

PROVIDER CERTIFICATION MANUAL
FOR
DELAWARE
COMMUNITY MENTAL HEALTH CENTERS

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

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OVERVIEW

This manual contains the standards by which the Division of Substance Abuse and Mental Health certifies Comprehensive Community Mental Health Center Clinic programs for persons with psychiatric disabilities. Certification is required for provider enrollment with the Division of Social Services, Medical Assistance Program for Medicaid reimbursement through Title XIX of the Social Security Amendments.

Through an Inter-Divisional Agreement the Division of Substance Abuse and Mental Health has been delegated authority for administration of certain provisions of the Medicaid program pertaining to optional clinic services. These provisions include the following: 1) certification of programs for provider enrollment; 2) rate setting; and 3) quality assurance. Delegated quality assurance functions include program monitoring, utilization review, training and technical assistance.

This Certification Manual addresses the provision of mental health clinic services on an outpatient basis. The clinic services are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided to outpatients; are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and are furnished under the direction of a physician. The Delaware Medical Assistance Program covers clinic services provided to eligible Medicaid recipients by eligible providers.

1 **CERTIFICATION FOR PROVIDER PARTICIPATION**

- 1.1 **Authority** - Through an Inter-Divisional Agreement, the Division of Social Services (DSS) Delaware Medical Assistance Program has delegated the function of certifying organizations for enrollment as providers of mental health clinic services to the Division of Substance Abuse and Mental Health (Division or DSAMH).
- 1.2 **Certification Criteria** - Agencies designated by the Division as comprehensive community mental health centers are eligible for certification to provide community mental health clinic services. Comprehensive community mental health centers are public or private non-profit agencies that provide for the mental health needs of a geographically designated population, as determined by the Division, that provide the following services:
- 1.2.1 24-hour mobile emergency services which shall be:
- 1.2.1.1 Organized as a self-contained program, within a center, available to respond to the site of the emergency;
- 1.2.1.2 Staffed on a 24-hour basis; and
- 1.2.1.3 Provide access to community-based, face to face psychiatrist intervention at all times;
- 1.2.2 Clinical liaison to the Delaware State Hospital and private psychiatric inpatient facilities, provided by a full time designated hospital liaison clinician who visits patients while in the hospital to coordinate their discharge and post discharge linkage to continuing care;
- 1.2.3 Individual and group counseling and psychiatric services, provided to any resident of the service area who has a mental illness without regard to a consumer's ability to pay;
- 1.2.4 Evaluation and, when appropriate, treatment services for consumers of the Department of Correction and the Division of Vocational Rehabilitation;

- 1.2.5 Case Management services to assist consumers in obtaining social security benefits and other entitlements and to provide outreach to consumers when needed;
- 1.2.6 Case consultation and crisis intervention services to local school districts;
- 1.2.7 Case consultation and crisis intervention services to local nursing facilities;
- 1.2.8 24-hour assistance to law enforcement agencies in managing the psychiatric dimensions of emergency situations they encounter;
- 1.2.9 Outreach to homeless persons who have a mental illness and service agreements to assist agencies that provide services to homeless persons.
- 1.2.10 The Division bases its certification of programs and enrollment recommendation to DSS upon the organization's compliance with state level organizational, administrative and program standards, and with federal requirements for the administration of Medicaid services as contained in federal statutes, regulations and guidelines.
 - 1.2.2.1 The division may establish and apply minimum compliance guidelines to be used in making certification determinations.
- 1.2.11 The Division uses a certification survey to measure compliance with organizational, administrative and program standards. The determination with regard to a program's certification Division to DSS is based on:
 - 1.2.11.1 Statements of the organization's authorized representatives;
 - 1.2.11.2 Documents provided to the Division by the organization;
 - 1.2.11.3 Documented compliance with organizational, program and administrative standards;

1.2.11.4 On-site observations by surveyors.

1.3 Standard

1.3.1 Enrolled provider status under the Delaware Medical Assistance Program shall be obtained from DSS in accordance with the following procedure:

1.3.1.1 Upon request to the Division, the organization shall receive a certification survey package and a date for a certification survey site visit from the Division.

1.3.1.2 Recertification of enrolled providers shall be determined annually. The Division will forward a certification package containing a certification application and set a date for a certification survey within 90 days of the expiration of the provider's existing certification.

1.3.1.3 The organization shall return the completed certification application contained in the certification package within 30 days of receipt.

1.3.1.4 Upon receipt of the completed certification application, the Division will conduct a preliminary review to ensure that all pre-survey information is complete. If additional information is required, the Division will send a written request specifying the additional information needed.

1.3.1.5 When all application form information is complete, the Division will conduct an on-site inspection of the applicant organization.

1.3.1.6 Upon completion of the site visit, the Division surveyor will submit an inspection report to the Director describing the findings of the review of the certification application and the site visit. The inspection report, along with the application will form the basis

for the review process and certification determination.

1.3.1.7 The Division shall complete its certification survey and make a certification determination within 60 days of forwarding the certification package to the organization/enrolled provider. The Director of the Division shall notify the organization of its certification determination.

1.3.1.8 The Division shall forward to the provider and to DSS notice of certification for provision of clinic services to Medicaid beneficiaries.

1.3.1.9 Upon receipt of initial certification, the provider may enroll as a provider of clinic programs under Delaware's Medical Assistance Program (Medicaid) in accordance with policy and standards established by DSS for such enrollment.

1.3.2 To facilitate the determination by the Division of the organization's eligibility for certification, the organization shall make all necessary documentation available for the Division's review, including the following:

1.3.2.1 Policies and procedures;

1.3.2.2 Staff qualifications and work schedules;

1.3.2.3 Documentation of clinical supervision;

1.3.2.4 Consumer records;

1.3.2.5 Consumer billing records; and

1.3.2.6 Other documentation as requested by the Division.

1.3.3 The division surveyor may meet with the director, supervisors, staff members and consumers in the process of conducting a site visit to evaluate the applicant organization's adherence to the following standards:

1.3.3.1 Organizational;

1.3.3.2 Administrative; and

1.3.3.3 Program.

1.4 **Ongoing Monitoring** - As an authorized representative of DSS, the Division has the right to access any information directly related to the provider's administration of the Medicaid program. The Division may conduct on-site visits to a provider and review consumer records periodically to monitor ongoing compliance with certification standards. The Division will notify a provider in writing of any deficiencies found during a monitoring visit. The provider shall submit a plan of correction of any deficiencies within 30 days of notification.

1.4.1 The Division shall provide quality assurance monitoring, technical assistance and utilization control through staff of the Division Management Information System/Quality Assurance Unit.

1.4.1.1 The role of this unit is to review, define, and educate the mental health centers as to Medicaid policy.

1.4.1.2 They also monitor for compliance and certification.

1.4.2 The Division's Management Information System/Quality Assurance Unit will conduct at least yearly on-site program reviews of Community Mental Health Centers to verify the following:

1.4.2.1 Services reimbursed by Medicaid were actually furnished to consumers;

1.4.2.2 Services were provided under supervision;

1.4.2.3 Services were provided in accordance with an individual treatment plan;

1.4.2.4 Services rendered were medically necessary.

1.4.3 The Division's Management Information System/Quality Assurance Unit will monitor and evaluate activities concerning utilization control through a program that:

- 1.4.3.1 Assesses the quality of community mental health services;
- 1.4.3.2 Assesses the timeliness of services;
- 1.4.3.3 Uses written criteria for evaluating the appropriateness and quality of Medicaid services;

1.4.4 Site visits will include, but not be limited to, review of the following:

- 1.4.4.1 Consumer records;
- 1.4.4.2 Treatment plans;
- 1.4.4.3 Internal policies;
- 1.4.4.4 Procedures;
- 1.4.4.5 Documentation;
- 1.4.4.6 Face to face interviews with staff, consumers and collaterals.

1.4.5 The Division will determine which sites will be reviewed and will determine which records will be reviewed.

1.4.6 Providers will be notified of the Divisions site visits at least one week in advance where possible.

- 1.4.6.1 Unannounced site visits may also be conducted at the discretion of the Division.

1.4.7 In addition to monitoring by the Division, community mental health centers are subject to program audits by the Health Care Financing Administration (HCFA).

1.5 **Suspension or Revocation of Certification**

1.5.1 The Division may suspend provider certification at any time upon 15 days written notice to the provider of the intent to suspend when the provider fails to satisfy or continue to meet the requirements for certification.

