

**DELAWARE  
ADULT BEHAVIORAL HEALTH DHSS  
SERVICE CERTIFICATION AND  
REIMBURSEMENT MANUAL**

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<http://dhss.delaware.gov/dsamh/>

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## 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 Medicaid fee-for-service program including individuals in Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) receiving state plan services from non-physician licensed practitioners and substance use disorder (SUD) treatment services. Department of Substance Abuse Mental Health (DSAMH) has adopted this same guidance for their funded programs providing behavioral health services to individuals residing in Delaware without insurance.<sup>1</sup>

## Non-Physician Licensed Behavioral Health Practitioners

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

### 1.1. Definition

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

### 1.2. Provider Qualifications

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

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

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

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#### 1 LEGAL DISCLAIMER

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

To provide Medicaid fee-for-service, an LBHP must have a current provider enrollment with the Medicaid agency.

LBHPs may be practicing independently or be practicing within an addiction treatment or a 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.

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

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

### 1.3. Taxonomies

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

- 103T00000X Psychologist (must bill with HP modifier).
- 103TF0000X Psychotherapy Group (must bill claims with HP modifier for psychologist).
- 101Y00000X Clinical Social Worker (must bill with HO modifier).
- 101YM0800X Mental Health Counselor (must bill with HO modifier).
- 106H00000X Marriage & Family Therapist (must bill with HO modifier).
- Co-occurring Clinic: 261QM0850X Clinic/Center – Adult Mental Health (bill with either no modifier – for physician; HO – for psychologist; HO – for LMFT, LPCMH, or LMFT).

### 1.4. Eligibility Criteria

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

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

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

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

### 1.6. Limitations/Exclusions

All services must be medically necessary. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. The provider is

required to obtain prior authorization for all psychological testing exceeding six hours annually. All neuropsychological testing must be prior authorized.

In addition to individual provider licensure, service providers employed by addiction 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 in supervision for the purpose of those individuals obtaining licensure and billing for services rendered. Services by unlicensed assistants or post-doctoral professionals under supervision may not be billed under this section of the State Plan. Instead, those unlicensed professionals must qualify under the Early and Periodic Screening, Diagnosis, and Treatment program or rehabilitation sections of the State Plan or provide services under home- and community-based authorities.

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

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

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

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

### **1.7. Additional Service Criteria**

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

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

**The codes in each category above are defined below.**

Code	Description	Admission Evaluation	Individual Therapy	Family Therapy	Group Therapy	Psychological Testing
90791	Psychiatric diagnostic evaluation.	4 units				
90832	Psychotherapy, 30 minutes with patient and/or family member.		2 units			
90834	Psychotherapy, 45 minutes with patient and/or family member.		3 units			
90837	Psychotherapy, 60 minutes with patient and/or family member.		4 units			
90845	Psychoanalysis.		4 units			
90846	Family psychotherapy (without the patient present).			4 units		
90847	Family psychotherapy (conjoint psychotherapy) (with patient present).			4 units		
90849	Multiple-family group psychotherapy.				6 units	
90853	Group psychotherapy (other than of a multiple-family group).				6 units	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach WAIS) per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.					1 unit
96102	Psychological testing (e.g., includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS) with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face.					1 unit
96103	Psychological testing (e.g., includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI) administered by a computer, with qualified health care professional interpretation and report.					1 unit
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.					1 unit
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test) administered by computer, with qualified healthcare professional interpretation and report.					1 unit



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

**Note:** this code requires prior authorization for all units delivered.

96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.					
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Billing CPT codes with “interactive” in their description are used most frequently with adults who, due to injury or disability, have impairments in the ability to communicate verbally; these codes may also be utilized.

## 1.8. Telemedicine

The Delaware Medical Assistance Program (DMAP) covers medically necessary health services furnished to eligible DMAP members as specified in the Medicaid State Plan. To facilitate the ability of recipients to receive medically necessary services, DMAP allows for the use of telemedicine delivery system 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 a patient'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
- The 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.

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

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

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 has 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 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 which does not meet this definition or which is non-secure and non-HIPAA compliant is not covered. Secure video-conferencing 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 patient setting comply with this DMAP telemedicine policy.

Asynchronous or "store and forward" applications do not meet the DMAP definition of telemedicine. Information is not permitted to be stored in any format for future use.

Asynchronous or "Store and Forward" technology means transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

*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; and
- Usage of unique passwords or identifiers for each employee or other person with access to the client records; and,
- Ensuring a system to prevent unauthorized access, particularly via the internet; and
- 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 which protect the confidentiality of the client 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 Plan* - 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 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 client agreeing to participate in services delivered via the means of telemedicine. The client has the right to refuse these services at any time and must be made

aware of any alternatives, including any delays in service, 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 client'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 client 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 client safeguards and confidentiality. Exceptions to informed consent end upon the discharge of the recipient from any facility where the individual was involuntarily detained.

*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 the Delaware Medical Assistance Program (DMAP) or in a DMAP Managed Care Organization (MCO) in order 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 Medicaid patient 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 the DMAP or in a DMAP Managed Care Organization in order to be reimbursed for the services provided. A facility fee for the originating site is covered. *Please note: 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 client's home.*

### **Medicaid 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 provider billing numbers (NPI and Taxonomy). 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 or MCOs, healthcare practitioners must.

:

- Act within their scope of practice;
  - 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 DMMA-contracted MCOs, when needed;
  - Submit a DMMA Disclosure Form.
- Originating Site Providers include the following:
    - 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
- 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 include the following:
  - Inpatient/Outpatient Hospitals (including ER)
  - 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 the 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 treatment 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 assure that the recipient is a willing participant in the telemedicine delivered service and to assure that the recipient retains a voice in their treatment plan.

See "Informed Consent" below for additional information.

- Prior approval for Telemedicine-delivered services is not required, but the Distant Site provider must obtain prior approval for any other covered services which 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 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**

*Procedures for 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; 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”.

*Procedures 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:

- First Model - 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.
- Second Model - 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.
- Third Model - 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, and 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 fee under the CPT code, Q3014, when the originating site is located in a physician’s office or similar setting, and will bill CPT code Q3014 along with Revenue Center codes, 0780 – 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 client. 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 of the 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 which indicate telemedicine as the mode of service delivery but are not substantiated by either the claim form or written medical records are subject to disallowances in the course of an audit.

### Non-Covered Services

DMAP will NOT reimburse 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 health care practitioner and a patient or a consultation between two health care practitioners

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

Provider Type	Percent of Physician Fee Schedule	Rate
Medicare Physician Rate for CPT Code 99354	100% of Medicare rate	\$103.20
Delaware Medicaid Physician and Psychologist	98% of Medicare rate	\$101.14
Delaware Clinical Nurse Specialist, NP, Physician's Assistant (Medicaid Fee)	See relevant Medicaid fee schedule	
Delaware Clinical Nurse Specialist, NP, Physician's Assistant (Non-Medicaid Fee)	100% of the Delaware Medicaid physician rate	\$101.14
Delaware LCSW, LMFT, LPCMH	75% of Delaware Medicaid physician rate	\$75.86

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

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

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

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The agency's fee schedule rate was set as of July 1, 2014, and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at [www.dmap.state.de.us/downloads/hcpcs.html](http://www.dmap.state.de.us/downloads/hcpcs.html).

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

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

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

## 1.9. Coding

**Key:**

LMFT: Licensed Marriage and Family Therapist

LPCMH: Licensed Professional Counselor of Mental Health

LCSW: Licensed Clinical Social Worker

APN/NP: Advanced Practice Nurse/Nurse Practitioner

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

+ Add-on code, which describes a service that, with one exception, is always performed in conjunction with another primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner.

			Practitioner Type (Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)							Place of Service	
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW		APN/NP
+90785	Interactive complexity (list separately in addition to the code for primary procedure). (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management (E&M) service [90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350], and group psychotherapy [90853]). (Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E&M services when no psychotherapy service is also reported).		\$13.92	\$10.44	X	X	X	X	X	X	Any
90791	Psychiatric diagnostic evaluation.	Per evaluation	\$131.78	\$98.84	X	X	X	X	X	X	Any
90792	Psychiatric diagnostic evaluation with medical services. (Do not report 90791 or 90792 in conjunction with 99201–99337, 99341–99350, 99366–99368, 99401–99444). (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services).	Per evaluation	\$146.15	N/A	X					X	Any
90832	Psychotherapy, 30 minutes with patient and/or family member.	Per evaluation	\$63.89	\$47.42	X	X	X	X	X	X	Any
+90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure). (Use 90833 in conjunction with 99201–99255, 99304–99337, 99341–99350).	Per evaluation	\$66.08	N/A	X					X	Any
90834	Psychotherapy, 45 minutes with patient and/or family member.	Per evaluation	\$84.95	\$63.71	X	X	X	X	X	X	Any



