to confrontational approaches.

Screening/Assessment/Treatment Plan Review

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes:

- A comprehensive bio-psychosocial assessment completed within 14 days of admission that includes a comprehensive substance use and addictive disorders history obtained as part of the initial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). Assessment must be reviewed and signed by a QHP.
- Documentation of a physical examination by a qualified medical professional completed within 90 days prior to admission or of a good faith effort to refer the patient for a physical and/or efforts made to obtain documentation of the previously conducted physical examination.
- Individualized, interdisciplinary recovery 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 patient and reflect their goals and articulate short-term, measurable recovery goals, preferences and activities designed to meet those goals.
- Recovery plan reviewed/updated in collaboration with the patient as needed based on changes in functioning, or at a minimum of every 30 days.
- Discharge/transfer planning that begins at admission.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admissions Guidelines

Dimension 1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or patient's withdrawal can be safely managed in an intensive outpatient setting.

Dimension 2. Biomedical conditions and complications: The patient's biomedical conditions/problems (if any) are stable or are being addressed concurrently and thus will not interfere with treatment.

Dimension 3. Emotional, behavioral, or cognitive conditions and complications: Problems in Dimension 3 are not necessary for admission to a 2.1 but if any are present the patient must be admitted to either a co-occurring capable or a co-occurring enhanced program depending on the person's level of function, stability and degree of impairment in this dimension.

Dimension 4. Readiness to change: The patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions to another level of care have failed.

- Such interventions are not feasible or likely to succeed in a Level 1 program or the patient's perspective inhibits their ability to make behavioral changes without repeated, structured, clinically directed motivational interventions.
- Such interventions are not feasible or likely to succeed in a Level 1 program. However, the patient's willingness to participate in treatment and explore their level of awareness and readiness to change suggests that treatment at Level 2.1 can be effective.

Dimension 5. Relapse, continued use or continued problem potential: Although the patient has been an active participant at a less intense level of care they are experiencing an intensification of symptoms of the SUD and their level of functioning is deteriorating despite modification of the treatment plan; or, there is a high likelihood that the patient will continue to use or return to use of substances/gambling without close outpatient monitoring and structured therapeutic services, as indicated by their lack of awareness of recurrence triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment. The patient has unsuccessfully attempted treatment at a less intense level of care, or such treatment is adjudged insufficient to stabilize the person's condition so that direct admission to Level 2.1 is indicated.

Dimension 6. Recovery environment: Continued exposure to the patient's current school, work or living environment will render recovery unlikely. The patient lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a level 2.1 program; or, the patient lacks social contacts, has unsupportive social contacts that jeopardize recovery or has few friends or peers who do not use substances. They also lack the resources or skills necessary to maintain an adequate level of functioning without Level 2.1 services.

Billing Guidance

To bill any H0015 code for IOP or Partial Hospitalization, the practitioner must provide over half of the time assumed in the development of the fee.

For example, for IOP, the practitioner is assumed to deliver 4 hours of group therapy. To bill a unit, the program would have to provide over 2 hours of group therapy led by a practitioner of those qualifications. (For H0015 HK, for example, a licensed practitioner would have to deliver over 2 hours of group therapy to bill one unit.) Also, the group must be led by the highest-credentialed staff person to bill the fee code with the highest-credentialed staff person. Other staff can assist with the group so long as staffing levels consistent with the billing guidance are maintained.

- For SUD IOP, only one per diem may be billed in a day.
- SUD Group Therapy may not be billed on the same day that the provider bills SUDIOP or SUD Partial Hospitalization (within or outside of the IOP or Partial Hospitalization program).
- SUD IOP and SUD Partial Hospitalization cannot be billed on the same day.

Any patient receiving services provided would be in addition to the program staffing required for the basic group per diem to be billed.

For example, to bill the per diem H0015, the program must always maintain at least the 1:10 group ratio (practitioner to patients) and cannot use staff necessary to maintain the 1:10 ratio to provide individual services that are separately billed.

The following activities may not be billed or considered the activity for which the IOP/PartialHospitalization per diem is billed and recouped if found in an audit:

- Contacts that are not medically necessary.
- Time spent doing, attending or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor.
- Time spent attending school (e.g., during a day treatment program).
- Habilitative services for the patient (adult) to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the patient or family. Services provided in the car are consideredTransportation and time may not be billed for IOP/Partial Hospitalization.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the prepaid inpatient health plan) have approved authorization.
- Individuals that do not meet admission criteria or medical necessity definitions.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the patient's authorized recovery plan.
- Services provided without prior authorization by the department or its designee.
- Services not in compliance with the contract or the service manual and not in compliance with standards.

- Services provided to children, spouse, parents or siblings of the eligible patient under treatment or others in the eligible patient's life to address problems not directly related to the eligible patient's issues and not listed on the eligible patient's recovery plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.
- Anything not included in the approved IOP/Partial Hospitalization service description.
- Changes made to IOP/Partial Hospitalization that do not follow the requirements outlined in the provider contract, service manual or IOP/Partial Hospitalization standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives and approved services will not be reimbursed.
- Employment of the patient.

For IOP per diems, the services must be delivered in accredited programs where there is a licensed practitioner on site and supervising unlicensed staff, and the patients must meet admission criteria for a higher level of care as specified in the provider manual. IOP per diems can only be billed for a group with group ratios of:

- No more than 1:10 with at least a bachelor's level practitioner leading a group.
- No more than 1:15 with at least a bachelor's or LPN leading a psychoeducation.
- No more than 20 patients when therapy or skill building is occurring with the appropriate staffing ratios.
- Group sizes may not exceed 30 patients when psychoeducation is occurring with the appropriate staffing ratios.

Partial Hospitalization Services ASAM Level 2.5

Definition and Setting

Partial hospitalization programs (PHP) or day treatment generally provide 20 or more hours of clinically intensive programming per week as specified on patient's recovery plans. Programs have direct access to psychiatric, medical, and laboratory services; thus, are better able to meet needs identified in Dimensions 1, 2, and 3 that warrant daily monitoring or management but can be addressed in a structured outpatient setting.

Intensive services at this location of care provide comprehensive bio-psychosocial assessments and individualized treatment and allow for a valid assessment of dependency. This location of care provides for frequent monitoring/management of the patient's medical and emotional concerns to avoid hospitalization. These conditions will lead to generalization of what was learned in treatment in the patient's natural environment.

Support Systems

- Medical, psychiatric, psychological, laboratory and toxicology services available on-site or through consultation or referral. Medical and psychiatric consultation is available within 8 hours by phone or within 48 hours in person.
- Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.
- Emergency services available by telephone 24/7 when the treatment program is not in session.

Staffing

Level 2.5 programs must have a medical director who is a physician and meets the following criteria:

- Completed an accredited residency program and meets one of the following:
    - Obtained addiction credentialing in addiction medicine or in addiction psychiatry, or
    - At least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
- Board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.

Level 2.5 outpatient settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, certified peer recovery specialists and credentialed behavioral health technicians operating within their scope of practice.

Caseload size is based on the needs of patients actively engaged in services to ensure effective, individualized treatment and recovery.

- Counseling groups should not exceed 15 patients (assumed average of 9); educational group size is not restricted.
- One FTE during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or Certified Peer Recovery Specialist.
- Supervisors must be on site at least 10 hours per week during hours of operation, always be available for phone consultation, and supervise no more than 10 staff.

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 always be available for phone consultation.

Therapies

- A minimum of 20 hours per week of skilled treatment services.
    - Services may include individual and group counseling, medication management, family therapy, educational groups, and other therapies.
    - Services are provided in amounts, frequencies and intensities appropriate to the objectives of the recovery plan.
- Family therapy involves family members, guardians or significant others in the assessment, treatment and continuing care of the patient.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient's developmental stage and comprehension level.
- Motivational interviewing, enhancement and engagement strategies used in preference to confrontational approaches.

Screening/Assessment/Treatment Plan Review

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes:

- A comprehensive bio-psychosocial assessment completed within 14 days of admission that includes a comprehensive substance use and addictive disorders history obtained as part of the initial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). Assessment must be reviewed and signed by a QHP.
- Documentation of a physical examination by a qualified medical professional completed within 90 days prior to admission or of a good faith effort to refer the patient for a physical and/or efforts made to obtain documentation of the previously conducted physical examination.
- Individualized, interdisciplinary recovery 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 patient and reflect their goals and articulate short-term, measurable recovery goals, preferences and activities designed to meet those goals.
- Recovery plan reviewed/updated in collaboration with the patient as needed based on changes in functioning or at a minimum every 30 days.
- Discharge/transfer planning that begins at admission.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admissions Guidelines

Dimension 1. Acute intoxication and/or withdrawal potential: The patient has no signs or symptoms of withdrawal, or their needs can be safely managed in a Level 2.5 setting

Dimension 2. Biomedical conditions and complications: The patient's biomedical conditions/problems (if any) are not sufficient to interfere with treatment but severe enough to distract from recovery efforts. These problems require medical monitoring and/or medical management, which can be provided by a level 2.5 program either directly or through an arrangement with another treatment provider.

Dimension 3. Emotional, behavioral, or cognitive conditions and complications: Problems in Dimension 3 are not required for admission to a 2.5 but if any are present the patient must be admitted to either a co-occurring capable or a co-occurring enhanced program depending on the person's level of function, stability and degree of impairment in this dimension.

Dimension 4. Readiness to change: The patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program or the patient's perspective and lack of impulse control inhibit their ability to make behavioral changes without repeated, structured, 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 patient's willingness to participate in treatment and to explore their level of awareness and readiness to change suggest treatment at Level 2.5 can be effective.

Dimension 5. Relapse, continued use or continued problem potential: Although the patient has been an active participant in a less intensive level of care, they are experiencing an intensification of symptoms of the SUD or addictive disorder, and their level of functioning is deteriorating despite modifications of the recovery plan or there is a high likelihood the patient will continue to use or return to use of substances/gambling without close outpatient monitoring and structured therapeutic services, as indicated by their lack of awareness of relapse triggers, difficulty in coping or postponing immediate gratification, or ambivalence to treatment. The person has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the person's condition so that direct admission to Level 2.5 is indicated.