- 1.5.1.1 DSAMH shall advise the provider of the reason(s) for suspension.
- 1.5.1.2 Upon receipt of the written notice of DSAMH's intent to suspend provider certification, the affected provider may request a hearing by the Division Director for the purpose of demonstrating that the reasons for suspension have been corrected.
- 1.5.1.3 Failure of the provider to demonstrate the correction of the reasons for suspension within 60-days of receipt of the notice of intent to suspend shall result in the revocation of the provider's certification.
 - 1.5.1.3.1 The Division Director may extend the period of suspension without revocation by not more than 30-days.
- 1.5.1.4 Upon revocation of a provider's certification, DSAMH shall notify DSS of such revocation and the concomitant failure of the provider to meet the requirements to be recognized as an enrolled provider under the Delaware Medical Assistance Plan.
- 1.5.2 DSAMH may revoke a provider's certification and so advise DSS without prior written notice to the provider in the event that the provider has evidenced conduct which has caused or which can reasonably be expected to cause harm to program participants.
 - 1.5.2.1 DSAMH shall provide written notification of revocation to the affected provider within 5 working days of the effective date of such revocation.
- 1.5.3 Failure of DSAMH to timely reissue a Certification to a provider on the anniversary of an existing Certification shall be construed as, and have the effect of, the issuance of a Certification and the concurrent suspension of same unless such failure of DSAMH to reissue Certification is caused by action taken by DSAMH pursuant to 1.5.2.

1.5.3.1 No written notice of intent to suspend shall be required upon the failure of DSAMH to timely reissue a Certification on the anniversary of an existing Certification.

2 **CLINICAL STAFF AUTHORIZED TO PROVIDE SERVICES:** The Delaware Medical Assistance Program will reimburse qualified providers for those services provided to eligible recipients of the Medical Assistance Program. The services must be rendered by members of the clinical staff who hold the credentials required by each covered billable activity. The categories of clinical staff and their definitions for community mental health centers clinic option are as follows:

2.1 **Physician:** a person with a Medical Degree or Doctor of Osteopathy degree, is licensed to practice medicine in Delaware and has completed (or is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

2.2 **Clinician:** a person with a doctoral or masters degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university (or a registered nurse with a certificate in mental health nursing from the American Nurses Association).

2.3 **Associate Clinician:** a person with a bachelors degree in a human service field or a registered nurse.

3 **RECIPIENT ELIGIBILITY:** Eligible recipients are Medicaid recipients who are certified by a community mental health center program physician as being in medical need of community mental health services in accordance with an assessment procedure approved by the Division of Substance Abuse and Mental Health.

3.1 Determination of Consumer eligibility for Medicaid benefits is the sole responsibility of DSS.

3.2 The Division audits recipients' records to determine whether the assessment procedure has been appropriately conducted and may disallow medicaid payment in the event that a determination of medical necessity by the physician does not appear to DSAMH to be supported by the assessment materials.

3.3 Payment will be authorized for visits up to 45 days prior to the physician's certification of medical necessity if

those visits are for the purpose of providing emergency or comprehensive psychosocial assessment services.

- 4 **COVERED STANDARDS:** Community Mental Health Center Clinic Option Services may be billed to the Delaware Medical Assistance Program for eligible Medicaid recipients for the following activities which are further defined in section 6:

4.1 **Comprehensive Psychosocial Assessment (Non MD)**

4.2 **Psychiatric Evaluation/Therapy**

4.3 **Emergency Services**

4.4 **Medication Injection**

4.5 **Medication Check/Medical Monitoring**

4.6 **Counseling and Psychotherapy**

4.7 **Group Counseling/Therapy**

- 5 **SERVICE LIMITATIONS:** The following limitations apply to coverage for Community Mental Health Centers clinic option:

5.1 **Appropriate Use:** Services are reimbursable only when provided in accordance with a treatment plan approved by a physician in conjunction with the certification of medical necessity (as indicated by physician signature on the treatment plan).

5.1.1 Exclusions to this general rule include emergency services.

5.1.2 Services to collaterals are reimbursable under specific standards.

5.1.2.1 A collateral is defined as a consumer's family member or others with significant ties to the consumer (includes guardians, advocates, significant other, etc.).

5.1.3 Services can only be billed for the staff who actually provided the service to the consumer.

5.1.4 ONLY one service provided by one staff can be billed for at the same time even if more than one staff are present during the delivery of the service.

- 5.1.5 All third party resources, when available, must be utilized prior to billing the Medical Assistance Program.
- 5.2 **Non-Covered Services:** The following are not reimbursable:
- 5.2.1 Vocational and (non medically related) educational services;
- 5.2.2 Services which are solely recreational in nature;
- 5.2.3 Services delivered by telephone;
- 5.2.4 Services provided to consumer in an institute for mental disease;
- 5.2.5 Services provided to consumer in a correctional institution.
- 5.2.6 Services provided off site.
- 5.3 **Service Utilization:** Community mental health centers clinic option is a service predominantly provided within the context of consumer visits to the offices of the programs. The number of visits and frequency is based on consumer status and as outlined in the treatment plan.
- 5.3.1 Exclusions to this general rule include emergency services provided by emergency services staff.
- 5.3.2 Other exclusions include services furnished outside the offices of the program, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- 5.4 **Sub-Contracting of Services:** Services billed to Medicaid must be provided by an employee or by a physician or other clinician under contract with the provider.
- 5.4.1 Component services (e.g. emergency services, group therapy, etc.) of clinic option programs may not be subcontracted to independent provider organizations.

- 5.5 **Physician Supervision:** Services billed to Medicaid must be authorized by a physician's determination of medical necessity, must be supported by an individual treatment plan signed by the physician within 45 days and must be supervised by a physician in a manner prescribed by program standards of the Division.

6 **COMMUNITY MENTAL HEALTH CENTERS CLINIC OPTION STANDARDS**

6.1 **Program Organization and Operation**

- 6.1.1 A community mental health center shall operate with on site staff during all regularly scheduled work days. Emergency services staff shall be available on site and mobile in the community on a 24 hour basis for 7 days per week.
- 6.1.2 Staff of the mental health center clinic programs shall meet regularly to conduct treatment planning and treatment plan reviews. A schedule of upcoming treatment plans and reviews shall be maintained. A clinic supervisor shall lead treatment planning and review meetings.
- 6.1.3 Each consumer shall have a treatment team consisting of at least the physician and one staff member who are primarily involved in his/her treatment plan.
- 6.1.4 All staff listed on the treatment plan as responsible staff for delivery of services are considered an integral part of the treatment team.
- 6.1.5 It shall be evident from review of clinical records and from observation of staff interactions with consumers that the provider is organized and operates in a manner consistent with the following principles:
- 6.1.5.1 Minimizing disability by providing consumers with clinical interventions in the course of their interactions with the program;

- 6.1.5.2 Providing outreach, when appropriate, to ensure that consumers have access to and receive needed services;
- 6.1.5.3 Maximizing consumer involvement and choice in all aspects of his/her treatment;
- 6.1.5.4 Assisting consumers to develop and maintain supportive networks.

6.2 **Program Staff**

- 6.2.1 There shall be an overall director of the community mental health center who shall be a clinician with at least seven years of clinical/administrative experience in providing community mental health center services.
- 6.2.2 There shall be an overall clinical supervisor who shall supervise the overall provision of services to consumers. The clinical supervisor shall be a clinician with at least five years of post-graduate experience in providing community mental health center services.
- 6.2.3 Clinicians and associate clinicians shall have appropriate education, experience, and skills for the treatment activities they engage in and shall be supervised on a regular and consistent basis.
- 6.2.4 A physician shall be available to the staff at all times.
- 6.2.5 When volunteers or student interns are used, they shall be clinically supervised on a regular and consistent basis by clinicians.
 - 6.2.5.1 There shall be written procedures for the selection, orientation, in-service training and supervision of volunteers and students.

6.3 Intake

- 6.3.1 During the intake process, the consumer shall be informed of:
- 6.3.1.1 The program's services and aims;
 - 6.3.1.2 The manner in which the program operates to ensure that consumers receive the services they need;
 - 6.3.1.3 The program's expectations of consumers regarding their responsibilities;
 - 6.3.1.4 How consumers can obtain assistance during an emergency or whenever the program offices are closed;
 - 6.3.1.5 The program's provisions for maintaining confidentiality;
 - 6.3.1.6 Charges for which consumers or a third party may be billed;
 - 6.3.1.7 The process for appeal and review of problems consumers experience in regard to the quality and responsiveness of services provided by program staff;
 - 6.3.1.8 Their rights.

6.4 Assessment

- 6.4.1 A Comprehensive Medical/Psychosocial Evaluation approved by the Division as an assessment procedure shall be begun at the time of the consumer's admission to the program which shall be completed within 45 days.
- 6.4.1.1 The evaluation shall be conducted by authorized staff.
 - 6.4.1.2 Assessment instruments shall conform to formats approved by the Division.
 - 6.4.1.3 Assessments shall be conducted with the active participation of the consumer and, when appropriate, collaterals, and shall be responsive to the consumer's goals.