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			Practitioner Type (Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)								Place of Service
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
+90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M services (list separately in addition to the code for primary procedure). (Use 90836 in conjunction with 99201–99255, 99304–99337, 99341–99350).	Per evaluation	\$83.95	N/A	X					X	Any
90837	Psychotherapy, 60 minutes with patient and/or family member. (Use the appropriate prolonged services code [99354–99357] for psychotherapy services 90 minutes or longer).	Per evaluation	\$127.43	\$95.57	X	X	X	X	X	X	Any
+90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M services (list separately in addition to the code for primary procedure). (Use 90838 in conjunction with 99201–99255, 99304–99337, 99341–99350). (Use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services.)	Per evaluation	\$110.75	N/A	X					X	Any
90839	Psychotherapy for crisis; first 60 minutes.	Per evaluation	\$133.14	\$99.86	X	X	X	X	X	X	Any
+90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.) (Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785–90899).	Per evaluation	\$63.52	\$47.64	X	X	X	X	X	X	Any
90845	Psychoanalysis.	Per evaluation	\$91.78	N/A	X	X					Any
90846	Family psychotherapy (without the patient present).	Per evaluation	\$103.18	\$77.39	X	X	X	X	X	X	Any
90847	Family psychotherapy (conjoint psychotherapy) (with patient present).	Per evaluation	\$106.73	\$80.05	X	X	X	X	X	X	Any
90849	Multiple-family group psychotherapy.	Per evaluation	\$34.42	\$25.82	X	X	X	X	X	X	Any
90853	Group psychotherapy (other than of a multiple-family group). (Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity).	Per evaluation	\$25.71	\$19.28	X	X	X	X	X	X	Any
90870	Electroconvulsive therapy (includes necessary monitoring).	Per treatment	\$179.15	N/A	X						21, 51
90885	Psychological evaluation of records.		\$50.15	N/A	X					X	Any
96101	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Rorschach, Wechsler Adult Intelligence Scale [WAIS]), per hour of the psychologist's or	Per hour	\$80.34	N/A	X	X					Any

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			Practitioner Type (Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)								Place of Service
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
	physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.										
96102	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g. MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	Per hour	\$64.52	N/A	X	X					Any
96103	Psychological testing includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report.	Per test	\$28.33	N/A	X	X					Any
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Scoring Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	Per hour	\$98.79	N/A	X	X					Any
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Weschler Memory Scales, and Wisconsin Card Sorting Test), with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	Per hour	\$81.48	N/A	X	X					Any
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by computer, with qualified healthcare professional interpretation and report.		\$48.96	N/A	X	X					Any
96150	Health and behavior assessment (e.g., health focused clinical interview, behavioral observations, psychophysiological monitoring, health oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.	15 minutes	\$21.79	N/A	X	X					Any
96151	Health and behavior assessment (e.g., health focused clinical interview, behavioral observations, psycho-physiological monitoring, health oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment.	Per evaluation	\$20.71	N/A	X	X					Any
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual.	Per evaluation	\$20.00	N/A	X	X					Any
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (two or more	Per evaluation	\$4.66	N/A	X	X					Any

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Procedure Code	Description	Unit	Delaware Physician and Psychologist  (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH  (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
	patients).										
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).	Per evaluation	\$19.65	N/A	X	X					Any
99211 HE	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  99211 HE for MH medications (e.g., haloperidol, risperidone, fluphenazine, benztropine, and diphenhydramine).	Per visit	\$20.17	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99201	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a problem focused history; 2) a problem focused examination; and 3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$44.66	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99202	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) an expanded problem focused history; 2) an expanded problem focused examination; and 3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$75.91	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71

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			Practitioner Type (Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)								Place of Service
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
99203	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a detailed history; 2) a detailed examination; and 3) medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$109.74	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99204	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$166.75	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99205	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$209.09	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99211	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.	Per evaluation	\$20.17	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99212	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a problem-focused history; 2) a problem focused examination; and 3) straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided,	Per evaluation	\$44.28	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71

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			Practitioner Type (Note: Psychiatrists is for non-Medicaid only and not included under Medicaid OLP State Plan.)								Place of Service
Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
	consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.										
99213	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) an expanded problem focused history; 2) an expanded problem focused examination; and 3) medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$73.69	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99214	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a detailed history; 2) a detailed examination; and 3) medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$108.51	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
99215	Office or other outpatient visit for the E&M of an established patient, which requires two of these three key components: 1) a comprehensive history; 2) a comprehensive examination; and 3) medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided, consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	Per evaluation	\$146.20	N/A	X					X	11, 20, 22, 49, 50, 53, 57, 71
+99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient E&M service). Use 99354 in conjunction with 90837, 99201-99215, 99241-99245, 99324-99337, 99341-99350.	First Hour	\$101.14	\$75.86	X	X*	X*	X*	X*	X	Any

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Procedure Code	Description	Unit	Delaware Physician and Psychologist (Psychologist Use HP Modifier)	LCSW, LMFT, LPCMH (Use HO Modifier)	Psychiatrist	Psychologist	LMFT	LPCMH	LCSW	APN/NP	
	The practitioner types in bold* can use +99354 only in conjunction with 90837.										
+99355	Each additional 30 minutes (list separately in addition to code for prolonged service). Use in conjunction with 99354.  The practitioner types in bold* can use +99354 only in conjunction with 90837.	30 minutes	\$98.23	\$73.67	X	<b>X*</b>	<b>X*</b>	<b>X*</b>	<b>X*</b>	X	Any
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., Alcohol Use Disorders Identification Test [AUDIT], Drug Abuse Screening Test [DAST]) and brief intervention (SBI) services, 15 to 30 minutes.	Per evaluation	\$35.48	N/A	X	X					Any
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services, over 30 minutes.	Per evaluation	\$69.15	N/A	X	X					Any
Q3014	Telehealth Facility Fee note: The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee).		\$23.76	\$17.82 (no modifier)							Any

### 1.10. Place of Service Description

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), 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.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or 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 nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. <i>(Description change effective January 1, 2016)</i>
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 located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric	A facility that provides inpatient psychiatric services for the diagnosis and treatment

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	Facility	
		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 diagnosis 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.
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.

**Source:** Place of Service Codes for Professional Claims Database (updated August 6, 2015):

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>

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

Addiction services include an array of individual-centered outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse or gambling disorder symptoms and behaviors. Hereinafter, throughout this manual, whenever substance use or substance use disorder (SUD) is referenced, gambling disorder, as an addiction disorder recognized under the DSM 5<sup>3</sup>, may be used as an eligible condition for purposes of certification and reimbursement for services.

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

Outpatient activities may be indicated as an initial modality of care for a beneficiary whose severity of illness warrants this level of treatment, or when a beneficiary's progress warrants a less intensive modality of service than they are currently

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

<sup>3</sup> As defined in the Fifth Edition of the DSM-5, 2013, Gambling Disorder is:

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12month period:

- a. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
- b. Is restless or irritable when attempting to cut down or stop gambling.
- c. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
- d. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
- e. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
- f. After losing money gambling, often returns another day to get even ("chasing" one's losses).
- g. Lies to conceal the extent of involvement with gambling.
- h. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- i. Relies on others to provide money to relieve desperate financial situations caused by gambling.

And, the gambling behavior is not better explained by a manic episode.



receiving. The intensity of the services will be driven by medical necessity. MAT should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT.

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

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

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

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

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

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and be based on the beneficiary's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial

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

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

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

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

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

For programs offering both outpatient and residential care, the beneficiary's chart must reflect admission to the program which marks the start of the current episode and any reimbursement. If the beneficiary is in a service that is paid FFS and changes levels of care within 24 hours to a per diem funded service, it shall be considered part of the per diem service. Both FFS and per diem billing will not be permitted unless the service billed

is MAT which is not included in the outpatient or per diem rate or another specific code permitted only by permission of the DSAMH fiscal officer in writing as not duplicative of current reimbursement rates. If the beneficiary is in a per diem service and changes levels of care to another per diem level of care, then only one per diem may be billed for the 24 hour period and a new episode will not be allowed (i.e., a single facility cannot bill for discrete services and multiple per diems in a single 24 hour period). For specific billing guidance on detoxification, see the ASAM 2-WM section.

## 2.2 Provider Qualifications for all SUD and Addiction Services

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

- **Addiction-credentialed physicians** include:
  - Physicians certified by ASAM or the American Board of Addiction Medicine (ABAM)
  - Physicians with an Addiction Psychiatry certification bestowed by the American Board of Psychiatry and Neurology (ABPN)
  - Licensed Physicians with prescribing privileges in the state of Delaware, Board-eligible or Board certified, and knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CME credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy.  
**Note:** Prescribing clinicians who are psychiatric nurse practitioners may be utilized by a licensed 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 assisted therapy and (c) prescribing medications permissible under law and SAMHSA regulations. These clinicians are not considered addiction-credentialed physicians under ASAM.
- **Licensed practitioners** under the State of Delaware regulation are licensed by Delaware and include, but are not limited to LCSWs, LPCMH, and LMFTs, NPs, APNs, medical doctors (MD and DO), and psychologists. Effective 7/1/2016, Licensed Chemical Dependency Professionals (LCDPs) will be included in this section. If a medical director is required by a program, the medical director must at least have prescribing privileges under State law and may include NPs, APNs, and medical doctors (MD and DO) in addition to any other requirements specified for the particular service.  
**Note:** *State licensure of practitioners does not drive the Medicaid reimbursement (for example, RNs are licensed but are grouped with “unlicensed staff” due to staffing costs). The description below and the services manual, codes and rates drive reimbursement in Medicaid SUD programs*
- **Any staff who is unlicensed and providing addiction services** must be credentialed by DSAMH and/or the credentialing board. Certified and Credentialed staff under State regulation for SUD services include certified recovery coaches, credentialed behavioral health technicians, RNs and LPNs, certified alcohol and drug counselor, internationally certified alcohol and drug counselor, certified co-occurring disorders professional, internationally certified co-occurring disorders professional diplomate, and licensed chemical dependency professional (LCDP). Effective 7/1/2016, Licensed Chemical Dependency Professionals (LCDPs) will not be considered “unlicensed”. State regulations require supervision of recovery coaches and credentialed behavioral health technicians by a QHP meeting the supervisory standards established by DSAMH. A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMH, and LMFTs, APNs, NPs, medical doctors (MD and DO), and psychologists.