Dimension 6. Recovery environment: Continued exposure to the person's current school/work/living environment will render recovery unlikely. The person lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program or family members and/or significant others who live with the person are not supportive of their recovery goals or are passively opposed to their treatment. The person requires the intermittent structure of Level 2.5 treatment services and relief from the home environment to remain focused on recovery but may live at home because there is no active opposition to or sabotaging of their recovery efforts.

Billing Guidance

To bill any H0015 code for Partial Hospitalization, the practitioner must provide over half the time assumed in development of the fee. Also, the group must be led by the highest-credentialed/licensed staff person to bill the related fee code. Other staff can assist with the group so long as staffing levels consistent with the billing guidance are maintained.

- For SUD Partial Hospitalization, only one per diem may be billed in a day.
- SUD Group Therapy may not be billed on the same day that the provider bills SUD Partial Hospitalization (within or outside of the Partial Hospitalization program).
- SUD IOP and SUD Partial Hospitalization cannot be billed on the same day.

Any individual services provided would be in addition to the program staffing required for the basic group per diem to be billed.

For example, to bill the per diem H0015, the program must always maintain at least the 1:10 group ratio (practitioner to patients) and cannot use staff necessary to maintain the 1:10 ratio to provide individual services that are separately billed.

The following activities may not be billed or considered the activity for which the IOP/Partial Hospitalization per diem is billed and recouped if found in an audit:

- Contacts that are not medically necessary.
- Time spent doing, attending or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or academic tutor.
- Time spent attending school (e.g., during a day treatment program).
- Habilitative services for the patient (adult) to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.

- Transportation for the patient or family. Services provided in the car are considered Transportation and time may not be billed for Partial Hospitalization.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the prepaid inpatient health plan) have approved authorization.
- Individuals not meeting admission criteria or medical necessity definitions.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the patient's authorized recovery plan.
- Services provided without prior authorization by the department or its designee.
- Services not in compliance with the contract or the service manual and not in compliance with standards.
- Services provided to children, spouse, parents or siblings of the eligible patient under treatment or others in the eligible patient's life to address problems not directly related to the eligible patient's issues and not listed on the eligible patient's recovery plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance or drama therapies.
- Anything not included in the approved Partial Hospitalization service description.
- Changes made to Partial Hospitalization that do not follow the requirements outlined in the provider contract, service manual or Partial Hospitalization standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

For Partial Hospitalization per diems, the services must be delivered in accredited programs where there is a licensed practitioner on site and supervising unlicensed staff and the patients must meet admission criteria for a higher level of care as specified in the provider manual. Partial Hospitalization and IOP per diems can only be billed for a group with group ratios of no more than 1:10 (practitioner to patients) with at least a bachelor's level practitioner leading a group when therapy or skill-building is occurring and no more than 1:15 (practitioner to patients) with at least a Bachelor's or LPN leading a group when psychoeducation is occurring. Group sizes would not exceed 20 patients when therapy or skill building is occurring with the appropriate staffing ratios. Group sizes would not exceed 30 when psychoeducation is occurring with the appropriate staffing ratios.

Ambulatory Withdrawal Management with Extended Onsite Monitoring ASAM Level 2

Definition and Setting

Level 2-WM is an organized outpatient service that may be delivered in an office setting, general healthcare or mental healthcare facility or addiction treatment facility by medical and nursing professionals who provide medically supervised evaluation, withdrawal management and referral services.

Services are provided in regularly scheduled sessions and under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. These services are designed to treat the patient's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the patient'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 safe. Counseling services may be available through the withdrawal management program or may be accessed through affiliation with entities providing outpatient services. Medication for addiction treatment (MAT) can be utilized when a patient has an established SUD (e.g., opioid or alcohol use disorder) that is clinically appropriate for MAT.

Additionally, this location of care can include up to 23 hours of continuous observation, monitoring and support in a supervised environment for a patient to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate location of care to continue the recovery process. These 23-hour programs are called Level 2-WM (23-hour) in this manual.

Because these programs operate 24/7 and the patient 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 patients in need of greater than 23 hours, Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management should be used depending on the severity of the patient's withdrawal syndrome.

Support Systems

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive disorders.
- Ability to obtain a comprehensive medical history and physical examination of the person at admission.
- Access to psychological and psychiatric consultation.
- Affiliation with other levels of care, including other levels of specialty addiction treatment, and general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.
- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing.
- 24-hour access to emergency medical consultation services, should such services become indicated.
- Ability to provide or assist in accessing transportation services for persons who lack safe transportation.

Staffing

Level 2-WM and Level 2-WM (23-hour) must have a medical director who is a physician and meets the following criteria:

- Completed an accredited residency program and meets one of the following:
    - Obtained addiction credentialing in addiction medicine or in addiction psychiatry; or
    - At least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
- Board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.

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 patients being admitted to the program. All clinicians who assess and treat can obtain and interpret information about these patients' needs and know about the biopsychosocial dimensions of alcohol and other drug addictions. Knowledge includes the signs and symptoms of alcohol or other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of these conditions and how to facilitate entry into ongoing care.

One FTE during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer recovery specialist.

Level 2-WM Staffing

- On-call addiction-credentialed physician always designated as medical director available, as allowed by law.
- Designated prescriber available on site at least 10 hours per week and with on-call availability for consultation 24/7; a physician's assistant (PA), NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.
- At least one nurse: NP, RN, or LPN with RN supervision is available on site at least 10 hours per week, but at no time serves more than 15 patients.
- Licensed practitioners or unlicensed counselors with direct supervision on site; one clinician per 12 patients.
- One full-time certified peer recovery specialist.

Level 2-WM (23-hour) Staffing

- On-call addiction-credentialed physician always designated as medical director available, as allowed by 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.
- Designated prescriber available on site for at least 10 hours per week and with on call availability 24/7 for consultation and to discharge participant to higher location of care if necessary. PAs, NPs, or APRNs, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.
- At least two nurses (NP, RN, or LPN) per 12 patients on site always.
- 0.5 FTE certified peer recovery specialist per 12 patients on site during days.
- 0.5 FTE behavioral health technician per 12 patients on site during days and evenings

Therapies

- Individualized assessment, medication or non-medication methods of withdrawal management, education, non-pharmacological clinical support.
- Involvement of family members or significant others in the withdrawal management process and discharge/transfer planning, including referral for counseling and involvement in community recovery support groups.
- Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal using validated withdrawal assessment tools.

Screening/Assessment/Treatment Plan Review

Level 2-WM

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes:

- An addiction-focused history, obtained as part of the initial assessment and reviewed by a physician during the admission process
- Urine drug screens, which are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
- Nursing assessment and behavioral health assessment at time of admission reviewed by a physician to determine need for withdrawal management, eligibility and appropriateness (proper patient placement) for admission and referral.
- Medical care plan within 24 hours of admission based on the findings of a physical examination completed by a physician or NP prior to admission or on site by psychiatric medical staff or nursing staff. The medical plan shall be reviewed by a physician, filed in the patient's record, and updated as needed.
- Initial and individualized recovery plan within 24 hours of admission and comprehensive recovery plan within 7 days of admission. The plan should include problem identification in Dimensions 2 through 6 and articulate short-term, measurable recovery goals, preferences and activities designed to meet those goals.
- Daily assessment of progress during withdrawal management and any treatment changes.
- Updates to treatment plan every 7 days.
- Methadone and buprenorphine/naloxone must be available for use with opioid withdrawal as preferred medications. Opioid withdrawal with medications must follow DSAMH protocols.
- Discharge/transfer planning that begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.
- Serial medical/nursing assessments using a validated withdrawal assessment measure.
- Physician orders are required for medical and psychiatric management.

Level 2-WM (23-hour)

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes:

- An addiction-focused history, obtained as part of the initial assessment and reviewed by a physician during the admission process
- Urine drug screens, which are required upon admission and as directed by the treatment planand are considered covered under the rates paid to the provider.
- Nursing assessment and behavioral health assessment at time of admission reviewed by a physician to determine need for withdrawal management, eligibility and appropriateness.
- Initial treatment plan at admission.
- Methadone and buprenorphine/naloxone must be available for use with opioid withdrawal as preferred medications. Opioid withdrawal with medications must follow DSAMH protocols.
- Discharge/transfer planning that begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
- If the patient steps down to Level 2-WM, then all screening/assessment/treatment plan review for that ASAM level must be completed consistent with that location of care.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.
- Serial medical/nursing assessments using a validated withdrawal assessment measure.
- Physician orders are required for medical and psychiatric management.
- Discharge/transfer planning begins at admission.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

The program shall implement the withdrawal management/treatment plan and document the patient's response to and/or participation in scheduled activities.

Notes shall include:

- The patient's physical condition, including vital signs.
- The patient's mood and behavior.
- Statements about the patient's condition and needs.
- Information about the patient's progress or lack of progress in relation to withdrawal management/treatment goals.
- Additional notes shall be documented as needed.

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 to determine the most appropriate location of care (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).

Billing Guidance

If the patient is admitted to withdrawal management 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 withdrawal 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:

- Urine drug screens, which are required upon admission, and as directed by the treatment plan and are considered covered under the rates paid to the provider.
- 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.
- Discharge/transfer planning that begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
- If the patient 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 patient remains in the facility for more than 24 hours, then it is a residential detox bed and the H0014 and H0012 codes would not be billed. Instead, the residential per diem would be billed. It would be expected that the patient 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 patient does not remain that long.

- The residential withdrawal management program would begin billing the per diem rate upon admission to the facility. No outpatient H0014 or H0012 codes would be permitted.
- The facility may not bill using the H0014 or H0012 codes within 24 hours of admission to a residential withdrawal management level of care.
- The residential withdrawal management 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).

Residential Substance Use Disorder Services

Clinically Managed Low-Intensity Residential Treatment Services ASAM Level 3.1

For authorization requirements please see Policy 54 in Appendix G.

Definition and Setting

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 5 hours a week of individual, group, family therapy, medication management and psychoeducation. All facilities are licensed and certified by DSAMH.

Treatment is directed toward applying recovery skills, preventing recurrence, emotional coping strategies, promoting personal responsibility and reintegrating the patient into the worlds of work, education and family life. Mutual/self-help meetings (that are supportive of MAT) are usually available on site or easily accessible in the community.

Level 3.1 is often considered appropriate for patients who need time and structure to practice and integrate their recovery and coping skills in a residential and supportive environment.

It 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 level of care.