- 6.4.2 Written assessment instruments shall be completed and explained to the consumer. The assessment shall include but not be limited to the following:
- 6.4.2.1 Extent and effects of drug and/or alcohol use;
 - 6.4.2.2 Compliance with and response to prescribed medical (when appropriate)/psychiatric treatment;
 - 6.4.2.3 History of prior treatment for psychiatric problems and/or substance abuse;
 - 6.4.2.4 Current psychiatric symptomatology and mental status;
 - 6.4.2.5 Recent key life events;
 - 6.4.2.6 Vocational and educational functioning (when appropriate);
 - 6.4.2.7 Current social functioning; and
 - 6.4.2.8 Conditions of daily living.

6.5 **Treatment Planning**

- 6.5.1 A written treatment plan shall be developed within 45 days of the admission date.
- 6.5.2 The treatment plan shall include long-range goals; objectives stated in measurable terms; and include criteria for termination of treatment.
- 6.5.2.1 It shall include the specific treatment, modalities and interventions, and their frequency, planned to achieve treatment goals.
 - 6.5.2.2 Participation in the development of the treatment plan by consumers and collaterals shall be documented.

6.5.2.3 With the permission of the consumer, program staff shall engage the involvement of other service providers and members of the consumer's social network in formulating treatment plans when appropriate.

6.5.3 The treatment plan shall be reviewed in full at least every six months.

6.5.3.1 The date, results of the review and any changes in the treatment plan shall be recorded.

6.5.3.2 Appropriate signatures will be obtained.

6.6 **Consumer Rights**

6.6.1 The provider shall establish a formal process for soliciting consumer's complaints and for reviewing treatment decisions by staff with which consumers disagree.

6.6.2 The provider shall not establish any general conditions of program participation that limit a consumer's rights to self-determination.

6.6.3 The provider shall comply with DHSS Policy Memorandum 46 regarding reporting and responding to allegations of abuse and neglect, and to incidents resulting in injury or death.

6.6.4 The provider shall promote any self-help and mutual support efforts among consumers.

6.6.5 Consumers shall be kept informed (as evidenced through written guidelines and through documentation in their clinical records) of their rights and responsibilities contained in written policies and procedures including reference to:

6.6.5.1 Behavioral expectations and limitations;

- 6.6.5.2 Consumer grievances;
- 6.6.5.3 Confidentiality;
- 6.6.5.4 Fees;
- 6.6.5.5 Appeals of decisions by program staff.

6.7 **Management of Case**

- 6.7.1 A member of the community mental health program's clinic staff shall be designated responsible for maintaining a primary treatment relationship with each consumer and shall:
 - 6.7.1.1 Maintain the clinical file for the consumer to include:
 - 6.7.1.1.1 assurance that written assessments are completed;
 - 6.7.1.1.2 preparation of treatment plans;
 - 6.7.1.1.3 documentation of services and response to treatment;
 - 6.7.1.1.4 order and completeness.
 - 6.7.1.2 Conduct and participate in treatment planning and case conferences with other staff and other agencies when appropriate;
 - 6.7.1.3 Maintain a therapeutic alliance with the consumer and serve as his/her primary therapist;
 - 6.7.1.4 Support and consult with the consumer's collaterals when appropriate.
- 6.7.2 In addition to the above responsibilities of the clinician who serves as the manager of the case, all staff of the program shall share the following responsibilities, for which they are credentialed, for each consumer:

- 6.7.2.1 Document and keep other staff informed of all significant changes in the consumer's mental or social status as it effects treatment;
- 6.7.2.2 Provide any of the above functions on behalf or in place of the primary therapist as conditions dictate.

6.8 **STANDARD: COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT (NON MD)**

6.8.1DEFINITION: Comprehensive Psychosocial Assessment refers to services provided in face to face interaction with consumers and collaterals as diagnostic and evaluative methods to determine a consumers' current status and needs. They involve a professional determination of the nature and intensity of an individuals' problems, resources and assets. A complete assessment takes place when a consumer first comes in contact with the community mental health center. Appropriate components of the assessment should be repeated as reassessment in preparation for semi-annual treatment plan reviews and/or whenever a consumer experiences a significant change in psychosocial functioning.

6.8.2MEDICAL NECESSITY CRITERIA: All consumers are eligible for psychosocial assessment (non MD).

6.8.3AUTHORIZED STAFF: Comprehensive Psychosocial Assessment (non MD) may be provided by a Clinician or Associate Clinician.

6.8.3.1 Exclusions to this service are physicians who may, in fact, provide this type of treatment service but who will bill under Psychiatric Evaluation when applicable.

6.8.3.2 Staff not listed above may also provide some of these services in certain circumstances but the service may not be billed.

6.8.3.3 If services are delivered by staff not listed the service should be documented in the consumer record according to the standard documentation guidelines.

6.8.4 PROGRAM GUIDELINES

6.8.4.1 Assessments involve a wide range of tools and procedures and are acceptable if used in clinical practice, as deemed appropriate, by staff listed under authorized staff.

6.8.4.2 Psychological testing, where indicated, is included in this standard. Examples of testing may include but are not limited to:

6.8.4.2.1 Projective tests;
Standardized personality inventories;
Intellectual assessment;
Tests for specific disorders;
Rating scales;
Questionnaires;
Differential diagnostic tests.

6.8.4.3 Assessments shall be furnished under the supervision of a physician. Physician shall confirm the review of a consumer's treatment and record by a signature and date on the treatment plan. This signature is required to confirm the diagnosis, medical necessity of treatment, and appropriateness of care.

6.8.4.4 Staff may utilize this service to secure information from a collateral. Such face to face contacts are billable but must be utilized solely in connection with gathering information pertinent to a clinical assessment process.

6.8.4.5 Court ordered evaluation and external requests for evaluation are included within this service. They must be face to face in order to be billed.

6.8.5SERVICES: May include but not be limited to:

- 6.8.5.1 Interview;
- 6.8.5.2 Medical History/Care;
- 6.8.5.3 Psychiatric History;
- 6.8.5.4 Social History;
- 6.8.5.5 Substance Abuse/Use (includes alcohol);
- 6.8.5.6 Mental Status;
- 6.8.5.7 Testing;
- 6.8.5.8 Questionnaires;
- 6.8.5.9 Screening for admission to other services;
- 6.8.5.10 Diagnostic Evaluation;
- 6.8.5.11 Legal involvement(s) (when applicable).

6.8.6DOCUMENTATION

- 6.8.6.1 The acceptable abbreviation for this standard is Assess.
- 6.8.6.2 Initial assessment of a consumer shall include but not be limited to the completion of the following:
 - 6.8.6.2.1 Consumer Rights;
 - 6.8.6.2.2 Applicable Releases;
 - 6.8.6.2.3 Delawares Community Mental Health Screening Instrument;
 - 6.8.6.2.4 Michigan Alcoholism Screening Test;
 - 6.8.6.2.5 Medical History ;
 - 6.8.6.2.6 Intake Data Base (Psycho Social History);
 - 6.8.6.2.7 Face Sheet (Stat Sheet);

6.8.6.2.8 Signed Consent to Treatment;

6.8.6.2.9 Signed Consent for Medication;

6.8.6.2.10 Treatment Plan;

6.8.6.2.10.1 The treatment plan should be discussed and agreed to with consumer by 45th day following admission or by next visit thereafter.

6.8.6.2.10.2 Consumer signature is required.

6.8.6.2.10.2.1 If consumer, by nature of illness, is not cooperative a notation on the consumer signature line of the treatment plan should be made explaining the circumstances.

6.8.6.2.10.2.2 At least every six months attempts should be made to both explain and encourage consumer participation in the treatment planning process throughout the consumers length of stay in community mental health center treatment.

6.8.6.3 If a clinic document, test, or form is completed, reviewed with consumer and signed and dated it will suffice for documentation for billing purposes.

6.8.6.3.1 An additional progress note to describe completion of said form does not need to be completed.

6.8.6.3.2 However, if, during the session other areas of concern or treatment issues are addressed a corresponding note should be placed in the consumer record.

6.8.6.4 Yearly reassessment of a consumer shall include but not be limited to completion of the following updates:

6.8.6.4.1 Comprehensive Psychosocial Assessment (Non MD);

6.8.6.4.2 Psychiatric Evaluation;

6.8.6.4.3 Treatment Plan.

6.8.6.5 Assessment must be entered on the treatment plan if/when it is indicated following the completion of the initial assessment during the first 45 days of treatment. Examples include but are not limited to:

6.8.6.5.1 Request from court for assessment due to recent consumer behavior that resulted in legal involvement.

6.8.6.5.2 Consumer is being referred to another and more intensive program which requires an assessment be completed.

6.8.6.5.3 Rule out diagnosis is being monitored.

6.8.6.6 Documentation must be placed in the consumer record within 24 hours from the date of service.

6.8.7 REIMBURSEMENT

6.8.7.1 Assessment must be face to face to be billed.

6.8.7.2 Bill in 10 minute units of service.

6.8.7.3 Travel time is not reimbursable.

6.8.7.4 Telephone time is not billable.

6.8.7.5 If staff normally assigned to the emergency services program of the Community Mental Health Center provide this service when they are not on duty for emergency services the service should be billed as comprehensive psychosocial assessment (non MD). If the staff are on duty for emergency services and are providing this service they should bill for emergency service.