Effective 7/1/2016, LCDPs and CDACs will be included in the definition of a QHP. The QHP provides clinical/administrative oversight and supervision of recovery coaches and credentialed behavioral health technicians staff in a manner consistent with their scope of practice.

- **Recovery coaches** must be trained and certified in the State of Delaware to provide services. Recovery coaches are at least 18 years old, and have a high school diploma or equivalent. The certification includes criminal, abuse/neglect registry and professional background checks, and completion of a State-approved standardized basic training program. Recovery coaches must self-identify as a present or former primary beneficiary of SUD services. **Note:** Recovery coaches within a licensed and/or certified residential program must provide counseling consistent with an approved treatment plan. Medicaid will not reimburse for 12-step programs run by recovery coaches.
- **LCDPs** are credentialed by the Delaware Department of State, Division of Professional Regulation.
  - If the LCDP holds a current Chemical Dependency Professional license in another jurisdiction, then the professional is granted reciprocity if the license has been held for a period of time or the license is found to be similar to the Delaware certification standards.
  - If the professional is not licensed in another jurisdiction but is applying for certification in Delaware and is currently certified by the Delaware Certification Board, Inc., or other national certification board such as the NAADAC as either a NCAC or MAC, then the applicant must also have a criminal history record check and verify any current or previous licensure and/or certification. Professionals who are certified must have documentation of a Master's degree with graduate semester courses in counseling or related education and post-Master's experience including supervised counseling in substance abuse counseling.
- **Credentialed behavioral health technicians** are trained in ASAM techniques and credentialed, unlicensed professional staff who are at least 18 years of age with a high school or equivalent diploma.
- **All other unlicensed practitioners** who are certified by a national body must meet the requirements for credentialed behavioral health technicians in addition to any requirements for their national certification. 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 and all programs with MAT interventions must comply with federal and State laws regarding controlled substance prescriber availability.

To provide both Medicaid fee-for-service and DSAMH-only funded services, a SUD provider must have provider qualifications verified through DSAMH by having a contract award from DSAMH and current provider enrollment with the Medicaid agency. SUD providers may be practicing independently only if they are a physician in an office-based opioid treatment program or a physician treating an individual with SUD in their practice. Otherwise, all practitioners must practice within an addiction treatment or a co-occurring 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 client capacity requested; and a copy of the agency's Delaware business license and home

state license, when applicable. The licensure also requires a description of the services to be provided by the program, including a statement of the program philosophy, goals and objectives, and a description of the methodology for each service element; and organization charts of showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships. At this time, certification for SUD service provision is only available under DSAMH for programs related to the Treatment Access Center (TASC) program.

## 2.2.1 Behavioral Health Technician Credentialing

Credentialed Behavioral Health Technicians are recognized as a member of the multidisciplinary team in both outpatient and residential SUD treatment settings.

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

1. Education;
2. Informal counseling focused on goal setting and skill development for coping and managing symptoms;
3. Informal counseling to address lifestyle, attitudinal, and behavioral problems;
4. Social support;
5. Referral and assistance with accessing resources;
6. Assistance with clinical treatment plan development.

### Credentialing criteria

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

- Be at least 18 years of age;
- Have a high school or equivalent diploma;
- 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;
  - Client 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 treatment plan development; and
  - Medical records and documentation.

### Supervision

Behavioral health technicians must receive clinical and administrative supervision and oversight by a qualified healthcare professional (QHP). A QHP includes the following professionals who are currently registered with their respective Delaware board LCSWs, LPCMH, LMFTs, APNs, NPs, medical doctors (MD and DO), and psychologists. Behavioral health technicians should have access to both individual and group supervision.

### **Credentialing process**

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 organization 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 individual'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. The Annual Attestation Form should be submitted to the DSAMH Provider Relations Unit.

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.

## Individual Behavioral Health Technician Credentialing Attestation Form To be maintained in each Personnel Record

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: Provider Agency Representative name

\_\_\_\_\_  
Title

## Agency Annual Behavioral Health Technician Credentialing Attestation Form

**To be maintained at the agency and submitted to DSAMH annually**

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

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.

Behavioral Health Technician Names (print) with date of hire and date of annual recertification:

Name	Date of Hire	Date(s) of Annual Training



### Annual Certification Requirements

Completed annual training regarding the following information:

- 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: Provider Agency Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print: Provider Agency Representative name

\_\_\_\_\_  
Title

## 2.3 Taxonomies

- The following programs can bill SUD codes to the extent the code is medically necessary for the client, consistent with billing guidance, and is covered under their license:
  - Co-occurring Clinic: 261QM0850X Clinic/Center – Adult Mental Health (bill with either no modifier – for physician; HO – for psychologist; HO – for LMFT, LPCMH, or LMFT; SA - Nurse).
  - SUD: 261QR0405X Clinic/Center - Rehabilitation, SUD
  - MA-OTP providers remain under their existing taxonomy (261QM2800X Methadone Clinic) and may only bill the codes outlined below:
    - Medication Assisted Outpatient Treatment Program (MA-OTP) Clinic – MA-OTP clinics are reimbursed by DMMA for the cost of administration and cost of the drug for methadone and buprenorphine products only. MA-OTPs billing for methadone only should use code H0020. MA-OTPs billing for buprenorphine should bill T1502 for the administration of the drug and J8499 for the cost of the drug. Administration of buprenorphine requires prior authorization. MA-OTP clinicians are expected to check the Prescription Monitoring Program on a regular basis (monthly at a minimum) to verify the clients are not receiving opioids from any other source. The substance abuse treatment is provided by other SUD providers as noted in this Manual.
    - MA-OTP provider taxonomy may also bill 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.
  
- The following programs can bill MAT codes for which they have the appropriate SAMHSA waiver. **Note:** *These programs are subject to audit at any given point of time to ensure the appropriate documentation is on hand.*
  - Crisis Intervention: 251S00000X Agency – Community/Behavioral Health
  - PROMISE providers (ACT, ICM, GH, etc.) - 261QM0801X Mental health Clinic/Community-Support
  - Methadone Clinic - 261QM2800X
  - FQHC 261QF0400x
  - Inpatient and outpatient hospital and individual physicians listed below with a waiver at the federal level. **Note:** *many of the individual physicians will not bill the SUD MAT codes.*

<b>SUR COS Description</b>	<b>Taxonomy</b>	<b>Taxonomy Description</b>
Inpatient Services	273Y00000X 282N00000X 283Q00000X 283X00000X 284300000X 323P00000X	Hospital Rehabilitation Unit General Acute Care Hospital Psychiatric Hospital Rehabilitation Hospital Special Hospital Inpatient Adolescent Psychiatric Services (DSCYF)
Outpatient Services	273Y00000X 282N00000X 283Q00000X 283X00000X 284300000X	Hospital Rehabilitation Unit General Acute Care Hospital Psychiatric Hospital Special Hospital
Physician Services Licensed Physicians with	207KA0200X 207L00000X 207N00000X	Allergy Anesthesiology Dermatology

<b>SUR COS Description</b>	<b>Taxonomy</b>	<b>Taxonomy Description</b>
<p>prescribing privileges in the state of Delaware, Board-eligible or Board certified, and knowledgeable about addiction treatment as demonstrated by completion of at least 10 hours of CME credits each calendar year that focuses on treatment of SUDs, including medication assisted therapy.</p> <p><b>Note:</b> <i>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 assisted therapy, and (c) prescribing medications permissible under law and SAMHSA regulations. These clinicians are not considered addiction-credentialed physicians under ASAM.</i></p>	<p>207P00000X 207Q00000X 207QA0000X 207QA0505X 207QG0300X 207R00000X 207RA00000X 207RC00000X 207RE0101X 207RG0100X 207RG0300X 207RH0003X 207RI0200X 207RN0300X 207RP1001X 207RR0500X 207RX0202X 207T00000X 207U00000X 207V00000X 207X00000X 207Y00000X 207ZP0101X 208000000X 2080A0000X 2080N0001X 208100000X 208200000X 2084N0400X 2084P0800X 2085R0202X 2085R0203X 208500000X 2086S0129X 208800000X 208C00000X 208D00000X 208G00000X 213E00000X 367500000X 367A00000X 367H00000X 208VP0000X</p>	<p>Emergency Physician Family Practice Family Practice, Adolescent Family Practice, Adult Family Practice, Gerontology Internal Medicine Internal Medicine, Adolescent Cardiology Endocrinology Gastroenterology Internal Medicine, Geriatric Hematology Infectious Diseases Nephrology Pulmonary Disease Rheumatology Oncology Surgery, Neurological Nuclear Medicine Obstetrics &amp; Gynecology Surgery, Orthopedic Otolaryngology Pathology Pediatrics Pediatrics, Adolescent Neonatology Physical Medicine &amp; Rehabilitation Surgery, Plastic Neurology Psychiatry Radiology Radiation Therapy Surgery, General Surgery, Cardiology Urology Surgery, Colon &amp; Rectal General Practice Surgery, Thoracic Podiatry Nurse Anesthetist, Certified (Crossover) Nurse Midwife Nurse Anesthetist, Certified (CNRA) Pain Medicine</p>

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## Specific Outpatient SUD and Addiction Services

### 3.1 Addiction Assessment and Referral

Addiction assessment and referral programs provide ongoing assessment and referral services for individuals presenting with a current or past pattern of alcohol, drug or gambling related disorders. The assessment is designed to gather and analyze information regarding an individual's current substance use and problem gambling behavior and social, medical, and treatment history. The purpose of the assessment is to provide 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 beneficiary to gain access to other needed Medicaid SUD or mental health services. Referral arrangements may include:

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

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

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; the maximum client capacity requested; and 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, and a description of the methodology for each service element; and organization charts of showing

incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

### ***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 of his or her 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.