Support Services

- Telephone or in-person consultation with a physician and emergency services are available 24/7.
- Direct affiliation with other levels of care or close coordination through referral to more and less intensive levels of care and other services.
- Ability to arrange for needed procedures.
- Ability to arrange for pharmacotherapy for psychiatric or medications for addiction treatment.

Staffing

Level 3.1 residential settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of patients being admitted to the program.

- Level 3.1 programs must have a medical director who is a physician and meets the following criteria:
    - Completed an accredited residency program and meets one of the following:
        - Obtained addiction credentialing in addiction medicine or in addiction psychiatry, or
        - At least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
    - Board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.
- 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 is available at least 2.5 hours per week, reviews admission decisions and confirms medical necessity of services.

- 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.
- One certified peer recovery specialist per 16 residents is on site during day and evening hours, while residents are awake.
- One FTE during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer recovery specialist. Caseload size is based on the needs of patients actively engaged in services to ensure effective, individualized treatment and rehabilitation but should not exceed 35 active patients for each licensed practitioner and unlicensed counselor. For this standard, active is defined as being treated at least every 90 days.
- House manager (1 FTE per shift) awake and on site at night to supervise activities of the facility. This person must have adequate orientation and skills to assess recurrence situations and provide access to appropriate medical care when needed.

Therapies

Services are designed to improve the patient's ability to structure and organize the tasks of daily living, such as personal responsibility, personal appearance and punctuality.

- Planned clinical activities (at least 10 hours per week of professionally directed treatment) to stabilize and maintain the stability of the patient's substance use disorder symptoms and to help them develop and apply recovery skills.
- Addiction pharmacotherapy.
- Random drug screening to monitor and reinforce treatment gains as appropriate to the patient's treatment plan.
- Motivational enhancement and engagement strategies appropriate to the patient's stage of readiness to change are used in preference to confrontational approaches.
- Counseling and clinical monitoring to support successful initial involvement or reinvolvement in regular, productive daily activity and, as indicated, successful reintegration into family living.
- Health education services.
- Regular monitoring of the patient's medication adherence.
- Recovery support services.
- Services for the patient's family and significant others, as appropriate.
- Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage their addictive disorder.

Screening/Assessment/Treatment Plan Review

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes:

- A comprehensive bio-psychosocial assessment completed within 72 hours of admission that includes a comprehensive substance use and addictive disorders history obtained as part of the initial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). Assessment must be reviewed and signed by a QHP.
- A urine drug screen and tuberculosis test required within 72 hours of admission and as directed by the treatment plan and considered covered under the rates paid to the provider.
- Physical examination performed within 72 hours, as determined by the patient's medical condition. A physical examination from an outside provider may be accepted if conducted within 90 days of admission and reviewed by the medical director.
  This refers to community providers not involved with direct services in ASAM 3.1.
- Individualized interdisciplinary recovery plan developed within 72 hours of admission consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). This plan includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals and should be developed in collaboration with the patient and reflect their personal goals.
- The plan should be renewed on the 30th day and every 30 days thereafter.
- Discharge/transfer planning that begins at admission.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admission Guidelines

Dimension 1. Acute intoxication and/or withdrawal potential*:* No signs or symptoms of withdrawal or their withdrawal can be safely managed in a 3.1 setting.

Dimension 2. Biomedical conditions and complications: Biomedical problems, if any, are stable and do not require medical or nurse monitoring, and the patient can self-administer any prescribed medications, or a current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring that can be provided by the program or through an established arrangement with another provider.

Dimension 3. Emotional, behavioral, or cognitive conditions and complications: The patent's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to allow the person to participate in the therapeutic interventions provided at this level of care and to benefit from treatment; and the patient's psychiatric condition is stable and they are assessed as having minimal problems in this area, as evidenced by both of the following:

1. The patient's thought disorder, anxiety, guilt and/or depression may be related to substance use problems or to a stable co-occurring emotional, behavioral or cognitive condition, with imminent likelihood of relapse with dangerous consequences outside of a structured environment; and
2. The patient is assessed as not posing a risk to self or others.

OR

The patient's symptoms, and functional limitations, when considered in the context of their home environment, are sufficiently severe that they are assessed as not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting. Functional limitations may include (but are not limited to) residual psychiatric symptoms, chronic addictive disorder, history of criminality, marginal intellectual ability, limited educational achievement, poor vocational skills, inadequate anger management skills and the sequalae of physical, sexual or emotional trauma (may be complicated by problems in Dimensions 2 through 6);

OR

The patient demonstrates (through distractibility, negative emotions or generalized anxiety) an inability to maintain stable behavior over a 24-hour period without the structure and support of a 24/7 setting.

OR

The patient's co-occurring psychiatric, emotional, behavioral or cognitive conditions are being addressed concurrently through appropriate psychiatric services.

Dimension 4. Readiness to change: The patient acknowledges the existence of a psychiatric condition and/or substance use disorder. They recognize specific negative consequences and dysfunctional behaviors and their effect on the desire to change. They are sufficiently ready to change and cooperative enough to respond to treatment at Level 3.1;

OR

The patient is assessed as appropriately placed at Level 1 or 2 and is receiving 3.1 services concurrently. The person may be at an early stage of readiness to change and thus in need of engagement and motivational strategies.

OR

The patient requires a 24/7 structured milieu to promote treatment progress and recovery because motivating interventions have failed in the past and such interventions are assessed as not likely to succeed in an outpatient setting.

OR

The patient's perspective impairs their ability to make behavior changes without the support of a structured environment. For example, the person attributes their SUD or mental health condition to other persons or external events, rather than SUD/mental health. Interventions are assessed as not likely to succeed in an outpatient setting.

Dimension 5. Relapse continued use or continued problem potential*:* The patient demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning. Thus, they are in imminent danger of relapse, with dangerous emotional, behavioral or cognitive consequences and need 24/7 structure to help them apply recovery and coping skills.

OR

The patient understands their addiction and/or mental health disorder but is at risk of relapse in a less structured level of care because they are unable to consistently address either or both.

OR

The patient needs staff support to maintain engagement in their recovery program while transitioning to life in the community.

OR

The patient is at high risk of substance use, addictive behaviors or deteriorated mental functioning with dangerous emotional, behavioral or cognitive consequences in the absence of close 24/7 structured support and these issues are being addressed concurrently in a Level 2 program.

Dimension 6. Recovery environment*:* The patient can cope, for limited periods, outside the 24/7 structure of a Level 3.1 program to pursue clinical, vocational, educational and community activities and the patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use so endemic that the person is assessed as being unable to achieve/maintain recovery at a less intense level of care;

OR

The patient lacks social contacts or has high-risk social contacts that jeopardize their recovery, or their social network is characterized by significant social isolation and withdrawal. The patient's social network includes many friends who regularly use substances/gamble, leading recovery goals to be assessed as unachievable outside a 24/7 structured setting.

OR

The patient's social network involves living in an environment that is so highly invested in alcohol and drug use that the person's recovery goals are assessed as unachievable.

OR

Continued exposure to the person's school, work or living environment makes recovery unlikely and the patient has insufficient resources and skills to maintain an adequate level of functioning outside of a 24/7 supportive environment.

OR

The patient is in danger of victimization by another and thus requires 24/7 supervision.

ASAM Level 3.5 Clinically Managed High-Intensity Residential Services

For authorization requirements please see Policy 54 in Appendix G.

Definition and Setting

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to stabilize a person who needs safe and stable living environments to develop and/or demonstrate sufficient recovery skills so that they do not immediately have a recurrence or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. Their addiction is so out of control they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. Their multi-dimensional needs are of such severity they can't safely be treated in less intensive levels of care.

Patients in need of 3.5 often have never developed adequate coping skills and the mere cessation of substance use or addictive behavior does not result in re-emergence of previous coping skills. Delaware ASAM criteria are used to determine level of care.

Support Systems

- Telephone or in-person consultation with a physician or NP and emergency services are available 24/7.
- Direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services (such as vocational assessment and training, literacy training and adult education).
- Arranged medical, psychiatric, psychological, laboratory and toxicology services as appropriate to the severity and urgency of the person's condition.

Staffing

Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, licensed counselors, certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of patients 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 patient's problems.

Level 3.5 programs must have a medical director who is a physician and meets the following criteria:

- Completed an accredited residency program and meet one of the following:
    - Obtained addiction credentialing in addiction medicine or in addiction psychiatry; or,
    - At least one year of full-time documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including the treatment of narcotic addiction by prescribing a narcotic drug.
- Board certification in their primary medical specialty. DSAMH recommends board certification in addiction medicine or addiction psychiatry.
- The medical director, or designated physician or NP, must be available on call at all times.
- An RN on site per 16 residents during the day shift.
- A psychiatrist or psychiatric NP is on site at least 5 hours/week for every 16 residents.

- A primary care/physical health physician (or physician extender) is on site at least 2.5 hours/week for every 16 residents.
- 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.
- One behavioral health technician and/or certified peer recovery specialist per 16 residents is on site and awake at all times.
- One FTE during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer recovery specialist.

Therapies

- Daily clinical services to improve the patient's ability to structure and organize the tasks of daily living and recovery and to develop and practice pro-social behaviors.
- Planned clinical program activities to stabilize and maintain stabilization of the patient's addiction symptoms and to help them develop and apply recovery skills. Activities may include recurrence prevention, exploring interpersonal choices and developing a social network supportive of recovery.
- Counseling and clinical monitoring to promote successful initial involvement or reinvolvement in regular, productive daily activity.
- Random drug screening to shape behavior and reinforce treatment gains as appropriate to their individualized recovery plan.
- A range of evidence-based cognitive, behavioral and other therapies administered on an individual and group basis, medication education and management, addiction pharmacotherapy, educational skill building groups, and adapted to the patient's developmental stage and level of comprehension, understanding and physical abilities.
- Motivational enhancement and engagement strategies appropriate to the patient's stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to confrontational strategies.
- Counseling and clinical interventions to facilitate teaching the patient skills needed for productive daily activity.

Health education services

- Monitoring of the patient's adherence to any prescribed or permitted over-the-counter medications or supplements.
- Planned clinical activities to enhance the patient's understanding of their substance use/mental health disorders.
- Daily scheduled professional services, including interdisciplinary assessments and treatment designed to develop and apply recovery skills.
- Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
- Services for the patient's family and significant others.

Screening/Assessment/Treatment Plan Review

For patients new to the program, a multi-dimensional assessment according to the ASAM criteria must be completed to determine the level of care. The assessment includes.