6.9 **STANDARD: PSYCHIATRIC EVALUATION/THERAPY**

6.9.1 DEFINITION: A face to face interaction between a physician and consumer or physician and a collateral. Contacts may include all interactions to provide clinical diagnostic, monitoring, treatment services, and prescription of pharmacotherapy. The scope of issues addressed in this service is based on consumer need.

6.9.2 MEDICAL NECESSITY CRITERIA: All consumers are eligible for Psychiatric Evaluation.

6.9.3 AUTHORIZED STAFF: Psychiatric Evaluation shall be rendered by a physician, licensed to practice medicine or osteopathy within the State of Delaware.

6.9.4 PROGRAM GUIDELINES

6.9.4.1 Each consumer should have a completed psychiatric evaluation, at a minimum, within 45 days of admission to the community mental health center or the next visit thereafter.

6.9.4.1.1 Any exceptions must be clearly documented and explained in the progress note section of the consumer record. An example may be that the consumer has been hospitalized.

6.9.4.2 Each consumer should have a completed psychiatric evaluation, at a minimum, yearly regardless of whether or not medications are being prescribed.

6.9.4.2.1 Any exceptions must be clearly documented and explained in the progress note section of the consumer record. Examples may be that the consumer refuses to authorize this service or that the consumer has been hospitalized.

6.9.4.2.2 The evaluation should take place plus or minus 30 days from the one year time limit from the last evaluation.

6.9.5 SERVICES

6.9.5.1 May include but not be limited to:

Assessment	Therapy
Mental Status	Testing
Diagnosis	Specialized Needs
Initiate Medication(s)	Monitoring
Continue Medication(s)	Treatment Planning
Need for Referral	Status in Response to Treatment

6.9.6 DOCUMENTATION

6.9.6.1 The acceptable abbreviation for this standard is Psych Eval/Ther.

6.9.6.2 Each consumer record documentation shall reflect the date the service was rendered.

6.9.6.3 Psychiatric diagnosis form is part of the treatment plan. It may be completed by any staff but must be signed by Physician by 45th day of consumer admission or next visit thereafter.

6.9.6.3.1 Evidencing data (symptoms/problems) MUST be included on each axis of the psychiatric data form.

6.9.6.4 A new Standardized Diagnosis Form must be completed whenever there is a change in diagnosis or a new treatment plan is generated.

6.9.6.5 Medication orders should be documented on a medication order form.

6.9.6.5.1 ALL medication orders need to be completely re-written each time there is a change in any one aspect of an order including but not limited to the following:

6.9.6.5.1.1 Initiation;

6.9.6.5.1.2 Discontinuance;

6.9.6.5.1.3 Type;

6.9.6.5.1.4 Strength;

6.9.6.5.1.5 Frequency;

6.9.6.5.1.6 Amount; and,

6.9.6.5.1.7 Refill.

6.9.6.5.2 If there are no medication changes over a period of three months, ALL orders need to be re-written at that time or at the next consumer visit to the physician if the visit does not coincide with the three month time frame.

6.9.6.6 Written documentation in a format approved by the Division must be provided for each face to face contact.

6.9.6.6.1 Information included should be relevant to topic of that visit. Examples include:

6.9.6.6.1.1 Initial visit to psychiatrist: Documentation shall include but not be limited to review of

history, mental status exam, observations, impression, diagnosis, and plan.

6.9.6.6.1.1.1 Documentation shall be on a Division approved Psychiatric Evaluation form.

6.9.6.6.1.2 Follow up visit to psychiatrist: Documentation shall include but not be limited to consumer report of progress, content of session, psychiatrists' opinion of consumer status, affirmation of diagnosis, and continuation of plan as it relates to the treatment plan.

6.9.6.6.1.2.1 Documentation shall be in a Division approved progress note format.

6.9.6.7 Psychiatrist shall provide at least yearly reviews for consumers.

6.9.6.7.1 Documentation shall be on a Division approved Psychiatric Evaluation form.

6.9.6.7.2 Yearly documentation should include but not be limited to:

6.9.6.7.2.1 Review of consumer progress that year;

6.9.6.7.2.2 Changes noted;

6.9.6.7.2.3 Mental status exam;

6.9.6.7.2.4 Observation;

6.9.6.7.2.5 Impression;

- 6.9.6.7.2.6 Diagnosis; and
- 6.9.6.7.2.7 Plan.
- 6.9.6.8 Psychiatrist shall provide documentation with an opinion of consumer progress each time there is a face to face visit.
- 6.9.6.9 Each medication prescribed must have an informed consent presented initially and annually. It shall contain information about:
 - 6.9.6.9.1 The medication;
 - 6.9.6.9.2 Potential side effects;
 - 6.9.6.9.3 Purpose;
 - 6.9.6.9.4 Potential long term effects and;
 - 6.9.6.9.5 Precautions.
 - 6.9.6.9.6 If a consumer is unable or unwilling to sign the circumstances should be documented directly on the informed consent and a minimum of every six months in the progress notes.
- 6.9.6.10 The physician rendering this service shall sign the documentation in the consumer record with his/her first initial, last name and credentials.
- 6.9.6.11 Documentation must be placed in the consumer record within 24 hours from the date of service.

6.9.7 REIMBURSEMENT

- 6.9.7.1 Bill in 10 minute units of service.
- 6.9.7.2 Face to face contacts with collaterals are billable under Psychiatric Evaluation when the contact pertains to consumer treatment issues and appropriate releases have been obtained. Examples include but are not limited to:

6.9.7.2.1 Psychiatrist sees a consumer's parents to gather or verify information regarding consumer behavior.

6.9.7.2.2 Psychiatrist sees consumer's friend to explain and/or reinforce conflict resolution particular to consumer's treatment plan.

6.9.7.2.3 Sister of consumer requests visit with psychiatrist to describe consumer's increased isolation, refusal of medication, increased response to internal stimuli and other signs and symptoms of decompensation.

6.9.7.3 Travel time is not reimbursable.

6.9.7.4 Telephone time is not reimbursable.

6.10 **STANDARD: EMERGENCY SERVICES**

6.10.1 DEFINITION: Emergency services are short term interactions provided to consumers experiencing an increase in personal distress which threatens to cause the admission of the consumer to a hospital, detoxification, or other crisis facility. They are provided when a consumer suffers an acute episode despite having received other clinic services or when a consumer initially enters the community mental health system due to a crisis in their life. Emergency services are available on a 24 hour per day, 7 day per week basis on site or mobile in the community and by telephone.

6.10.2 MEDICAL NECESSITY CRITERIA: This service is available to all consumers. A physician does not have to see a consumer prior to the delivery of this service.

6.10.3 AUTHORIZED STAFF: Emergency services may be provided by a physician, clinician or associate clinician.

- 6.10.3.1 Emergency services may ONLY be provided by mental health professionals on duty in the emergency services department at the time of service delivery.
- 6.10.3.2 A psychiatrist shall be available to emergency services staff at all times.
- 6.10.4 PROGRAM GUIDELINES
 - 6.10.4.1 After an initial contact it is permissible to provide up to three additional face to face emergency services aimed at resolving the immediate crisis if clinically indicated.
 - 6.10.4.1.1 The additional contacts should be provided within a 72 hour time frame of the initial contact.
 - 6.10.4.2 Repeated, frequent, and/or cyclical use of emergency services by an individual consumer should trigger a review of the consumer's treatment plan.
 - 6.10.4.3 All referrals shall be based on utilization of the least restrictive, clinically appropriate, and available alternative.
 - 6.10.4.4 It is not necessary to include emergency services in the treatment plan.
- 6.10.5 SERVICES: May include but not be limited to:
 - 6.10.5.1 Evaluation and Assessment
 - 6.10.5.2 Counseling and Psychotherapy
 - 6.10.5.3 Medical Treatment
 - 6.10.5.4 Resource Coordination
 - 6.10.5.5 Conflict Resolution
 - 6.10.5.6 Crisis Intervention

6.10.6 DOCUMENTATION

6.10.6.1 The acceptable abbreviation for this standard is Em Serv.

6.10.6.2 Each face to face and telephone contact shall be documented on a Division approved emergency services contact form.