### **3.2 ASAM Level 0.5: Early Intervention<sup>4</sup>**

Early intervention services are organized services provided in a non-residential treatment setting that meets State licensure and/or certification standards. 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) under OLP, Nurse Practitioner or Physician service authority under the Medicaid State Plan.

These one-to-one services are to assess and address problems or risk factors that appear to be related to substance use and addictive behavior and to help the individual recognize the harmful consequences of high-risk substance use and/or addictive behavior. Delaware-ASAM criteria are used to determine appropriate medical necessity and level of care (LOC). These services may be a component of a court-ordered program (e.g., Superior Court Drug Court, Re-entry Court, Veterans Court) and the length of service/participation may be mandated and determined by the program and regulatory rules. Services include assessment, preventive counseling, referral and service coordination. Group preventive SUD interventions are not Medicaid reimbursable.

#### ***Admission Guidelines for ASAM Level 0.5***

1. Acute intoxication and/or withdrawal potential: No withdrawal risk.
2. Biomedical conditions and complications: None or very stable. Any identifiable problems are stable or are being addressed through appropriate outpatient medical services.
3. Emotional, behavioral, or cognitive conditions and complications: None or very stable. Any identifiable problems are stable or are being addressed through appropriate outpatient mental health services.
4. Readiness to change: The individual is willing to explore how current alcohol or other drug use, and/or high-risk behaviors may impair ability to meet responsibilities and/or affect achievement of personal goals. This could also include individuals who are ambivalent about exploring how current behavior may be harmful or those whose motivation is to achieve some goal other than the modification of their substance use behaviors (e.g., having driving privileges restored).
5. Relapse, continued use, or continued problem potential: The individual does not understand the need to alter his or her current behavior or pattern of use to prevent harm that may be related to use, or the individual needs to acquire specific skills needed to change his or her current pattern of use.
6. Recovery environment: The individual's social support system, family members, and/or significant other increases the risk of personal conflict about alcohol and/or other drug use.

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<sup>4</sup> ASAM Level 0.5: Early Intervention does not apply to Gambling Disorders.

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

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) or similar certification standard completed within 72 hours of referral. The assessment confirms appropriate patient placement and informs the treatment plan and ongoing care. Assessments must be reviewed and signed by a qualified professional. A recommendation for care must be obtained from a licensed practitioner per CMS Rehabilitation requirements at 42 CFR 440.60.
2. Individualized treatment plan per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) or similar certification standard, completed within 7 days of referral. This plan should be developed in collaboration with the individual.
3. Recovery plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 30 days.
4. Discharge/transfer planning begins at initial referral.
5. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

### **Staffing**

1. Level 0.5 outpatient settings include an array of licensed practitioners, unlicensed counselors, credentialed behavioral health technicians, and peers operating within their scope of practice.
2. Care coordination services are provided 1:1 with the individual.
3. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation but should not exceed 50 active individuals for each licensed practitioner and unlicensed counselor. For this standard, *active* is defined as being treated at least every 90 days.
4. QHP supervisors must be on site or available for phone consultation in a crisis 24/7 and supervise no more than 10 unlicensed staff.

### **3.3 ASAM Level 1: Outpatient Services**

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

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

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

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.
2. Biomedical conditions and complications: None or very stable or receiving medical monitoring.

3. Emotional, behavioral, or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring. May have a co-occurring diagnosis.
4. Readiness to change: Participant should be open to recovery or be willing to explore his/her substance use in order to avoid a negative consequence as in mandated treatment. The individual requires monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.
5. Relapse, continued use, or continued problem potential: Participant is able to achieve abstinence, controlled use and/or addictive behaviors, and related recovery goals with minimal support or willing to explore abstinence and related goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to ambivalence about preoccupation of alcohol use, other drug use or gambling; cravings, peer pressure, and lifestyle, and attitude changes.
6. Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system.

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

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

### ***Staffing***

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

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

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

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

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

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

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

1. Nursing assessment at time of admission that is reviewed by a physician to determine need for opioid treatment services, eligibility, and appropriateness (proper patient placement) for admission and referral (applies to both OPT and OBOT).
2. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD



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

### **Staffing**

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

### **OTP**

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

### **OBOT**

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

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

1. Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered

- in any appropriate community setting that meets State licensure. All outpatient SUD programs are licensed or certified under State law.
2. Services include, but are not limited to individual, group, and family counseling including psycho-education on recovery. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy. Services also include monitoring of 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.
  3. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but must be nine or more contact hours per week for adults, age 18 years and older, with a minimum of contact three days per week (not to exceed 19 hours per week). This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient, or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. Delaware-ASAM criteria are used to determine LOC.

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

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

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

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

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

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

### **Staffing**

1. Level 2.1 outpatient settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers, and credentialed behavioral health technicians operating within their scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment and rehabilitation but should not exceed 35 active individuals for each licensed practitioner or unlicensed counselor. For this standard, active is defined as being treated at least every 90 days.
3. Counseling groups should not exceed 15 individuals (assumed average of 9); educational group size is not restricted.
4. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.
5. QHP supervisors must be on site at least 10 hours per week during hours of operation, be available for phone consultation at all times, and supervise no more than 10 staff.
6. Addiction-credentialed physicians are part of the interdisciplinary team and must be on site at least 10 hours per week during hours of operation and be available for phone consultation at all times. **Note:** *If the program is only providing outpatient therapy, then it should focus on providing just those ASAM 1.0 services solely to individuals needing that level of care. However, if the program is appropriately staffed, then the program could provide IOP to individuals needing a higher level of care and outpatient services to individuals needing the 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.*

### **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. In order 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 level staff person in order to bill the fee code with the highest level staff person. Other lower

level staff can assist with the group so long as staffing levels consistent with the billing guidance are maintained.

- For SUD IOP and 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 IOP 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 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 maintain at least the 1:10 group ratio (practitioner to clients) at all times 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 an academic tutor.
- Time spent attending school (e.g., during a day treatment program)
- Habilitative services for the beneficiary (adult) to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered Transportation 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) has 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 beneficiary's authorized Treatment 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 beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment 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 beneficiary.

For Partial Hospitalization and 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 individuals 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 clients) 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 clients) with at least a Bachelor's or LPN leading a group when psychoeducation is occurring. The group sizes would not exceed 20 individuals 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.

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

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

These services include, but are not limited to individual, group, family counseling, and psycho-education on recovery, as well as monitoring of addictive behaviors, medication management, medical, and psychiatric examinations, CI coverage, and orientation to community-based support groups. Partial hospitalization services should include evidence-informed practices, such as CBT, motivational interviewing, and multidimensional family therapy.

These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of 20 contact hours per week for adults, age 18 years and older, at a minimum of three days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. Delaware-ASAM criteria are used to determine LOC.

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

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in a partial hospital setting.
2. Biomedical conditions and complications: None, or not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management.
3. Emotional, behavioral, or cognitive conditions and complications: None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability, and degree of impairment.
4. Readiness to change: Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another LOC have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program. Alternatively, the client's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the client's willingness to

participate in treatment and to explore his or her level of awareness and readiness to change suggest the treatment at Level 2.5 can be effective.

5. Relapse, continued use, or continued problem potential: Participant is experiencing an intensification of symptoms related to their addiction, and their level of functioning is deteriorating despite modification of the treatment plan and active participation in a Level 1 or Level 2.1 program. Alternatively, there is a high likelihood of relapse or continued use or continued problems without near-daily support and monitoring, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment.
6. Recovery environment: Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in a partial hospitalization program. Alternatively, family members and/or significant others who live with the client are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The client requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is not active opposition to, or sabotaging of, his or her recovery efforts.

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

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

### **Staffing**

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

6. Addiction-credentialed physicians are part of the interdisciplinary team and must be on site at least 10 hours per week during hours of operation and be available for phone consultation at all times.

## ***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. In order 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 level staff person in order to bill the fee code with the highest level staff person. Other lower level staff can assist with the group so long as staffing levels consistent with the billing guidance are maintained.

- For SUD IOP and 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 IOP 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 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 maintain at least the 1:10 group ratio (practitioner to clients) at all times 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 an academic tutor.
- Time spent attending school (e.g., during a day treatment program)
- Habilitative services for the beneficiary (adult) to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered Transportation 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) has 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 beneficiary's authorized Treatment 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 beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment 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 beneficiary.

For Partial Hospitalization and 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 individuals 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 clients) 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 clients) with at least a Bachelor's or LPN leading a group when psychoeducation is occurring. The group sizes would not exceed 20 individuals 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.