- A physical examination performed within 24 hours of admission.
- Nursing assessment within 24 hours of admission, reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
- A urine drug screen and tuberculosis test required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
- Individualized, interdisciplinary recovery plan completed within 72 hours of admission consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards).
    - This plan includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals and should be developed in collaboration with the patient.
    - The treatment/treatment plan is reviewed in collaboration with the patient every 30 days and documented accordingly.
- A comprehensive bio-psychosocial assessment completed within 14 days of admission that includes a comprehensive substance use and addictive disorders history obtained as part of the initial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards). Assessment must be reviewed and signed by a QHP.
- Discharge/transfer planning begins at admission.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

Documentation

Documentation includes individualized progress notes in the person's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.

Admission Guidelines

Dimension 1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal or their withdrawal can be safely managed in a 3.5 setting.

Dimension 2. Biomedical conditions and complications: Biomedical problems, if any, are stable and don't require 24/7 medical or nurse monitoring and the person can self-administer any prescribed medications;

OR

A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. Requires medical monitoring that can be provided by the program or through an established arrangement with another provider.

Dimension 3. Emotional, behavioral, or cognitive conditions and complications: The patient's mental status is assessed as sufficiently stable to permit the patient to participate in the therapeutic interventions provided at this level of care and to benefit from treatment; and, psychiatric condition is stabilizing but despite best efforts the patient is unable to control use of substances/antisocial behavior with probable imminent danger;

OR

Demonstrates repeated inability to control their impulses to use substances/engage in antisocial behavior and is in imminent danger of recurrence with likelihood of harm to self/others/property. So severe it precludes treatment outside of a 24/7 structured setting;

OR

The patient demonstrates antisocial behavior patterns (as evidenced by criminal activity) that could have led/could lead to significant criminal justice problems, lack of concern for others and an extreme lack of respect for authority that prevents movement toward positive change and precludes participation in a less structured level of care;

OR

Significant functional deficits, likely to respond to staff interventions. When considered in the context of the home environment, are sufficiently severe that the person is not likely to maintain mental stability and/or abstinence if treatment is not provided in a residential setting. Deficits are pervasive, requiring treatment that is mainly habilitative in nature and do not require medical monitoring;

OR

The patient's concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors provide opportunities to promote continuous boundary setting interventions.

Dimension 4. Readiness to change: Because of the intensity and chronicity of the disorder or the patient's mental health conditions they have limited insight and little awareness of the need for continuing care, or the existence of their substance use or mental health condition and need for treatment and thus has limited readiness to change;

OR

Despite experiencing serious consequences or effects of the addictive disorder or mental health condition, the patient has marked difficulty in understanding the relationship between their substance use, addiction, mental health or life challenges and their impaired coping skills and level of functioning, often blaming others for addiction problems;

OR

The patient demonstrates passive or active opposition to addressing the severity of their mental health problem or does not recognize the need for treatment. Continued substance use or inability to follow through with mental health treatment poses a danger of harm to self or others. However, assessment shows interventions at a 3.5 level of care may increase motivation;

OR

The patient requires structured therapy and a 24-hour programmatic milieu to promote treatment progress and recovery because motivational interventions have not succeeded at a lower level of care, and such interventions are assessed as not likely succeed at a less intensive level of care;

OR

The patient's perspective impairs their ability to make behavior changes without repeated, structured, clinically directed motivational interventions that will enable them to develop insight into the role they play in their substance use and/or mental health condition and empower them to make behavioral changes that can only be delivered in a 24/7 milieu;

OR

Despite recognition of and the connection of substance use to problems in their life; the patient expresses little desire to change. Because of intensity or chronicity of addictive disorder and criminogenic needs, they are in imminent danger of continued use or addictive behavior. This poses imminent serious life consequences and/or continued pattern of risk of harm to others while under the influence of substances;

OR

The patient attributes their SUD, addictive or mental health condition to other persons or external events, rather than to disorder. They require clinical directed motivation interventions that will enable them to develop insight into the role they play in their health condition and empower them to make behavioral changes. Interventions are not feasible or unlikely to succeed at a lower level.

Dimension 5. Relapse, continued use or continued problem potential: The patient does not recognize relapse triggers and lacks insight into the benefits of continuing care and is therefore not committed to treatment. Continued use poses an imminent danger to self of others;

OR

The patient's psychiatric condition is stabilizing; however, despite best efforts, they are unable to control their use and/or antisocial behaviors with probability of harm to self or others. The patient has limited ability to interrupt the recurrence process or continued use or to use peer support when at risk for relapse. Continued use poses an imminent danger of harm to self or others without 24-hour monitoring/structured support;

OR

The patient is experiencing psychiatric or addiction symptoms such as craving, insufficient ability to postpone immediate gratification and other drug-seeking behaviors. The situation poses an immediate danger of harm to self or others in the absence of close 24-hour monitoring/structured support. Introduction of psychopharmacologic support is indicated to decrease psychiatric or addictive symptoms, such as cravings, that will enable them to delay immediate gratification and reinforce positive recovery behaviors;

OR

The patient is in imminent danger of relapse or continued use with dangerous emotional, behavioral or cognitive consequences as a result of a crisis situation;

OR

Despite recent, active participation in treatment at a less intensive level of care, the person continues to use alcohol or other drugs or to deteriorate psychiatrically, with imminent serious consequences, and is at high risk of continued substance use or mental deterioration in the absence of close 24/7 monitoring/structured treatment;

OR

The patient demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of recurrence of addiction or mental health problems and recidivism to criminal behavior that poses imminent risk of harm to self or others. Imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-offending-incarceration-release-relapse without the opportunity for treatment. Requires 24/7 monitoring/structure to assist in the initiation and application of recovery and coping skills.

Dimension 6. Recovery environment: The patient has been living in an environment that is characterized by a moderately high risk of neglect; initiation or repetition of physical/sexual/emotional abuse; or substance use so endemic that the person is assessed as being unable to achieve or maintain recovery at a less intense level of care;

OR

The patient's social network includes people who regularly use substances such that recovery goals are assessed as unachievable at a less intensive level of care;

OR

The patient's social network is characterized by significant isolation or withdrawal, such that recovery goals are assessed as inconsistently achievable at a less intense level of care;

OR

The patient's social network involves living with a patient who regularly uses substances, has an active SUD or deals substances, or their environment is so highly invested in substance use that recovery goals are assessed as unachievable;

OR

The patient is unable to cope, for even limited periods of time, outside of 24/7 care. They need staff monitoring to learn to cope with Dimension 6 problems before being transferred safely to a less intensive setting.

Medically Monitored Intensive Inpatient Services ASAM Level 3.7 and Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7-WM

For authorization requirements please see Policy 54 in Appendix G.

Definition and Setting

Medically monitored inpatient withdrawal management within a residential setting is an organized service delivered by medical and nursing professionals that provides 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 and certified by DSAMH and have federal Center for Substance Abuse Treatment OTP certification and Drug Enforcement Agency (DEA) approval.

Support Systems

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems.
- Availability of medical nursing care and observation as warranted, based on clinical judgment.
- Direct affiliation with other levels of care.
- Ability to conduct or arrange for appropriate toxicology and laboratory tests.

Staffing

An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the patient and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate for the range and severity of the patient's problems.

The interdisciplinary team also includes an array of licensed practitioners, unlicensed counselors working under the supervision of a licensed clinician, certified recovery coaches and credentialed behavioral health technicians operating within their scopes of practice to provide services appropriate to the bio-psychosocial needs of patients 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 for the range and severity of the patient's problems.

- An on-call addiction-credentialed physician designated as medical director is available at all times, as allowed under law.
- A psychiatrist, psychiatric NP, or APRN is on site at least 15 hours/week per 16 residents to assess the patient within 24 hours of admission (or earlier, if medically necessary), and available to provide onsite monitoring of care and further evaluation daily.
- Primary care/physical health physician (or physician extender) on site at least 15 hours/week for 16 residents.
- One nurse (RN or LPN) per 16 residents is on site at all times with an RN supervisor or NP on call. RN is available to conduct a nursing assessment on admission. LPNs and RNs are responsible for administering medications.
- One licensed practitioner or unlicensed counselor with direct supervision is on site during days and evenings per 16 residents.

- One recovery coach per 16 residents is on site days and evenings.
- One behavioral health technician is on site and awake at all times per 16 residents.
- Staff during clinic hours dedicated to performing referral arrangements for all patients served by the facility. This FTE may be a licensed practitioner, unlicensed counselor or certified peer recovery specialist.
- All residential programs are licensed under State law.

Therapies

- A range of cognitive, behavioral, medical, mental health and other therapies are administered to the patient on an individual or group basis. They are designed to enhance their understanding of addiction, the completion of the withdrawal management process, and must be completed to determine the level of care for continuing treatment.
- A urine drug screen is required upon admission and as directed by the treatment plan, and these are considered covered under the rates paid to the provider.
- A comprehensive nursing assessment is completed at admission by a licensed and credentialed nurse.
    - This initial assessment should include an addiction-focused history and ASI to provide a clear understanding of the patient's present status.
    - Withdrawal management medications are to be administered by nursing. A physical examination by a physician, physician assistant, or NP should be made at time of admission.
    - Assessment of addiction-focused history and validated withdrawal scales (COWS for OUD and CIWA for AUD and sedative/hypnotic disorders) are to be reviewed with a physician during the admission process.

For patients new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) must be completed within 24 hours of admission to substantiate appropriate patient placement. The 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 level of care and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care. The assessment includes:

- Full physical exam within 24 hours of admission. If 3.7 WM is a step-down from 4.0 WM, records of a physical examination within the preceding 7 days are evaluated by a physician within 24 hours of admission
- Initial individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 24 hours that 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 patient.
- A comprehensive treatment plan within 3 days if participant is still in the service and additional updates to the treatment plan as indicated.
- Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
- Referral and assistance as needed for the patient to gain access to other needed SUD or mental health services.

- The program shall implement the withdrawal management/treatment plan and document the patient's response to and/or participation in scheduled activities. Notes shall include:
    - The patient's physical condition, including vital signs.
    - The patient's mood and behavior.
    - Statements about the patient's condition and needs.
    - Information about the patient's progress or lack of progress in relation to withdrawal management/treatment goals.
- Additional notes shall be documented, as needed.
- Physician orders are required for medical and psychiatric management.
- Appropriately licensed and credentialed staff are available to administer medications in accordance with physician or advanced practice provider orders.