6.10.6.3 Documentation shall include but not be limited to:

6.10.6.3.1 Date of service;

6.10.6.3.2 Name and staff title of individual providing the service;

6.10.6.3.3 Setting where services were rendered;

6.10.6.3.4 Time services rendered;

6.10.6.3.5 Amount of time to render service;

6.10.6.3.6 Complete description of services rendered;

6.10.6.3.7 Effect of services on consumer condition;

6.10.6.3.8 Events or circumstances leading to consumer need for emergency services;

6.10.6.3.9 Discharge/follow-up.

6.10.6.4 Emergency contact sheet shall be placed in consumer record in chronological order in the progress note section within 24 hours of actual service delivery.

6.10.7 REIMBURSEMENT

6.10.7.1 Emergency contacts must be performed by Emergency Services On Duty personnel in order to be billable.

6.10.7.2 Emergency services employees may bill for only one eligible consumer at any given time.

6.10.7.2.1 There is no provision for group emergency services or group crisis intervention.

6.10.7.3 Telephone contacts are not billable.

6.10.7.4 Face to face work with collaterals to resolve the emergency is billable.

6.10.7.5 Travel time is not reimbursable.

6.10.7.6 Bill for 10 minute units of service.

6.11 **STANDARD: MEDICATION INJECTION**

6.11.1 DEFINITION: A face to face interaction during which the prescribed medication as ordered by a physician and outlined in the treatment plan is administered, or in the case of an emergency, when the medication may not be included in the treatment plan. Medications are provided in order to restore, maintain and/or improve the consumer's role performance or mental status.

6.11.2 MEDICAL NECESSITY CRITERIA: All consumers are eligible for this service if physicians who, within the scope of their medical practice, believe the consumer would benefit from it.

6.11.3 AUTHORIZED STAFF: Medication injection may be provided by a physician or registered nurse.

6.11.4 PROGRAM GUIDELINES

6.11.4.1 There must be a current physician order in the consumer's record.

6.11.4.1.1 The exception to this is in case of an emergency when medical staff should follow the procedures as outlined in their individual programs.

- 6.11.4.2 When the service is rendered by a nurse, a physician must be available in case of an emergency.
- 6.11.4.3 The physician shall authorize medication injection.
- 6.11.4.4 Physician shall confirm the review of a consumer's treatment and record by a signature and date on the treatment plan. This signature is required to confirm the diagnosis, medical necessity of treatment, and appropriateness of care.

6.11.5 DOCUMENTATION

- 6.11.5.1 The acceptable abbreviation for this standard is IM.
- 6.11.5.2 Medication injection shall be included in the treatment plan for consumers whom the physician believes would benefit from this service.
- 6.11.5.3 Division approved medication order forms shall be used.
- 6.11.5.4 When the injection is given the specific service rendered shall be listed in the consumer record providing date and actual time the injection was given.
- 6.11.5.5 The Physician or Registered Nurse shall sign his/her first initial, last name and credentials, in the consumer record when documenting each injection.
- 6.11.5.6 The documentation shall address the following items in order to provide a pertinent clinical description, assure the service conforms to the service description, and authenticate the charges:

6.11.5.6.1 Medication Administered;

6.11.5.6.2 Dosage given (quantity; strength);

6.11.5.6.3 Route (I.M., I.D., I.V.);

6.11.5.6.4 Injection Site;

6.11.5.6.5 Side effects or adverse reactions noted.

6.11.5.7 Documentation must be placed in the consumer record within 24 hours from the date of service.

6.11.6 REIMBURSEMENT

6.11.6.1 Bill in 10 minute units of service.

6.11.6.2 Bill only for actual administration of the injection.

6.11.6.2.1 The medication will be billed for separately.

6.12 **STANDARD: MEDICATION CHECK/MEDICAL MONITORING**

6.12.1 DEFINITION: A face to face interaction between a consumer and medical personnel to monitor effects of medications prescribed; discuss new or ongoing physical problems; provide education regarding medication, nutrition, exercise or other medically related topics when the activities are described as an integral part of the treatment regimen in the treatment plan.

6.12.2 MEDICAL NECESSITY CRITERIA: All consumers are eligible for this service if physicians who, within the scope of their medical practice, believe the consumer would benefit from it.

6.12.3 AUTHORIZED STAFF: Medication Check/medical monitoring may be provided by a physician or registered nurse.

6.12.4 PROGRAM GUIDELINES

6.12.4.1 Only the above authorized staff are eligible to provide this service and bill for it.

6.12.4.2 Other non-medical staff may document information reported to them by a consumer in regards to their medication/medical condition in the context of providing other services.

6.12.4.2.1 These staff are not eligible to bill for a medication check.

6.12.4.3 Telephone contacts to determine medication effect or consumer medical condition are not billable services. They should, however, be documented in the consumer record.

6.12.4.4 Medication dispensing should be billed for under this standard.

6.12.4.5 A consumer does not have to be receiving medications to receive this service.

6.12.4.6 Vital signs, monitoring weight fluctuations, and other medically related services are considered to be billable under this standard.

6.12.4.7 A physician must be available in case of an emergency.

6.12.4.8 Medication Check/Medical Monitoring shall be furnished under the supervision of a physician. The physician shall authorize medication check/medical monitoring. Physician shall confirm the review of a consumer's treatment and record by a signature and date on the treatment plan. This signature is required to confirm the diagnosis, medical necessity of treatment and appropriateness of care.

6.12.5 SERVICES: May include but not be limited to:

6.12.5.1 Administration of medications other than injectable;

6.12.5.2 Assessment to determine need for consumer to see the physician;

- 6.12.5.3 Determine overt physiological effects related to the medications prescribed;
- 6.12.5.4 Determine psychological effects of medications prescribed;
- 6.12.5.5 Monitor compliance;
- 6.12.5.6 Vital Signs;
- 6.12.5.7 Explanation of laboratory findings or need for laboratory work to be completed;
- 6.12.5.8 Conducting or arranging for any laboratory tests that may be ordered when such services are performed face to face with consumer;
- 6.12.5.9 Medically related education; Examples include:
 - 6.12.5.9.1 Information to help the consumer be informed as to the dosage, type, benefits, actions and potential side effects of medication(s) being prescribed.
 - 6.12.5.9.2 Information to help the consumer live a healthy life such as use of tobacco products, alcohol, illegal substances, nutrition.
- 6.12.6 DOCUMENTATION
 - 6.12.6.1 The acceptable abbreviation for this standard is Med Ck.
 - 6.12.6.2 Medication check/medical monitoring shall be included in the treatment plan for consumers whom the physician believes would benefit from the service.
 - 6.12.6.3 A separate entry in the consumer record shall correspond to each service delivery of medication check/medical monitoring.

6.12.6.4 Documentation shall address the following items:

6.12.6.4.1 Current medications consumer is taking (if applicable).

6.12.6.4.2 Side effects or adverse reactions the consumer is experiencing or has experienced.

6.12.6.4.3 Refusal of consumer to comply with medication administration as ordered.

6.12.6.4.4 Effect medications are having, or not having, on symptom control.

6.12.6.4.5 Staff assessment of consumer progress.

6.12.6.5 The staff person rendering this service shall sign the documentation in the consumer record with his/her first initial, last name and credentials.

6.12.6.6 Each consumer record documentation shall reflect the date the service was rendered.

6.12.6.7 Results of any tests, vital signs, or weight taken must be recorded in the consumer record with corresponding date of service, explanation of service, and signature of staff providing service.

6.12.6.8 Documentation must be placed in the consumer record within 24 hours from the date of service.

6.12.7 REIMBURSEMENT

6.12.7.1 Bill in 10 minute units of service.

6.12.7.2 Telephone contacts are not billable but should be documented in the consumer record.

6.13 **STANDARD: COUNSELING AND PSYCHOTHERAPY**

6.13.1 DEFINITION: Counseling and psychotherapy is performed in face to face interaction with the consumer and/or collateral to listen to, interpret and respond to the consumer's expressions of physical, emotional, and/or cognitive functioning. Treatment focus is on the prevention of deterioration, remediation, development, and/or rehabilitation of the consumer's functional abilities within society. The scope of issues addressed within this service is based on consumer need as is the therapy modality utilized. The orientation of this service may be supportive, palliative, or therapeutic.

6.13.2 MEDICAL NECESSITY CRITERIA: All consumers are eligible for counseling and psychotherapy if a physician, within the scope of his/her medical practice, believes the consumer would benefit from participation.

6.13.3 AUTHORIZED STAFF: Counseling and psychotherapy may be provided by a Clinician or Associate Clinician.

6.13.3.1 Exclusions to this service are physicians who may, in fact, provide this type of treatment but who will bill under psychiatric evaluation/therapy when applicable.

6.13.3.2 Psychotherapy may be provided by staff who are credentialed in specific modalities or learning and practicing under the supervision of one who is credentialed.

6.13.3.3 Staff not listed as authorized staff may also provide this service in certain circumstances but the service may not be billed.