### **3.6 ASAM Level 2-WM Ambulatory Withdrawal Management with Extended Onsite Monitoring<sup>5</sup>**

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

Additionally, this LOC can include up to 23 hours of continuous observation, monitoring, and support in a supervised environment for an individual to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate LOC to continue the recovery process. These 23-hour programs are referred to as Level 2-WM (23 hour) in this manual. Because these programs operate 24/7 and the client must be discharged within 23 hours of admission, program expectations differ from other

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<sup>5</sup> ASAM Level 2-WM Ambulatory Withdrawal Management with Extended Onsite Monitoring is not applicable to Gambling Disorders.



ambulatory withdrawal management with extended onsite monitoring programs (i.e., Level 2-WM (23 hour) has different requirements than Level 2-WM). For individuals in need of greater than 23 hours, Level 3.2-WM, Clinically Managed Residential Withdrawal Management or Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management should be used depending on the severity of the individual's withdrawal syndrome.

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

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

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

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

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

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

## **Admission Guidelines**

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

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

complications; and would safely respond to several hours of monitoring, medication, and treatment.

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

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

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

### *Level 2-WM*

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

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

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and

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

### **Staffing**

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

### **Level 2-WM**

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

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

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law. Programs unable to comply with this requirement for an addiction-credentialed physician may obtain, at the discretion of DSAMH, a time-limited waiver following the submission of a plan to ameliorate this deficiency.
2. A designated prescriber with on call availability 24/7 for consultation and in order to discharge participant to higher LOC if necessary. A PA, NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.

3. At least two nurses onsite at all times (NP, RN, or LPN) per 12 individuals on site at all times.
4. 0.5 FTE certified peer per 12 individuals on site during days.
5. 0.5 FTE behavioral health technician per 12 individuals on site during days and evenings

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## Specific Residential SUD and Addiction Services

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; the maximum client capacity requested; and 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, and a description of the methodology for each service element; and organization charts of showing incumbent names, positions, degrees and credentials (e.g., license, certification); all vacant positions; and illustrating direct and indirect reporting and supervisory relationships.

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

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

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

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

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

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

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

### ***Staffing***

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

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

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from

the effects of the addiction. The program emphasis is on peer and support, not medical and nursing care. All facilities are licensed by DSAMH.

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

### ***Admission Guidelines***

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

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

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

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

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

### **Staffing**

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

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

### **4.3 ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential Treatment<sup>6</sup>**

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

The functional limitations seen in individuals who are appropriately placed at Level 3.3 are primarily cognitive and can be either temporary or permanent. They may result in problems in interpersonal relationships, emotional coping skills, or comprehension. For example, temporary limitations may be seen in the individual who suffers from an organic brain syndrome as a result of his or her substance use and who requires treatment that is slower

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<sup>6</sup>ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential Treatment is not applicable for the treatment of gambling disorders in the absence of co-occurring disorders requiring this intensity or type of service.



paced, more concrete, and more repetitive until his or her cognitive impairment subsides. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. All facilities are licensed or certified by DSAMH.

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

### ***Admission Guidelines***

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

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

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

8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

## **Staffing**

### **Staffing (10 beds or less)**

1. Level 3.3 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. An RN on site during the day shift.
4. A psychiatrist or psychiatric NP is on site at least three hours/week.
5. A primary care/physical health physician (or physician extender) is on site at least one and one half hours/week.
6. One licensed practitioner or unlicensed counselor with direct supervision on site during days and evenings and on call 24/7 when not on site.
7. One behavioral health technician and/or recovery coach on site and awake at all times. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

### **Staffing (11-16 beds)**

1. Level 3.3 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. An RN on site during the day shift.
4. A psychiatrist or psychiatric NP is on site at least five hours/week.
5. A primary care/physical health physician (or physician extender) is on site at least two and one half hours/week.
6. One licensed practitioner or unlicensed counselor with direct supervision on site during days and evenings and on call 24/7 when not on site.
7. One behavioral health technician and/or recovery coach on site and awake at all times.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

### **Staffing (45- 50 beds)**

1. Level 3.3 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches, and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to

the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

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

#### **4.4 ASAM Level 3.5 Clinically Managed High Intensity Residential Treatment<sup>7</sup>**

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

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

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

1. Acute intoxication and/or withdrawal potential: None, or withdrawal symptoms can be safely managed at this level.
2. Biomedical conditions and complications: None or stable and participant can self-administer any prescribed medication, or, if condition is severe enough to distract from treatment and recovery participant can receive medical monitoring within the program or through another provider.
3. Emotional, behavioral, or cognitive conditions and complications: Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder enhanced setting is required for seriously and persistently mentally ill patients.
4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences. If there is high severity in this dimension but not in other dimensions, the individual; therefore, needs ASAM Level 1 placement with inclusion of motivational

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<sup>7</sup>ASAM Level 3.5 Clinically Managed High Intensity Residential Treatment is not applicable for the treatment of gambling disorders in the absence of co-occurring disorders requiring this intensity or type of service.

enhancement therapy (MET). MET is a therapeutic intervention and a component part of the program.

5. Relapse, continued use, or continued problem potential: Participant is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued use, with limited ability to initiate or sustain ongoing recovery and sobriety in a less structured environment.
6. Recovery environment: Participant lives in an environment with moderately high risk or abuse or is a culture highly invested in substance use. Participant lacks skills to cope with challenges to recovery outside of a highly structured 24-hour setting.

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

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

### **Staffing**

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

7. One behavioral health technician and/or recovery coach per 16 residents is on site and awake at all times.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

#### **4.5 ASAM Level 3.7 Medically Monitored Intensive Inpatient Treatment<sup>8</sup>**

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

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

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

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

1. Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program.
2. Biomedical conditions and complications: Moderate to severe conditions which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital.
3. Emotional, behavioral, or cognitive conditions and complications: Moderate to severe conditions and complications (such as diagnosable co-morbid mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others. Psychiatric symptoms are interfering with

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<sup>8</sup> ASAM Level 3.7 Medically Monitored Intensive Inpatient Treatment is not applicable for the treatment of gambling disorders in the absence of co-occurring disorders requiring this intensity or type of service.

abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.

4. Readiness to change: Participant unable to acknowledge the relationship between the addictive disorder and mental health and/or medical issues, or participant is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured medically monitored setting (but not medically managed).
5. Relapse, continued use, or continued problem potential: Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support.
6. Recovery environment: Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive LOC.

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

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

### **Staffing**

1. Level 3.7 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
2. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
3. A psychiatrist or psychiatric NP is on site at least 10 hours/week for every 16 residents.

4. A primary care/physical health physician (or physician extender) is on site at least five hours/week for every 16 residents.
5. One RN on day shift per 16 residents to oversee and monitor participant progress and medication administration. One LPN at all times per 16 residents.
6. One licensed or certified clinician or counselor with direct supervision on site during days and evenings for every 16 residents.
7. One behavioral health technician and/or recovery coach on site and awake at all times for every 16 residents.
8. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

#### **4.6 ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management<sup>9</sup>**

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

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

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

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

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission, including an addiction-focused history and ASI, about the individual to provide a clear understanding of the individual's present status. If self-administered withdrawal management medications are to be used, a physical examination by a physician, physician assistant, or NP should be made at time of admission. Assessment of addiction-focused history and ASI to be reviewed with a physician during the admission process.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. Full physical exam within 24 hours.
5. Initial individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Delaware Administrative Code 6001 (Substance Abuse Facility Licensing Standards), completed within 24 hours which includes problem formulation and articulation of short-term,

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<sup>9</sup> ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management is not applicable for the treatment of gambling disorders in the absence of co-occurring disorders requiring this intensity or type of service

measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.

6. A comprehensive treatment plan within three days if participant is still in the service and additional updates to the treatment plan as indicated.
7. Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
8. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
  - a. The individual's physical condition, including vital signs.
  - b. The individual's mood and behavior.
  - c. Statements about the individual's condition and needs.
  - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
  - e. Additional notes shall be documented, as needed.
10. Physician orders are required for medical and psychiatric management.

## **Staffing**

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

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



# 5

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## Reimbursement for SUD and Addiction Services

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

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

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

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register [of Regulations]. The agency's fee schedule rate was set as of 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](http://www.dmap.state.de.us/downloads/hcpcs.html).

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

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

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

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

**Note:** Claims for unlicensed staff (e.g., certified peers) will bill using their licensed supervisor as the rendering provider number.