Documentation

Documentation includes individualized progress notes in the patient's record that clearly reflect implementation of the recovery plan and the person's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Reviews are conducted and recorded in the treatment plan and updated at a frequency relevant to the patient's level of stability and severity of illness.

Withdrawal rating scale tables and flow sheets, which may include tabulation of vital signs, are included.

Admission Guidelines

Provides care to patients whose symptoms in Dimensions 1, 2 and 3 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. Intake is accepted 24/7. Delaware ASAM criteria are used to determine location of care.

Dimension 1: Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program.

Dimension 2. Biomedical conditions and complications: Interaction of biomedical condition and continued use places the patient at risk of serious damage to physical health or biomedical conditions;

OR

A biomedical condition that requires 24/7 nursing.

Dimension 3. Emotional, behavioral, or cognitive conditions and complications: Condition is unstable and requires a structured 24/7 medically monitored setting;

OR

The patient, exhibiting stress behaviors associated with loss and reemergence once abstinence is achieved, requires a secure medically monitored environment;

OR

They exhibit significant functional limitations that require active psychiatric monitoring or moderate risk of endangering self, others or property;

OR

The patient is actively intoxicated with resulting violent or disruptive behaviors that pose imminent danger to self or others;

OR

They are psychiatrically unstable or have cognitive limitations that require stabilization but not medical management.

Dimension 4. Readiness to change: Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, does not accept or relate the addictive disorder to the severity of the problem;

OR

The person needs intensive motivating strategies and processes available only in a 24-hour structured medically monitored setting;

OR

They need ongoing 24-hour psychiatric monitoring to assure follow-through with the treatment regimen and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.

Dimension 5. Relapse, continued use or continued problem potential: The person is experiencing acute psychiatric, or SUD crisis marked by intensification of symptoms of addictive or mental health disorder;

OR

The are experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms placing them at serious risk to self or others in the absence of 24-hour monitoring/structured support;

OR

The modality or intensity of treatment protocols to address relapse require care in 3.7.

Dimension 6. Recovery environment: Requires continuous medical monitoring because current living situation is characterized by high risk of initiation or repetition of physical, sexual or emotional abuse;

OR

Family members or significant others living with the person are not supportive of recovery goals and actively sabotage treatment;

OR

The patient is unable to cope without 24-hour care and needs staff monitoring to learn to cope with Dimension 6 problems.

Reimbursement for SUD and Addiction Services

Reimbursements for services are based upon a Medicaid fee schedule and DSAMH rates 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, LPCMHs, 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 July 1, 2014, 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.

The fee development methodology will primarily be composed of provider cost modeling, though Delaware provider compensation studies, cost data and fees from similar State Medicaid programs may also be considered. 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.

Guidance

For ASAM Level 2-WM, 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 and certified residential SUD programs regardless of licensure must be consistent with the residential codes found in this SUD section of the State Plan manual.

Claims for unlicensed staff (e.g., certified peer recovery specialist) will bill using their licensed supervisor as the rendering provider number.

Reimbursement and Coding Summary

For ASAM Level 2-WM, 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.

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.

To the extent clinical nurse specialists, nurse practitioners and physician's assistants bill under the State Plan, they should refer to the relevant Medicaid fee schedule (generally the Delaware Physician rate).

Intensive Outpatient Program (IOP) and Partial Hospitalization Services Billing Guidance:

Please note the billing requirements in sections 3.4 and 3.5 above regarding these services.

***H00048 Billing Guidance:

- H0048 cannot be billed for collection and handling during a residential stay, or other per diem SUD services, because the cost of time and supplies are included in the per diem rate.
- H0048 cannot be billed in addition to billing for the time spent by the nurse for the same process (e.g., 99211).
- Rates include expenses for cups, wipes, instant testing and other supplies, and cost to send specimens to a third-party lab. It does not include the third-party lab expenses.
- When the specimen is sent to the third-party lab, the third-party lab will bill the Medicaid MCO for MCO members.
- Only one H0048 may be billed a day, with a maximum of 2 units in a week.

Crisis Intervention Services

Crisis intervention (CI) services are provided to a beneficiary who is experiencing a behavioral health crisis. CI services are designed to interrupt and/or ameliorate a crisis experience and include an assessment, de-escalation and/or immediate crisis resolution, 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 higher 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, clinic setting, or 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, and/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-escalation 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. Note: follow-up with collateral contacts can only occur with the appropriate releases of information in place.
- 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 individuals 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; screening assessment under the supervision of a certified screener; and referral and linkage, if indicated.
- CI specialists, who are nurses, may also provide medication monitoring and nursing assessments. Psychiatrists 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.

Consumer Participation Criteria

These services are provided as part of a comprehensive specialized psychiatric program available to all individuals served. CI services must be medically necessary. The medical necessity for these rehabilitative services must be recommended by a licensed practitioner such as LBHPs, APNs, NPs, or a physician who is acting within the scope of his/her professional license and as applicable State law to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. All individuals who are identified as experiencing a seriously acute psychological/emotional change, resulting in a

marked increase in personal distress, and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible.

An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. Individuals 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, 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

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

Staffing and Provider Qualifications

Title 16, Chapter 51of the Delaware Code states that only psychiatrists and professionals credentialed by the Delaware Department of Health & Social Services (DHSS) as a Credentialed Mental Health Screener (MH Screener) have the authority to detain a person involuntarily for a psychiatric evaluation. No person shall hold themselves out to the public as a MH Screener unless the persons are credentialed in accordance with Title 16, Chapter 6002 of the Delaware Administrative Code. DSAMH is the DHSS Division responsible for implementing and enforcing this law.

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.
- Registered Nurse (RN)
- Advanced Practice Nurse (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 bachelor's 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 following completion of the mental health screener training and satisfactory score on the mental health screener credentialing examination.
- A certified peer specialist 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 specialist must have the following credentials:
    - A high school education or GED, (preferably with some college background).
    - Delaware state-approved standardized peer specialist training that includes academic DSAMH information as well as practical knowledge and creative activities
- A CI specialist who is an unlicensed mental health professional with a bachelor's 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.

Certification

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 CI services are provided by the State of Delaware's Mobile Crisis Unit which must be certified by DSAMH and current provider enrollment with the Medicaid agency.

Mobile Crisis Intervention Services

Mobile Crisis Intervention Activity Definition

Crisis Intervention (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.

Mobile Crisis Intervention services are defined as: face-to-face interventions that can occur in a variety of locations including, but not limited to, an emergency room, crisis office, or anywhere in the community where the beneficiary works, attends school, and/or socializes. Services are available 24 hours a day to anyone experiencing a mental health crisis.

Each crisis program is supervised by a licensed mental health practitioner who is acting within the scope of his/her professional licensed and applicable State law. A licensed mental health practitioner who is acting within the scope of his/her professional license and applicable State law (e.g., LPCMH, LCSW, LMFT, 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 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.

Mobile Crisis Intervention Policies and Procedures

Mobile CI programs must have a policy and procedure manual consistent with the requirements in these standards to address operations and services. All policies and procedures must comply with the privacy and confidentiality requirements set forth in 42 CFR Part 2, the Health Information and Portability Accountability Act, 45 CFR Parts 160 and 164, and 16 Del. C. Ch. 12. The program's policies and procedures shall include:

- A statement of program philosophy and goals;
- Geographical area to be served;
- Types of services offered;
- Intake, assessment, and referrals;
- Completion and utilization of all forms used by the program;
- The requirement that staff comply with all State mandatory reporting requirements as set forth in 16 Del. C. §§ 903-904, 1132-1133, 2224, and 5184. Such requirement must include a provision that personnel will not be subjected to any retaliation or any form of professional detriment for reporting suspected abuse or neglect as required by State law;
- How the program will respond to medical emergencies;
- How the program will engage with peace officers, other emergency response personnel, and other mental health professionals as necessary;
- Patient rights pursuant to 16 Del. C. § 2220 and 16 Del. C. § 5182.

Mobile Crisis Intervention Personnel Manual and Personnel Files

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

- Staff rules of conduct consistent with due process including:
- Examples of conduct that constitute grounds for disciplinary action;
- Examples of unacceptable performance that constitute grounds for disciplinary action.
- Policies and procedures on mental health, and alcohol and drug abuse problems of staff (including staff member assistance policies and procedures).
- Safety and health of staff, including:
- 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:

- The name and telephone number of a person the agency can contact in an emergency;
- The current job title and job description signed by the staff member;
- An application for employment signed by the staff member or a resume;
- A copy of the staff member's license or certification;
- 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.

Mobile Crisis Intervention State Training and Supervision

Orientation Curriculum

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 the following:

a. Personnel policies and procedures regarding the health and safety of staff;

b. Program policies and procedures which address State mandatory reporting requirements;

c. Program policies and procedures regarding client's rights;

d. Program policies and procedure regarding the training of all staff regarding culturally competent practices;

e. 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 any other appropriate reporting State or Federal authority; and

f. All staff, trainees and volunteers shall receive training within the first year of employment about:

- Hepatitis;
- HIV/AIDS;
- Tuberculosis;
- Other sexually transmitted diseases; and

Ongoing Training

Each program shall have an on-going training program which satisfies the following minimum standards:

- 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.
- Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually.
- 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.

Mobile Crisis Intervention Client Rights

The Program shall:

- 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.
- Not deny any person equal access to its facilities or services on the basis of age or gender.
- Comply with the federal Americans with Disabilities Act, 28 U.S.C. §§12101 et seq. and 28 CFR Part 36, the Patient Rights enumerated in Delaware's Substance Abuse Treatment Act, 16 Del.C. §2220, and the Community Mental Health Patient Rights enumerated in Delaware's Community Mental Health Treatment Act, 16 Del. C. § 5182.

Mobile Crisis Intervention Quality Assurance

All CI programs shall:

1. Have a written quality assurance plan that provides for the peri responsive services including:
    - Professional services;
    - Administrative services; and
    - 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.

Mobile Crisis Intervention Hours of Operation, Staffing and Staff Schedules

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:

- Whenever there is indication that there may be a reasonable likelihood of dangerousness to self, others, or property due to mental illness;
- 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
- 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.

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

CI programs must 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).