6.13.3.3.1 If services are delivered by staff not listed the service should be documented in the consumer record according to the standard documentation guidelines.

6.13.4 PROGRAM GUIDELINES

6.13.4.1 Services are provided within the context of the goals of the consumer's treatment plan.

6.13.4.2 Counseling and Psychotherapy shall be furnished under the supervision of a physician. The physician shall authorize counseling and psychotherapy. A physician shall sign and date the treatment plan and thereby confirm the diagnosis, medical necessity of treatment, and appropriateness of treatment.

6.13.4.3 The purpose of counseling and psychotherapy is to help the consumer achieve and maintain psychiatric stability.

6.13.4.4 Its broader purpose is to help consumers improve their physical and emotional health and to cope with or gain control over the symptoms of their illness and effects of their disabilities.

6.13.4.5 Restoration of role functioning in the natural environment is the primary emphasis of all treatment related to counseling and psychotherapy.

6.13.5 SERVICES: Counseling and Psychotherapy may include but is not limited to the following:

6.13.5.1 Counseling

6.13.5.2 Psychotherapy

6.13.5.2.1 There are several highly specific modalities of psychotherapy, each based on an empirically valid body of knowledge about human behavior.

6.13.5.2.1.1 Provision of each requires specific training and/or credentials.

6.13.5.2.2 Although the nature of the consumer's needs and the specific modality of therapy determines its duration, psychotherapy has circumscribed goals, a definite schedule and a finite duration.

6.13.5.2.2.1 Examples include but are not limited to:
Psychodynamic therapy;
Psychoeducational
Family therapy;
Cognitive therapy.

therapy;

6.13.5.3 Face to face counseling and psychotherapy sessions may be conducted to:

6.13.5.3.1 Assess the consumer's behavior;

6.13.5.3.2 Modify treatment goal(s);

6.13.5.3.3 Increase self esteem/self worth;

6.13.5.3.4 Decrease anxieties;

6.13.5.3.5 Decrease depression;

6.13.5.3.6 Develop appropriate behavior;

6.13.5.3.7 Develop interactional skills;

6.13.5.3.8 Allow/encourage consumer to verbalize;

6.13.5.3.9 Promote consumer awareness of goals.

6.13.6 DOCUMENTATION

- 6.13.6.1 The acceptable abbreviation for this standard is Coun/Ther.
- 6.13.6.2 Counseling and psychotherapy shall be included in the treatment plan for consumers whom a physician believes would benefit from this individual service.
- 6.13.6.3 Each face to face interaction shall result in a progress note entry referring to the treatment plan goal(s) which the interaction addresses.
- 6.13.6.4 The progress note shall outline the content of the session, consumer involvement in the session and the involvement of the staff in provision of service.
- 6.13.6.5 The staff person rendering this service shall sign the documentation in the consumer record with his/her first initial, last name and credentials.
- 6.13.6.6 Each consumer record documentation shall reflect the date the service was rendered.
- 6.13.6.7 Staff are expected to provide documentation pertaining to each service delivery that includes their assessment of consumer progress.
- 6.13.6.8 Each entry shall include a plan for description of continuation of treatment.
- 6.13.6.9 Documentation must be placed in the consumer record within 24 hours from the date of service.

6.13.7 REIMBURSEMENT

- 6.13.7.1 Counseling and Psychotherapy must be face to face in order to be billed.
- 6.13.7.2 Bill in 10 minute units of service.

- 6.13.7.3 Face to face contacts with collaterals are billable under Counseling and Psychotherapy when the contact pertains to consumer treatment issues and appropriate releases have been obtained.
- 6.13.7.4 Telephone contacts are not billable.
- 6.13.7.5 Emergency service staff on duty in emergency service may not bill for this service. They should use the emergency service standard. If, however, an employee normally assigned to emergency service is providing counseling and psychotherapy within the context of another clinic program (not emergency services) they are eligible (if they meet authorized staff requirements) to both provide the service and bill accordingly.

6.14 **STANDARD: GROUP COUNSELING/THERAPY**

- 6.14.1 **DEFINITION:** Group Counseling/Therapy are face to face interactions with more than one consumer at the same time to provide mutual deliberations, support, response and/or interpretation of consumer issues. Group counseling/therapy is provided under the immediate guidance of authorized staff and is directed toward the restoration, enhancement, or prevention of deterioration of individual consumer functioning. Commonality of consumer issues provides a basis for authorized staff to establish group treatment.
- 6.14.2 **MEDICAL NECESSITY CRITERIA:** All consumers are eligible for group counseling/therapy if a physician, within the scope of his/her medical practice, believes the consumer would benefit from participation.
- 6.14.3 **AUTHORIZED STAFF:** Group counseling/therapy may be provided by a physician, clinician, or associate clinician.

6.14.4 PROGRAM GUIDELINES

6.14.4.1 Services are provided within the context of the goals of the consumer's treatment plan.

6.14.4.2 Group counseling/therapy shall be furnished under the supervision of a physician. The physician shall authorize group counseling/therapy. A physician shall sign and date the treatment plan and thereby confirm the diagnosis, medical necessity of treatment, and appropriateness of treatment.

6.14.5 DOCUMENTATION

6.14.5.1 The acceptable abbreviation for this standard is Group.

6.14.5.2 Group counseling/therapy shall be included in the treatment plan for consumers whom a physician believes would benefit from this service.

6.14.5.3 Each group service rendered shall be documented in an individual progress note in the consumer record which shall include the following:

6.14.5.3.1 Outline the content of the group session;

6.14.5.3.2 Consumer's involvement in the group;

6.14.5.3.3 Involvement of the staff in the provision of the group; and

6.14.5.3.4 Consumer's status in relation to treatment.

6.14.5.4 The staff person(s) rendering this service shall sign the documentation in the consumer record with his/her first initial, last name and credentials.

6.14.5.5 Each consumer record documentation shall reflect the date the service was rendered.

6.14.5.6 The progress note must be placed in the consumer record within 24 hours from the date of service.

6.14.6 REIMBURSEMENT

6.14.6.1 Group counseling/therapy must be face to face in order to be billed.

6.14.6.2 Bill for 10 minute units of service.

6.14.6.3 Interventions with collaterals are not included in this billable service.

6.14.6.4 Telephone contacts are not billable.

7 **ORGANIZATIONAL STANDARDS**

7.1 The Community Mental Health program shall be managed by a Director and other supervisory staff who will elicit consumer and family participation in the process of setting and evaluating the values, mission, goals, objectives and service strategies of the program and to assist the program in representing its interest to the community in which it operates.

7.2 The facility(ies) within which the community mental health center programs operate shall meet the following criteria:

7.2.1 They shall meet all applicable fire and life safety codes;

7.2.2 They shall have the appearance of a high quality therapeutic environment;

7.2.3 They shall be accessible to the consumer's served;

7.2.4 They shall provide a smoke free environment for non-smokers.

ADMINISTRATIVE STANDARDS**8.1 Consumer Records**

- 8.1.1 There shall be a treatment record for each consumer that includes sufficient documentation of assessments, treatment plans and treatment to justify Medicaid participation and to permit a clinician not familiar with the consumer to evaluate the course of treatment.
- 8.1.2 There shall be a designated consumer record manager who shall be responsible for the maintenance and security of consumer records.
- 8.1.3 The record keeping format and system for purging shall provide for consistency, facilitate information retrieval and shall be approved by the Division.
- 8.1.3.1 The format and system shall be available in up to date written policies and procedures.
- 8.1.4 Consumer treatment records shall be kept confidential and safeguarded in a manner identical to the requirements of Section 5161 of Title 16 of the Delaware Code governing the rights of mental health inpatients. The consumer record shall contain, at a minimum, the following:
- 8.1.4.1 An up-to-date face sheet;
- 8.1.4.2 Consumer consent to treatment and consent to any occasion of release of treatment information;
- 8.1.4.3 Results of all assessment information, examinations, and tests.
- 8.1.4.3.1 Assessments shall be completed on forms approved by the Division;
- 8.1.4.4 Reports from referral sources and clinical consults;

- 8.1.4.5 Hospital discharge summaries;
- 8.1.4.6 A treatment plan in a format approved by the Division.
 - 8.1.4.6.1 All mental health services covered by Medicaid, with the exception of emergency services and initial and yearly assessments involving specific and signed forms, must be provided in accordance with a comprehensive treatment plan.
 - 8.1.4.6.2 The treatment plan must document the medical necessity of the services prescribed as evidenced by the presence of the following:
 - 8.1.4.6.2.1 Symptoms (problems);
 - 8.1.4.6.2.2 Diagnosis (using DSM III-R criteria, all axis);
 - 8.1.4.6.2.3 MD signature
 - 8.1.4.6.3 The DSM III-R diagnosis or current DSAMH approved diagnostic procedure and symptoms (problems) must be present on the treatment plan and must be the basis from which the plan is developed.
 - 8.1.4.6.4 There should be a clear connection between the services or treatment provided and the symptoms of the consumer as described in the treatment plan and the diagnosis.
 - 8.1.4.6.5 Medicaid regards a treatment plan as a prescription for services which the consumer then has filled by the staff of the center.
 - 8.1.4.6.5.1 Unsigned plans, or plans signed by an inappropriate individual, are invalid and any services provided to consumers based on them

are not reimbursable by Medicaid.