## 5.1 Addiction Services Reimbursement and Coding Summary

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

### Modifiers:

**HF** – Substance abuse program

**HE** – Mental health program

**HK** – Specialized mental health programs for high risk populations

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

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

**HG** – Opioid addiction treatment program

**HQ** – Group setting

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

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

**TG** – Complex/high tech LOC

**U1** – Home/Community

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

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
+90785	HF		Interactive complexity (list separately in addition to the code for primary procedure).					Any
			<i>(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an E&amp;M service [90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350], and group psychotherapy [90853].)</i>			\$13.92	\$10.44	
			<i>(Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E&amp;M services when no psychotherapy service is also reported.)</i>					
			<i>Licensed practitioners only.</i>					
90832	HF		Psychotherapy, 30 minutes with patient and/or family member.	Per session		\$63.89	\$47.92	Any
			<i>Licensed practitioners only for substance abuse program.</i>					
90834	HF		Psychotherapy, 45 minutes with patient and/or family member.	Per session		\$84.95	\$63.71	Any

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HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
			<i>Licensed practitioners only for substance abuse program.</i>					
90837	HF		Psychotherapy, 60 minutes with patient and/or family member.	Per session		\$127.43	\$95.57	Any
			<i>Licensed practitioners only for substance abuse program.</i>					
90839	HF		Psychotherapy for crisis; first 60 minutes.	60 minutes		\$133.14	\$99.86	Any
			<i>Licensed practitioners only for substance abuse program must be part of certified crisis program.</i>					
+90840	HF		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service).	30 minutes follow-on		\$63.52	\$47.64	Any
			(Use 90840 in conjunction with 90839.)					
			<i>Licensed practitioners only for substance abuse program must be part of certified crisis program.</i>					
90846	HF		Family psychotherapy (without the patient present).	Per session		\$103.18	\$77.39	Any
			<i>Licensed practitioners only for substance abuse program.</i>					
90847	HF		Family psychotherapy (conjoint psychotherapy) (with patient present).	Per session		\$106.73	\$80.05	Any
			<i>Licensed practitioners only for substance abuse program.</i>					
90849	HF		Multiple-family group psychotherapy.			\$34.42	\$25.82	Any
90853	HF		Group psychotherapy (other than of a multiple-family group).	Per session		\$25.71	\$19.28	Any
H0001			Alcohol and/or drug assessment. (ASAM Level .5 or 1).	One session (One visit)	\$77.30			Any
H0001	U1		Alcohol and/or drug assessment, Home/Community. (ASAM Level .5 or 1).	One Session (One hour visit)	\$90.26			Any
H0004	HF		Behavioral health counseling and therapy (ASAM Level .5 or 1).	15 minutes	\$19.33			Any
			<b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.					
H0004	HF	U1	Behavioral health counseling and therapy (ASAM Level .5 or 1), Home/Community.	15 Minutes	\$22.57			Any
			<b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.					
H0005			Alcohol and/or drug services, group counseling by a clinician (ASAM Level 1).	One session	\$9.66			Any
			<b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.	(45 minutes)				
H0005	U1		Alcohol and/or drug services, group counseling by a clinician (ASAM Level 1), Home/Community.	One session	\$11.28			Any
			<b>Note:</b> Utilize HR and HS modifiers as needed for family/couple therapy.	(45 Minutes)				

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HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
H0010			Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient) (Level 3.2-WM).	Per diem (medical portion)	\$290.70			Any
H0010	HW		Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient) (Level 3.2-WM).	Per diem	\$58.10			Any
			<b>Room and board note:</b> MMIS will not process — not Medicaid.	(room and board portion)				
H0011			Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (Level 3.7-WM).	Per diem (medical portion)	\$354.67			Any
H0011	HW		Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (Level 3.7-WM).	Per diem	\$65.84			Any
			<b>Room and board note:</b> MMIS will not process — not Medicaid.	(room and board portion)				
H0012			Alcohol and/or drug abuse service; subacute detoxification (residential addiction program outpatient) (Level 2-WM 23-hour).	Per diem	\$334.27			Any
H0014	TD		Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Registered Nurse	Per 60 minutes	\$104.45			Any
H0014			Alcohol and/or drug abuse services; ambulatory detoxification (Level 2-WM). Unlicensed Practitioner	Per 60 minutes	\$77.30			Any
H0015			Alcohol and/or drug services, intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education.	Per hour	\$77.30 per hour			Any
			Level 2.1 at least 9 contact hours per week but not in excess of 19 hours per week; a minimum of contact 3 days per week.  Without a modifier, this will be hourly and only may be billed for individuals under the age of 18.					
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.	Per diem	\$103.09 per diem**			Any
			Level 2.1 at least 9 contact hours per week but not in excess of 19 hours per week; a minimum of contact 3 days per week.					
			Unlicensed					

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HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
			<b>**Refer to billing guidance within section 3.4 and 3.5</b>					
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; a minimum of contact 3 days per week. Licensed <b>**Refer to billing guidance within section 3.4 and 3.5</b>	Per diem	\$126.79 per diem**			Any
H0015	HQ	U1	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 2.1 at least 9 contact hours per week but not in excess of 19 hours per week; a minimum of contact 3 days per week. Unlicensed <b>**Refer to billing guidance within section 3.4 and 3.5</b>	Per diem	\$120.37 per diem**			Any
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. Level 2.5 a minimum of 20 contact hours per week; a minimum of contact 3 days per week. Licensed <b>**Refer to billing guidance within section 3.4 and 3.5</b>	Per diem	\$190.18 per diem**			Any

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HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
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; a minimum of contact 3 days per week. Unlicensed <b>**Refer to billing guidance within section 3.4 and 3.5</b>	Per diem	\$154.64 per diem**			Any
H0015	HQ	TG	U1 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; a minimum of contact 3 days per week. Unlicensed <b>**Refer to billing guidance within section 3.4 and 3.5</b>	Per diem	\$180.56 per diem***			Any
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.) <b>Note:</b> MA-OTPs may bill this code.	Per Service		\$4.00		57, 71
H0038	HF		Self-help/peer services, substance abuse program.	Per 15 minute	\$14.75			Any
H0048	HF		Alcohol and/or other drug testing: collection and handling only, specimens other than blood. Collection and handling of specimens (UAs) for alcohol/drug analysis. To ensure the integrity of the specimen a chain of custody from the point of collection throughout the analysis process is necessary. Service frequency is limited based on medical necessity. <b>***Refer to billing guidance at the end of the section.</b>	Per service	\$8.20***			Any
H2034			Alcohol and/or drug abuse halfway house services, per diem (Level 3.1).	Per diem (medical portion)	\$150.53			Any
H2034	HW		Alcohol and/or drug abuse halfway house services, per diem (Level 3.1). <b>Room and Board Note:</b> MMIS will not process — not Medicaid.	Per diem (room and board)	\$41.14			Any
H2036	HI		Alcohol and/or drug treatment program, per diem	Per diem	\$273.25 (Medicaid 10 and under)			Any

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HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
			(Level 3.3 – cognitive impairment).		beds) \$189.44 (Medicaid 11-16 beds)			
				(medical portion)	\$114.05 (Non- Medicaid 47 beds)			
H2036			Alcohol and/or drug treatment program, per diem (Level 3.5 – no cognitive impairment).	Per diem  (medical portion)	\$189.44 (Medicaid 11-16 beds)			Any
H2036	TG		Alcohol and/or drug treatment program, per diem (Level 3.7).	Per diem  (medical portion)	\$291.65			Any
H2036	HW		Alcohol and/or drug treatment program, per diem.  <b>Room and Board Note:</b> MMIS will not process — not Medicaid.	Per diem  (room and board)	45.84*			Any
J0571			Buprenorphine, oral, 1 mg	1 unit	\$ .44 per unit			49, 57
J0572			Buprenorphine/naloxone, oral, less than or equal to 3 mg  <b>Note:</b> Do not enter cubic centimeter (cc) volume	1 unit	\$4.25 per unit			49, 57
J0573			Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg <b>Note:</b> Do not enter cubic centimeter (cc) volume	1 unit	\$7.03 per unit			49, 57
J0574			Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg <b>Note:</b> Do not enter cubic centimeter (cc) volume	1 unit	\$8.02 per unit			49, 57
J0575			Buprenorphine/naloxone, oral, greater than 10 mg <b>Note:</b> Do not enter cubic centimeter (cc) volume.	1 unit	\$12.48 per unit			49, 57
J2315			Injection, naltrexone, depot form, 1 mg  <b>Note:</b> Do not enter cubic centimeter (cc) volume	Per unit	\$3.18 per unit			11, 49, 50, 57, 71
T1502	HF		Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit. This code may only be used for the following medication assisted therapies: buprenorphine (SUBUTEX®), buprenorphine and naloxone (SUBOXONE®), by an alcohol and drug provider type. Frequency max 7 administrations per week (1 unit–1	Per service		\$4.00		57

HCPCS Code	Modifier		Description	Units	Rate Per Unit	2016 Physician	2016 Delaware	Place of Service
	(1)	(2)			Unlicensed and Residential		LCSW, LMFT, LPMCH, or LCDP (Use HO modifier)	
			administration). No modifier = oral. <b>Note:</b> MA-OTP may bill this code.					
99211	HE		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  99211 HE for injection of MH medications, including long-acting and acute forms of anti-psychotic medications and medications used to treat acute side effects of antipsychotic medications (e.g., haloperidol, risperidone, benztropine).	Per visit		\$20.17		11, 20, 22, 49, 50, 53, 57, 71
99211	HF		Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.  For Vivitrol up to 1 time per month.	Per visit		\$20.17		11, 20, 22, 49, 50, 53, 57, 71

\*Room and Board rate is not applicable to ASAM 3.3 47-bed homes. Room and board expenses related to this service are paid entirely by DSAMH and not separately paid.

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

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

**\*\*\*H0048 Billing Guidance:**

1. H0048 cannot be billed for collection and handling during a residential or other SUD services billed on a per diem basis because the cost of time and supplies were built into those rates.
2. H0048 cannot be billed in addition to separately billing for the time spent by the nurse for the same process (e.g., 99211)
3. Rates are inclusive of expenses for cups, wipes, instant testing, and other supplies as well as for sending the specimens to a third-party lab. It does not include the third-party lab expenses.
4. When the specimen is sent to the third-party lab, the third-party lab will bill the Medicaid MCO for MCO members.
5. Only one H0048 may be billed a day with a maximum of 2 units in a week.

**5.2 Place of Service Definitions**

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), 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.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.



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22	On Campus- Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. <i>(Description change effective January 1, 2016)</i>
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 located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
53	Community Mental Health Center	A facility for the diagnosis 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.
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.