Each crisis program shall be supervised by a licensed mental health practitioner 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.

Mobile CI programs shall have adequate qualified staff to respond within 1 hour of referral.

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:

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:

- 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.
- 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.

Mobile CI programs shall respond within 1 hour of referral to initiate the assessment.

Short-term CI includes crisis resolution and de-briefing with the identified Medicaid beneficiary. Short-term CI, including:

- Crisis resolution and de-briefing with the beneficiary;
- Provision of emergency and consensual treatment to the person receiving the assessment;
- Crisis/early intervention counseling; and
- Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis.
- For mobile CI programs, development of a crisis plans if one is not already in place.

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.

- 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;
- Initiation of involuntary emergency detention proceedings, where appropriate and consistent with state law.

Consultation with a physician or with other qualified providers to assist with the beneficiary's specific crisis, as clinically indicated

Mobile Crisis Intervention Clinical Records

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:

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):

- Date and time of assessment.
- Beneficiary name, address, telephone number, gender, date of birth and unique identifier number (e.g., Medicaid number);
- The client's significant medical history documenting:
    - Current medical conditions;
    - Any medications the client is currently taking; and
    - Allergies.
- The name and telephone number of the person to contact in an emergency;
- Assessment;
- Treatment/Crisis Plan (if not already developed);
- Progress notes;
- Discharge plan; and
- Discharge summary
- Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff
- Update each record within twenty-four (24) hours of delivery of a service

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 have prior authorization 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 listed on page 119. Providers visiting individuals discharged from a site-based program within 24 hours is considered reimbursement within 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 nor DSAMH funding.

Reimbursement for Crisis Intervention Behavioral Health Services

Reimbursements for services are based upon a Medicaid fee schedule and DSAMH rates 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 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.

Appendix A:1 Allowable HCPCS Codes Per ASAM Level 1.0

HCPCS Code	Modifier 1	Modifier 2	Description	Units	Rate
H0001			Alcohol and/or drug assessment	One Session-One Visit	$141.79
H0001	U1		Alcohol and/or drug assessment Home/Community	One session-One Visit	$194.75
H0004			Behavioral health counseling and therapy	15 minutes	$22.10
H0004	U1		Behavioral health counseling and therapy Home/Community	15 minutes	$22.57
H0005			Alcohol and/or drug services, group counseling by a clinician	One Session 45 minutes	$13.25
H0005	U1		Alcohol and/or drug services, group counseling by a clinician Home/Community	One Session 45 minutes	$11.28
H0038			Self-help/Peer Services-Substance Abuse Program	15 Minutes	$16.38
H0038	U1		Self-help/Peer Services-Substance Abuse Program Home/Community	15 Minutes	$21.88

H0048			Alcohol and/or other drug testing: collection and handling only, specimens other than blood	One Session	$8.20
Q3014			Telehealth originating site facility fee	One Unit	$29.36
			Physician and Licensed Practitioner Coding		
Procedure Code	**Modifier 1**		**Description**	**Units**	Rate
90785	**HP** Physician/NP/PA		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 E&M service [90833, 90836,90838, 99201–99255, 99304–99337,99341–99350], and group psychotherapy [90853].) (Do not report 90785 in	1.0	$13.92

			conjunction with 90839, 90840, or in conjunction with E&M services when no psychotherapy service is also reported.)		
90785	**HO** LCSW, LMFT, LPMCH OR LCDP		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 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.)	1.0	$10.44
90791	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation	1.0	$166.53

90792	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation with medical services	1.0	$187.30
90832	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient and/or family member	Per Session 30 Minutes	$63.89
90832	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 30 minutes with patient and/or family member.	Per Session 30 Minutes	$47.92
90833	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient when performed with an E&M service.	Per Session 30 Minutes	$69.52
90834	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$84.95
90834	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$63.71
90836	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient when performed with an E&M service	Per Session 45 Minutes	$87.88
90837	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$127.43

90837	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$95.57
90838	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient when performed with an E&M service	Per Session 60 Minutes	$116.51
90839	**HP** Physician/NP/PA		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$133.14
90839	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$99.86
90840	**HP** Physician/NP/PA		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$63.52
90840	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$47.64
90845	**HP** Physician/NP/PA		Psychoanalysis	No Time Limit	$94.69
90846	**HP** Physician/NP/PA		Family psychotherapy (without the patient present)	Per Session	$103.18

90846	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (without the patient present)	Per Session	$77.39
90847	**HP** Physician/NP/PA		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$106.73
90847	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$80.05
90849	**HP** Physician/NP/PA		Multiple-family group psychotherapy	Per Session	$34.42
90849	**HO** LCSW, LMFT, LPMCH OR LCDP		Multiple-family group psychotherapy	Per Session	$25.82
90853	**HP** Physician/NP/PA		Group psychotherapy (other than of a multiple-family group)	Per Session	$25.71
90853	**HO** LCSW, LMFT, LPMCH OR LCDP		Group psychotherapy (other than of a multiple-family group)	Per Session	$19.28
90885	**HP** Physician/NP/PA		Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	One Session	$45.33
99202	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination	Per Evaluation 15 Minute Minimum	$75.91

			and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded		
99203	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded	Per Evaluation 30 Minute Minimum	$109.74
99204	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded	Per Evaluation 45 Minute Minimum	$166.75

99205	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded	Per Evaluation 60 Minute Minimum	$209.09
99211	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient	Per Evaluation 5 Minute Minimum	$20.17
99212	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded	Per Evaluation 10 Minute Minimum	$44.28
99213	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for	Per Evaluation 15 Minute Minimum	$73.69

			code selection, 15 minutes must be met or exceeded.		
99214	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded	Per Evaluation 25 Minute Minimum	$108.51
99215	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded	Per Evaluation 40 Minute Minimum	$146.20
99408	**HP** Physician/NP/PA		Alcohol/substance screening & intervention 15-30 minutes	Per Evaluation 15-30 Minutes	$32.77
99409	**HP** Physician/NP/PA		Alcohol/substance screening & intervention greater than 30 minutes	Per Evaluation Greater than 30 Minutes	$63.31

Appendix A:2 : Allowable HCPCS Codes for ASAM Level 1.0 with OTP

HCPCS Code	Modifier 1	Modifier 2	Description	Units	Rate
H0001			Alcohol and/or drug assessment	One Session-One Visit	$141.79
H0001	U1		Alcohol and/or drug assessment Home/Community	One session-One Visit	$194.75
H0004			Behavioral health counseling and therapy	15 minutes	$22.10
H0004	U1		Behavioral health counseling and therapy Home/Community	15 minutes	$22.57
H0005			Alcohol and/or drug services, group counseling by a clinician	One Session 45 minutes	$13.25
H0005	U1		Alcohol and/or drug services, group counseling by a clinician Home/Community	One Session 45 minutes	$11.28
H0020			Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed or certified program). (Limited to one per day.) Note: MA-OTPs may bill this code.	One Session	$12.00

H0038			Self-help/Peer Services-Substance Abuse Program	15 Minutes	$16.38
H0038	U1		Self-help/Peer Services-Substance Abuse Program Home/Community	15 Minutes	$21.88
H0048			Alcohol and/or other drug testing: collection and handling only, specimens other than blood	One Session	$8.20
J0571			Buprenorphine, oral, 1 mg	1 Unit	$.44 Per Unit
J0572			Buprenorphine/naloxone, oral, less than or equal to 3 mg	1 Unit	$4.25 Per Unit
J0573			Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	1 Unit	$7.03 Per Unit
J0574			Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	1 Unit	$8.02 Per Unit
J0575			Buprenorphine/naloxone, oral, greater than 10 mg	1 Unit	$12.48 Per Unit
J2315			Injection, naltrexone, depot form, 1 mg	1 Unit	$3.18 Per Unit
Q3014			Telehealth originating site facility fee	1 Unit	$29.36

			Physician and Licensed Practitioner Coding		
Procedure Code	**Modifier 1**		**Description**	**Units**	Rate
90785	**HP** Physician/NP/PA		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 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.)	1.0	$13.92

90785	**HO** LCSW, LMFT, LPMCH OR LCDP		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 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.)	1.0	$10.44
90791	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation	1.0	$166.53
90792	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation with medical services	1.0	$187.30

90832	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient and/or family member	Per Session 30 Minutes	$63.89
90832	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 30 minutes with patient and/or family member.	Per Session 30 Minutes	$47.92
90833	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient when performed with an E&M service.	Per Session 30 Minutes	$69.52
90834	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$84.95
90834	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$63.71
90836	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient when performed with an E&M service	Per Session 45 Minutes	$87.88
90837	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$127.43
90837	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$95.57

90838	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient when performed with an E&M service	Per Session 60 Minutes	$116.51
90839	**HP** Physician/NP/PA		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$133.14
90839	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$99.86
90840	**HP** Physician/NP/PA		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$63.52
90840	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$47.64
90845	**HP** Physician/NP/PA		Psychoanalysis	No Time Limit	$94.69
90846	**HP** Physician/NP/PA		Family psychotherapy (without the patient present)	Per Session	$103.18
90846	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (without the patient present)	Per Session	$77.39
90847	**HP** Physician/NP/PA		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$106.73

90847	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$80.05
90849	**HP** Physician/NP/PA		Multiple-family group psychotherapy	Per Session	$34.42
90849	**HO** LCSW, LMFT, LPMCH OR LCDP		Multiple-family group psychotherapy	Per Session	$25.82
90853	**HP** Physician/NP/PA		Group psychotherapy (other than of a multiple-family group)	Per Session	$25.71
90853	**HO** LCSW, LMFT, LPMCH OR LCDP		Group psychotherapy (other than of a multiple-family group)	Per Session	$19.28
90885	**HP** Physician/NP/PA		Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	One Session	$45.33
99202	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded	Per Evaluation 15 Minute Minimum	$75.91

99203	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded	Per Evaluation 30 Minute Minimum	$109.74
99204	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded	Per Evaluation 45 Minute Minimum	$166.75
99205	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code	Per Evaluation 60 Minute Minimum	$209.09

			selection, 60 minutes must be met or exceeded.		
99211	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient.	Per Evaluation 5 Minute Minimum	$20.17