8.1.4.6.6 In addition, the treatment plan should adhere to the following:

- 8.1.4.6.6.1 Individual;
- 8.1.4.6.6.2 Written;
- 8.1.4.6.6.3 Comprehensive;
- 8.1.4.6.6.4 Based on assessment of consumer;
- 8.1.4.6.6.5 Be completed within 45 days of admission or next visit thereafter;
- 8.1.4.6.6.6 Identify strengths and limitations;
- 8.1.4.6.6.7 Specify services necessary to meet the consumer's needs;
- 8.1.4.6.6.8 Contain goals for the consumer to address emotional and/or physical health as well as growth and adaptive capabilities.
 - 8.1.4.6.6.8.1 Goals should be based on periodic assessment of the consumer.
 - 8.1.4.6.6.8.2 It is acceptable to group like needs identified in an assessment and develop a single goal to describe the group rather than have too many individual goals.
- 8.1.4.6.6.9 Objectives for treatment that relate to the goals.

Objectives should be described in terms of being:

- 8.1.4.6.6.9.1 Specific;
- 8.1.4.6.6.9.2 Measurable;
- 8.1.4.6.6.9.3 Time limited;
- 8.1.4.6.6.9.4 Observable changes in behavior, skills and/or circumstances;
- 8.1.4.6.6.9.5 Attainable.
- 8.1.4.6.6.10 Expected length of treatment or achievement dates;
- 8.1.4.6.6.11 Frequency and duration of service;
- 8.1.4.6.6.12 Criteria for termination;
- 8.1.4.6.6.13 Consumer participation;
- 8.1.4.6.6.14 Names of staff responsible for individual services;
- 8.1.4.6.6.15 Referrals for needed services;
- 8.1.4.6.6.16 Signatures and credentials of all responsible staff involved in treatment plan service delivery;
- 8.1.4.6.6.17 Dates of signatures, additions, deletions;
- 8.1.4.6.6.18 Must be reviewed at major decision points in the consumer's course of treatment. These decision points include

but are not limited to the following:

- 8.1.4.6.6.18.1 Time of admission;
 - 8.1.4.6.6.18.2 Change in diagnosis;
 - 8.1.4.6.6.18.3 Transfer between programs;
 - 8.1.4.6.6.18.4 Discharge;
 - 8.1.4.6.6.18.5 Major changes in consumer's life situation/condition;
 - 8.1.4.6.6.18.6 At least every six months;
 - 8.1.4.6.6.18.7 Frequent use or patterns of use of emergency services;
- 8.1.4.6.7 Changes in a current treatment plan can be made by adding and deleting those changes on the same treatment plan form with a corresponding progress note explaining.
- 8.1.4.6.8 The first review at the expiration of a treatment plan may be an update on the same existing treatment plan form.
- 8.1.4.6.8.1 It requires all new signatures and dates indicating agreement to prescription of services.
- 8.1.4.6.9 A new treatment plan must be developed annually.
- 8.1.4.6.10 If there are discrepancies between interventions prescribed and those actually delivered there must be documentation describing why it has occurred and what steps are

being taken to rectify the situation.

8.1.4.6.10.1 Failure to document deviations from written prescriptions could result in audit exceptions.

8.1.4.7 Documentation for each service provided shall include:

8.1.4.7.1 Date of service provision;

8.1.4.7.2 Signature and credentials of individual making entry;

8.1.4.7.3 Summary of the intervention(s) and their relationship to the treatment plan documented in a clinical format; and

8.1.4.7.4 Consumer's condition and response to the intervention(s).

8.1.4.7.5 BE CLEARLY LEGIBLE.

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8.1.4.8 The consumer record should be organized a way conducive to a clear understanding of the consumer's current status and treatment, as well as history.

8.1.4.9 Progress note format should be uniform throughout the program in a manner approved by the Division.

8.1.4.10 Progress notes should be entered into the consumer record within 24 hours of the provision of service.

8.1.4.11 Documentation shall be on forms prescribed by the Division.

8.1.4.12 Medication records (on forms prescribed or approved by the Division) shall allow for ongoing monitoring of all medication administered and the detection of adverse drug reactions.

8.1.4.12.1 All medication orders and records in the consumer case record shall specify the following:

8.1.4.12.1.1 Name of the medication;

8.1.4.12.1.2 Dose;

8.1.4.12.1.3 Route of administration;

8.1.4.12.1.4 Injection site (when applicable);

8.1.4.12.1.5 Frequency of administration;

8.1.4.12.1.6 Side effects or adverse reactions noted (when applicable);

8.1.4.12.1.7 Signature and credentials of the person prescribing and/or administering;

8.1.4.13 Discharge documentation shall be in a format prescribed or approved by the Division to include the following:

8.1.4.13.1 Be completed and entered into the consumer record no later than 90 days from last face to face visit.

8.1.4.13.1.1 Any exceptions must be documented in a progress note and co-signed by a supervisor.

8.1.4.13.2 A description of the reasons for discharge indicating whether the discharge was planned, unplanned, and circumstance;

8.1.4.13.3 Overall observations about consumer initially, during treatment, at discharge;

- 8.1.4.13.4 The consumer's status and condition at discharge;
- 8.1.4.13.5 Assessment of attainment of goals;
- 8.1.4.13.6 Final diagnosis;
- 8.1.4.13.7 A plan developed with the consumer regarding the consumer's continuing or future service needs where applicable;
- 8.1.4.13.8 Clear documentation of referral to other programs or agencies (when applicable) including, whenever possible:
 - 8.1.4.13.8.1 Date of referral;
 - 8.1.4.13.8.2 Telephone number;
 - 8.1.4.13.8.3 Address and contact person at referral; as well as
 - 8.1.4.13.8.4 Date of first scheduled appointment.
- 8.1.4.18 Documentation that the consumer has been informed of client rights, including the right to contest treatment decisions and or practices or otherwise express grievances regarding program activities.
 - 8.1.4.18.1 Consumers shall be provided with information regarding the process by which grievances can be addressed.
 - 8.1.4.18.2 A record of all grievances filed with the program by a consumer shall be included in the program's records, together with a statement of disposition or resolution.

8.2 Procedure Manual

- 8.2.1 The Community Mental Health programs shall maintain a written procedure manual for its staff. A mechanism shall be in place to ensure that the procedure manual is updated continuously and that the staff of the program are notified promptly of changes. The manual shall include:
- 8.2.1.1 A statement of the program's values, mission and objectives;
 - 8.2.1.2 Referral policies and procedures that facilitate consumer referral;
 - 8.2.1.3 Detailed instructions for assessment, treatment planning and documentation procedures;
 - 8.2.1.4 Policies and procedures for medication management which shall include, but not be limited to:
 - 8.2.1.4.1 Prescribing;
 - 8.2.1.4.2 Storage;
 - 8.2.1.4.3 Handling;
 - 8.2.1.4.4 Distribution;
 - 8.2.1.4.5 Dispensing;
 - 8.2.1.4.6 Disposing; and
 - 8.2.1.4.7 Recording of medication and it's use by consumers.
 - 8.2.1.4.8 Such policies and procedures shall conform to all applicable rules, regulations and requirements of the (Delaware) Board of Nursing and, as applicable, the (Delaware) State Board of Pharmacy.
 - 8.2.1.4.9 The medication policy and procedure shall be reviewed and approved by

the program physician and registered nurse(s).

- 8.2.1.5 Policies and procedures for handling on-call responsibilities and consumer emergencies;
- 8.2.1.6 Detailed instructions for application to and communication with entitlement authorities;
- 8.2.1.7 Policies and procedures for sharing of information about consumers with family members or others;
 - 8.2.1.7.1 Policy and procedure regarding confidentiality should include a signed statement by all personnel regarding their understanding and agreement to abide by the policy.
- 8.2.1.8 Policies and procedures for the receipt, consideration and resolution of consumer complaints and/or grievances regarding treatment decisions and practices or other program activities.
- 8.2.1.9 Policies and procedures regarding the management of consumer's funds for whom the program has been designated payee;
- 8.2.1.10 Policies and procedures for student placements and supervision within the community mental health program.
- 8.2.1.11 Admission and discharge criteria.
- 8.2.1.12 Policies and procedures regarding duty to warn.
- 8.2.1.13 Policies and procedures for acceptable handling of cases involving communicable disease.
- 8.2.1.14 Policies and procedures for response to staff who are exposed to potential communicable disease while working in the mental health program.