**Source:** Place of Service Codes for Professional Claims Database (updated August 6, 2015):

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>

# 6

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## Crisis Intervention

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

Specific activities include:

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

Qualified staff shall assess, refer, and link all Medicaid beneficiaries in crisis. This shall include, but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of beneficiaries; and arranging for linkage, transfer, transport, or admission as necessary for Medicaid beneficiaries at the conclusion of the CI service. CI specialists shall provide CI counseling, on and off-site; monitoring of beneficiaries; 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.

### 6.1 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 an 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 which results in

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

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.

## 6.2 Taxonomies

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

## 6.3 Provider Qualifications under the Medicaid State Plan Authority

Individual practitioners may be licensed as:

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

Individual practitioners may be certified as:

- A credentialed mental health screener who is not licensed must meet all State requirements, including having two years of clinical and/or crisis experience; at least a 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 on a CI team who is an individual who has self-identified as a beneficiary of mental health and/or SUD services, is at least 21 years of age, and meets the qualifications set by the State, including specialized peer specialist training, certification and registration. A certified peer must have, at minimum, a high school education or GED, (preferably with some college background). Delaware state-approved standardized peer specialist training includes academic information as well as practical knowledge and creative activities. The training shall

be focused on the principles and concepts of peer support and how it differs from clinical support. The training will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. Each crisis program including certified peers staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law.

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

## **6.4 Certification**

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 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 particular authority and reimbursement structure may not practice independently and must practice within a program certified by DSAMH as having met the CI certification standards contained within this Manual.

Title 16, Chapter 51 of the Delaware Code states that only psychiatrists and professionals credentialed by the Delaware Department of Health & Social Services (DHSS) as a 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.

### 6.5 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:

1. A statement of program philosophy and goals;
2. Geographical area to be served;
3. Types of services offered;
4. Intake, assessment, and referrals;
5. Completion and utilization of all forms used by the program;
6. 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;
7. How the program will respond to medical emergencies;
8. How the program will engage with peace officers, other emergency response personnel, and other mental health professionals as necessary;
9. Patient rights pursuant to 16 Del. C. § 2220 and 16 Del. C. § 5182.

### 6.6 Mobile Crisis Intervention Personnel Manual and Personnel Files

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

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

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

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

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

## **6.7 Mobile Crisis Intervention State Training and Supervision**

1. 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:
    - i. Hepatitis;
    - ii. HIV/AIDS;
    - iii. Tuberculosis;
    - iv. Other sexually transmitted diseases; and
    - v. Infection control
2. Each program shall have an on-going training program which satisfies the following minimum standards:
  - a. 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.
  - b. Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually.

- c. Training shall be provided on a continuing basis and shall include, but not be limited to, orientation to the screening system, provisions contained within the screening law, explanation of mental illness, CI skills, systems interaction and transportation.

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

The Program shall:

1. 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.
2. Not deny any person equal access to its facilities or services on the basis of age or gender.
3. 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.

## **6.9 Mobile Crisis Intervention Quality Assurance**

All CI programs shall:

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

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

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

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

## 6.11 Mobile Crisis Intervention Activity Definition

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

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

1. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. Includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. The Assessment by qualified staff, includes:
  - i. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. This includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. This may include an evaluation of any person found within the service area of the center to determine the need for community-based services, PROMISE program eligibility or inpatient or involuntary psychiatric care and treatment. Assessment of the crisis situation and identification of stabilization, diversion and support services needed and/or screening for commitment.
  - ii. The assessment of risk, mental status, and medical stability must be completed by a credentialed mental health screener, LBHP, APN, NP, or physician with experience regarding this specialized mental health service, practicing within the scope of their professional license or certification.
  - iii. Mobile CI programs shall respond within 1 hour of referral to initiate the assessment.
2. Short-term CI including crisis resolution and de-briefing with the identified Medicaid beneficiary. Short-term CI, including:
  - i. Crisis resolution and de-briefing with the beneficiary;
  - ii. Provision of emergency and consensual treatment to the person receiving the assessment;
  - iii. Crisis/early intervention counseling; and
  - iv. Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis.
  - v. For mobile CI programs, development of a crisis plan if one is not already in place.
3. Follow up with the individual, and as necessary, with the beneficiary's caretaker and/or family member(s), including follow up for the beneficiary who is in crisis and assessed in an emergency room prior to a referral to the CI team, to determine the need for any further services or referral to any services. Arranging for linkage, transfer, transport, or



admission as necessary for beneficiaries at the conclusion of the CI service including referral to psychiatric and other community services, when appropriate.

- i. This includes referral via personal contact to the most appropriate, least restrictive treatment setting indicated, linkage and follow-up in order to maintain contact with all consumers until they are engaged in another service licensed by the appropriate authority, where applicable, or are no longer in crisis;
  - ii. Initiation of involuntary emergency detention proceedings, where appropriate and consistent with state law.
4. Consultation with a physician or with other qualified providers to assist with the beneficiary's specific crisis, as clinically indicated

## 6.12 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:

1. Maintain a standardized client record-keeping system, with client records that are uniform in format and content and includes (to the extent applicable and possible):
  - a) Date and time of assessment;
  - b) Beneficiary name, address, telephone number, gender, date of birth and unique identifier number (e.g., Medicaid number);
  - c) The client's significant medical history documenting:
    - i) Current medical conditions;
    - ii) Any medications the client is currently taking; and
    - iii) Allergies.
  - d) The name and telephone number of the person to contact in an emergency;
  - e) Assessment;
  - f) Treatment/Crisis Plan (if not already developed);
  - g) Progress notes;
  - h) Discharge plan; and
  - i) Discharge summary.
2. Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff.
3. Update each record within twenty-four (24) hours of delivery of a service.

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

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

CI services by their nature are crisis services and are not subject to prior approval. CI services are authorized for no more than 23 hours per episode. Activities beyond the 23 hour period must 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. Providers visiting individuals discharged from a site-based program within 24 hours is considered reimbursement within in the original 23 hour charge. If a site-based program bills using the 15-minute unit, the program's reimbursement may not exceed the site-based per diem rate in a 24 hour period (e.g., five 15-minute units are roughly equal to one per diem).

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

## 6.14 Reimbursement for Crisis Intervention Behavioral Health Services

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

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

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

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of **July 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](http://www.dmap.state.de.us/downloads/hcpcs.html).

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

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

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

### 6.16 Mobile Crisis Intervention Coding

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

## Facility Based Crisis Intervention Services - Adults

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

Specific activities include:

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

Qualified staff shall assess, refer, and link all 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 the individual at the conclusion of the CI service. CI specialists shall provide CI counseling; assessment under the supervision of a certified assessor; and referral and linkage, if indicated.

CI specialists, who are nurses, may also provide medication monitoring and nursing assessments.

Psychiatrists 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 individual and follow up.

### **6.17 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 an LBHP, APN, NP or a physician who is acting within the scope of his/her professional license and applicable State law to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. All individuals who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible.

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.

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

Individual practitioners may be licensed as:

- Psychiatrists, board certified emergency physicians, or a physician in another area of specialty.
- Registered Nurse.
- Advance Practice Nurse operating in collaboration with a Delaware licensed physician.
- Licensed Behavioral Health Practitioner including:
  - Licensed psychologist.
  - LCSW.
  - LPCMH.
  - LMFT.
- Licensed Physician Assistant supervised by a licensed physician.

Individual practitioners may be certified as:

- A credentialed mental health screener who is not licensed must meet all State requirements, including having two years of clinical and/or crisis experience; at least a bachelors or master's degree in a mental health related field; and completing 40 hours of crisis services in an employed position under direct supervision of a psychiatrist following completion of the mental health screener training and satisfactory score on the mental health screener credentialing examination.
- A certified peer on a CI team who is an individual who has self-identified as a beneficiary of mental health and/or SUD services, is at least 21 years of age, and meets the qualifications set by the State, including specialized peer specialist training, certification and registration. A certified peer must have, at minimum, a high school education or GED, (preferably with some college background). Delaware state-approved standardized peer specialist training includes academic information as well as practical knowledge and creative activities. The training shall be focused on the principles and concepts of peer support and how it differs from clinical support. The training will also provide practical tools for promoting wellness and recovery, knowledge about beneficiary rights and advocacy, as well as approaches to care that incorporate creativity. Each crisis program including certified peers staff is supervised by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law.

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

## 6.19 Certification Standards

Programs shall be certified by Medicaid and/or its designee as a crisis program providing Facility-based CI services.

These services are available 24 hours a day to assist people, 18 years and older experiencing a mental health crisis and services are provided in an established location that is staffed with a multi-disciplinary team of physicians, nurses, LBHPs, certified peers and certified CI specialists. Facility-based programs offer walk-in services and provide CI services for up to 23 hours for an individual.

Each crisis program is supervised by a licensed physician who is acting within the scope of his/her professional licensed and applicable State law. A licensed practitioner such as an LBHP, APN, NP or a physician who is acting within the scope of his/her professional license and applicable State 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 providers may not practice independently. All practitioners must practice within a program certified by DSAMH as having met the certification standards contained within Section 6.3 of this Manual.