99212	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	Per Evaluation 10 Minute Minimum	$44.28
99213	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	Per Evaluation 15 Minute Minimum	$73.69
99214	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the	Per Evaluation 25 Minute Minimum	$108.51

			encounter for code selection, 25 minutes must be met or exceeded		
99215	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded	Per Evaluation 40 Minute Minimum	$146.20
99408	**HP** Physician/NP/PA		Alcohol/substance screening & intervention 15-30 minutes	Per Evaluation 15-30 Minutes	$32.77
99409	**HP** Physician/NP/PA		Alcohol/substance screening & intervention greater than 30 minutes	Per Evaluation Greater than 30 Minutes	$63.31

Appendix A:2 Allowable HCPCS Codes for ASAM Level 1.0 & 2.1

HCPCS Code	Modifier 1	Modifier 2	Description	Units	Rate
H0001			Alcohol and/or drug assessment	One Session-One Visit	$141.79
H0001	U1		Alcohol and/or drug assessment Home/Community	One session-One Visit	$194.75
H0004			Behavioral health counseling and therapy	15 minutes	$22.10
H0004	U1		Behavioral health counseling and therapy Home/Community	15 minutes	$22.57
H0005			Alcohol and/or drug services, group counseling by a clinician	One Session 45 minutes	$13.25
H0005	U1		Alcohol and/or drug services, group counseling by a clinician Home/Community	One Session 45 minutes	$11.28
H0038			Self-help/Peer Services-Substance Abuse Program	15 Minutes	$16.38

H0038	U1		Self-help/Peer Services-Substance Abuse Program Home/Community	15 Minutes	$21.88
H0048			Alcohol and/or other drug testing: collection and handling only, specimens other than blood	One Session	$8.20
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. Unlicensed	Per Diem	$103.09
H0015	HQ	HK	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	Per Diem	$149.68

			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. Licensed		
H0015	HQ	Y2	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. Home/Community Based Unlicensed	Per Diem	$120.37
Q3014			Telehealth originating site facility fee	One Unit	$29.36

			Physician and Licensed Practitioner Coding		
Procedure Code	**Modifier 1**		**Description**	**Units**	Rate
90785	**HP** Physician/NP/PA		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 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.)	1.0	$13.92

90785	**HO** LCSW, LMFT, LPMCH OR LCDP		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 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.)	1.0	$10.44
90791	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation	1.0	$166.53
90792	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation with medical services	1.0	$187.30

90832	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient and/or family member	Per Session 30 Minutes	$63.89
90832	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 30 minutes with patient and/or family member.	Per Session 30 Minutes	$47.92
90833	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient when performed with an E&M service.	Per Session 30 Minutes	$69.52
90834	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$84.95
90834	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$63.71
90836	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient when performed with an E&M service	Per Session 45 Minutes	$87.88
90837	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$127.43
90837	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$95.57

90838	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient when performed with an E&M service	Per Session 60 Minutes	$116.51
90839	**HP** Physician/NP/PA		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$133.14
90839	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$99.86
90840	**HP** Physician/NP/PA		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$63.52
90840	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$47.64
90845	**HP** Physician/NP/PA		Psychoanalysis	No Time Limit	$94.69
90846	**HP** Physician/NP/PA		Family psychotherapy (without the patient present)	Per Session	$103.18
90846	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (without the patient present)	Per Session	$77.39
90847	**HP** Physician/NP/PA		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$106.73

90847	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$80.05
90849	**HP** Physician/NP/PA		Multiple-family group psychotherapy	Per Session	$34.42
90849	**HO** LCSW, LMFT, LPMCH OR LCDP		Multiple-family group psychotherapy	Per Session	$25.82
90853	**HP** Physician/NP/PA		Group psychotherapy (other than of a multiple-family group)	Per Session	$25.71
90853	**HO** LCSW, LMFT, LPMCH OR LCDP		Group psychotherapy (other than of a multiple-family group)	Per Session	$19.28
90885	**HP** Physician/NP/PA		Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	One Session	$45.33
99202	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded	Per Evaluation 15 Minute Minimum	$75.91

99203	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded	Per Evaluation 30 Minute Minimum	$109.74
99204	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded	Per Evaluation 45 Minute Minimum	$166.75
99205	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code	Per Evaluation 60 Minute Minimum	$209.09

			selection, 60 minutes must be met or exceeded.		
99211	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient	Per Evaluation 5 Minute Minimum	$20.17
99212	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded	Per Evaluation 10 Minute Minimum	$44.28
99213	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	Per Evaluation 15 Minute Minimum	$73.69

99214	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded	Per Evaluation 25 Minute Minimum	$108.51
99215	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded	Per Evaluation 40 Minute Minimum	$146.20
99408	**HP** Physician/NP/PA		Alcohol/substance screening & intervention 15-30 minutes	Per Evaluation 15-30 Minutes	$32.77
99409	**HP** Physician/NP/PA		Alcohol/substance screening & intervention greater than 30 minutes	Per Evaluation Greater	$63.31

				than 30 Minutes	
			Contracted providers may not bill for any other services, outside of physician codes listed on this sheet on the same day that an IOP per diem code is billed		**Providers may bill for other services such as individual counseling, so long as it is not billed for on the same day as the IOP per diem rate**

Appendix A:3 Allowable HCPCS Codes for ASAM Level 2.1

HCPCS Code	Modifier 1	Modifier 2	Description	Units	Rate
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. Unlicensed	Per Diem	$103.09

H0015	HQ	HK	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. Licensed	Per Diem	$149.68
H0015	HQ	Y2	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 Diem	$120.37

			Level 2.1 at least 9 contact hours per week but not in excess of 19 hours per week. Home/Community Based Unlicensed		
			Physician and Licensed Practitioner Coding		
Procedure Code	**Modifier 1**		**Description**	**Units**	Rate
90785	**HP** Physician/NP/PA		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 E&M service [90833, 90836,90838, 99201–99255,	1.0	$13.92

			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.)		
90785	**HO** LCSW, LMFT, LPMCH OR LCDP		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 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.)	1.0	$10.44

90791	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation	1.0	$166.53
90792	**HP** Physician/NP/PA		Psychiatric diagnostic evaluation with medical services	1.0	$187.30
90832	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient and/or family member	Per Session 30 Minutes	$63.89
90832	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 30 minutes with patient and/or family member.	Per Session 30 Minutes	$47.92
90833	**HP** Physician/NP/PA		Psychotherapy, 30 minutes with patient when performed with an E&M service.	Per Session 30 Minutes	$69.52
90834	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$84.95
90834	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 45 minutes with patient and/or family member	Per Session 45 Minutes	$63.71
90836	**HP** Physician/NP/PA		Psychotherapy, 45 minutes with patient when performed with an E&M service	Per Session 45 Minutes	$87.88

90837	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$127.43
90837	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy, 60 minutes with patient and/or family member	Per Session 60 Minutes	$95.57
90838	**HP** Physician/NP/PA		Psychotherapy, 60 minutes with patient when performed with an E&M service	Per Session 60 Minutes	$116.51
90839	**HP** Physician/NP/PA		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$133.14
90839	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; first 60 minutes.	60 Minutes	$99.86
90840	**HP** Physician/NP/PA		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$63.52
90840	**HO** LCSW, LMFT, LPMCH OR LCDP		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	30 Minutes Follow On	$47.64
90845	**HP** Physician/NP/PA		Psychoanalysis	No Time Limit	$94.69

90846	**HP** Physician/NP/PA		Family psychotherapy (without the patient present)	Per Session	$103.18
90846	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (without the patient present)	Per Session	$77.39
90847	**HP** Physician/NP/PA		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$106.73
90847	**HO** LCSW, LMFT, LPMCH OR LCDP		Family psychotherapy (conjoint psychotherapy) (with patient present)	Per Session	$80.05
90849	**HP** Physician/NP/PA		Multiple-family group psychotherapy	Per Session	$34.42
90849	**HO** LCSW, LMFT, LPMCH OR LCDP		Multiple-family group psychotherapy	Per Session	$25.82
90853	**HP** Physician/NP/PA		Group psychotherapy (other than of a multiple-family group)	Per Session	$25.71
90853	**HO** LCSW, LMFT, LPMCH OR LCDP		Group psychotherapy (other than of a multiple-family group)	Per Session	$19.28
90885	**HP** Physician/NP/PA		Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	One Session	$45.33
99202	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new	Per Evaluation	$75.91

			patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded	15 Minute Minimum	
99203	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded	Per Evaluation 30 Minute Minimum	$109.74
99204	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded	Per Evaluation 45 Minute Minimum	$166.75

99205	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	Per Evaluation 60 Minute Minimum	$209.09
99211	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient	Per Evaluation 5 Minute Minimum	$20.17
99212	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded	Per Evaluation 10 Minute Minimum	$44.28
99213	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically	Per Evaluation 15 Minute Minimum	$73.69

			appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.		
99214	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded	Per Evaluation 25 Minute Minimum	$108.51
99215	**HP** Physician/NP/PA		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded	Per Evaluation 40 Minute Minimum	$146.20

99408	**HP** Physician/NP/PA		Alcohol/substance screening & intervention 15-30 minutes	Per Evaluation 15-30 Minutes	$32.77
99409	**HP** Physician/NP/PA		Alcohol/substance screening & intervention greater than 30 minutes	Per Evaluation Greater than 30 Minutes	$63.31
			Contracted providers may not bill for any other services, outside of physician codes listed on this sheet on the same day that an IOP per diem code is billed		**Providers may bill for other services such as individual counseling, so long as it is not billed for on the same day as the IOP per diem rate**

Appendix A:4 Allowable HCPCS Codes for ASAM Level 2.5

HCPCS Code	Modifier 1	Modifier 2	Modifier 3	Description	Units	Rate
H0015	HQ	HK	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 Diem	$283.89

				Level 2.5 a minimum of 20 contact hours per week.		
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. Level 2.5 a minimum of 20 contact hours per week.	Per Diem	$154.64
H0015	HQ	TG	Y2	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. Home/ Community Level 2.5 a minimum of 20 contact hours per week.	Per Diem	$180.56

Appendix A:5 Allowable HCPCS Codes for ASAM Level WM 2.0

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H0014			Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Unlicensed Practitioner	Per 60 Minutes	$77.30

H0014	TD		Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Registered Nurse	Per 60 Minutes	$104.45

Appendix A:6 Allowable HCPCS Codes for ASAM Level WM 23-HR 2.0

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H0012			Alcohol and/or drug abuse service; subacute detoxification (residential addiction program outpatient)	Per Diem	$334.27