8.2.1.15 Policies and procedures regarding documentation including clinical; financial; and personnel.

8.2.1.16 Other policies and procedures as may be promulgated or required by the Division and/or DSS.

8.3 **Financial Management**

8.3.1 There shall be written policies and procedures regarding committing and handling financial resources of the program.

8.3.2 The accounting system of the community mental health program shall be in accordance with generally accepted accounting practices.

8.3.3 The Community Mental Health program shall submit an independent annual audit and management letter prepared by a certified public accountant to the Division within 90 days of the end of the budget period.

8.3.4 The program's budget shall be in a format prescribed by the Division and approved by the Division. Funding shifts within the budget shall be made in accordance with the financial policies of the Division.

8.3.5 Procurement of equipment and services for the program shall be made in compliance with the Code of Federal Regulations.

8.3.6 For Medicaid consumers, the fee paid by DSS, Delaware Medical Assistance Program will constitute full payment for services rendered.

8.3.6.1 The community mental health program will bill for services rendered to non-Medicaid consumers according to the Medicaid approved rate.

8.3.6.2 In addition, the program will seek third party reimbursement and will establish a

sliding fee scale for non-Medicaid consumers.

- 8.3.6.3 The program's charges, sliding fee scale, collections policies and procedures and write-off policies and procedures shall be subject to approval by the Division.
- 8.3.6.4 Non-Medicaid billings and revenue collected shall be reported to the Division.
- 8.3.7 Fee for service reimbursement rates paid by Delaware Medical Assistance Program are based on the program's approved budget and actual costs; and are subject to approval by the rate setting committee as appointed by DSS; and
 - 8.3.7.1 Are subject to periodic monitoring and adjustment.
- 8.3.8 The Community Mental Health program shall maintain insurance policies for property and liability in accordance with Division guidelines.
- 8.3.9 The Community Mental Health program shall operate in accordance with a Financial Management Procedure Manual which shall address the following:
 - 8.3.9.1 Processing of funds: i.e.,
 - 8.3.9.1.1 Procedures for receiving, recording and depositing incoming funds; and
 - 8.3.9.1.2 Procedures for disbursement of funds;
 - 8.3.9.2 Purchasing: i.e.,
 - 8.3.9.2.1 Establishment and use of agency charge accounts;
 - 8.3.9.2.2 Transactions requiring prior approval; and
 - 8.3.9.2.3 Procedure for acquisition of goods and services requiring bids;

- 8.3.9.3 Payroll: i.e.,
 - 8.3.9.3.1 Preparation process;
 - 8.3.9.3.2 Pay periods;
 - 8.3.9.3.3 Maintenance and approval of time sheets;
 - 8.3.9.3.4 Payroll register;
 - 8.3.9.3.5 Employee earnings;
 - 8.3.9.3.6 Payment of payroll taxes;
 - 8.3.9.3.7 Signatures required on payroll checks; and
 - 8.3.9.3.8 Maintenance of payroll records;
- 8.3.9.4 Petty Cash: i.e.,
 - 8.3.9.4.1 Allowable uses;
 - 8.3.9.4.2 Authorization;
 - 8.3.9.4.3 Maximum balance;
 - 8.3.9.4.4 Limits on transactions;
 - 8.3.9.4.5 Documentation and reconciliation and replenishment of petty cash;
- 8.3.9.5 Internal Controls:
 - 8.3.9.5.1 Accurate and complete books of account;
 - 8.3.9.5.2 Separation of functional responsibilities;
 - 8.3.9.5.3 Financial reports;
 - 8.3.9.5.4 Proper documentation;
 - 8.3.9.5.5 Annual audit; and
 - 8.3.9.5.6 Bonding for employees handling financial transactions.

8.4 Personnel Management

8.4.1 The Community Mental Health program shall maintain an up-to-date Personnel Policies and Procedures Manual and make it readily available for reference by the program staff. State operated programs shall comply with Merit Rules and Labor Contracts. The Manual will include:

8.4.1.1 Policies and procedures regarding equal employment opportunity and affirmative action to include compliance with:

8.4.1.1.1 The Americans with Disabilities Act and the Vocational Rehabilitation Act of 1973, Sections 503 and 504 prohibiting discrimination against the handicapped;

8.4.1.1.2 Title VII of the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color, creed, sex or national origin;

8.4.1.1.3 Age discrimination Act of 1975 prohibiting discrimination based on age;

8.4.1.1.4 Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974 prohibiting discrimination against disabled Vietnam Era veterans.

8.4.1.2 Policies and procedures for interviews and selection of candidates including verification of credentials and references;

8.4.1.3 Policies and procedures for employee performance appraisal;

8.4.1.4 A code of ethics;

8.4.1.5 Conditions and procedures for termination of employment;

8.4.1.6 Conditions and procedures for grievances and appeals;

- 8.4.1.7 A staff development plan;
- 8.4.1.8 Maintenance and access to personnel files which shall contain employees' applications, credentials, job descriptions, and performance appraisals, job titles, training, orientation, salary, staff statement of confidentiality.
- 8.4.1.9 Work hours including hours of program operation, shifts and overtime compensation.
- 8.4.1.10 Agency policies regarding compensation including:
 - 8.4.1.10.1 salary ranges, salary increases, and payroll procedures;
 - 8.4.1.10.2 Use of personal automobile for program activities;
 - 8.4.1.10.3 Reimbursement for work related expenses;
 - 8.4.1.10.4 Description of employee benefits.

8.5 **Staff Development Plan**

- 8.5.1 The staff development plan shall include provisions for orientation of paid staff, student interns and volunteers and for continuing education.
- 8.5.2 Orientation shall include the following:
 - 8.5.2.1 Review of these procedures;
 - 8.5.2.2 Review of the program's procedure and personnel manuals;
 - 8.5.2.3 Review of DHSS Policy Memorandum #46;
 - 8.5.2.4 Review of section 5161 of Title 16 of the Delaware Code regarding safeguarding confidentiality;

8.5.3 Staff Development shall include the following:

8.5.3.1 An annual plan for continuing education both through on-site training and participation in state, regional and national programs;

8.5.3.2 Provision for regularly scheduled clinical supervision by clinician level staff which teach and enhance the clinical skills of staff. In addition, the following should also be provided:

8.5.3.2.1 Regularly scheduled staff meetings led by a supervisor during which assessments, treatment plans and progress toward treatment goals are reviewed and staff receive direction regarding clinical management of treatment issues.

8.5.3.2.2 Regularly scheduled individual, face-to-face sessions between a supervisor and staff to review cases, assess performance and give feedback.

8.5.3.2.3 Individual, side-by-side sessions during which the supervisor attends clinical sessions conducted by staff to assess performance, teach clinical skills, and give feedback.

8.5.3.2.4 The frequency, duration, and specifics of all supervision should be described in the community mental health center's policy and procedure manual.

8.5.3.2.4.1 Documentation of supervision should be maintained by each supervisor. At a minimum, it should contain:

8.5.3.2.4.1.1 Date of supervision;

8.5.3.2.4.1.2 Names of staff present;

8.5.3.2.4.1.3 Issues addressed/content of session;

8.5.3.2.4.1.4 Assignments made;

8.5.3.2.4.1.5 Resolutions of any issues.

8.5.3.2.4.2 All supervision documentation must be available for review by site surveyors upon request.

8.5.3.2.5 Regular staff conferences at which current principles and methods of treatment, rehabilitation and support services are presented.

8.5.3.2.6 Provision of a method for staff to receive suggestions and/or feedback from multiple disciplines regarding cases difficult to treat and/or cases of unusual components.

8.6 Quality Assurance Program

8.6.1 The Community Mental Health program shall prepare an annual quality assurance plan which shall be subject to approval by the Division. A clinician employed by the program shall be designated quality assurance coordinator. The provider shall establish the following quality assurance mechanisms which shall be carried out in accordance with the quality assurance plan: a concurrent utilization review process; a retrospective quality assurance review process; a process for clinical care evaluation studies; and a process for self-survey for compliance with the certification procedures.

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Waiver of Provisions

10.1. The Director of DSAMH, at his/her discretion, may issue a waiver of any of the requirements of these certification procedures upon the

good-cause-shown request of a program seeking certification/recertification. Such request for a waiver must demonstrate that the waiver will not in any substantial or material manner have a deleterious effect on the essential quality of services to the consumer.

10.1.1 Waivers issued by the Director shall be in writing and shall specify the maximum duration of the waiver's effect.

10.1.1.1 Any waiver issued by the Director may be rescinded at any time at the discretion of the Director and will be rescinded if deleterious effect on the essential quality of service to the consumer is evidenced.

10.1.1.2 Extensions and/or renewals of any waiver shall be made at the Director's discretion.