### ***Provider qualifications required for DSAMH Certification in addition to the Medicaid requirements:***

1. Title 16, Chapter 51 of the Delaware Code states that only psychiatrists and professionals credentialed by the Delaware Department of Health & Social Services (DHSS) as Credentialed Mental Health Screeners (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 person is credentialed in accordance with Title 16, Chapter 51 of the Delaware Administrative Code. The Division of Substance Abuse and Mental Health (DSAMH) is the DHSS Division responsible for implementing this law.
2. "Licensed Mental Health Professionals" means individuals who are licensed by the State of Delaware and include licensed physicians (MD/DO) whose practice specialty is other than psychiatry; licensed registered nurses with a bachelor's degree in nursing (BSN); licensed advanced practice registered nurses (APN); licensed physician assistants (PA-C); licensed clinical psychologists (PhD/Psy.D); licensed clinical social workers (LCSW); licensed mental health counselors (LMHC); and licensed marriage and family therapists (LMFT).

### **6.19.1 Policies and Procedures**

The program 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:

1. A statement of program philosophy and goals;
2. Types of services offered;
3. Intake, assessment, and referrals;
4. Completion and utilization of all forms used by the program;
5. 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;
6. A description of the circumstances which allow a treatment provider to share otherwise confidential information in order to notify peace officers and/or a potential victim of likely harm, pursuant to 16 Del. C. § 5184;
7. Responding to medical emergencies;
8. Engagement of police, other emergency response personnel and other professionals as necessary;
9. Provisions which address confidentiality of client information and treatment records;
10. Patient rights pursuant to 16 Del. C. § 2220;
11. Policies and procedures for admission and discharge processes;
12. Policies and procedures for discharging, if clinically merited, a client involved in the commission of a crime on the premises of the program or against its staff, including designation of the person who shall make a report to the appropriate law enforcement program;
13. Policies and procedures which address when a client leaves against medical or staff advice and the client may be dangerous to self or others;
14. Policies and procedures for mandated reporting of infectious or contagious diseases;
15. Medication policies and procedures, in compliance with the Delaware State Boards of Medical Practice, Nursing, and Pharmacy;
16. Policies and procedures, as applicable, for the collection of urine specimens; and
17. Policies and procedures for reporting any employee violations of law or codes of ethics to the appropriate certification and/or licensure boards, and any other appropriate reporting State or Federal authority.

### **6.19.2 Personnel Manual and Personnel Files**

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

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

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

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

### **6.19.3 Staff Training and Supervision**

1. 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:
  - 1.1 Personnel policies and procedures, regarding the health and safety of staff;
  - 1.2 Program policies and procedures which address State mandatory reporting requirements;
  - 1.3 Program policies and procedures regarding client's rights;
  - 1.4 Instruction and training in the elements of the fire plan for the facility in which the program will be provided;
  - 1.5 Program policies and procedures regarding the obligation to report violations of law and applicable codes of ethics to the appropriate certification and/or licensure boards;
  - 1.6 All staff, trainees and volunteers shall receive training within the first year of employment about: (i) Hepatitis, (ii) HIV/AIDS, (iii) Tuberculosis, (iv) other sexually transmitted diseases, (v) infection control, (vi) CPR, and (vii) Mandt or another evidence based community crisis de-escalation training.  
Such 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, crisis intervention skills, systems interaction and transportation.
2. 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.
3. Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually

### **6.19.4 Client rights**

The Program shall:

1. 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.
2. Not deny any person equal access to its facilities or services on the basis of age or gender.



3. Comply with the federal Americans with Disabilities Act, 28 U.S.C. §§12101 et seq. and 28 CFR Part 36 and the Patient Rights enumerated in Delaware's Substance Abuse Treatment Act, 16 Del.C. §2220.

### **6.19.5 Quality Assurance**

Facility-based CI programs shall:

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

### **6.19.6 Hours of Operation, Staffing, Staff Schedules**

1. CI programs shall operate seven (7) days per week, twenty-four (24) hours per day.
2. Each crisis program shall be supervised by a licensed practitioner who is acting within the scope of his/her professional licensed and applicable state law. A licensed practitioner 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.
3. Programs shall be staffed at all times with:
  - a. Psychiatrist/NP,
  - b. Nurses;
  - c. LBHPs;
  - d. Certified peers;
  - e. Credentialed mental health screeners;
  - f. CI specialists; and
  - g. Constables

### **6.19.7 Services Required**

CI programs provide CI services to an individual 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.

CI programs shall provide the following services:

1. All activities must occur within the context of a potential or actual behavioral health crisis.
2. Maintain twenty-four (24) hour per day screening capability.
3. Provide capacity to receive individuals in crisis with 24-hour capability, for the purpose of assessment, intensive supervision, and medication monitoring and crisis stabilization.
4. Specific activities include:
  - a. Assessment by qualified staff, including:

- i. An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. This includes contact with the client, family members, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level. This may include an evaluation to determine the need for community-based services, PROMISE program eligibility or inpatient or involuntary psychiatric care and treatment. Assessment of the crisis situation and identification of stabilization, diversion and support services needed and/or screening for commitment.
    - ii. The assessment of risk, mental status, and medical stability must be completed by a credentialed mental health screener, LBHP, APN, NP, or physician with experience regarding this specialized mental health service, practicing within the scope of their professional license or certification.
    - iii. Programs shall initiate the assessment within 1 hour of admission and complete that assessment within 4 hours of admission. The evaluation shall be completed sooner if necessary to provide inpatient or involuntary psychiatric care and treatment.
  - b. Short-term crisis intervention, including:
    - i. Crisis resolution and de-briefing with the beneficiary;
    - ii. Provision of emergency and consensual treatment to the person receiving the assessment;
    - iii. Crisis/early intervention counseling; and
    - iv. Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis.
  - c. Development of a combined recovery/discharge plan based on the individuals assessed needs.
  - d. Follow up with the individual, and as necessary, with the beneficiary's caretaker and/or family member(s) for any consumer seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services or referral to any services.
  - e. Arranging for linkage, transfer, transport, or admission as necessary for beneficiaries at the conclusion of the CI service including referral to psychiatric and other community services, when appropriate.
    - i. This includes referral via personal contact to the most appropriate, least restrictive treatment setting indicated, linkage and follow-up in order to maintain contact with all consumers until they are engaged in another service licensed by the appropriate authority, where applicable, or are no longer in crisis;
    - ii. Initiation of involuntary emergency detention proceedings, where appropriate and consistent with state law;
  - f. Programs shall provide medication monitoring, which shall include medication for the purpose of crisis stabilization. Medication shall be administered in accordance with state law and shall not be given to consumers in non-emergency situations without their consent. There shall be no administration of prescription or non-prescription medications until qualified medical personnel have examined the client, or qualified medical personnel have been consulted.

### **6.19.8 Clinical Records**

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

Programs shall:

1. Maintain a standardized client record-keeping system, with client records that are uniform in format and content and includes:
  - a) Date and time of admission;
  - b) Beneficiary name, address, telephone number, gender, and date of birth;
  - c) The client's significant medical history documenting:
    - i) Current medical conditions;
    - ii) Any medications the client is currently taking; and
    - iii) Allergies.
  - d) The name and telephone number of the person to contact in an emergency;
  - e) Appropriate Consent to Release Information forms;
  - f) Acknowledging receipt of the notice of clients' rights;
  - g) Acknowledging his/her understanding of the agency's agreement with the confidentiality requirements;
  - h) Copies of any laboratory reports and drug tests ordered by the program;
  - i) Informed consent regarding prescribed pharmacotherapy obtained from the client prior to delivery of the medication prescription;
  - j) Assessment;
  - k) Treatment/Discharge Plan including date and time of discharge; and
  - l) Progress notes.
  - m)
2. Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff.
3. Update each record within twenty-four (24) hours of delivery of a service.

### **6.19.9 Facility Standards**

Programs shall:

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

- f) Governing how the program will effectively activate community resources to prevent or minimize the consequences of a disaster;
- g) Concerning staff preparedness and the designation of roles and functions;
- h) Concerning criteria for the cessation of nonessential services and client transfer determinations; and
- i) Governing how it will protect the safety of clients and staff and the security of its records.

## 6.20 Eligibility for Services

1. The medical necessity for these rehabilitative services must be recommended by a licensed practitioner who is acting within the scope of his/her professional license and applicable State law to promote the maximum reduction of symptoms and/or restoration of a beneficiary to his/her best age-appropriate functional level. Licensed include, but are not limited to: LBHPs, APNs, NPs, and physicians.
2. All individuals who are identified as experiencing a seriously acute psychological/ emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible.
3. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the beneficiary's capabilities and functioning.
4. Crisis services cannot be denied based upon substance use. Beneficiaries in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

### 6.20.1 Length of service

1. 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.

### 6.20.2 Amount, Duration, and Scope

A unit of service is defined according to the HCPCS approved code set unless otherwise specified. CI services by their nature are crisis services and are not subject to prior approval. CI services are authorized for no more than 23 hours per episode. Activities beyond the 23 hour period must be prior authorized by the State or its designee (e.g., the Medicaid MCO). 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 1 per diem). Service components that are not provided to, or directed exclusively toward the treatment of the individual are not eligible for reimbursement.

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

## 6.21 Reimbursement for Crisis Intervention Behavioral Health Services

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

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

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

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

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. The Agency's fee schedule rate was set as of 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](http://www.dmap.state.de.us/downloads/hcpcs.html).

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

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

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

## 6.22 Crisis Intervention Coding

HCPCS Code	Modifier		Provider Qualification	Tx Context	Description	Units	Rate Per		Place of Service
	(1)	(2)					¼ hour	Diem	
S9485				Ind.	CI mental health services, per diem.	Per Diem		\$766.52	Any
H2011				Ind.	CI service, per 15 minutes, (mobile crisis team).	15 min.	\$146.99		Any