Appendix A:7 Allowable HCPCS Codes for Residential ASAM Level 3.1 Clinically Managed

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H2034			Alcohol and/or drug abuse halfway house services	Per Diem (Medical Portion)	$219.25
H2034	HW		Room and Board -Individual Rate Room and Board Note: Medicaid does not reimburse Room and Board. **DSAMH PAYS ALL ROOM AND BOARD**	Per Diem (Room and Board)	$41.14

Appendix A:8 Allowable HCPCS Codes for Residential ASAM Level 3.5 Clinically Managed

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H2036			Alcohol and/or drug treatment program- No cognitive impairment.	Per Diem (Medical Portion)	$259.95
H2036	HW		Room and Board Room and Board Note: Medicaid does not reimburse Room and Board. **DSAMH PAYS ALL ROOM AND BOARD**	Per Diem (Room and Board Portion)	$45.84

Appendix A:9 Allowable HCPCS Codes for Residential ASAM Level 3.7 Medically Monitored

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H2036	TG		Alcohol and/or drug treatment program	Per Diem (Medical Portion)	$377.60
H2036	HW		Room and Board Room and Board Note: Medicaid does not reimburse Room and Board. **DSAMH PAYS ALL ROOM AND BOARD**	Per Diem (Room and Board Portion)	$45.84

Appendix A:10 Allowable HCPCS Codes for Residential ASAM Level 3.7 Withdrawal Management

HCPCS CODE	Modifier 1	Modifier 2	Description	Units	Rate
H0011			Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)	Per Diem (Medical Portion)	$452.43
H0010	HW		Room and Board Room and Board Note: Medicaid does not reimburse Room and Board. **DSAMH PAYS ALL ROOM AND BOARD**	Per Diem (Room and Board Portion)	$65.84

Appendix C: Modifier Codes and Descriptions

Modifier	Modifier Description
HE	Mental Health Program
HF	Substance Abuse Program
HK	Specialized mental health programs for high-risk populations
HW	Funded by state mental health agency
HI	Integrated mental health and intellectual/developmental disabilities program
HG	Opioid addition treatment program
HO	Clinical Social Worker, Mental Health Counselor, Marriage & Family Therapist
HP	Licensed Health Professional – Physician, Psychologist, Nurse Practitioner, and Advanced Practice Nurse
HQ	Group setting
HR	Family/Couple with client present
HS	Family/Couple without client present
TD	Service completed by RN
TG	Complex/high tech LOC
U1	Home/Community

Appendix D: Place of Service Codes and Descriptions

Place of Service (POS) Codes	Place of Service Name	Place of Service Description
02	Telehealth	Telehealth Provided Other than in Patient's Home
10	Telehealth	Telehealth Provided in a Patient's Home
11	Office	Location, other than a hospital, skilled nursing facility, military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
20	Urgent Care	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness of injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital's main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.
49	Independent Clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility or clinic that serves medically underserved areas and populations, providing primary care services under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
53	Community Mental health Center	A facility for the diagnostic and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Place of Service (POS) Codes	Place of Service Name	Place of Service Description
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
71	Public Health Clinic	A facility maintained by either state or local health departments, that provides ambulatory primary medical care under the general direction of a physician.

Appendix E: Individual Behavioral Health Technician Credentialing Attestation Form

A copy of this form should be maintained in each behavioral health technician's personnel file.

Behavioral Health Technician Name (print):

Substance Use Disorder/Co-occurring Clinic name:

Current Provider Agency DSAMH License # (if applicable):

I attest that the above individual meets the following criteria:

- Is at least 18 years of age
- Has a high school or equivalent diploma
- Passed criminal, abuse/neglect, and professional background checks
- Completed the following trainings within 30 days of hire:
    - Cardiopulmonary resuscitation (CPR)
    - Basic first aid
    - Reporting suspected abuse or neglect
    - Client rights and protections
    - Confidentiality
    - Basic principles of recovery-oriented services and trauma informed care (including gambling disorders for BHTs in addiction programs providing addiction services for gambling disorders)
    - ASAM criteria, including guiding principles, and levels of care
    - Co-occurring conditions and goals for integrated care
    - Person-centered treatment plan development
    - Medical records and documentation

Signature: Behavioral Health Technician, Date:

Signature: Provider Agency Representative, Date:

Print Name: Provider Agency Representative

Provider Agency Representative Title:

Appendix F: Agency Annual Behavioral Health Technician Credentialing Attestation Form

Substance Use Disorder/Co-occurring Clinic name:
Current Provider Agency DSAMH License # (if applicable):
I attest that each of the Behavioral Health Technicians listed below met the following Initial Certification requirements within 30 days of hire:

- Is at least 18 years of age
- Has a high school or equivalent diploma
- Passed criminal, abuse/neglect, and professional background checks
- Completed the following trainings within 30 days of hire (A complete copy of the Initial Training material is available for inspection in the agency's human resources files for DSAMH inspection):
  - Cardiopulmonary resuscitation (CPR)
  - Basic first aid
  - Reporting suspected abuse or neglect
  - Client rights and protections
  - Confidentiality
  - Basic principles of recovery-oriented services and trauma informed care (including gambling disorders for BHTs in addiction programs providing addiction services for gambling disorders)
  - ASAM criteria, including guiding principles, and levels of care
  - Co-occurring conditions and goals for integrated care
  - Person-centered treatment plan development
  - Medical records and documentation

Complete the table that follows with Behavioral Health Technician Names (print), date of hire and date(s) of completion of initial required trainings.

- I further attest that each Behavioral Health Technician completed annual recertification training on the date(s) listed below. A copy of the Annual Recertification Training material is available for inspection in the agency's human resources files for DSAMH inspection.
  - Cardiopulmonary resuscitation (CPR)
  - Basic first aid
  - Reporting suspected abuse or neglect
  - Client rights and protections
  - Confidentiality
  - Basic principles of recovery-oriented services and trauma informed care (including gambling disorders for BHTs in addiction programs providing addiction services for gambling disorders)
  - ASAM criteria, including guiding principles, and levels of care
  - Co-occurring conditions and goals for integrated care
  - Person-centered treatment plan development
  - Medical records and documentation

Name (First and Last)	Date of Hire	Date(s) of Initial Training (within 30 days of hire)	Dates of Annual

Provider Agency Representative Signature:

Print Name: Provider Agency Representative

Date:

Appendix G: DSAMH Utilization Management Common Criteria for All Levels of Care
(Policy Number 54)

Purpose

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

Policy Statement

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

Definitions

- Delaware resident means an individual who is not eligible for an out-of-state Medicaid plan and meets either of the following criteria:
- An individual is domiciled in a permanent location or maintains a place of abode that they stay in that is a building, structure, or vehicle within the limits of the State, and spends more than 183 days in the State.
- A person who possesses a valid Delaware-issued identification card such as driver's license or non-driver identification card.
- DSAMH Common Criteria means a set of objective behavioral health criteria used to standardize coverage determinations, standardize eligibility for DSAMH-covered services, promote evidence-based practices, and support clients' recovery, resiliency, and well-being.
- Medical necessity means healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
- PROMISE Program means Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) Home and Community-Based Services (HCBS) waiver program under DSAMH. PROMISE assesses clients for level of care needs and monitors services to ensure the client receives appropriate care from contracted providers.
- Underinsured means a third-party payor exists, but the service is not a covered benefit under their active plan, the benefit was denied by the third-party payor, or their insurance benefits have been exhausted. The PM37 form must be used to determine underinsured eligibility and sliding scale fees (as of 12/13/23 PM37 currently only applies to IMD programs).
- Uninsured means no third-party payer exists; the client is considered indigent.

Scope

This policy applies to all DSAMH contracted providers.

Procedures/Responsibilities

DSAMH Eligibility Criteria

The provider must determine client eligibility by meeting the following criteria:

The Client MUST be a resident of Delaware as defined and be one of the following:

- Be uninsured; or,
- Be underinsured; or,
- Receiving services under the PROMISE waiver.

The Client MUST:

- Have a condition or illness covered by DSAMH services; and,
- Be 18 years old or older

The Client MUST:

- Meet DSAMH common criteria; and/or,
- Meet ASAM criteria; or,
- Other tools approved by the Division.

The Client MUST NOT:

- Be covered under a private insurance plan; or,
- Have or be eligible for an out-of-state Medicaid plan.

Common Criteria for All Levels of Care:

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

Common Clinical Best Practice Criteria for All Levels of Care

The initial evaluation:

- Gathers information about the presenting issues from the client's perspective, and includes the client's understanding of the factors that lead to requesting the services in a trauma-informed and person-centered manner;
- Focuses on the client's specific needs;
- Identifies the client's goals and expectations;
- Is completed in a timeframe commensurate with the client's needs or otherwise in accordance with clinical best practices, DSAMH standards, Medicaid regulations, and/or contract requirements.

Services meet the following conditions:

- Consistent with generally accepted standards of clinical practice;
- Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
- Consistent with generally accepted best practices;
- Clinically appropriate for the client's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks; and,
    - There is a reasonable expectation that the service(s) will improve the client's presenting problems within a reasonable period of time.
- The provider collects information from the client and other sources and completes an initial evaluation pursuant to Title 16 6001 8.1.2.1.7.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the client, use the findings of the initial evaluation and diagnosis to develop a treatment plan pursuant to Title 16 6001.1.2.1.8.
    - In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.
    - As needed, the treatment plan also includes interventions that enhance the client's motivation, promote informed decisions, and support the client's recovery, resiliency, and well-being. Examples include, but are not limited to, psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
    - The provider informs the client of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The client gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
    - Treatment focuses on addressing the factors precipitating admission to the point that the client's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or client no longer requires care.
    - The treatment plan and level of care are reassessed when the client's condition improves, worsens, or does not respond to treatment. The treatment plan may be reassessed when specifically requested by the client.

    - When the client's condition has improved, the provider determines if the treatment plan should be altered, or if treatment at the current level of care is no longer required.
    - When the client's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the client's condition should be treated in another level of care.
- Discharge planning begins at admission with the goal of stable community reintegration. This includes addressing social determinants of health that may not be directly related to behavioral health needs pursuant to DSAMH013 Discharge from Services.

Policy Lifespan

This policy will be reviewed annually.

Resources

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